Enhancing Resilience in Children affected by HIV and AIDS

Children's Views and Experiences of Resilience Enhancing Family and Community Practices

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Executive Summary

The province of KwaZulu-Natal, where this research was undertaken, is particularly hard hit by HIV and AIDS as a result of high prevalence coupled with high levels of poverty and low levels of service reach and resources in relation to other provinces in the country. In such communities, children face multiple risk factors to their healthy development due to the impact of HIV and AIDS and poverty (Foster & Williamson, 2000).

HIV and AIDS can render children vulnerable in a multitude of ways, including placing them at increased risk of experiencing negative life events, exposing them to increased poverty, losing their parent and other significant adults, dropping out of school and being excluded from other social networks and processes. What is clear at this point in the epidemic is that there are not likely to be any quick solutions. While addressing widespread poverty, and improving social protection, treatment and prevention in the longer term, it is also vital that we work to enhance children's, families' and communities' resilience in the face of such adversity.

While considerable effort has been invested in research which examines maladaptive behaviours resulting from high exposures to risk situations, it is equally valuable to explore the mechanisms by which some children come through high risk situations exhibiting adaptive behaviours. Given that children affected by HIV and AIDS face a multitude of risks, the examination of resilience offers an important opportunity to guide prevention and intervention programming aimed at improving children's lives. At this point in the epidemic, while the majority of children remain in school and families are able take in children the opportunities to better understand resilience at both a child and family level are abundant. It is also a time when child rights-based approaches convince us of the need to seek out ways to engage and empower children and families as agents of change in a world of HIV and AIDS.

The focus of this qualitative research was to explore children's experiences of family and community practices which children perceive to enhance their resilience. The study explores the extent to which local existing cultural practices and relationships offer opportunities to build children's resilience prior to, during and after loss, crisis

or adversity. The study adopts a developmental approach and examines children's experience over a range of age groups and uses methodology aimed at facilitating real life, meaning-laden data in participation with children

The report provides a framework against which to understand resilience by providing a short overview of important research evidence on risk and resilience. It describes approaches which have to been developed to understand and enhance resilience outside of the context of HIV and AIDS in order to explore possibilities of useful applications to the field of children and HIV and AIDS. The overview explores the contextualised nature of resilience in childhood, making a strong argument for the use and application of participatory research with children and the invaluable contribution it can make in understanding the needs of children and communities affected by HIV and AIDS. Thereafter the report provides a discussion of the findings of the research and the experience of children of different ages through the categories of people, places, practices and programmes. Comparisons are made between the existing evidence on resilience and the voices of the children participating in this study - and conclusions are drawn regarding the implications for both practice and research.

Recommendations are made for framing responses in the form of external support to people, places, practices and programming which could enhance and support the resilience of children, families and communities. These are summarised below.

Inventions in support of people: A stable and consistent, responsive care giver or the presence of a replacement caring adult who will champion for the child, invest in the child's future and have hope for them is one of the clearest mechanisms for enhancing resilience, both from the literature and the children's data. Two ways in which building resilience can be supported is through support and training of replacement care givers and the development of friendship and peer support networks. **Interventions in support of places:** Crime and other threats related to place are linked to poverty and disrupted social structures in communities; these require both intervention and prevention efforts. Schools are an investment in children's future and provide children with support and structure. They offer the advantage of a fixed framework within which resources can be invested and monitored in order to assist

children. The literatures as well as children's voices indicate that schools are an important source of assistance to children.

Intervention in support of practices: While the epidemic seems overwhelming, what is clear in both the literature and the children's data is that caring consistent everyday practices contribute tremendously to helping children cope and build resilience. In many respects, understanding the importance of everyday practices opens an opportunity to take small and approachable steps towards helping children. More importantly it provides a clear set of interventions ideas with which families and other community members can engage. This provides an opportunity to support and encourage community members to feel valued in the care of their own children.

Interventions in support of programmes: The sheer extent of the epidemic requires that all communities, starting from small units of care, such as families but extending to external support organisations, civil society, government and the international community need to invest in ways to bring children into a new hopeful era. These investments in community need to be integrated, use resources effectively and be thoughtful and sustainable if they are to hold value for children in the longer term and build resilience in the shorter and medium term.

This research demonstrates that children's voices are similar to and support evidence from resilience literature regarding how to support and assist children living in adversity. Conducting research together with children offers the advantage of ensuring that interventions are culturally valuable and meaningful for children and the communities in which they live.

1. Introduction

1.1. Children and HIV and AIDS

The HIV and AIDS epidemic is one of the greatest tragedies confronting humankind. Reports on the numbers of children, families and communities living with HIV and those affected by HIV and AIDS across the globe are overwhelming in their proportions (UNICEF, 2006; WHO & UNICEF, 2007). The magnitude of the epidemic confounds the imagination and children are exposed to extensive vulnerability and adversity living in a world affected by HIV and AIDS.

In Sub Saharan Africa where over 80% of all HIV and AIDS deaths occur and where over two thirds of new infections originate, HIV and AIDS is a disease of the poor and the disempowered. Unlike developed countries it is also predominantly a heterosexual disease - affecting couples, parents, and family. As a result, children are one of the most severely affected and exposed population groups (UNICEF, 2007). Characteristics normally associated with childhood are becoming an almost impossible aspiration in the face of poverty, constant change, uncertainty and loss, conflict and adversity.

South Africa, already severally impacted by colonialisation, *apartheid*, migration and political violence, is also a country where children and their families and communities are brutally affected by HIV and AIDS. The province of KwaZulu-Natal (where this study was undertaken) is particularly hard hit as a result of high prevalence coupled with high levels of poverty and low levels of service reach and resources in relation to other provinces in the country (Department of Health, 2007). In such communities children face multiple risk factors to their healthy development due to the impact of HIV and AIDS and poverty.

HIV and AIDS can render children vulnerable in a multitude of ways, including placing them at increased risk of experiencing negative life events, exposing them to

increased poverty, losing their parent and other significant adults, dropping out of school and being excluded from other social networks and processes (Richter, Foster, & Sherr, 2006). What is clear at this point in the epidemic is that there are not likely to be any quick solutions. While addressing widespread poverty, social protection and improving treatment and prevention in the longer term, it is also vital that we work to enhance children's, families' and communities' resilience in the face of such adversity.

Even prior to the death of a family member, HIV and AIDS place enormous pressure on families and the communities (Patterson, 2007). Children are forced to live with illness, uncertainty and repeated crisis, communities suffer loss of labour and leaders and struggle under increasing social and health service demands, all of which have a profound impact on the functioning of community (Fox & Parker, 2007). The landscape within which childhood takes place is explicably altered for the worse, yet despite this children and families continually adapt and respond.

While considerable effort has been invested in research which examines maladaptive behaviours resulting from high exposures to risk situations (for example, studies of depression and anxiety in children who have been exposed to death or trauma - and the possible consequences of this for a child's future), it is equally valuable to explore the mechanisms by which some children come through high risk situations exhibiting adaptive behaviours (for example, that most young children remain in school and maintain school performance despite having lost a caregiver, Skinner Cook, Fritz, & Mwonya, 2007). Given that children affected by HIV and AIDS face a multitude of risks, the examination of resilience offers an important opportunity for guiding prevention and intervention programming aimed at improving children's lives.

Increasing attention is being drawn to the primary role which families and communities have and are playing, mostly unassisted by programmes, governments and international aid, in mitigating the economic, social and psychological effects of HIV and AIDS on children and communities (Richter & Foster, 2005; Richter & Rama, 2006a; Richter et al., 2006a). At this point in the epidemic, the opportunities to better understand resilience and coping at both a child and family level are abundant. It is also a time when child rights-based approaches convince us of the need to seek

out ways to engage and empower children and families as agents of change in a world of HIV and AIDS.

1.2. Children and research

As recognition and attention of the extent and impact of the HIV and AIDS epidemic has grown so have the media, public and policy agendas associated with responses to the epidemic. In as much as the need for response has driven a need for better knowledge and a clearer understanding of the direct and indirect effects of HIV and AIDS - research on children, families and communities and the effects of HIV and AIDS has burgeoned. Various types of research attempt to to service the children's agenda in differing ways.

Some studies have focused on understanding the causes of HIV and AIDS, the biology of the disease, its pathways and patterns of development and the nature of transmission of the disease in paediatric populations (UNICEF, 2007). Such investigations tend to be biomedical in nature and focus on prevention, treatment and vertical transmission, the aim frequently is to *save* children. Other research has focused on enumerating the nature and extent of the disease (for example, through studies of incidence and prevalence) and at examining the direct impacts of HIV and AIDS (for example, morbidity and mortality) and indirect impacts of HIV and AIDS (for example changes in the movement of children through migration, population level shifts in family composition, levels of poverty and access to education). Such research focuses on the larger scale impacts of HIV and AIDS on childhoods, with the aim normally being to *describe* children (Health Systems Trust, 2006). Research has also been undertaken which aims at developing and designing interventions to improve the delivery of prevention, treatment and the health and wellbeing of children living with HIV and AIDS, the aim is often to provide models of providing *service* for children (Horizons Program, 2005; UNICEF, 2007). Lastly research has also focused on developing the understanding of the psychological, social and anthropological impact of HIV and AIDS. These efforts have been dominated by a specific focus on categories of risks (for example stigma, or death and bereavement) and identifiable risk groups (for example orphans) with the aim of *drawing attention to or diagnosing* children (Sherr, 2005).

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As the biomedical evidence on children and HIV and AIDS has grown, so has the demand for a clearer understanding of the social, psychological and behavioural explanatory variables and social context within which children live - which may impact on and mediate biomedical outcomes in large scale intervention work (Richter et al., 2005; UNICEF, 2007). It is important to note that these types of research are most commonly undertaken on behalf of children, or conducted on children or for children, but are very seldom undertaken in participation with children as active participants in the research.

In research less attention has been given to studies which examine how interventions may work in practice and how acceptable they may or may not be to children, families and communities (Patterson, 2007; Singhal, 2007). As a result calls are being made for a more in-depth and meaningful understanding of the personal, relational and contextual components of childhood as lived experience in the context of HIV and AIDS. Disillusion is developing for research approaches which drive the application of westernised approaches of change and wellness devoid of meaning within African culture.

A significant body of research has demonstrated that interventions aimed at well being and behaviour change which have meaning in personal frameworks and make practical sense in people's cultural frameworks are more likely to bring about sustainable and meaningful change (Mkhize, 2005). Likewise, research with at risk families indicates that a family's satisfaction with the support received is more important in determining a sense of competence and improving outcomes than the size of the support network or the total amount of help received (Skinner Cook et al., 2007).

1.3. Children and resilience

The focus of this qualitative research was thus to explore children's experiences of everyday and ordinary family and community practices which children perceive to enhance their resilience. The study explores the extent to which local existing cultural practices and relationships offer opportunities to build children's resilience prior to,

during and after loss, crisis or adversity. The study adopts a developmental approach and examines children's experience across middle childhood and early adolescence and uses methodology aimed at facilitating a real life, meaning laden data in participation with children.

In working with children, we recognise that they exist in context and, as such, this research adopts a socio-cultural approach. In psychology there has been a growing awareness of the dialectical interaction between individuals and their contexts. Socio-cultural theory argues that knowledge, thinking and social practices are anchored by collective practices, traditions and belief systems within institutions, cultural contexts and within particular historical timeframes (Hedegaard, 2002; Mkhize, 2005; Vygotsky, 1978). Practices are therefore be specific to context, and affected by the everyday practices and resources for thinking, behaving, and solving problems in that context (Gilbert, 1997).

In providing a framework against which to understand resilience, the report begins with an overview of some important research evidence on risk and resilience. It describes approaches which have been developed to understand and enhance resilience outside of the context of HIV and AIDS in order to explore possibilities of useful applications to the field of children and HIV and AIDS. The overview explores the contextualised nature of resilience in childhood, making a strong argument for the use and application of participatory research with children and the invaluable contribution it can make in understanding the needs of children and communities affected by HIV and AIDS.

Thereafter the report describes the methods used and provides a discussion of the findings of the research. C children's experiences are explicated through the categories of people, places, practices and programmes. Comparisons are made between the existing evidence on resilience and the voices of the children participating in this study - and conclusions are drawn regarding the implications for both practice and research.

Lastly, recommendations are made for framing responses in the form of external support for people, places, practices and programming which could enhance and support the resilience of children, families and communities.

2. Review of Research Evidence

Resilience is defined in multiple ways and has developed over time as the concept has grown in popularity and received more attention in the literature. Simply stated, resilience is positive adaptation in the face of significant threat. As such, resilience also refers to individual variations in abilities to cope positively in the face of adverse and threatening circumstances (Foster & Williamson, 2000; Grotberg, 1995; Rutter, 1990).

It is generally recognised that resilience is a process through which people, including children, are able to continue or resume a long term positive trend in growth and adaptation, despite their exposure to adversity (McCallin, 2005; Bouvier, 2005). The conceptualisation of resilience as a *process* rather than a state or trait acknowledges that resilience is a dynamic, ongoing, active capacity which children develop over the lifespan; and that it is dependent on interactions between individuals and environment, and established and maintained through relationships.

The review which follows provides a framework for understanding and approaching resilience through an exploration of risk, resilience, ecological and process contexts of resilience, and models for understanding resilience and its applications to practice. The review considers important contributions from child rights approaches and the context of HIV and AIDS in South Africa. This justifies the relevance and appropriateness of enquiry that includes children's voices and a situated understanding of family and community practices that can be strengthened in order to enhance resilience in children.

2.1. Risk

Initial research in this field broadly focused on identifying environmental factors that, either singly or in combination, were shown to render it more likely that a child would fail to thrive. The aim of this approach was to identify and then work to limit factors that render children vulnerable (Howard, Dryden, & Johnson, 1999; Rutter & Garmezy, 1983). Risk refers to endogenous (internal) or exogenous (external) variables that increase the chance of negative outcomes in development (Masten,

2001). Risk may be a combination of individual, familial, and socio-demographic factors which threaten healthy emotional, social, psychological and physical development and place the child '*at risk*' for future negative outcomes (Mangham, McGrath, Reid, & Stewart, 1996; McWhiter, McWhiter, McWhiter, & McWhiter, 2007).

Liddell suggests that risks are "multidimensional in origin, interactive in process, and cumulative in their effects" (2002, p. 97). Exposure to risk can open up the likelihood of further exposure to risks through spirals by which outcomes at one age become adverse antecedents at another stage. The impact of exposure to risk is cumulative. The greater the intensity of risk factors, the longer the exposure to risks, and the greater the number of risk factors to which a child is exposed, the greater will be an individual's likelihood of showing adverse outcomes (McWhiter et al., 2007).

Risk and protective factors are often the flip side of the same coin. Risks are at the negative end of a continuum of factors at the personal, family, school and community level. Risk factors are seldom one-dimensional or separate events; they tend to cluster together as part of a complex set of person-environmental interactions (Haggerty & Sherrod, 1994). In recognition of this, the focus in resilience research shifted to understanding the interrelatedness and clustering of risk factors. For example, poverty is associated with significant clustering, and results in disproportionate exposure to multiple risk factors such as inadequate health care and housing, family stress and the like (Garmezy & Masten, 1994).

Children are at higher risk of multiple adversities which extend over time. The death of a parent or other caregiver, for example, is not a single event but an often lengthy process of multiple stressors and changes occurring before, during, and after the death itself (Masten, 2001). Resilience allows the child to adapt and respond to the causes of risks more effectively. Many factors such as a lack of social support and concurrent stressors have been linked to poor adjustment and when these factors accumulate they tax the psychological and emotional capacity of children and their families – and hence result in an increased risk of dysfunction and negative consequences.

Steps taken to protect children from risk depend very much on how risk is understood – for example, whether risk is attributed to human agency or personality type, a world of avoidable or unavoidable dangers, or supernatural forces or fate. In addition, it also depends on whether child development is perceived as a process of natural maturation or whether it is seen as a process that occurs in direct interaction with the environment, principally facilitated by caregivers (Liddell, 2002).

Newman (2005) summarises the current state of knowledge highlighting that risk factors tend to be cumulative, that acute stressors are usually less harmful than chronic ones, and if the chain of risks is broken, that children have opportunities to resume their normal developmental course and most children can recover. Children learn to cope through managed exposure to risk and by being connected in supportive relationships during and following adverse experiences and conditions.

2.2. Resilience

Initially the idea of resilience focused on avoiding or minimising risk factors and exploring resilient personality traits. As stated earlier resilience is now recognised as a dynamic process involving the complex interplay of risk and protective factors. The individual showing resilience is not showing a static resilient trait. Rather, they demonstrate a positive outcome within a particular set of circumstances at a given time.

In a review of literature on resilience, Bernard (1991) identified three characteristics that were predictive of positive outcomes for children in risk laden environments. These were:
(i)   A meaningful relationship with at least one caring and supportive adult
(ii)   The presence of high expectations for the child's future
(iii)   The chance for meaningful participation

As an example of the application of these characteristics, Skinner Cook (2007) describes how a child who experiences loss as a result of the death of a parent or other close relatives can, by the presence of a caring adult, be buffered from the loss and be provided some protection from new risks which emerge as a result of a loss. The

caring adult may do this by ensuring that the child is provided for in terms of their daily needs, by continuing to give and to receive affection, and by offering the child a feeling of being connected to somebody who has an expectation that they will be all right, and by including the child in practices that allow them to feel connected and to know that their life continues to be meaningful. Other studies, such as Werner (1990), have demonstrated that favourite teachers and caring friends contribute substantially to the development of resilience amongst disadvantaged groups. Three characteristics of resilience in Werner's work include having a sociable personality, a supportive adult and opportunities for achievement.

Grotberg (1995) proposes that resilience should also be thought about as existing beyond the individual level, in that groups and communities may also be collectively resilient. Grotberg extends the definition of resilience to "a universal capacity which allows a person, group or community to prevent, minimise or overcome the demanding effects of adversity" (1995, p7). The evidence is growing that connection to caring adults and to places such as schools which offer support and structure as being part of the development of resilience. The concept of collective efficiency is also being researched.

Research that asks children what protects them and helps them recover, as well as the clinical literature, indicates the importance of supportive family, people whom a child can trust with their troubles, being able to take part in decisions, having good friends, doing well in school or achievement in other areas, having the personal capacity to avoid helplessness and being able to make the best out of bad circumstances are all associated with resilience (Newman, 2005).

Newman (2005) argues for the critical importance of social capital within communities in order to support the development of children across age groups. By social capital, is generally meant that the members of the community connect to one another, that there is mutual trust and help, confidence in local institutions and supportive networks. Families and communities with strong social capital have a variety of strategies that avoid or minimise multiple or chronic risk for children and thus are able to improve the protection of children.

Most experts agree that resilience develops and changes over time, is enhanced by protective factors within the individual and the environment (particularly supportive relationships) and contributes to the maintenance or enhancement of health and well being. Resilient children often exhibit flexibility, good communication skills and an ability to be reflective; they tend to have a sense of independence and mastery and a sense of a purpose and a future. However, there is some debate in the literature regarding the exact definitions of resilience and as Richter (2002) points out resilience is variously used to refer to:

(i)   An outcome, such as achievement at school
(ii)   A skill or capacity, such as getting on with people
(iii)   An ability to access support, such as a sociable personality and an available network of people
(iv)   A process of adaptive coping, such as gradually changing with or without the support of others
(v)   A set of person and environmental variables, involving both personality factors, relationships, and prior and ensuing circumstances

A difficult issue which Killian (2005) raises, is that there is also disagreement about the timing or chronology of resilience. Does resilience exist before the adversity, and this enables the child to cope; does it come into being at the time of adversity; is it developed in response to adversity; or does it begin to emerge as part of a process of recovery? In addition, it must be borne in mind that children are not passive but actively shape their own development. Therefore personal, temperamental and personality factors also play a role.

Resilience in children must also be understood in light of the child's developmental stage, which influences their capacity for effective coping (The Association for the Study and Development of Community, 2003). Younger children, in particular those under five years of age, may lack or have incompletely developed capacities such as self regulation of affect, behaviour and attention, thinking, and planning, and use of self-talk to direct behaviour - all of which appear to increase resilience. A developmental perspective on resilience argues that some children will vary in the degree of resilience they demonstrate at different points in their lives (Killian, 2005).

Bouvier (2005) suggests that optimal development is a result of the capabilities inherent to the child and also those available to the child in his or her social and physical environment. Children's development evolves over time in interaction with family, school, community, culture and larger societal systems. In this sense, human development and the development of resilience is both transactional and ecological.

2.3. Models of resilience

Initially, risk and resilience were explored in one-dimensional *deficit models*. That is, risk was associated with single exposures, such as parental divorce, exposure to sexual abuse, being reared by a parent with schizophrenia, low socioeconomic status, and the like. Similarly, single outcomes were considered, such as depression or withdrawal or school failure (Garmezy, 1993; Haggerty et al., 1994). The aim of such approaches was to identify factors, genetic or experiential, that increased a child's chances of developing difficulties later in life. During the 1970's groups of children were identified who developed well despite exposure to risk or adverse situations (Garmezy, 1971; Rutter, 1979, Werner & Smith, 1982, in Garmezy, 1993). The factors that enabled them to do so were called resilience. Approaches evolved investigating factors that promote resilience (Howard et al., 1999).

Resilience was thus initially conceived of as the 'opposite of risk' (Killian, 2005), but this view was challenged by, for example, by Grotberg (1995), who advanced the notion that resilience was a universal human capacity that enabled individuals, groups and communities to cope with and be transformed by adversity. This shift away from a deficit-model was seen as positive, but it also enabled the view that children could be unscathed by adversity if they were sufficiently prepared, or supported, or special in some way. Early conceptions of resilience were that it was something remarkable, possessed by certain children, who were described as somehow 'invulnerable'.

However, Masten (2001) in her paper titled 'Ordinary Magic' argues that resilience is a relatively common phenomenon and dependent on quite ordinary human adaptive systems. This approach argues that if the systems surrounding the child are in good order, for example, there is a supportive family and extended kin and other networks, development can be robust in the face of exposure to adversity. However, if these

systems are impaired, risk to the child increases. By this view, resilience is a function of the social environment rather than a quality of an individual child.

More recent conceptions of resilience recognise that there are protective processes and capacities that enable individuals and families to cope (Killian, 2005). This recognizes that resilience is not a static state but a function of the interaction between risk and protective factors, and that resilience can be enhanced.

In developing a model for conceptualising the process of resilience, Rutter (1990) identified three processes important to resilience. Firstly, a positive self-image, that includes children having values and faith in their ability and in the future. Secondly, protective factors which may be present and may reduce the effects of risk factors, for example, interaction with a teacher who believes in the capacity of a child may reduce the stress the child suffers from home as a result of parental illness or absence, and this may allow the child to concentrate on and continue to achieve in his or her schoolwork. Thirdly, that protective factors can operate by breaking a negative cycle and open up new opportunities for the child which can create hope and some expectation of success in the future; for example, if a relative steps in and offers to pay a child's school fees after the death of the parent, which enables the child to return to school.

In order to describe these protective factors, several authors have divided them into different categories. Grotberg (1995) for example describes resilience by three useful and practical components: '*I have*' (external support), '*I am*' (the child's internal strength such as feelings, values and faith, and '*I can*' (interpersonal skills such as management of feelings and temperament, problem solving skills and communication skills).

Likewise McCreanor & Watson (2004) in (McWhiter et al., 2007) suggest that resilience is a function of three related but distinct areas described as:

- Internal factors: such as personal factors, genetic dispositions, temperament
- Interpersonal assets: such as familial networks, adaptive relationships, accessing psychosocial support

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- External supports and environment: such as effective schools, families, and communities

According to Gunnestad (2006), protective factors are built up from the beginning of life and continue to be established and consolidated throughout childhood and youth. Interpersonal skills and support are established through the child's interaction with people and situations in his or her environment. Gunnestad's (2003) model for developing resilience is reproduced in the Figure 1 below.


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                        ┌──────────────────────────┐
                        │    Protective Factors    │
                        └──────────────────────────┘

┌───────────────┐      ┌──────────────────┐      ┌───────────────────┐
│ Network       │      │ Abilities and    │      │ Meaning, Values   │
│ Factors       │      │ Skills           │      │ and Faith         │
│               │      │                  │      │                   │
│ Friends       │◄────►│ Physical         │◄────►│ Values such as    │
│ Family        │      │ attributes       │      │ hope, love        │
│ Institutions  │      │ Appearance       │      │ honesty           │
│ Community     │      │ Intellect        │      │ Friendship        │
│               │      │ Practice skills  │      │ Solidarity        │
│               │      │ Social skills    │      │ Prayer and        │
│               │      │ Helping skills   │      │ fellowship        │
│               │      │ Past experience  │      │ Rituals           │
│               │      │ & mastery over   │      │                   │
│               │      │ challenges       │      │                   │
└───────────────┘      └──────────────────┘      └───────────────────┘

┌────────────────────────────────────────────────────────────────────┐
│ Operate through:                                                     │
│   1. Establishing and maintaining positive self image               │
│   2. Reducing the effects of risk factors                           │
│   3. Breaking negative change reactions and allowing for new        │
│      opportunities                                                   │
└────────────────────────────────────────────────────────────────────┘

                     ┌───────────────────────────┐
                     │        RESILIENCE         │
                     └───────────────────────────┘

                                        Adapted from Gunnestad (2003)
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Figure 1 The Gunnestad model of the process of developing resilience

Vanistendael and Lecomte (2000) proposed the image of a *casita* or small house as a model for understanding the key elements of resilience, see Figure 2. In this model, social bonds and networks between the child and stable caregivers who believe in the potential of the child are key to resilience and form the basement level of a house. The ground level reflects the capacity for meaning in life through religious or cultural practices and human engagement, and built on top of this are internal constructs such as self esteem, sense of humour and so forth. The roof or attic level represents the child's openness to new experiences as an expression of their resilience. Critical to this model of resilience is the construct of human bonds, since resilience is not built in isolation but rather through interactions and relationships with others.
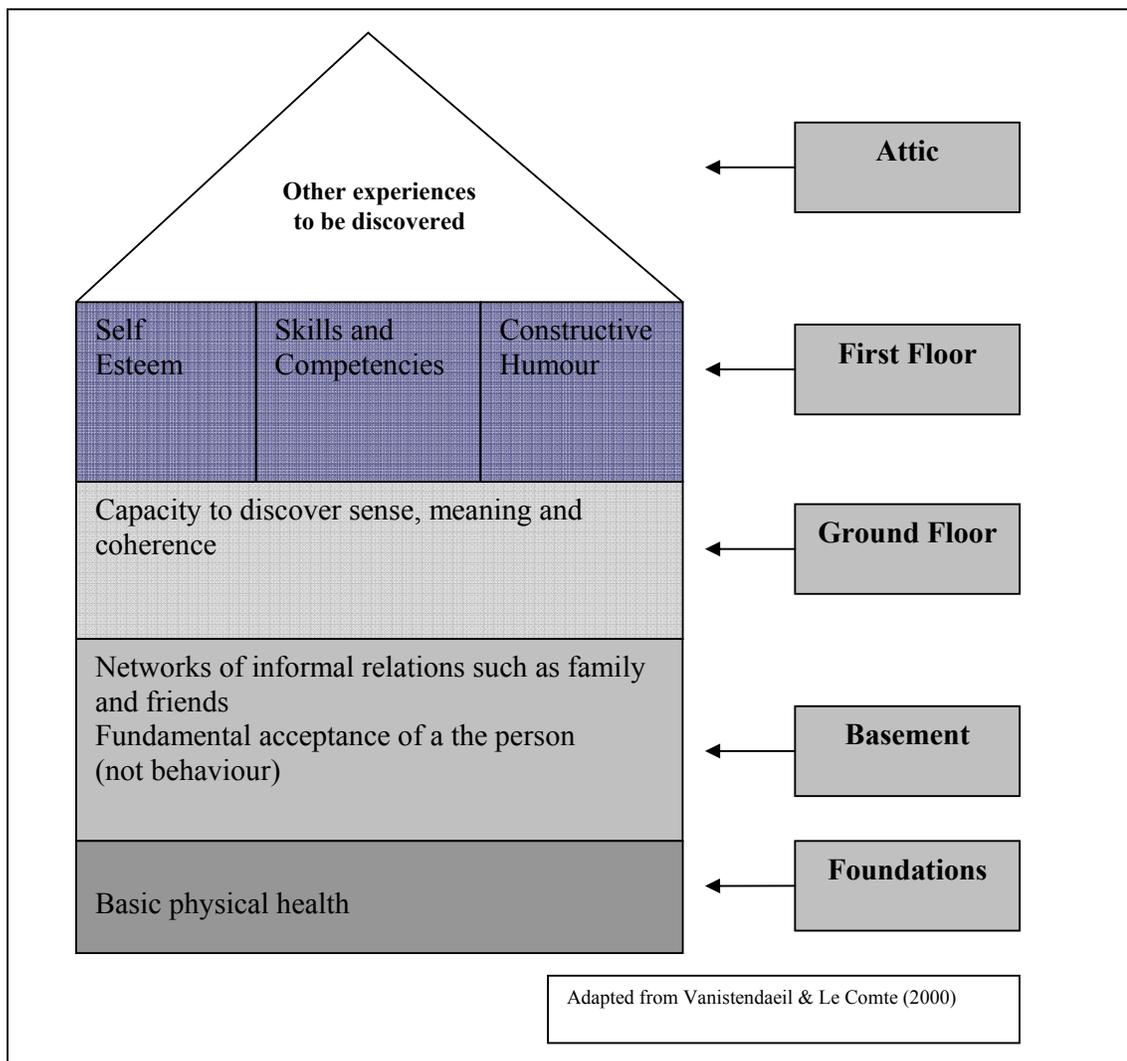
Figure 2 The Vanistendaeil & Le Comte 'Casita' (House) Model of resilience building

In a review of resilience models, Killian (2004) suggests that a sense of belonging and feeling integral to a family, community and culture is another key feature of resilient children. Modern approaches to the understanding of resilience rely heavily on ecological models to conceptualise the interactional, transactional and interdependent nature of resilience.

Bronfenbrenner's (1979) ecological model often used for explicating resilience since it supports the view of interdependent links between child, family, and community and also highlights the importance of cultural connections and a sense of history. It is argued that resilient children's sense of belonging makes them more likely to participate actively in decision-making processes—which, in turn, reinforces meaning and resilience. Furthermore the models allows for the conceptualisation of the networks of people from whom social support can be sought by children in times of distress. Killian (2004) argues that feeling part of a community and believing that you belong generates both security and pride, which, in turn, precipitates helpfulness, altruistic and other positive social behaviours.

Using Bronfenbrenner's approach to describe how external supports and resources can operate in three primary systems of the child's world—at micro systemic, meso systemic and exo systemic levels, Killian (2004) argues that it is clear that certain families, schools, communities and cultures have protective processes that promote resilience. Resilient families who live in poor and disrupted communities, yet cope successfully through disadvantage, serve as important positive role models for their children.

Killian (2004) proposes an integrated model of resilience in the context of children and HIV and AIDS illustrated in the Figure 3.

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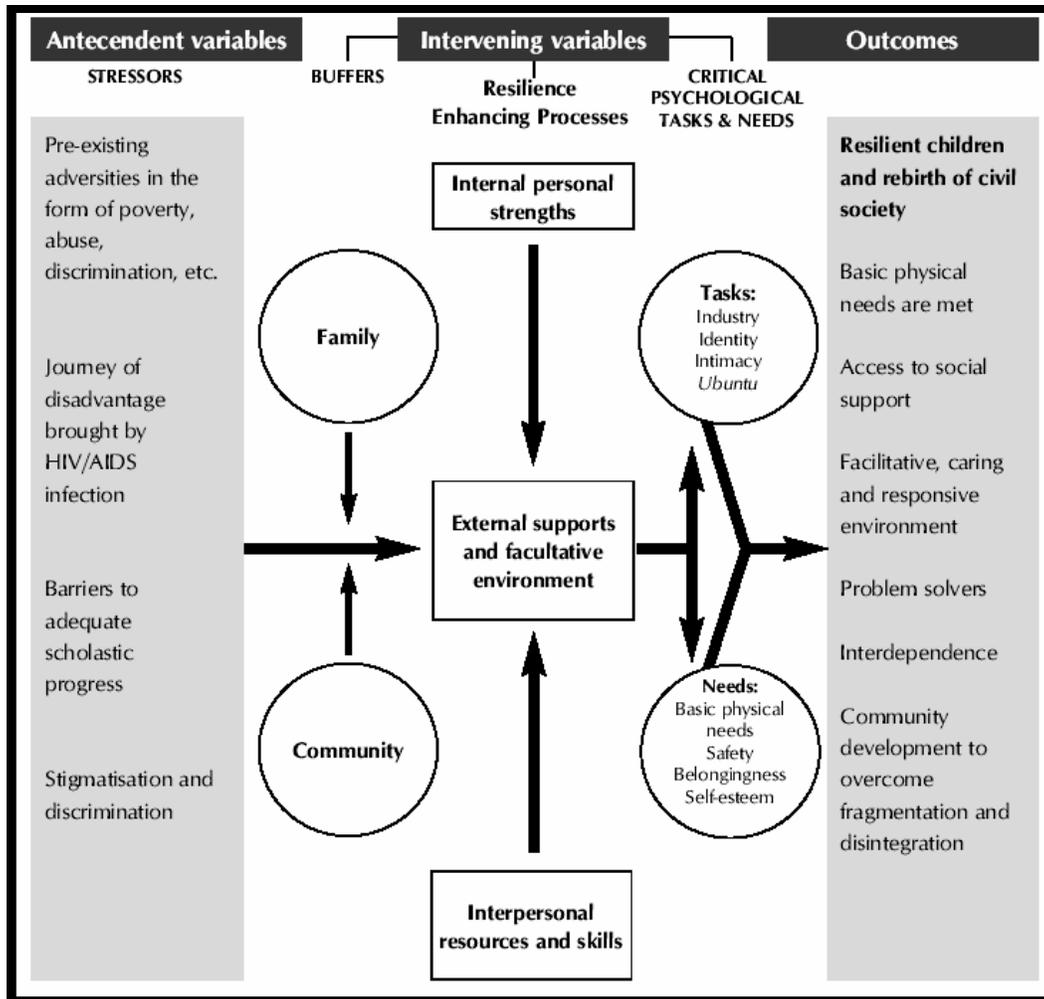
Figure 3 An integrated model of resilience in the context of HIV and AIDS (Killian, 2004)

This model is useful for emphasising that the effects of risk and resilience are dependent on a system of interaction with other factors. It also draws attention to the child as an active agent within the levels of interaction.

2.4 Resilience and HIV and AIDS

Richter, Foster and Sherr (2006) provide a useful framework for thinking about the many ways in which HIV and AIDS can make a child vulnerable, see Figure 4.

Children indirectly affected. Children are vulnerable through mechanisms such as increased child labour, lowered access to health care services or education – many of these vulnerabilities facing all children are heightened when a community is also under siege from HIV and AIDS.

Children in households that foster children. Family fostering has constituted the largest response to children in the face of the pandemic. However in a context of poverty, children who live in households that fosters in children may face similar vulnerabilities when resources are stretched to accommodate additional dependents.

Children living with chronically ill adults. Children who live with ill adults are exposed to psychological, social and economic effects, they may suffer compromised parenting and child care, have less access to resources - which are shifted to respond to the illness in the family or may experience parentification where they are exposed to adult roles at a developmentally inappropriate age.

Children living with HIV and AIDS. Children living with HIV and AIDS have a lower life expectancy, require access to paediatric treatment which is seldom available and may be vulnerable to stigma and discrimination and the pain and distress associated with a chronic illness.

Children orphaned or abandoned as a result of HIV and AIDS. The loss of a mother, father, parenting or consistent care giver creates major ongoing challenges for children - especially so when more than one caregiver has been lost. The order, spacing and nature of death experiences can influence the degree of vulnerability - as does the support of kin and family networks.

Figure 4 Ways in which HIV and AIDS affects children (Richter, Foster and Sherr,2006, pg 17)

As ecological models for understanding resilience have clearly demonstrated the impact of HIV and AIDS on children can differ dependent on a number of contextual factors; for example, which family member is infected. A death of a father could lead to a financial crisis or questions of inheritance while the death of a mother may result in an absence of care giving. Nevertheless, Kelly (2007) argues that family disintegration is likely the most significant and clearly identifiable risk factors facing children.

Skinner Cook (2007) offers an example of how the literature on resilience can guide responses in the context of HIV and AIDS. Resilience, under these circumstances, can

be fostered by: reducing risk factors (for example, by providing antiretroviral treatment which reduces exposure to illness and death); or by intervening to stop the occurrence of cumulative risks (for example, by ensuring that even though a parent and breadwinner has died that a child is still able to attend school); and providing new opportunities for mastery (for example encouraging children to master self-care skills and to contribute meaningfully and equitably to their new household if they have been required to move or are fostered by extended family).

Despite HIV and AIDS introducing a multitude of risk factors for children research indicates that children develop resilience through ongoing supportive and caring relationships, continued social network associations and participation in familiar institutions (Kruger, 2006; Garmezy, 1993; Condly, 2006).Children are found to be most resilient when they are surrounded by and connected to people who love and care for them, and when they have a sense of belonging and hope. It is in and through such relationships that children are able to cope with hardships stemming from hunger, loss, and discomfort (Richter et al., 2006). When children face such difficulties, especially when these risks seem to be constant and cumulative, they particularly need stability, affection, and reassurance (Richter et al., 2006).

Killian (2004) proposes that it is clear that certain families, schools, communities and cultures have protective characteristics that promote resilience. Resilient families who live in poor and disrupted communities, yet cope successfully through disadvantage, serve as important positive role models for their children. Resilient families tend to have certain characteristics in common (Killian, 2004) such families:

1. Have a strong, durable belief in their ability to control life and establish and maintain a sense of order, amongst others the implementation of routines for activities such as meals, bedtimes, household tasks, etc.
2. Have rituals and other ways for celebrating and acknowledging key events in the life of the family and its members;
3. Establish clearly delineated parent–child roles and relationships with firm boundaries; children are not expected to be the parent's friend, confidante, or to provide emotional support;

4. Have parents who provide firm and consistent guidance without rejecting the child;

5. Have parents who display an active interest in school, encourage the constructive use of leisure time and support the child's achievements;

6. Exhibit a manageable maternal workload, both in terms of the number of children cared for and daily tasks;

7. Enjoy financial stability so that families are able to get on with the business of living and bringing up children without constant worry about where the next meal will come from

As highlighted by the review of evidence above, resilience is a complex concept. Resilience is dependent on the length, nature, number and intensity of exposure to risk factors, the internal qualities of a child, and the 'external' experiences, relationships and context within which a child is embedded. Of critical importance is recognition that the interplay of these factors is also situated within family and societal contexts (Lazarus, 2004).

2.5 Culture and context

Taking the current evidence on resilience into account, an exploration of resilience cannot be reduced to an exploration of variables but requires an exploration of the complexity of interactions. In addition, it requires not only an emphasis on the mechanisms which facilitate coping, but also the cultural meaning and value of those mechanisms within family value systems and frameworks for belonging. In this way, we ensure that endeavours to build resilience take cultural practices into account and provide opportunities to build resilience in a manner which is empowering and respectful to the families, communities and cultures within which children live and grow. Aspects of children's lives that contribute to resilience are related to one another in patterns that reflect a child's culture and context, and how tensions between individuals and their cultures and contexts are resolved will affect the way aspects of resilience group together.

Resilience is not a fixed trait that can be gained; rather it is a dynamic process. It is recognized that resilience is embedded in what Masten (2001) calls 'everyday magic',

everyday ordinary practices and relationships that facilitate the capacity cope with adversity. Bouvier (2005) argues that while there are many ways to study resilience one should not underestimate the importance of life stories as these often bear evidence to the reality and authenticity of resilience. Stories are important in highlighting that the process of resilience is ongoing and can be given new direction and shape. In fact, the very act of story telling may in fact contribute to the process of resilience. This project builds on existing literature on the importance of children's voices in research about children and HIV and AIDS (Clacherty, 2001).

This project also takes the perspective that resilience is a complex dynamic process of interaction between multiple factors. It is a human process and is therefore dependent on meanings attached to it. The research focused on exploring children's perceptions and understandings of what for them enhances resilience. We therefore did not set out to measure indicators of resilience, but rather undertook to explore the concept qualitatively.

In exploring socio-historical meanings attached to behaviours and practices Richter (2005) and Liddell (2002) argue that we should not assume western perspectives. In this project we aimed to understand the eco-systemic factors which enhance resilience, recognising that all levels are infused by culturally embedded understandings. Because enhancing resilience is based in practices, it is important that we understand the culturally specific values, beliefs and practices within which they are embedded. Local knowledge can be defined as situated knowledge that people in a particular context use to make sense of their lives. In participatory research, local knowledge and experience are important and the researcher attempts to enter the research context without premeditated ideas or beliefs (van Vlenderen & Neves, 2004).

2.6 Child participation

Christiansen and James (2002) argue that children are active participants in the construction of meaning of their experiences and are valuable co-constructors in the research process. In this study, the choice of methodology and the use of participatory research techniques aimed at shifting the emphasis from research *on* children to research *with* children.

As highlighted above, children's participation in research is becoming increasingly recognised as important - not only as a child rights issue - but also in terms of the quality and validity of research. Various authors argue that children are experts in their own lives and are best positioned to comment on the problems that they face and to participate in the generation of solutions to these problems (Black, 2003; Hart, 1997; Johnson & Ivan-Smith, 1998; Miller, 2003). Life as lived by children is not easily elicited or consciously reflected on in a research process. However finding ways to give meaning and develop an understanding of children's worlds allows us to approach our interventions with children and families in a reflective and meaningful way. Research which gains an understanding of the world in which children live, and which offers insight into the lived experiences and meaning by which children negotiate their daily lives can hold tremendous value for both intervention and prevention programming in the context of HIV and AIDS and adversity.

Barriers to research with children include the assumption that children cannot (by lack of capacity) participate in research. However as Clacherty & Kushlick (2004) have demonstrated in seminal research with children in South Africa, that this is a result of adult approaches to research being applied to children. They argue that when the research activities are sensitive, ethical and take into account the developmental stage of the child, that children can participate meaningfully. Because of the nature and extent of children's vulnerability in such circumstances, direct elicitation of such experiences by traditional research methodology may be painful and inappropriate.

Understandably, undertaking research in participation with children is a more difficult and complex process than with adult research processes. Children live and operate in very concrete worlds and reflection on experiences or articulating opinions is

generally difficult for them. If one adds to this a sensitive topic that deals with HIV and AIDS, then enabling and assisting young children to articulate their knowledge, feelings, or lived experiences (without leading their responses and within the responsibility of an ethical framework) requires a skilled approach with tailored methodologies and tools.

Pillay (2007) argues that when attempting to address and approach the psychological challenges faced by children made vulnerable by HIV and AIDS in Africa one should consciously avoid strategies that are alien and intrusive, and rather make use of local language, culture and systems of expression and understanding. Story telling, projective techniques and photo-elicitation provided three important and appropriate participation methodologies with which one can achieve this, and were used in this project (Mitchell, Stuart, Moletsane, & Buthelezi, 2004; Clark & Statham, 2005; Greig, Taylor, & MacKay, 2007). The oral tradition is a strong and meaningful vehicle for self understanding in many Africa cultures.

The telling of stories provides children with an opportunity to deal with emotions, and questions of purpose and meaning, in a culturally approved manner. It also frees children to withdraw from anxiety provoking material and to engage in a manner which is controlled and self paced (Rose, 2007). Likewise, the use of projective techniques allow a child to develop some emotional distance when talking about difficult issues, and in this sense, photo elicitation or the presentation of photographs as stimuli in projective exercises, serves as an important and innovative research tool.

Photographs are able to evoke in-depth and textual content not easily elicited by verbal questioning (because, in many senses, emotional content often evades verbal expression) especially if a child is defending against a high level of distressing affect. The use of this methodology allows the researcher to elicit and understand emotional content without interfering with a child's healthy and functional defence system (Rose, 2007).

 Photo elicitation methodology offers an opportunity to gain different insights from those revealed by research methodology relying only on oral or written data. The emotional and material representations which photographs can capture, and which

allow a child agency in how they represent their social world to the researcher without being invasive, are exceptionally useful as a participatory and empowering research tool. A photograph taken by the research participant and discussed with him or her, allows for talk about different things. It can evoke memories and allows the participant to bring the content to the researcher. The distance with which the research participant is able to reflect upon their lives allows for the articulation of taken for granted practical knowledge about lived life (Rose, 2007).

Story telling gives personal affirmation through talking about one's own situation and is a cultural practices that has been suggested to enhance resilience (Pillay, 2007; Clark et al., 2005). When people converse they are not only exchanging information, but they are also building up some kind of a relationship. Sometimes – not always – the fact of talking to each other about the past has a healing effect as it facilitates the grieving process (Denis, 2003).

This project was developed to use visual methodologies as tools to explore the construct of resilience with children. The project explores resilience from a much needed children's perspectives looking to understand what children identify as constituting risk and what helps children to be resilient. The project aimed to use participatory techniques to give children a voice and agency to speak about how adversity affects them and what they find helpful and useful in coping with this adversity.

3. Methodology

The aim of this project was to explore, capture and record the stories and understandings of children about the people, places and practices that enable them to cope, build resilience and to feel safe prior to, during or after loss or adversity. A qualitative research approach, using participatory research methodology was best suited to this study as the focus was on the child's situated subjective experience. The study was exploratory and descriptive in nature as it sought to access children's voices and gain insights into their experiences of resilience.

The research process was designed to maximise the participation of the children. Children were met over four data collection points. Repeat interviews over time facilitated the collection of valid information and allowed topics to be explored in depth. The principle of this approach was to facilitate the development of trust, engagement and rich dialogue. The group activities using participatory techniques were structured to maximise interchange and to reduce the effects of power differentials.

In developing child participatory methodology Clacherty and Kushlick (2004) recommend that two key principles should guide the approach to research with children. Firstly, the importance of working within a strong ethical framework that protects and respects children and, secondly, recognising the capacities and thinking styles of children at different ages and stages of development.

In terms of providing an ethical framework, the researcher should work from the principle of 'least harm' and should strive to reduce vulnerability and further exposure to risk. Where possible, the principle of least harm should be applied by making sure that all children who participated in the study are part of an ongoing support programme and children are able to limit their participation to that which they felt comfortable. They should be reassured that they can feel comfortable to stop or leave the research at any time.

The groups in which children participated were facilitated by psychologists and provided children an opportunity to engage in activities which were therapeutic and supportive. Participation also allowed for the use of photo elicitation as a means for children to narrate their own stories. Children were encouraged to create their own photo collages to take home. The application of the principle of ethical work with children allowed us to collect textured information about the lives of young children while respecting and protecting their needs (Rose, 2007).

This research received ethical clearance from the Research Ethics Committee of the Human Sciences Research Council. A copy of the final letter of clearance was submitted to the CINDI network.

The methods used in the group activities drew on experience within the research team and on previous studies in South Africa. This included the work of Clacherty (2002), Clacherty and Kushlick (2004) and Van der Riet, Hough, & Killian (2005) The method used for the photo voice activities was developed from similar work by Professor Linda Richter in South Africa http://www.hsrc.ac.za/fatherhood/index.html.

The research team included:

(i)   Four researchers, who designed and developed the research protocol, conducted a review of literature, provided oversight of data collection and participated in data analysis, interpretation and write up.

(ii)   Two IsiZulu-speaking psychologists, and an IsiZulu-speaking educationalist, who facilitated the group work and conducted individual interviews with child participants.

(iii)   A research psychologist intern, who provided oversight of data collection, support and quality assurance during focus groups.

(iv)   A research assistant who assisted in general logistical tasks and also participated in the analysis and write up.

3.1 Research aims

The aim of the study was to understand how risk and resilience are constructed by children in terms of local language, practices and culture.

Specific goals were to:

(i)   Explore children's experiences of people, places and practices that provide them with comfort and promote their resilience.

(ii)   Develop recommendations for programming based on the voices and experiences of children and families in communities facing adversity.

Key questions:

(i)   What can we learn from the literature that will help us better approach and understand resilience and how to promote resilience among children facing widespread adversity?

(ii)   What are children's perception and experiences of risk and resilience and what cultural or local practices do they find useful and meaningful?

(iii)   How can the findings, from the literature and children's experiences, inform activities in the CINDI network?

3.2 Sampling

The study used purposeful sampling aimed at selecting a small sample with wide diversity in order for the data to yield two kinds of findings: Firstly, highly detailed descriptions of individual experiences which are useful for documenting uniqueness, and, secondly, finding important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity.

The CINDI network selected three organisations to participate in the research on the basis of the following criteria:

- Being part of the CINDI network
- Being engaged in providing direct services to children and families within a specific geographic context

- Having expressed a willingness and ability to participate in the research.

Using guidelines from similar work in South Africa is was decided that in applying the principle of least harm we would make sure that all children who participated in the study were part of an ongoing support programme. Although researchers clarify to the best of their ability that they cannot provide direct personal help, it is often the case that certain children may have expectations for support in the research interaction (Ivan-Smith & Johnson, 1998). It is important, therefore, to have a mechanism with which to provide support and referral for children after the research.

In discussions with participating organisations children were selected to participate based on the age ranges of the children for which the organisation was providing services and the variety of programmes of assistance in which the organisation was engaged. At each organisation, staff was asked to assist with recruiting children who were receiving different levels of support, who represented a mix of genders, and including children from the age ranges proposed by organisations based on the services provided which target particular age groups.

In summary children were selected to participate based on the following criteria:

(i) Two groups of children were selected from each site in line with the resource constraints of the project; in each of the two groups children of similar ages were grouped together to facilitate age appropriate tasks being used in group activities.

(ii) A diversity of children within the specific age ranges and included children who were receiving services from the organisations or were on waiting lists to receive services.

As a result, sampling was purposive and selective. If there was more than one child in a household, only one child in the family participated in order to avoid bias associated with shared background factors.

Organisation	Group One	Group Two
Kenosis	6-8 years (N=8)	10-12 years (N=6)
Thandanani	10-12 years (N=6)	16-18 years (N=9)
Izingane Zethu	6-8 years (N=7)	13-15 years (N=8)

Figure 5 Number of children by age groups and site

3.3 Research procedure

The research procedure with children entailed an individual intake interview, two focus groups and an individual photovoice interview, which took place over four weeks. These are described in more detail below. All interviews and focus groups were conducted in isiZulu (the first language of the participants) and the data collection process was tape recorded. Two isiZulu speaking psychologists and an educationalist facilitated the group activities with the children and the research procedure was overseen by a research psychology intern.

The member organisations delivering services to children and families facilitated community entry, and assisted in the enrolment of children from their communities. The organisation staff thus helped to identify possible participants and assisted in facilitating access to relevant guardians for consent. The researchers facilitated the transportation of children from communities to a central venue for all research activities and provided refreshments and meals.

A detailed field guide was developed and used to train facilitators, guide research activities and monitor quality assurance during data collection. This field guide is not included with this report but available from the researchers on request.

3.3.1   Intake procedures

The purpose of the intake interview was to explain the process of the research and for children to assent to participate, and to collect basic demographic information. The organisational staff that had facilitated the selection of the child and collected guardian consent was present so as to ensure that the participants felt supported and safe.

Once the interviews were completed, the participants were brought together as a group and introduced to one another, and they were then taught how to use the disposable cameras. A practice camera was available and each participant had a turn using the camera under supervision. Group camera training took approximately 45 minutes and each child participant understood that they were to be given a camera at the end of the first focus group. The guide used for camera training is included in figure 5 below.

Disposable cameras were used with 27 exposures and children were asked to take at least 4 photographs across three categories: people, places and practices which were helpful for them when they faced difficult times. Children were told that the balance of the photograph exposures could be used for their own activities, but that all exposures would be developed for them and that the photographs would be taken home by them after the end of the research.

IMPORTANT THINGS TO REMEMBER

1. Keep your camera in a safe place when you are not using it.
2. Do not drop it because it may break.
3. Do not get your camera wet because the photos will be damaged and you may get hurt.
4. Always remember to turn your camera on and off.

HOW TO DO IT

1. Switch your camera on. A red light will come on.
2. Wind the camera before you take a photo. If you don't wind it the camera won't work.
3. Look into the window at the back of the camera.
4. Point your camera at the thing you want to take a photo of.
5. Press the button on top of the camera to take the photo. The camera will click and a light will flash.
6. Turn the camera off or the battery will run out.

YOUR PROJECT TASK

1. Each camera has 27 photographs.
2. You must take 12 pictures to talk to us about
3. These pictures must be of people, places and practices (actions/ things people do) that make you feel safe/give you comfort or that make you feel like you belong.
4. The other 15 pictures are for you. You can take pictures of your friends. We will make one set of copies that you can take home with you.

Figure 6 Guide for camera training and instructions

3.3.2 Focus groups

Two focus groups were conducted with each group of children from the organisational sites. The groups took place at least one week apart from each other and were facilitated at a site arranged by the organisation. The groups were held in the afternoons after school. All children were provided with a meal prior to the beginning of the groups. Materials and activities for the groups were developed and provided by the researchers and the focus groups were tape recorded and observed by a researcher taking notes on process.

Focus Group 1: The first focus group was used to build rapport and to elicit children's understandings of risk and resilience in general. The first focus group took place within a week of the intake interview. The group was run over a time period of two hours and covered six topics which explored the importance of children's voices, popularity and marginalization, risk factors, resilience factors, accessing support, and explanation of the photo voice task. The focus group schedule which was used to guide the focus group activities in included in figure 7.

Photograph 1 Group work exploring risk and resilience

Photograph 2 Risk and resilience factors are ranked with beans.

Theme:	RISK & RESILIENCE GENERAL
Introductory tasks/icebreakers	Icebreakers (Name game, name and action game)
	Introduce self (facilitator) and research aims
	Discuss confidentiality (sign confidentiality pledge)
	Establish group norms
Activities in Focus group	**TOPIC 1: Why do you think children's voices are important?**
	Method: Focus group discussion, brainstorm. This took place in the form of a group discussion and it covered the topic of why participants think children's voices are important. Participants were asked to share their opinions about this topic and to discuss it within the group.
	TOPIC 2: Popularity and stigma
	Method: Photo presentation (person projection). The facilitators had two photographs of two different children which they showed to the group. The younger group was shown photos of younger children whilst the older group was shown pictures of young adults. One photo was shown to the group and the facilitator stated that this child was liked by other children. The participants were then asked to share why they thought that some children are liked by other children. The next photo was then shown to the group and the participants were told that this child was not liked by other children. They were the asked to share why they thought others did not like the person in the photo.

TOPIC 3: Risk factors

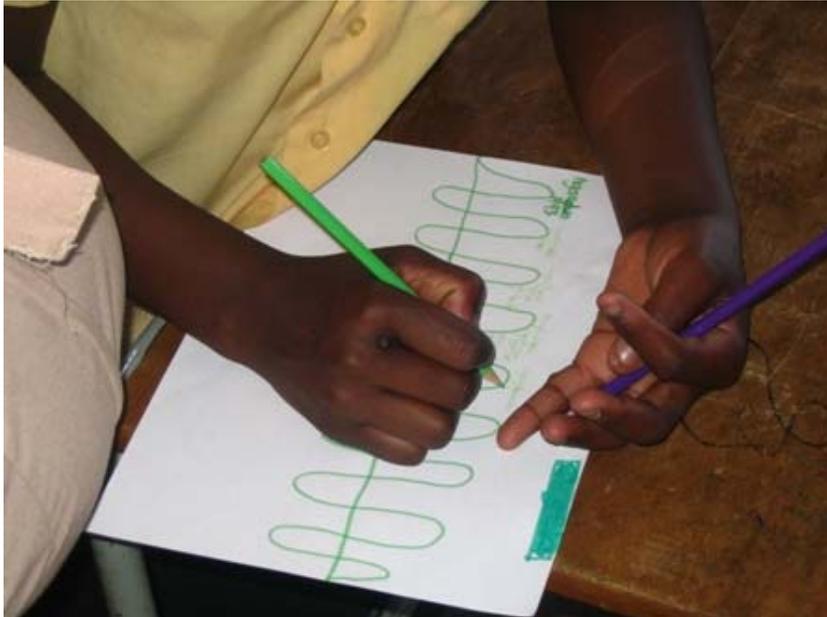**Method:** Photo presentation (person projection). A different photograph was shown to the group. The facilitator then told the participants that the child in the photo was at risk and that times were difficult for this child. The group was then asked to discuss what things they thought affect children negatively.

TOPIC 4: Resilience factors

Method: Photo presentation (person projection). A different photograph to the one above was shown to the group and they were told that even though the child (in the photo) has faced adversity/ difficult times- he/she is doing well. They were then asked to explain why they thought this was. In addition they were asked what they thought were the things or people that could help this child to cope.

TOPIC 5: Accessing support

Method: Photo presentation (person projection). The group was then shown another photo of a child and were told that the child had faced adversity/ difficult times- and they were asked where they thought the child could get help from or where they could go to feel safe.

TOPIC 6: Introduce cameras task and how to use:

The camera task was then introduced.

Closing tasks	Human knot
Indicators	Popularity/stigma
	Risk factors & Resilient factors

Figure 7 Focus group 1 guide

Focus Group 2: The second focus group took place a week after focus group 1. In the time period between the groups, the children had been tasked to take their photographs in order to return the cameras for picture development when they attended the second group. The aim of focus group 2 was to explore how participants personally dealt with risk and resilience. The group covered four topics including the worries and strengths children have; the participants' life stories and reflections on the research process. The focus group schedule for the second focus group is included in figure 8.
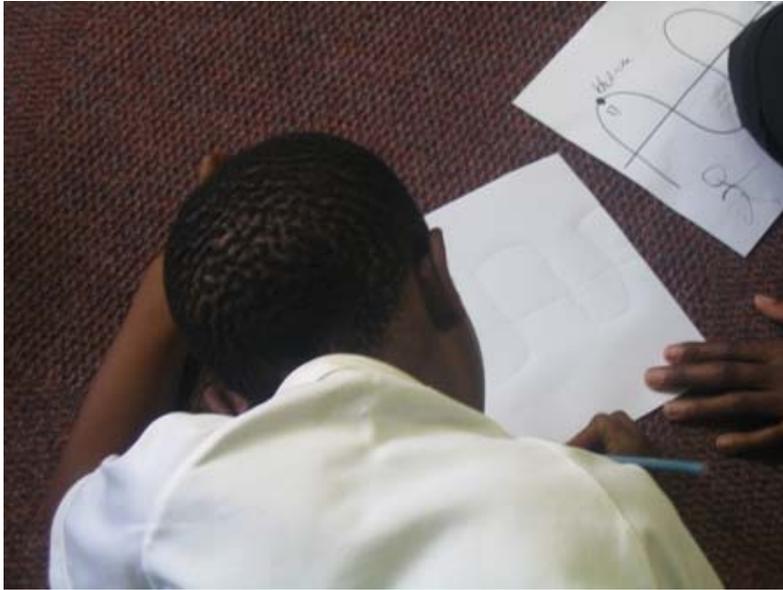
Photograph 3 Children use life story diagrams to express highs and lows

Photograph 4 Life story diagram – older child

Photograph 5 Life story diagram - younger child

Theme:	**RISK & RESILIENCE SELF**
Introductory tasks/icebreakers	Icebreakers (Greeting game, Finding animal pairs (cards) through noises) Remember group norms Put on code-name tags Collect cameras
Activities in Focus group	**TOPIC 1: What things worry you and what things make you feel strong** **Method:** Bean ranking (6 – 10) & diamond ranking (11-18) & focus group discussion. Participants were asked to list the things that worried them The facilitator then wrote each of these on a piece of paper, spread them out on the floor in front of the children and then read them out aloud so that each child knew what was on the pieces of paper. Participants were then given two beans each. The facilitator then explained that the pieces of paper indicated the things that the participants had listed to be the things that worried them. The participants were instructed to place the bean on two things that worry them most even if someone else had mentioned the worry. The number of beans on each piece of paper was recorded. The same exercise was repeated but this time the task was to list the things and people that made the participants feel strong, and free from worries.

	TOPIC 2: Telling life story
	Method: Journey of life drawing. Participants were told to draw a timeline of their life by drawing or writing the happy and sad events in their lives. The facilitator handed out paper and crayons and asked each child to find their own space in the room. They were asked to write their code name and grade at the top right corner of the paper. They were asked to draw a horizontal line in the middle of the page. They were then asked to mark on the line how many years they were. The facilitator then made an example of her own life and drew her life line. They were then told to think about their own experiences and to draw pictures/symbols or write when those events happened. If the event was happy or good, the picture or writing was made above the line. If the event was sad or bad, they were asked to draw or write below the line. They were told to think of their life from the time when they were born up until the present. They were told that there was no correct way to do the task and that no mistakes could be made. The participants were given 10 minutes to complete this task. After drawing, the participants were asked to tell the rest of the group about the things in their life story, and how they felt about them. During this discussion the facilitator probed about the participants life stories. The pictures were then collected.
	TOPIC 3: A task which asks about family constellations – who is in family?
	This task was undertaken with the older group only. The participants were given paper and stickers (round and square in white and black dots). They were told to use the round stickers for the women or girls, and the square stickers to indicate the boys and men. They were told to write the names of the people on the stickers. They were also asked to put black dots next to those people in their family who have died.
	Each person was given a chance to talk about the people in their family if they wanted to. The pictures were collected.
	TOPIC 4: Reflection on group process
	Method: Group drawing and reflection. The group **w**as asked to say what they had done over the last three sessions and to draw a group timeline of the things that they had done together/ discussed/ thought about. They were given the option to draw/ write / use symbols to show the topics. They were thanked for this contribution and were asked if they had any questions about the work done together
Closing tasks	Affirmations & power circle
Indicators	Support systems
	Emotional state
	Personal resilience factors

Figure 8 Focus group 2 guide

Photograph 6 Children work together

3.3.3   Photo elicitation and individual interviews

The individual photo elicitation interview took place two weeks after second focus group, allowing time for the processing and development of the children's photographs. The aim of the photo voice interview was to explore children's constructions of resilience through the photographs they had taken.

In the interview, two activities were covered; firstly, a photo exhibit where each participant was asked to give a title and describe the photographs.

Photograph 7 A child sorts through photographs to work with in the individual interview

Photograph 8 Child develops a label and descriptions for a photograph

The facilitator then worked together with the child to divide photographs by categories of people, places and practices and a fourth group of the child's own photographs not related to the research task. Once the photographs were organised

children selected out the four photographs from each category that they wanted to discuss and describe.

Photograph 9 A child works with a facilitator to describe the meaning of a photograph
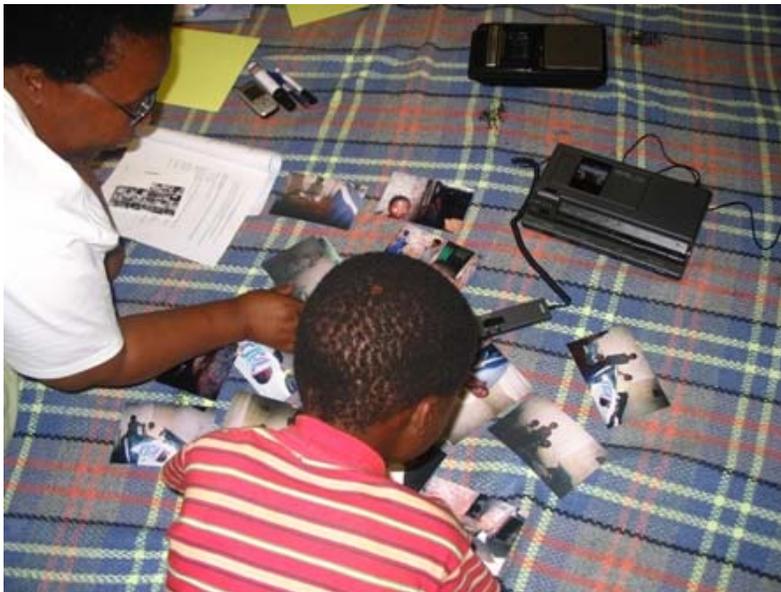
Photograph 10 Facilitator assists a child to organise their photographs

Thereafter the facilitator led a discussion regarding the photographs, their meaning to the participant and the interview explored risk and resilience factors that children

identified by looking at their photographs. The interview schedule is included in figure 9.

Photograph 11 Child discusses her photo collection during an interview

Photograph 12 Child develops narratives around a smaller set of selected photographs

Theme:	Constructions of Resilience
Introductory tasks/icebreakers	**TOPIC 1: Photo exhibit and discussion regarding photographs** The participants photos were handed out and he/she was given time to look through them. The facilitator then reminded the participant about the task to take pictures of people, places and practices (things people do) that help the participant to feel safe. The participant was asked to divide the photos into: people, places and practices and to tell the facilitator what his/her photos showed. In addition, the participant was asked which photos showed the most important ways in helping him/her to feel safe and comforted. A discussion about these topics ensued with the facilitator asking probing questions.
Activities in Focus group	**TOPIC 2: Resilience factors** The participants were given 3 cards each with the following phrase written on them: 1. I AM….. 2. I HAVE… 3. I CAN…. The facilitator then helped the participant to look at their photographs and from their photographs to fill in the following statements, for example: I am (friendly, good at), I have (a loving grandmother) I can (sing, tie my shoelaces). The participant was then given the cards to take home with them as well as a set of photographs.
Closing Task	Thank you for taking part in the research

Figure 9 Guideline individual photo elicitation interview

3.4 Analysis and interpretation

Once all data had been collected, facilitators' underwent a debriefing conducted by a psychologist and the researchers during a morning workshop. The debriefing was aimed at offering facilitators support and containment around the emotional content brought to the groups by the participants.

Photograph 13 Facilitators use artwork to process experience during debriefing

Photograph 14 Research psychology intern art work to describe overseeing the groups

Photograph 15 Facilitator artwork to describe experience of running groups with children

Data collected at each of the time points required transcription and translation. Thereafter, thematic analysis was undertaken. The procedure for the transformation and preparation of data for analysis is described below.

Transcription and Translation of Data: The transcribers had a minimum of a post-graduate degree and experience in transcription and translating. One translator was selected per site and, before transcribing commenced, a data review workshop was held at the Human Sciences Research Council office in Durban. The workshop was attended by the three transcribers. The two psychologists and educationalist who had facilitated the group work with children, along with the research psychologist who oversaw data collection and quality assurance, and the researchers, participated in the workshop. The workshop focused on an overview of the sites and the data collection process, training on transcribing conventions, discussions of the protocol, field work and field work experiences which could inform meaning and language in the transcription and translation process, as well as a discussion by each facilitator about the context and language considerations which may be relevant to the translation process at their sites. A schedule of regular contact was set up with transcribers for the purposes of quality assurance in order ensure that language and meaning was kept

consistent throughout the transcripts. Facilitators for each sight were available to site translators throughout the process by email and telephone.

Data Review Workshop: Following the transcription and translation of data, a data review meeting was held which included the researchers, transcribers and the facilitators. The purpose of the workshop was to review the dataset in order to clarify meaning, raise queries and to clarify issues related to the transcription of the data. Transcript data was also linked to materials produced in group activities such as bean maps, and life stories in order to add depth to transcriptions and in preparation of the data analysis workshop.

Data Analysis Workshop: In preparation for the data analysis workshop, each of the researchers were allocated a site dataset for analysis and review. Following review, the researchers participated in a two-day data analysis workshop, where data from all three sites, age groups and activities, along with photovoice data, was analysed together. The analysis identified themes in the data, and once themes had been identified, issues qualifying the themes were identified resulting in a complex set of themes and categories, which can be used to describe the entirety of the data presented (Boyatzis, 1998).

4. Results and discussion

The findings are a synthesis of the voices of the children. The methodology used participatory techniques in order to access children's perspectives regarding what helps them to cope, and to feel safe and comforted. The children's responses were facilitated by the group tasks, but the children were not led into answering in specific ways. The children voiced, in their own words, what factors put them at risk and what was protective. Our findings largely confirmed the resilience literature, that resilience is situational and context-specific. Rather than being able to 'bank' or acquire stable capacities such as self esteem, resilience is constantly negotiated in children's experiences, relationships and beliefs about self.

As described in the methodology, the data set includes an initial intake interview with each child, two focus groups held with two groups of children of different ages at each of the three research sites, and an individual photo elicitation interview with each child to discuss their photographs. The focus group and photo elicitation data for all three sites are integrated and described in this discussion and focus on risk and resilience factors and the material is categorised by people, practices and places.

Throughout the discussion direct quotes from the children are used to illustrate the findings and they are indicated in italics for ease of reference. The quotes have been labelled according to the research site, the age group and whether the quote came from individual interviews or focus groups. Data is described using the symbols outlined in the following key:

> **F**: refers to the facilitator
> **P**: refers to participant

4.1. People

The risk and resilience factors associated with people that were identified by children included personal qualities or self factors which put children at risk or made them more resilient. The presence or absence of particular people to play specific roles was seen to increase or decrease risks. In general healthy relationships with others facilitated resilience.

4.1.1. Risk

Personal factors: In terms of the relationships a child had with other people, the personal factors that children identified that they suggested made a child less likable included: *"being forward…. Nobody likes a forward person"* which encompassed being loud, rude, pushy and possibly disrespectful. They also suggested that a child that was not liked who tended to swear, was rude, was disrespectful to adults, and was stingy (such as eating alone and not sharing) being dirty, and not keeping secrets. These factors included a child who has lose morals, a child who steals from other people, or who has parents with HIV and AIDS or whose parents or family member are alcoholics indicating some self stigmatisation.

Children also indicated that when you do not have anyone guiding you as a child you tended to be drawn into risk situations by doing wrong things like sleeping out and bullying others which results into other people not liking you. This shows recognition of the risk of fractured family units and lack of guidance.

Children's identification of being loud and disrespectful is related to a value in these communities for children to be obedient, quiet and follow instructions. Certain values in a community will guide what are appropriate ways for children and young people to behave in order to be seen in a positive light and therefore facilitate being liked and more readily accessing support. It is through relationship that many young people access support, and there are ways in which one needs to behave and be, to make relationships work.

Losing parents: Children in all focus groups expressed exposure to repeated hardships. The most difficult hardship expressed by all the children (especially those children in the younger groups) was that of losing a parent. As highlighted by the literature, the loss of a parent is a significant risk factor and is related to multiple threats and losses before and after the death of the parent, including loss of income, home and security, access to schooling, community interaction, in addition to the loss of a caregiver and champion. The losses were aggravated if people taking over the care of the child also subsequently became ill, died or were in other ways

incapacitated such as being an alcoholic or mentally ill. Many children experienced multiple losses.

P: *"what problems do children your age face?"*
P1: *not getting food when we go to school.*
F: *okay going to school on an empty stomach, okay, what else?*
P2: *not having parents*
F: *being an orphan?*
P2: *Yes*
Izigange Zethu, Focus Group 2, 8-10 years

When completing the life story activities, the children in all the age groups related similar life stories. The death of their parents is the most common "unhappy" time among the children. Also observed in the "unhappy" times is the death of other family members such as sisters, brothers, granny, aunt or uncle. Children related having a relative (granny, aunt or uncle) who then takes care of them after the death of one of the parents, but in some cases even the guardians had passed away. All children in these groups had been exposed to multiple losses of people close to them.

P: *I love my granny and my problem is that she's sick. She had two strokes and I'm worried about her… you see when she was very sick I was very scared because she couldn't walk and even when she spoke she couldn't speak well. It was as though a little child was speaking, I don't know what happened to her tongue… Now I can hear what she says.*
(Thandanani, Photovoice Interview, 14+)

A secondary risk linked to loosing a parent, was not having money. This put children at risk because they did not have support and could not buy food or clothes and had to rely on others for support. This sometimes also increased the risk of abuse. Most of the children believed that if their parents were still alive, they would be happy like other children. The loss of a parent had often triggered a cycle of events, which had exposed the child to more risks.

> *F: What happens when your parents pass away, what difficulties do you go through?*
>
> *P1: You lose your mind.*
>
> *P2: He feels like nobody is paying attention to him*
>
> *P3: Sometimes he thinks about his parents and misses them. He thinks about them a lot and then you find the teacher would be teaching and his mind is somewhere else.*
>
> *F: You think that if his mother was here things would be different?*
>
> *P: Maybe your friend tells you that he and his mother are going to town and you find yourself thinking that is your mother were alive you might be telling her that… mom and I could be going to town….*
>
> *P4: They get Christmas clothing and you don't and then you think that if mom were still alive I could also be wearing new Christmas clothing, in fact I could   be looking nicer than all of them.*
>
> *(Thandanani focus group, 14 + years)*

In losing parents, children were also exposed to another major risk factor - the loss of a champion, in other words not having someone to advocate for the child. They were also less likely to have someone from whom they could seek counsel. Children also indicated feeling a great loss of material security as a result of loosing parents.

> *F: What do you guys think is most upsetting about being an orphan?*
>
> *P1: Because you are always thinking about things.*
>
> *F: What kinds of things do you think about?*
>
> *P1: Your parents and the things they did for you*
>
> *F: Yes like what*
>
> *P2: Buying you clothes and paying your school fees*
>
> *(Thandanani, FG2, 10 – 12 years)*

4.1.2. Resilience

Personal factors: The characteristics in all three sites that the group identified of someone who is liked by others included: being respectful of others and being good or obedient and doing all of one's chores. It included listening to others, "*he behaves himself*", being open, capable, good looking, clean and shy (meaning not talking too

much). Being liked also includes sharing with friends and discussing, and keeping stories confidential. In the literature, it is recognised that self-control, the ability to control one's behaviour to facilitate positive social relationships, is an important feature common in resilient children.

Children who are respectful, trustworthy, funny, and those who help their friends with homework are liked and appreciated by other people in the community. The main emphasis of personal characteristics for younger children was on being obedient and doing chores while, in older children, greater emphasis was placed on helping and being involved with others.

Children who had skills and were able to do things for themselves or for others were also regarded as resilient. An ability to do cleaning, washing clothes and dishes, bathing one self, writing and playing was seen as important.

For one to continue to be strong and resilient, children said that one has to love school and continue to go to school, no matter what. They said that respect makes other people like you and if other people liked you they would help you when you have problems. This social ability is also recognised in the work of Werner (1990).

Rogoff (1990) suggests that African contexts tend to have conceptions of children in which obedience to authority is valued. This raises an interesting point for discussion. On one hand, we need to promote characteristics such as emotional control that enable children to get along well with others who are likely to offer support and therefore facilitate their potential positive social relationships. In all these communities being respectful and obedient towards elders and peers, doing chores and being helpful and not being loud or too forward are qualities that are valued. However, we also need to recognise the potential that an over emphasis on obedience can give unscrupulous adults power and make it difficult for children to speak out against mistreatment.

Families: The children's data reiterates that resilience is a process - not a once off, but rather an ongoing, provision of care. This process of resilience happens within certain relationships and the most important people in all three sites were identified as family members. It is recognised that families were constituted in a multitude of ways

including grandmothers, aunties, siblings and uncles. The family unit played an important role in making children feel safe and protected and provided a place of belonging.

> *"I love my family more than anything else in this world."*
> *(Thandanani, Photovoice Interview, 14+)*

> *"I live with my family, if there is something that I need I can get it but*
> *if they are not there I don't get all the things."*
> *(Izingane Zethu, Photovoice Interview, 13-15 years)*

In all age groups, children said that the people they feel most protected and safe with were their families. Most of the psychosocial care and support in all three sites seemed to be provided by women who were extended family members (mothers, aunts and grandmothers). Fathers and uncles were less frequently mentioned, and when they were they were spoken of as bringing financial help.

> *F: Why did you choose these ones [these people to photograph]?*
> *P: People are important to me, in my life and they are, these are the photos of important people that I took [F: mmmh] and these are the places I live at, I feel good when I am at these places.*
> *F: You feel good?*
> *P: Yes because my mother was also born here…*
> *F: So home is important to you?*
> *P: Yes it is important*
> *F: So the photos you took there is no one from outside who is not family, these are all family members?*
> *P: These ones are only family.*
> *F: Okay, what do they do?*
> *P: My grandmother is the one who takes care of me, she buys food at home and my aunt is the person sending me to school.*
> *F: Your aunt pays your fees?*
> *P: Yes*
> *(Thandanani, Photovoice Interview, 14+ age group)*

For children who had mothers (biological, step- and adoptive mothers) they were cited as being the most helpful in providing resilience because children said they bring comfort and protection in their lives, they help financially and are the ones they tell when they are not feeling okay.

> *I am always well cared for when I am with her.*
> *(Izingane Zethu, Photovoice Interview, 13-15 years)*

> *She(mother) gives me everything I ask for, when I cry she makes me happy.*
> *(Kenosis, Photovoice interview, 10-12 years)*

> *I love my mother because she does things for me. Maybe my sister also does things for me but not like my mother does.*
> *(Kenosis, individual interview, 6-8 years)*

In the children's narratives people consist of the actual significant caring figures as well as the particular roles they play - such as the parenting role. Following the loss of significant caregivers, other people were needed to fulfil these roles. The more completely and consistently someone took on these roles, the less significant the gap between past and present functioning and the more enhancing the resilience. Most commonly in the groups children mentioned grandparents, aunts, sisters, brothers, uncles, cousins and friends as replacement care givers and people who make them feel safe.

> *Whenever I am suffering she's always there for me. She is a mom in her own way. Although I don't have a mother anymore, they close that gap, my granny and aunt.*
> *(Thandanani, Photovoice Interview, 14+)*

> *My Aunt ... loves me a lot and she even calls me ... shortening my name. She likes me a lot and other times she pulls me and holds me tight just playing with me. She likes joking around with me.*
> *(Kenosis, Photovoice interview, 10-12 years)*

Family generally and aunts and grandmothers equally, were reported as the most likely people providing support and resilience. Only one child made reference to receiving support from her father. In the photo activity, most participants had taken pictures of someone in their family such as an aunt, grandmother or siblings.

The family unit also emerged as an important 'place' of safety, support and belonging and where resilient practices 'take place'. The family represented a system of support rather than support by individual people.

> *P: It's just that I didn't get chance to take one of the whole family together.*
> *F: Otherwise you wanted to take the whole family together?*
> *P: Yes I wanted to take one of all of them together.*
> *(Thandanani, Photovoice Interview 14- 15years)*

Friends: Many children, particularly those in older groups also spoke about the importance of friends. Most children included pictures of their best friends in their photo interviews, and this was especially so in older age group. Positive relations with friends and other peers (in all three groups) appeared to be key to resilience - as it is with them that children talk, play, laugh and learn to share.

> *We just talk and I end up forgetting that I was being shouted at.*
> *(Thandanani, Photo interview, 10 – 12 years).*

Friends and siblings were mentioned most often in the older group as providing support. In reflecting on her photographs of her friends one participant said the following about friendships:

> *P: Because she loves me and I love her too.*
> *F: How do you know when someone loves you?*
> *P: We've been friends since first grade and we're still friends.*
> *(Photovoice interview, 10 – 12 years).*

Good friends are those who are always willing to share their money, lunch, toys and things like pens. Children expressed that positive relationships are facilitated through play, sharing, talking and being together in familiar surroundings with family and/or friends.

Community Members: Other community members are also seen to provide support and care, for example the support and love children receive from their teachers, was commonly cited by children. Teachers, as a source of external support for children, were a common finding in the research, as it is in the literature.

In both the young and the older group, difficulties are often managed through an engagement with others, seeking out outsiders to talk to about ones situation or to offer you comfort. Children reported that when they feel like they have nothing else and no one else to help them through it does help to talk to someone else from outside (for example a community member) who knows their situation and who can help them. Many at the more rural site referred to going to the river as helping because when they are there, they are with their peers, they talk, share jokes, and it cheers them up.

> *P: I was going to say when another person abuses you at home, you tell someone, an outsider, and then you are able to find peace in your heart once you have been able to voice out what upset you.*
> *(Izingane Zethu, Focus Group, 6-8 years)*

Children reported that the traditional chief was someone who provided protection to the whole community and to children.

> *P: Our chief is important in our community because when an incidence occurs, perhaps a burglary happens at your home, you report to the chief and he reports to the police.*
> *(Izingane Zethu, Photovoice Interview, 6-8 yrs).*

In general, when children felt that there was no one else to help them from their immediate family, they said it is always good to have someone from outside looking out for them. This included community members, teachers, health care workers, and volunteers.

4.2. Places

Children described risk in terms of generalised risk which prevailed in communities where they lived. Resilience in regard to places was highlighted as crossing three levels of social networks linked to place, including home, school and community.

4.2.1. Risk

Crime in communities: A dominant risk factor included places that seemed to be unsafe and which were related to living in a violent community; for example, threats of people stealing from homes, and threats of violence on the streets. This reflects communities that have been fragmented by poverty and loss and disrupted social structure. Crime, in particular stealing, was very common, for example, if a family left their house, the perception was that other people would steal, eat their food or take their TV's. This caused anxiety for children and a great need for vigilance. Young people also reported that they stole from their own families, foster families or support networks.

At this place there are bad things which they do at people's homes when there is nobody there. They get there and break in and the boys steal everything. Whatever it is they need, even whatever they don't have, they even eat the food in the pots. (Thandanani, Photovoice Interview, 14+)

A strong feature of the children's stories was that not only do HIV and AIDS and loss affect children - but that children are living in communities and homes that are broken and strained by poverty and violence. Violence of various forms is commonplace for children (e.g. bullying, rape and abuse) and featured strongly in children's stories as a

risk factor for all age groups. Children spoke of communities in which they feared being stabbed or raped. Theft and loss of material security was very common.

P: *Yes there are places that make me feel uncomfortable?*
F: *Which are those places?*
P: *One of them is Edendale.*
F: *What happens there?*
P: *If you pass by and they don't know you they stab you."*
(Thandanani, Photovoice Interview, 10 – 12 years old).

Neighbours were seen as an important part of family and social networks, but also as a threat.

A trustworthy neighbour is important but not an untrustworthy neighbour.
(Thandanani, Focus Group 1, 10 – 12years)

Poverty in communities: After the loss of parents, the second largest concern for many of the children (particularly in more rural settings) was not having money and going hungry. Children said that not having money put them at risk because they could not buy food or clothes. If they did not have access to grants, they felt overwhelmed by poverty. Having no money made them sad, sometimes to the extent of wanting to commit suicide.

You feel sad and even want to kill yourself
(Izingane Zethu, Focus Group, 6-8 years)

In most instances poverty and loss of security was related to losing parents or family members and this introduced unrelenting struggles for resources.

As evidence from other literature indicates, children in this study also reported that a lack of access to money and resources acted as a mechanism to increase the rate and severity of other risks. Children described poverty as affecting their health and well

being (going hungry and not feeling or growing well) but also affecting their self esteem and pride (having to beg and feeling dirty and worthless).

> *P: They live in a small house and use paraffin stove.*
> *P: They have to scratch in bins for food, there is no food, they sleep hungry*
> *(Kenosis, Focus Group, 10-12)*

> *P: It is not right to be poor*
> *P: Our parent gave us everything, now there is nothing*
> *(Kenosis, Focus Group, 10-12)*

4.2.2. Resilience

Places that were seen to be important for feeling safe were home and school, and thereafter community. The findings based on the children's data support the literature in suggesting that an aspect of belonging or connection to a person or social structure is important in identifying places that enhance resilience.

Home: Within both the older and younger groups from all three sites, the family home featured strongly as a place where children felt comfortable and free. Children felt safe, happy, loved, protected at home among their families and friends.

Home gives children a sense of belonging and identity and a sense of security because they know their families will be there for them.

> *When I am sitting here (dining room at home) I forget about all the pain and sorrow I have been through… I always have people around.'*
> *(Kenosis, Photovoice interview, 10-12 years).*

> *I feel safe (at home) because it is beautiful.*
> *(Kenosis, Photovoice interview, 10-12 years)*

Children primarily spoke about their homes, kitchens or shared bedrooms (sleeping spaces) as important. They also mentioned important possessions such as TV or kitchen cupboards bought before a mother died as important.

> F: Whose room is this?
> P: Its granny's room.
> F: Can you say what you feel in granny's room?
> F: I feel safe in it… for instance if there is lightning, I sleep with her.
> (Thandanani, Photovoice interview, 10 – 12 years)

> F: What do you like about the kitchen [talking about photo]?
> P: The cupboards because my mum bought them before she passed away.
> (Thandanani, Individual interview, 10 – 12 years)

School: After homes, schools emerged as very significant places for children. Evidence of resilience as existing through schools that provide structure, belonging and routine is very common in research on resilience. In these children's data schools as a place of safety and security is also a feature. Schools were often seen as safe, a place where their friends were, a place where they had hope of education and a bright future that, and where teachers were available to support them.

School emerged as an important place for being able to provide capacity for resilience especially when home is vulnerable.

> P: I am including this one of my classroom because I enjoy myself there.
> (Thandanani, Photovoice interview 14 – 15years)

> For me, even when I am angry … I become happy as soon as I get to school.
> (Kenosis, Photovoice interview, 10-12 years)

While school was identified as a place where risk did occur around bullying and abuse, school was also cited as a very important source of support, help, comfort and security for children.

> *F: Why do you feel safe at school?*
> *P: Because the teachers look after us. When like there's something… like when a child gets hurt the teachers take the child to the clinic or hospital where the child can get help.*
> *(Thandanani, Photovoice Interview, 10 – 12 years).*

> *P: Yes I feel safe there [talking about photo of school] because the teachers are looking out for us and the gates are locked.*
> *(Thandanani, Photovoice interview 10 – 12 years).*

> *It is beautiful there (school). And if there is something bothering you, you can just tell the teacher and s/he can help you.*
> *(Kenosis, Photovoice interview, 10-12 years)*

Communities: Community surroundings were also perceived of as places of safety. However many children and in particular younger children, felt less safe away from their homes, and perceived that communities were unsafe places for them. They felt safer during daylight and less safe at night as they thought they may get mugged or beaten by strangers at night. Children who felt unsafe in their homes or neighbourhoods found night time particularly hard.

> *P: I am not safe when they send me to the shop in the evening. I am only safe in the morning.*
> *(Izingane Zethu, Photovoice Interview, 6-8 yrs)*

Programmes: A common feature in the children's data was of organisations and programmes as safe places. For example, Thandanani was seen as having an open-

door policy and organisational volunteers' houses were seen as safe places. This will be discussed more under programmes.

> P: Y*ou see, the reason, I took photos of these places [house at end of our yard, Ma [name of community worker]- community workers' house, school and watching TV is that when I'm feeling a bit down or bored this is where I normally go to and end up feeling better.*
> *(Thandanani, Photovoice interview 14- 15)*

4.3. Practices

Children identified several practices as creating risk at home, school and community levels. Risks related to practice were intertwined with risks related to people and places. Resilience related to provision of basic needs, showing affection, sharing, special events, rituals and celebrations, and culture and belief systems.

4.3.1. Risk

Being treated differently: Children reported that one of the most difficult things for children, was being to be treated differently and for there to be inequality or perceived unfairness in the home. Children who were cared for by extended family members said that they were often treated differently to the 'first' children in that family.

> P3: *They don't give you money but they give the other child*
> F: *They only give their child and they don't give you*
> P3: *Yes*
> P4: *Some times you wear old things at Christmas but their child doesn't*
> P5: *You clean the house but their child doesn't s/he just sits there with her legs crossed and you do everything*
> *(Thandanani, Focus Group 2, 10 – 12 years).*

Although a vulnerable child may not feel able to demand much, it is still felt as deeply unfair to be treated differently, or as a second rate citizen. This seems to make the loss of a primary care giver even more poignant.

As demonstrated by other research (Clacherty, 2002) often when children are accepted into the extended family they often report receiving differential treatment, having to work harder and being given the least priority in terms of access to family and educational resources.

Physical, sexual and verbal abuse: At the peri-urban and rural sites, both the young and older age groups identified the primary risk factor as fear or experience of abuse. Children were concerned about sexual, physical, emotional or verbal abuse from community and family members alike. The younger children from both sites identified the primary risk they feared as being an experience of abuse, in particular sexual abuse and rape. Children in this group were a mix of children from both the foster care programme and children from community households who were being supported by volunteers. Many of the children who were living in a foster care environment were doing so having been placed there for the purposes of their safety following sexual or physical abuse.

P: They undress them and rape them…he would pull the girl and rape her and say she must pay…money for raping her, to thank him…If the girl does not thank him, he hits her or continues raping her.
(Kenosis, Focus Group, 6-8 years)

In both of the age groups, the issue of sexual abuse and rape of children by other children as well as adults at home, in the community and particularly in school and/or on the way to school was a very strong concern. Many children felt threatened even in places where they expected to feel safe. There was also a gendered nature to fear of or experience of sexual assault and abuse.

> *P: There are boys that rape girls*
>
> *P: There were other bad boys called --- and the other one I have forgotten his name, he was kissing those two --- and --- and he was pushing her against the wall, and there was a boy in Grade 3 he wanted --- to be his girlfriend but she did not want to.*
>
> *P: There are also boys who hit girls at school, and this boy called --- who also rapes boys if he takes them he closes there eyes and mouth in the boys toilets.*
>
> *(Kenosis, Focus Group, 6 – 8 years)*

Children reported that being abused caused significant distress in their and other children's lives and led to other adverse experiences these included that they do not feel well and sometimes missed school or that they do not learn at school because they are thinking about the abuse going on in their lives. If they are sexually abused, they say they become afraid be among other people because they fear that other people are laughing at them. Children reported finding this, and verbal abuse, particularly hurtful when it came from family members.

> *P: They say futsek (go away) I am not your mother*
>
> *P: Sometimes they discriminate against you*
>
> *(Izingane Zethu, Focus Group, 6-8 years)*

Bullying: Another adverse experience raised by children was bullying, relating particularly to physical abuse, most commonly within a school setting. An important feature of the experience reported by the children was that 'perpetrators' were described to be both adults and other children, and hence adverse situations included those where other children were responsible for creating the risk - or where being with other children did not protect them from or reduce adverse experiences. Bullying were reported at levels and children reported this to be common even from teachers in their schools.

> *P: There was this boy when I was playing with the other one, he wanted to hit us and we were running from him and he wanted to stab us, he was chasing us and saying we must come and play with us and we were saying no, and he kept chasing us.*
>
> *(Kenosis, Focus Group 1, 6 – 8 years)*

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Children in the older groups made reference to bullying in the home environment. In general children did not feel supported to respond to mistreatment and physical abuse.

> *P: It is that he gets punished all the time… and he is punished for no reason.*
> *(Kenosis, Focus Group, 10-12)*

Disrespect: Being or feeling disrespected featured strongly among the accounts of the older children and included being shouted at, treated differently, or fighting which were experienced as very distressing. While younger children are certainly dependent on parents or alternative adult caregivers, the older children are becoming more self-sufficient. They therefore experience disrespect to self as harmful because the self that they rely on is under threat.

Leaving Home: Children reported that one of the possible consequences of a parents or care givers death included being required leave home (which lead to subsequent other risks, such as sniffing glue, drinking and smoking). When probed for the reasons why children might have to leave home, children reported a variety of reasons, such as needing to get basics like food, others reported that perhaps children were caught stealing at home and be sent away, or that they had been given too many chores or had not wanted to do chores.

4.3.2. Resilience

Provision of basic needs: The practices most often reported by children to help to enhance resilience, fell into a category labelled basic provision. Basic provision in terms of food, school fees and uniforms, provision of clothing and money for school things were identified as most important things that people did for these children.

Most children reported that financial provision for a child and ensuring that a child had their basic needs met was a very important mechanism for increasing resilience. Practices which provided for their needs left them feeling good and they felt more secure and less exposed to the elements within their community which represent risk to them.

Provision of basic needs for survival was listed by all children as important for a child to be resilient and generally children relied on family members to provide this. In addition to financial support (shelter, food, clothes, and school material), children also recognised emotional (love, care and support) provision as very important for them to feel good.

Children stated that when they feel emotionally and financially secure they are able to focus on other things such as school, they do not have to keep worrying about things that they do not have, that they'd like to have or need to have. Basic provisioning is very important to children, as it makes them feel the same as and equal to other children and external support to enable families to be able to provide these basic needs is important.

Expression of affection: After provision for basic needs, the expression of love or comfort was identified as the next most important and was sometimes expressed as the provision of a 'mothering role'

> "*P: Yes they give you love like your mother did*"
> *(Thandanani, Focus Group, 10 – 12 years).*

> *P1: When I feel right it's when my mother holds me, puts me under her wing.*
> *P2: I feel alright when my uncle brushes my head… I feel better because it shows they still love me.*
> *(Thandanani, Focus Group 1, 10 – 12 years)*

Sharing: Sharing and spending time together or talking to others (this in particular seems to be in a way that indicates that they can understand the problems that children are experiencing) were also important practices referred to in the groups. Children also reported that having someone to talk to, be it a friend, teacher or family member is important to deal with hurtful feelings. Friends often helped children to forget their difficulties, and are valued as people children talk, play and laugh with.

Many children reported practices that were about being connected and this was a very important mechanism for increasing resilience. Practices such as being loved, being taken care of, getting assistance with homework and household tasks, being guided, being told things, being listened to were mentioned as some of the things that people do that can make children feel safe.

Chores and own skills: Self-practices, such as doing things that one can recognise in oneself or that one felt you were good at, were also mentioned by many of the children as important. Likewise having a sense of responsibility or a sense of mastery, which is often also highlighted in the literature on resilience, was very common to children's narratives about resilience.

P: I am not rude to my elders and treat children with kind hands."
F: Who are these children that are sitting under a tree?
P: It's the kids that I fetch from crèche.
(Thandanani, Photovoice Interview, 10 – 12years).

While there was less mention of any specific cultural practices amongst children many children referred to shared regular practices such as going to the river to fetch water with their friends on a regular basis where they share their problems and feel better. This demonstrates that resilience is situated in the context in which children live. Gardening, herding and looking after livestock and working with the land was also seen as useful activates to ease distress and to feel a sense of connection. Being able to contribute something useful makes children feel happy. There may even be some important connection that the animals provide, as livestock is highly valued.

P: When I am herding our family's goats I notice that they are happy with me and that makes me happy.
(Izingane Zethu, Photovoice Interview, 13-15 yrs)

Cultural practices and spirituality: Particularly at the rural site, the Chief and traditional culture and practices featured strongly as enhancing resilience for this

group of children. Children felt a sense of pride in their culture, traditional dress and enjoyed opportunities to participate in traditional practices.

> *P: I feel better when I am in traditional attire and go to dance.*
> *(Izingane Zethu, Photovoice interview, 13-15 yrs)*

> *P: I like singing and traditional dance.*
> *(Izingane Zethu, Photovoice interview, 6-8 yrs)*

Culture is important for giving these children a sense of history and a sense of belonging. These practices allow the children to hold onto community concepts which represent for them positive family values and positive elements of their community. Traditional culture emphasises tackling responsibility for and supporting children and families.

At the pastoral site (Kenosis), resilience was more focussed and expressed through Christian religion and prayer. Children in the groups at this site did not specifically refer to cultural practices beyond symbols of protection (such as wearing a cloth around the neck to ward off bad spirits). The children's expression of meaning and comfort through religion is likely linked to the level of religious engagement within community. Again this seems to reiterate that resilience is a practice dependent on context. Religion featured more strongly in this group of children than in other groups, while less or no mention was made of traditional or cultural practices that make children resilient. Taking problems to God or to the Sister were seen to be helpful practices and gave the children a sense of connectedness, more than other activities. This emphasises the important of context.

> *Ask a person to help you, asking for forgiveness, it helps, it helps to be prayed for*
> *(Kenosis, Focus Group, 10-12 yrs)*

> *Even if you play soccer you do not forget but when you have prayed it passes just a*
> *little*
> *(Kenosis, Focus Group, 10-12 yrs)*

Special events: Special events were also seen as important contributors to resilience. The majority of the children's narrative featured a highlight being linked to a celebration of some sort, such as a birthday or going to the beach at a special time in the year.

> *"Here my mum was throwing a birthday party for me. It was the best"*
> *(Thandanani, Photovoice interview, 10 – 12 years).*

4.4. Programmes and external support

Some children were able to access a supportive 'family' environment and care through volunteer's acting in mothering roles. The volunteer was also identified as being useful for providing support when it is difficult to speak to family. One of the benefits of organisations that are undertaking community-based support seems to be that the volunteers live in the area, and so their homes and families are easily accessible to the children.

For the older groups, both volunteers and teachers were mentioned as people who offer support, community workers (often referred to as or a organisation's named auntie or her family members) were identified as providing support to children in their homes, and teachers were identified as are important advocates for children in general, but particularly at school.

> *F: Who do you talk to most?*
> *P: I talk to my [Thandanani] aunt.*
> *F: Why don't you talk to your blood family?*
> *P: I am scared she is a relative. There is nothing wrong at home it's just that I am*
> *scared to talk to family.*
> *(Thandanani, Photovoice Interview, 10 – 12 years).*

Other external systems recognised by children as providing support (at the rural site, in particular) and enhancing resilience were the Child Support Grant and the support from the organisational activities in the community. In the younger groups (10 – 12 years), the provision of school uniform and food parcels through were frequently referred to as important external supports, as well as the provision of pocket money for school which children felt was very useful because their families could not help them with this.

A further important part of resilience which is provided for by external support is for children to be able to talk to someone about negative experiences. One child said:

P: I was going to say when another person abuses you at home, you tell someone, an outsider and then you are able to find peace in your heart once you have been able to voice out what upset you.
(Izingane Zethu, Photovoice interview, 6-8 yrs)

At Kenosis, children in the groups identified a connectedness with important role players like nuns, teachers, social workers, the police and other caregivers as being there for children when they need help. Teachers in particular provide support to children after the loss of their loved ones and were reported as being able to always be counted upon.

Programmes are important in proving supportive structures in which micro-systems could be facilitated to provide care for children. In many instances, where family support was absent, volunteers were seen to facilitate everyday caring and support, in this way programme support was providing people who were able to consistently give care to a child or family.

Programme support also offered safe places for children to come together, such at through therapeutic weekends and holiday camps. In many instances, children had adopted practices supported by the programmes in their area (for example, religion and prayer in Kenosis, support groups and peer support in Thandanani, traditional

and agricultural practices in Izingane Zethu). While children felt assisted with basic necessities, care and support, when children expressed and spoke of unmet needs, in many cases, reference was made to needs or services which could or were not being provided within their communities.

4.5. Children's understanding of risk and resilience

Three very important construct have emerged from the narratives of children. These are hope, perseverance and connectedness, all of which appear to be key facilitators of resilience for children.

Hope: When children where asked to report on what factors helped them to cope when things were difficult, they were asked to 'vote' for which things helped them the most by placing beans on particular helping factors they had identified. In the older group, a sense of self-reliance and hope emerged as the most important factor in resilience. In the younger group of children, having "good dreams" was representative of having hope for the future. Children in the younger group also made reference to more demonstrative and affectionate forms of helping such as physical affection (pat on the head or talking), which reflects their developmental needs.

Perseverance: Children reported that one of the most important construct which made it possible for them to be resilient and go on with life was to have perseverance. Children reported that believing in their own strengths and having experienced many harsh things built a sense of perseverance which made them carry on. Perseverance is described as a forced experience, not one which you would choose to live by – but one which becomes part of how you learn to survive when you have no other choices but to do so.

> *P: Tell yourself that you are going to live even if they mistreat you as long as they don't beat you up you will live if they just do you a favour of not killing you.*
> *(Izingane Zethu, Focus Group, 6-8 years)*

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P: They hit you and hit you and abuse you and through all these things you just persevere because it is not your home you don't know where to go
 (Izingane Zethu, Focus Group, 6-8 years)

Connectedness: Children reported that being happy related to entering school, or school related activities such as the school choir or being promoted into the next grade. The celebration of their birthday has also been observed to be one of the most common highlights of their lives. A strong theme of connectedness was raised as facilitating resilience. Being connected to people who were willing to help you was seen as a critical facilitator of resilience, and children had constructed clear narratives around how to manage connectedness. Family and a concept of family were critical to being and feeling connected.

It is just that they (family) are there.
(Kenosis, Photovoice interview, 6-8 years)

They are there for me and I just feel happy when I see them and her (sister).
(Kenosis, Photovoice interview, 10-12 years)

This research has conceptualised resilience as a set of interrelated processes and identified people, places and practices that either facilitate resilience or aggravate risk. Risk and resilience are balanced and need to be negotiated in relationship and maintained by a context and everyday practices. In order to describe different aspects of risk and resilience the findings were described according to four P's: people, places, practices and programmes. While this conceptual understanding of enhancing resilience in terms of situated practices, relationships to people and experiences of place, and programme support, is useful, the findings have reiterated that these aspects are all interrelated and interdependent, complex in their relations to one another. Practices that enhanced resilience were carried out by families, or consistent people in a child's life. If there was not a consistent stable caregiver, children were exposed to multiple risks. People carried out significant practices of providing basic needs and access to education, as well as proving comfort. The practices were ordinary, rather than being extraordinary.

4.5.1. Everyday practices

Practices include the things people do that provide comfort, care and support to children. Significantly, we found that these were not out of the ordinary but rather they were everyday practices of basic provision of food, safety, protection, clothing and shelter, as well as provision of care such as expression of love and spending time doing things together with children and gives children a sense of security and belonging.

Importantly children recognised that assistance in everyday issues (not just big things) was very useful. For example assistance with homework, getting ready for school, grooming, being there when a child is sick, assisting with basic provision, showing affection, and helping with chores like dishes and laundry. Children in the rural site regarded talking, playing and going to the river as important because it is when they engage with their friends and other significant caring adults.

4.5.2. Empathic care

The provision of love or comfort was sometimes expressed as the provision of a 'mother role' "*yes they give you love like your mother did*". This expression of a need for empathetic care is echoed in the literature where empathy is described as the capacity "to feel our self into the other" (Mead, 1934, cited in Richter, 2007, p46). It is argued that in most contexts of adversity, empathy can provide the cornerstone for committed care for children. Empathy and identification with the child is a necessary element for engaged care and stimulation of a child, regardless of whether by family members or alternative caregivers. When empathy is absent, the child can be labelled as an other or bad and may slips out of the zone of intimacy or care which then puts them greater risk of being mistreated (Richter, 2007).

While everyday practices are seen to be the most important facilitators of resilience, celebration and important events were also acknowledged by most children as being important, in particular in contributing specific special happy memories.

4.5.3. Having a place to belong

Practices that enhance resilience are actions carried out by significant people who are embedded in a cultural context. Resilience is situated in a context of practices such as going to the river or being involved in a gardening project. Significant and consistent relationships create safe places in which children could feel belonging.

Empathic care and resilience through everyday practices of care, are carried out by significant people in a child's life, and these typically happen in certain places, such as school and home. The children's data indicates that the aspect of belonging to some identifiable physical space or place was very important for saying where I belong, and providing them with a sense of identity.

> "…and this is home. There I have shelter, food, clothes and everything else that I need, I get from home."
> (Photovoice interview, Thandanani).

4.5.4. Safe and unsafe places

The data also indicates that places can be both safe and unsafe for children. Children may feel safe and protected at home, within their community and at school, but they may also be exposed to rape, abuse and bullying within these same places.
While home, in most instances, was seen as a safe secure place, because it was familiar and was home, but even in homes children could be treated unfairly.
Therefore, the experience of place tended to be dependent on the people or practices within them, and places provide a space and context within which practices (good or bad) and relationships (good or bad) and experiences (good or bad) took place.

4.5.5. Programmes and external support

Programmes were particularly important in supporting these microsystem relationships and practices to occur. They provide a holding function where the gaps

were and enabled care in communities to happen more effectively. The importance of social networks and layers of support was clear in the data.

4.6. Conclusions

Resilience is not a static state but the continual interplay between experiences that offer resilience and those that are risky. We could picture this as like a steam train. In order to keep the train going we need the fire to be fed with coal. Children need their basic needs of clothing, food and school fees met, they need their fires stoked with affection and acknowledgement. These practices are provided for by people who feed the fire and guide the train. The driver and fire stoker (significant people in a child's life) need to be competent, consistent, responsive and responsible for caring for the train to keep it running smoothly. If the people and practices run smoothly, the train becomes a safe place to be and children can feel belonging and identity. External support such as maintenance of tracks and the signal control need to be operating efficiently to support the train's journey along its path. If anything fails either in the functioning of the train or to one of the people, the train is at risk of an accident or coming to a grinding halt. The switch control changes and the developmental trajectory may change to a path of risk or a path of resilience. The child is also an agent in the train's direction. Keeping the train running requires effort and a willingness to embrace the difficult while still pursuing the journey.

Resilience is a dynamic process of needing to acknowledge and hold the difficult, rather than avoiding or denying the difficult, while at the same time holding hopefulness for the future, and courage and connections to others. There is a need to keep nurturing the potential for connection and hopefulness.

A Native American story describes a grandfather talking to his son about how he felt. *He said, "I feel as if I have two wolves fighting in my heart. One wolf is the vengeful, angry one. One wolf is the loving, compassionate one."*
The grandson asked him, "Which one will win the battle in your heart?"
The grandfather answered: "The one I feed."

In the same way we see that through certain types of support (through people, places and practices), we can encourage or feed responses to difficult life circumstances that enhance hopefulness and belief in self, developing a desire to make healthy connections to others and showing courage to continue while still acknowledging that things are very difficult.

We have seen in the data that places can be safe or unsafe, that people and the things they do (practices) can enhance or hinder resilience. Interventions by family or community facilitators should aim to make it possible for a child to have a sense of security and pride which in turn precipitates helpfulness, altruistic and social behaviours.

5.   Recommendations

5.1. Inventions in support of people

A stable and consistent, responsive caregiver or the presence of a replacement caring adult who will champion for the child, invest in the child's future and have expectations of a future for them is one of the clearest mechanisms for enhancing resilience, both from the literature and the children's data (Rutter & Garmezy, 1983; Sameroff, Rosenblum, & Katherine, 2006; Grotberg, 1995; Killian, 2005; Foster & Sherr, 2006).

5.1.1.   Replacement caregiving

After the loss of parents, other caregivers can and should assume the role of parent, but that person (s) needs to provide similar qualities in the relationship such as care, love and fair provision (Killian, 2005; Skinner Cook et al., 2007). The data from the children suggests that extended members of the family seem to be the most likely to take on this role, and that it is experienced as a continuation of care if family offer the role of parenting. When children had lost their parents other family members such as grandmothers, aunts or siblings supported them. We recommend that family structures need to be supported and kept together as much as possible. This would suggest that interventions should support extended families in being able to care for children. This can happen through programmes, which support families materially, but also with capacity to care, such as caregiver training and support.

It is critical the replacement caregivers are stable and consistent in the child's life and are able to invest in the future potential of the child in the longer term. Caregivers also need to have the capacity and be skilled at providing supportive and empathic care. It would be helpful for organisations offering psychosocial support to facilitate discussions in families before the death of a parent about who would continue the care of children, and agreements on responsibilities. These discussions are also useful for children to hear and express their love for parents, and vice versa, before their death. In instances where community volunteers take on caring responsibilities within a family setting, it is important to encourage the training of such volunteers on sensitive and responsive caregiving.

It would be beneficial to develop guidelines for the integration of children into new families; for example, guiding caregivers to know that when taking in another child, it is important to treat all children in the family the same. It could be helpful to assist families in thinking about ways that this can be achieved.

An important finding was that that most of the replacement caregiving and support for children is provided by women in the community. This has two implications; firstly, it would seem that programmes targeted at supporting and empowering women through social protection, access to services and emotional support are likely also to have a positive impact on improving the care of children. However it also seems relevant and important that men's nurturing roles be encouraged in communities where this resource is currently underutilised.

5.1.2. Developing peer and friendship support

While the development of the capacity of caregivers in caregiver-child interactions to provide psychosocial support and therefore promote better psychosocial development in children in vulnerable settings, is critically important. It is also important that peer support should be facilitated and encouraged through activities such as facilitating positive friendships, peer support groups, buddy systems, social interactions and support between children(Killian, 2005; Richter, Foster, & Sherr, 2006b; Richter & Rama, 2006b).

Activities that assist young people in building relationships with other children in their local community and which provide a safe place for children to engage in shared practices are very useful in building resilience. These should be enhanced with structures to support those relationships after intervention. Buddy systems and peer mentoring could be useful options. It is important that even when there is a loss of a parent that siblings and family groups are kept together as much as possible.

5.2. Interventions in support of places

Schools are an investment in children's future and provide children with support and structure (Skinner Cook et al., 2007; Fox et al., 2007; Singhal, 2007). They offer the advantage of a fixed framework within which resources can be invested and monitored in order to assist children. The literatures as well as children's voices indicate that schools are an important source of assistance to children.

5.2.1. Support in schools

Schools provide important places for feeling safe and having a sense of belonging, of a future and hope. The importance of schools for children has implications for service provision for two reasons; firstly, in the light of loss of parents, and secondly, in relation to this particular developmental stage for children. A large amount of support is derived from school, and school provides an important and specific resource for growth and development.

Several responses are required. Firstly, there is opportunity and need to lobby government structures to develop educator's abilities and resources and to offer improved support to enable them to be able to better respond to the educational and psychosocial needs of children. Secondly, since there is recognition that school provides such a tremendous opportunity for supporting children and since it is acknowledged that educators are already overburdened it is likely that providing additional psychosocial support positions in schools may be a useful strategy for harnessing the resiliency. Any external support which offers supervision and support for educators and that increases access to school either through providing school uniforms, non-fee paying schools etc. are likely to contribute to building resilience at the level of the child as well as the community. Collaborating and forming networks between psychosocial support systems in schools and in communities can be very useful because children seemed to be in touch with their teachers and comfortable with telling them things that they find difficult in their lives.

Sometimes the places within which children feel safe also put children at risk. Although most children feel safe at school, other children are exposed to bullying, abuse and rape within school. Children are exposed to harm and violence by other

children, and that some children do not have someone they can talk to about their experiences or fear of violence within school or their communities. Developing custodian roles within schools and the improving the capacity of educators to respond to psychosocial needs of children is a response to this need.

Developing programmes to specifically address bullying are also likely to be very useful but, more importantly, children need to know that they can depend on adults as the primary protectors of their rights. Family and other external support structures need to equip children with skills on how to deal with bullying, for example. Children also need to know where to go, should they experience abuse, rape and other forms of violence and family members and caregiver need to be empowered to act on behalf of their children so that acts of helping build resilience within the family structure.

5.3. Intervention in support of practices

While the epidemic can at times feel overwhelming to families what is evident in both the literature and the children's data is that caring consistent everyday practices contribute tremendously in helping children cope and build resilience. These acts of care that families and other community members are able to engage with provides an opportunity to support and encourage community members to feel valued in the care of their own children (Killian, 2005; Killian, 2007; Masten, Best, & Garmezy, 1990; Masten, 2001; Masten, 2007).

5.3.1. Everyday practices

It is recognised both in the literature and in the voices of the children that to support and build resilience is through everyday practices. However, training volunteers in 'everyday' responsive caregiving can be difficult. For example, being responsive to children and helping them to express emotion and support their feelings, but also set boundaries and limits are quite sophisticated skills. It is recommended that organisation consider specific training programmes such and the International Child Development Programme (Richter, 2001) in sensitising replacement care givers to be responsive and reflective in their everyday care of children. This trainings emphasises simple principles that can be supported and encouraged including: Showing and

expressing love for a child, talking with children, following a child's emotional lead, praising and appreciating a child for what they can do or master, and helping a child to focus their attention and share their experiences.

It is critical to begin to support and encourage the value and potential of everyday practices for children. This is not only so in the case of organisations providing external support to children, but also in supporting community members, family networks and caregivers to recognise and feel validated in the critically important things they can do for their children. Often times these everyday practices are being provided by families who are stretched and strained. Communicating and validating the importance of acts of love for children, the stroke on a head or a smile when a child arrives home from school, sitting and talking about the day, sharing time for homework, participating in chores together, offering a kiss goodnight, it is in these treasures or magic moments that children begin build the reservoirs of resilience which will see them through many exposures to risk.

Richter, Foster & Sherr (2006) acknowledge that young children affected by HIV and AIDS and other disruptions have many psychosocial needs. These needs are best met through 'everyday systems of care' embedded in their everyday lives. Therefore it is useful for us to strengthen caregivers' abilities to respond to and provide affection and care for 'their' children and to provide 'normal' routines and assist with access to school and social networking through participation in community and/ or faith based activities. Psychosocial care is best provided by families and communities (Richter, Foster & Sherr, 2006). "It is the day-by-day, consistently nurturant care that constitutes the building blocks of children's psychosocial wellbeing, including how children learn, develop and adapt." (Richter, Foster & Sherr, 2006, p.10).

5.4. Interventions in support of programmes

The sheer extent of the epidemic requires that all communities, starting from units of care such as families but extending to external support organisations, civil society, government and the international community need to invest in ways to bring children into a new hopeful era (Patterson, 2007; Singhal, 2007). These investments in community need to be integrated, use resources effectively, be thoughtful and

sustainable if they are hold value for children in the longer term and the build resilience in the shorter and medium term.

5.4.1. Integrated programming

As is strongly supported by the literature, organisations offering external support to children and families need to take a holistic and integrated approach to programming. Organisations who offer assistance to children and families from a rights-based perspective are more likely to provide sustainable and meaningful support. While a variety of needs are important for children at any one time, no one need (material or emotional) should be delivered at the expensive of another and no one need should be given special emphasis on account of organisational technical capacity or resources.

While organisations may be limited in the types of support services they can provide, it is critical that if and when providing of a limited set of needs that they partners with other organisations, government and communities themselves to develop systems of support around other unmet needs. Programmes that enhance capacity of people within communities to provide support for children are the most sustainable.

Programmes should enhance and build on resilient practices already existing within communities. In doing so they begin to find ways to help people be aware of their resilience-enhancing practices and to amplify them. Programmes which sensitise caregivers to the psychosocial needs of vulnerable children and how to respond to them within families, schools and communities are valuable. The value of such programmes is however degraded in communities where exposure to ongoing risk factors (such as poverty) is consistently high. We need to address poverty and socioeconomic conditions in which children live, and promote longer-term interventions that strengthen structures around children – such as developing caregivers and facilitating access to education. Rather than developing stand-alone interventions, we should make links with schools and other support structures.

McCallin (2005) argues that building resilience should not only focus on interventions which address identified risks but that they should also engage in prevention activities. As such, organisations providing external support should be encouraged to

include both risk-focused approaches such as the prevention or response to child abuse through community and parental education and support, but also resource-focused approaches which aim to prevent and reduce risk for the community as a whole by improving the number and quality of resources to support children and families. This includes strengthening existing community resources and reinforcing cultural norms and practices which promote resilience.

6. References

Alvord, K. M. & Grados, J. (2005). Enhancing resilience in children: A proactive approach. *Professional Psychology: Research and Practice, 36,* 238-245.

Arrington, E. G. & Wilson, M. N. (2000). A re-examination of risk and resilience during adolescence: Incorporating culture and diversity. *Journal of Child and Family Studies, 9,* 221-230.

Bateman C. (2003). Home-Based HIV/AIDS care. *South African Medical Journal Forum, 93,* 908.

Black, M. (2003). *Opening minds, opening opportunities: Children's participation in action for working children* London: Save the Children.

Bor, R., Miller, R., & Goldman, E. (1993). HIV/AIDS and the family: A review of research in the first decade. *Journal of Family Therapy, 15,* 264-267.

Bouvier, P. (2005). *Resilience: A different way of looking at things* Geneva: Papers from International Catholic Child Bureau.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks: Sage.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge: Havard University Press.

Chambers, R. (1994). The origins and practice of Participatory Rural Appraisal. *World Development, 22,* 953-969.

Chambers, R. (1994). Participatory Rural Appraisal (PRA): Analysis of experience. *World Development, 22,* 1253-1268.

Chirwa, W. C. (2002). Social exclusion and inclusion: Challenges to orphan care in Malawi. *Nordic Journal of African Studies, 11,* 93-113.

Christianson, P. & James, A. (2002). *Research with children: Perspectives and practices*. London: Falconer Press.

Clark, A. & Statham, J. (2005). Listening to young children: Experts in their own lives. *Adoption and Fostering, 29,* 45-56.

Denis, P. (2005). *Never too small to remember: Memory work and resilience in times of AIDS.* Pietermaritzburg: Cluster Publications.

Department of Health. (2007). *Government National AIDS Plan 2007 - 2011.* National Department of Health, Pretoria

Durrheim, K. (1999). Research Design. In M.Terre Blanche & K. Durrheim (Eds.), *Research in Practice: Applied methods for the social sciences* (pp. 379-397). Cape Town: UCT Press.

Fine, B. S. (1991). Resilience and human adaptability: Who rises above adversity? *The American Journal of Occupational Therapy, 45,* 493-503.

Foster, G. (2005). *Bottlenecks and drip-feeds: Channelling resources to communities responding to orphans and vulnerable children in southern Africa.* London: Save the Children.

Foster, G. & Sherr, L. (2006). Vulnerability and resilience of children and youth. *Vulnerable Children and Youth Studies, 1,* 1.

Foster, G. & Williamson, J. (2000). A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS, 14,* 275-284.

Fox, S. & Parker, W. (2007). HIV/AIDS, Children, and Sub-Saharan Africa: dealing with bereavement. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 119-130). Athens: Ohio University Press.

Freeman, M. & Nkomo, N. (2006). Assistance needed for the integration of orphaned and vulnerable children-views of South African family and community members. *Journal of Social Aspects, 3,* 503-509.

Garmezy, N. (1993). Children in poverty: Resilience despite risk. *Psychiatry, 56,* 127-136.

Garmezy, N. (1994). Reflections and commentary on risk, resilience and devlopment. In R.Haggerty, L. Sherrod, N. Garmezy, & M. Rutter (Eds.), *Stress, risk,*

and resilience in children and adolescents: Processes, mechanisms, and interventions (pp. 1-18). Cambridge: Cambridge University Press.

Garmezy, N. & Masten, A. (1994). *Reflections and Commentary on Risk, Resilience and Development In R. Haggerty, L. Sherrod, N. Garmezy, M. Rutter (Eds.) Stress, Risk, and Resilience in Children and Adolescents: Process, Mechanisms and Interventions (pp. 1-18)* . Cambridge: Cambridge University Press.

Gorman, C., Dale, S. S., Grossman, W., Klarreich, K., McDowell, J., & Whitaker, L. (2005). The importance of resilience. *Time, 165,* 52-55.

Greig, A., Taylor, J., & MacKay, T. (2007). *Doing research with children*. (2nd ed.) London: Sage Publications

Grotberg, E. (1995). *A guide to promotingrResilience in children: strengthening the human spirit* The Hague: Bernard van Leer Foundation: The International Resilience project.

Grover, S. (2005). Advocacy by children as a causal factor in promoting resilience. *Childhood, 12,* 527-538.

Gunnestad, A. (2006). Resilience in a cross-cultural perspective: How resilience is generated in different cultures. *Journal of Intercultural Communication 11, 1-22.*

Haggerty, R. & Sherrod, L. (1994). *Stress, Risk, and Resilience in Children and Adolescents: Processes, Mechanisms, and Interventions. Preface In R.Haggerty,L.Sherrod,N.Garmezy,M.Rutter.(Eds)*. Cambridge: Cambridge University Press.

Haggerty, R., Sherrod, L., Garmezy, N., & Rutter, M. (1994). *Stress, risk, and resilience in children and adolescents: Processes, mechanisms, and interventions*. Cambridge: Cambridge University Press.

Hart, R. A. (1997). *Children's participation: The theory and practice of involving young citizens in community development and environmental care*. London: Earthscan.

Health Systems Trust (2006). *South African Health Review 2006* (11th Edition). Durban, South Africa: Health Systems Trust.

Hedegaard, M. (2002). *Learning and development: A cultural historical study*. Aarhus: Aarhus University Press.

Heymann, J., Earle, A., Rajaraman, D., Miller, C., & Bogen, K. (2007). Extended family caring for children orphaned by AIDS: Balancing essential work and caregiving in a high HIV prevalence nations. *AIDS Care, 19,* 337-345.

Horizons Program (2005). *Strengthening care and supports services in the era of treatment* Washington DC: The Population Council.

Howard, S, Dryden, J & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford review of education*, 25, 3, 307 – 3 [electronic version] retrieved from
http://www.jstor.org/view/03054985/ap030078/03a00020

International Resilience Project Team (2006). *International Resilience Project* Halifax, Canada: Dalhousie University.

Jacobs, M., Shung-King, M., & Smith, C. (2005). *South African Child Gauge 2005*. Cape Town: Children's Institute, University of Cape Town.

Johnson, V. & Ivan-Smith, E. (1998). The Way Forward. In E.Ivan-Smith & V. Johnson (Eds.), *Stepping Forward: Children and young people's participation in the development process.* (London: Intermediate Technology Publications.

Kelly, M. J. (2007). Reducing the Vulnerability of Africa's Children to HIV/AIDS. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 59-84). Athens: Ohio University Press.

Kelly, K. & Van der Riet, M. (2001). Participatory research in community settings: Processes, methods and challenges. In M.Seedat, N. Duncan, & S. Lazarus (Eds.), *Community Psychology: Theory, method and practice: South African and other perspectives* (pp. 159-188). Cape Town: Oxford University Press.

Killian, B. (2005). Risk and resilience. In R.Pharoah (Ed.), *A generation at risk? HIV/Aids, vulnerable children and security in Southern Africa.* (pp. 33-63). Pretoria: Cape Town: Institute of Security Studies.

Killian, B. (2007). *The development and evaluation of a community-based programme offering psychosocial support to vulnerable children affected by HIV/Aids, poverty and violence.* A thesis submitted towards a degree of Doctor of Philosophy. University of KwaZulu Natal.

Kruger, J. (2006). Children, community, and HIV/AIDS in South Africa. *Children, Youth and Environment, 16,* 199-222.

Laurie, J. B., Camacho, S., Silver, E. J., Hudis, J., & Draimin, B. (2002). Behavioural problems in school-aged children of mothers with HIV/AIDS. *Clinical Child Psychology and Psychiatry, 7,* 39-54.

Lazarus, A. (2004). *Relationships Among Indicators of Child and Family Resilience and Adjustment Following the September 11, 2001 Tragedy* The Emory Centre for Myth and Ritual in American Life Working Paper No.36.

Lederach, J. P. (1995). *Preparing for Peace: Conflict Transformation Across Cultures*. Syracuse, NY: Syracuse University Press.

Liddell, C. (2002). Emic perspectives on risk in African childhood. *Developmental Review, 22,* 97-116.

Levin-Rozalis, M. (2004). Revisited a tracer study 10years later: Detective process. *Journal of early childhood research, 2,* 247-272.

Mallman, Sr. S. (2002). *Building resilience in children affected by HIV/AIDS: Catholic Aids Action Namibia*. Cape Town: Maskew Miller Longman.

Mangham, C., McGrath, P., Reid, G., & Stewart, M. (1996). Resiliency: Relevance to health promotion. *Health and Canadian Society, 4,* 84-116.

Martin, M. (2003). HIV/AIDS in South Africa: Can the visual arts make a difference? In K.Kauffman & D. Lindauer (Eds.), *AIDS in South Africa* (New York: Palgrave Macmillan.

Masten, A. (2001). Ordinary Magic: Resilience processes in development. *American Psychologist, 56,* 227-238.

Masten, A. (2001). Ordinary magic. *American Psychologist, 56,* 227-238.

Masten, A., Best, K., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathlogy, 2,* 425-444.

McCallin, M. (2005). *Child Rights and Resilience* Geneva: Papers from International Catholic consultation.

McWhiter, J. J., McWhiter, B. J., McWhiter, E. H., & McWhiter, R. (2007). *At Risk Youth: A Comprehensive Response for Counselors, Teachers, Psychologists and Human Service Professionals*. Belmont,CA: Fourth edition.Thomson.

Miller, R., Goldman, E., & Bor, R. (1994). Application of a family systes approach to working with people affected by HIV disease- two case studies. *Journal of Family Therapy, 16,* 295-312.

Mitchell, C., Stuart, J., Moletsane, L., & Buthelezi, T. (2004). Taking pictures /taking action: Photo-voice with young people. In Durban: A Multidiscliplinary Conference on Working with Children.

Mkhize, N. (2004). Sociocultural approaches to Psychology: Dialogism and African conceptions of the self. In D. Hook (Ed.). *Critical Psychology* (pp. 53-83). Cape Town: UCT Press.

Miller, J. (2003). *Never to young: How young people can take responsibility and make decisions*. London: Save the Children UK.

Newman, T. (2005). *Limits to the Concept of Resilience* Geneva: Papers from International Catholic Child Bereau consultation.

Nostlinger, C., Bartoli, G., Roberfroid, D., & Colebunders, R. (2006). Children and adolescents living with HIV positive parents: Emotional and behavioural problems. *Vulnerable Children and Youth Studies, 1,* 29-43.

O'Kane, C. (2000). The development of participatory techniques: Facilitating children's views about decisions which affect them. In P.Christensen & A. James (Eds.), *Research with children: Perspectives and practices* (pp. 136-159). London: Routledge Falmer.

Oleke, C., Blystad, A., & Rekdal, O. B. (2005). "When the obvious brother is not there": Political and cultural contexts of the orphan challenge in northern Uganda. *Social science and Medicine, 61,* 2628-2638.

Oleke, C., Blystad, A., Moland, K. M., Rekdal, O. B., & Heggenhougen, K. (2006). The varying vulnerability of African orphans: The case of Langi, Northern Uganda. *Childhood, 13,* 267-284.

Patterson, A. S. (2007). AIDS, Orphans, and the Future of Democracy in Africa. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 13-39). Athens: Ohio University Press.

Perry, B. D. (2000). Resilience: Where does it come from? *Early Childhood Today*.

Pharoah, R. (2005). *A generation at risk? HIV/Aids, vulnerable children and security in Southern Africa*. Pretoria: Cape Town: Institute of Security Studies.

Pillay, Y. (2007). Storytelling as a Psychological Intervention for AIDS Orphans in Africa. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 105-118). Athens: Ohio University Press.

Pivnick, A. & Villegas, N. (2000). Resilience and risk: Childhood and uncertainty in the AIDS epidemic. *Culture, Medicine, and Psychiatry, 24,* 101-136.

Richter, L. (2002). Strengthening infants and children: South African perspectives. In Paper delivered at the Conference in Infant Mental Health: Infants in Changing Cultures. Cape Town.

Richter, L., Foster, G. & Sherr, L. 9(2006). *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. The Hague,   The Netherlands: Bernard van leer Foundation.

Richter, L. & Rama, S. (2006b). *Building Resilience: A Rights-Based Approach to Children and HIV/AIDS in Africa* Summary version: Save the children Sweden.

Rotheram-Borus, M. J., Flannery, D., Rice, E., & Lester, P. (2005). Families living with HIV. *AIDS Care, 17,* 978-987.

Rogoff, B. (1990). *Apprenticeship in thinking*. Oxford: Oxford University Press.

Rose, G. (2007). *Visual methodologies: An introduction to the interpretation of visual materials: second edition*. London: Sage Publications.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorders. *British Journal of Psychiatry, 147,* 611.

Rutter, M. (1990). Psychosocial Resilience and Protective Mechanisms. In (New York: Cambridge University Press.

Rutter, M. & Garmezy, N. (1983). *Stress, Coping and Development in Children*. New York: McGraw-Hill.

Sameroff, A. J., Rosenblum, K. L., & Katherine, L. (2006). Psychosocial constraints on the development of resilience. *Annals New York Academy of Sciences, 1094,* 116-124.

Schratz, M. & Walker, R. (1995). *Research as social change: New opportunities for qualitative research*. London: Routledge.

Schweder, R. A. (1990). *Cultural Psychology- What is it? In J.W. Stigler, R.A. Sweder and G. Herdt (Eds.). Cultural Psychology (pp1-43)*. Cambridge: Cambridge University Press.

Sherr, L. (2005). *HIV and young children: an annotated bibliography on psychological perspectives* (Rep. No. Working Paper 35). The Hague: Bernard van Leer Foundation.

Singhal, A. (2007). Communication Strategies for Confronting AIDS: Empowering the Children of Africa. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 230-246). Athens: Ohio University Press.

Skinner Cook, A., Fritz, J. J., & Mwonya, R. (2007). Understanding the Psychological and Emotional Needs of AIDS Orphans in Africa. In A.Singhal & W. S. Howard (Eds.), *The children of Africa confront AIDS* (pp. 85-104). Athens: Ohio University Press.

Stewart, D. W. & Shamdasani, P. N. (1998). Focus group rseearch: exploration and discovery. In B.Bickman & D. J. Rog (Eds.), (pp. 473-502). Thousand Oaks: Sage Publications.

Swart-Kruger, J. (2002). *Children in a South African Squatter Camp Gain and Lose a Voice* London: Earthscan and UNESCO.

Theis, J. & Grady, H. M. (1991). *Participatory rapid appraisal for community development: A training manual based on experiences in the Middle East and North Africa* London: Save the Children Federation and IIED.

UNICEF (2006). *The State of the World's Children* Geneva: UNICEF.

UNICEF (2007). *Saving Children, Enhancing Lives: Combating HIV and AIDS in South Africa* UNICEF.

UNICEF (2006). *Africa's orphaned and vulnerable generations: Children affected by AIDS*. UNICEF, UNAIDS and PEPFAR.

van der Riet, M., Hough, A., & Killian, B. (2005). Mapping HIV/AIDS as a barrier to education: A reflection on the methodological and ethical challenges to child participation. *Journal of Education, 35,* 75-98.

Van der Riet, M., Hough, A. and Killian, B. (2005). Mapping HIV/AIDS as a barrier to education: a reflection on the methodological and ethical challenges to child participation. *Journal of Education* , 35, 75-98

Van der Riet, M., Hough, A., Killian, B., O'Neill, V., & Ram, A. (May, 2006). We struggle to learn. In N. Muthukrishna, (Ed.), *Mapping Barriers to Basic Education in the Context of HIV and AIDS. A Report on Research conducted in the Richmond District, KwaZulu-Natal.* National Research Foundation.

van Vlaenderen, H. & Neves, D. (2004). Participatory Action Research and local knowledge in community contexts. In D.Hook, N. J. Mkhize, P. Kiguwa, & A. Collins (Eds.), *Critical Psychology* (pp. 445-464). Cape Town: UCT Press.

Vygotsky, L. (1978). Mind in society. Cambridge, Mass.: Harvard University Press.

Werner, E. E. & Smith, R. S. (1992). *Overcoming the odds*. Ithaca, New York: Cornell University Press.

Werner, E. E. & Smith, R. S. (1993). *Vulnerable but invincible: A study of resilient children*. New York: McGraw-Hill.

WHO & UNICEF (2007). *Taking Stock: HIV in children, the state of affairs.* Geneva Switzerland: World HIV/AIDS Programme.

Zahan, D. (1979). *The religion, spirituality and thought of traditional Africa.* Chicago: University of Chicago Press.

Zandonella, C. (2007). Resilience in children overview of conference. http:///wwww/nyas.org/ebriefreps/main.asp?intEbriefID=490 [On-line].