FOSTER CARE OF AIDS ORPHANS: SOCIAL WORKERS' PERSPECTIVES

by

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DECLARATION

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SUMMARY

The goal of this study is to shed some light on the needs of children orphaned by AIDS as well as on the training and support that their foster parents will need, in order to provide guidelines for equipping foster parents to care for AIDS orphans. The motivation for this study was the rapid spread of HIV/AIDS in the South Africa and the one million South African AIDS orphans left in its wake. Most of these children end up in substitute homes, and many of them in foster care. Researchers agree that AIDS orphans have special needs because of the circumstances surrounding their parents' death. Foster parents will therefore need to be prepared to meet these needs. It is an internationally documented fact that foster parents have a need for training and support to meet the demands of foster care, and having an AIDS orphan as a foster child will increase, and focus this need. The study was also motivated by the current shortages and challenges in the foster care system in South Africa which makes it difficult for social workers to effectively train and support foster parents, and aims to contribute towards overcoming some of these problems so that foster parents can be properly prepared to see to the well-being of the AIDS orphans in their care.

The research was done based on a literature study, which firstly made use of the Ecological Systems Perspective to explore the effects of parental death by AIDS on their children. Subsequently an overview of foster care within the South African context is given, with emphasis on foster care in general, foster care within the challenging South African context and foster care of AIDS orphans. The last part of the literature review discusses foster parent cell groups as a means of training and supporting the foster parents of AIDS orphans for the parenting process.

The empirical investigation of the study investigated to what extent, and in what ways, social workers are training and supporting foster parents to care for AIDS orphans. This investigation confirmed some of the findings of the literature study, namely that AIDS orphans have needs that differ from those of other foster children and that social workers are too overburdened to be able to give the foster parents of these orphans the needed training and support.

In light of the findings derived from the literature study and empirical research, conclusions and recommendations are made concerning the phenomena under investigation. The recommendations focus on guidelines that can be used by social workers to train and support the foster parents of AIDS orphans. The recommendations centre on the utilisation of resource-friendly methods to train and support foster parents; bringing structure into the foster care process and on social workers having to use research for guidance.

OPSOMMING

Die doel van hierdie studie is om lig te werp op die behoeftes van kinders wat deur VIGS wees gelaat is, sowel as op die opleiding en ondersteuning wat hul pleegouers nodig het, ten einde riglyne te verskaf vir die toerus van pleegouers om na VIGS-weeskinders om te sien. Die studie is gemotiveer deur die vinnige verspreiding van MIV/VIGS in Suid-Afrika en die een miljoen VIGS-weeskinders wat agtergelaat is. Die meeste van hierdie kinders word in plaasvervangende huise ingeneem, waarvan baie pleegsorgplasings is. Navorsers stem saam dat VIGS-weeskinders spesiale behoeftes het as gevolg van die omstandighede wat met hul ouers se dood gepaard gaan. Pleegouers sal dus voorberei moet word om in hierdie behoeftes te voorsien. Internasionale studies bewys dat pleegouers self ‘n behoefte aan opleiding en ondersteuning het om aan die vereistes van pleegsorg te voldoen. Hierdie behoefte verdiep en word meer gefokus vir ‘n pleegouer wat ‘n VIGS-weeskind in pleegsorg neem. Die studie is ook gemotiveer deur die huidige tekortkominge en uitdagings inherent aan die pleegsorgstelsel in Suid-Afrika wat dit vir maatskaplike werkers moeilik maak om pleegouers genoegsaam op te lei en te ondersteun. Die studie het dus ten doel gehad om ‘n bydrae te lewer tot die oorkoming van sommige van hierdie probleme sodat pleegouers voorbereid kan wees om na die welsyn van hierdie weeskinders in hulle sorg om te sien.

Die navorsing is gebaseer op ‘n verreikende literatuurstudie. Die literatuurstudie het eerstens gefokus op die gebruik van die Ekologiese Sisteemperspektief om die effek van ouers se afsterwe weens MIV/VIGS op kinders te ondersoek. Daarna is ‘n oorsig gegee van pleegsorg binne die Suid-Afrikaanse konteks. Klem is geplaas op pleegsorg in die algemeen, pleegsorg binne die uitdagende Suid-Afrikaanse konteks, en pleegsorg spesifiek met VIGS-weeskinders. Die laaste deel van die literatuuroorsig bespreek die moontlikheid om pleegouer-selgroepe te benut om pleegouers die nodige opleiding en ondersteuning te gee vir die proses van ouerskap.

Die empiriese studie ondersoek ook in watter mate en op watter manier, maatskaplike werkers besig is om die pleegouers van VIGS-weeskinders op te lei en te ondersteun. Hierdie ondersoek bevestig sommige van die bevindinge van die literatuurstudie; spesifiek dat VIGS-weeskinders unieke behoeftes het en dat maatskaplike werkers te

oorlaai is om die pleegouers van hierdie weeskinders die nodige opleiding en ondersteuning te bied.

In die lig van die bevindinge van die literatuurstudie en empiriese navorsing is gevolgtrekkings en aanbevelings gemaak. Die aanbevelings het primêr gepoog om riglyne te verskaf wat deur maatskaplike werkers gebruik kan word om pleegouers op te lei en te ondersteun. Die aanbevelings het gesentreer rondom die gebruik van hulpbron-vriendelike maniere om pleegouers op te lei en te ondersteun; die strukturering van die pleegsorgproses en die noodsaaklikheid vir maatskaplike werkers om daadwerklik van navorsing gebruik te maak vir leiding.

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CHAPTER 1: INTRODUCTION

1.1 Preliminary study and rationale

UNAIDS (2007:3) estimates that there are 5.5 million South Africans living with HIV, making South Africa the country with the highest number of infections in the world. According to the Department of Health (in UNAIDS, 2007:3), the HIV prevalence in South Africa was 18.3% among adults aged 15 – 49 in 2006. It is also estimated that 1.8 million South Africans have died of AIDS-related diseases since the epidemic began (Dorrington, Johnson, Bradshaw & Daniel, 2006:30).

The HIV/AIDS epidemic has far-reaching implications, but the blunt truth of HIV/AIDS is that people die. In sub-Saharan Africa, AIDS is the leading cause of death among adults aged 15 - 59. One consequence is that 12 million children have been orphaned in this region (UNICEF, 2006:iv). In 2006 there were an estimated 1 million Aids orphans in South Africa alone (Dorrington *et al.,* 2006:24).

In short, an AIDS orphan is a child between the ages of 0 - 17, who has lost one or both parents to AIDS. The child does not necessarily have AIDS him/herself (Foster & Williamson, 2000:S276; UNICEF, 2006:5; UNAIDS, 2007:31).

HIV/AIDS affects children long before the parents die. The direct impact on the children often commences with the onset of the illness, occurring in the domains of material problems – impoverishment, missed opportunities in education, lack of food security and poor health; and non-material problems relating to protection, welfare and emotional health (Richter, Manegold & Pather, 2004:9; UNICEF, 2006:18). The consequences of HIV/AIDS can have many serious implications for the psychological well-being of affected children. These children probably spent months witnessing and sometimes caring for their dying parents, while the parenting they received became more affectively distant, punitive and inconsistent. It can lead to many negative emotional states such as helplessness, hopelessness, decreasing self-esteem, depression, anxiety (Townsend & Dawes, 2004:70), fear of the future and psychosocial distress caused by stigma and discrimination (Richter *et al*., 2004:10).

Townsend and Dawes (2006:70) pose the question – who will care for this large and increasing number of children orphaned by HIV/AIDS? Up to now, many of these children have been absorbed into their extended families to be looked after by grandparents, aunts or uncles (The International HIV/AIDS Alliance, 2003a:5). But due to the number of people dying, the families are becoming saturated with orphans (Booysen & Arnst, 2002:172; Derbyshire & Derbyshire, 2002:2; Townsend & Dawes, 2004:71), while continuing to lose potential caregivers to AIDS (The International HIV/AIDS Alliance, 2003a:5; UNICEF, 2006:17).

So the question remains – who will look after these children? Options other than kinship care mentioned above, are adoption, foster care, child-headed households, residential care and community-based care. Some children also inevitably end up on the street. Child-headed households and community-based care go together and are informal ways to care for these children. In such scenarios adult volunteers are asked to check up on children living in child-headed households to make sure that their basic needs are met (Derbyshire & Derbyshire, 2002:3). Otherwise, the children are left to fend for themselves. Residential care is the least favoured option, because it has been found that institutional life has a detrimental effect on children – it can lead to long-term developmental problems (The International HIV/AIDS Allliance, 2003b:18). Subbarao and Coury (in Richter *et al.,* 2004:39) agree with this by ranking residential care last on their list of most desirable living arrangements for children, where living with a parent is not an option: first is kin-family care, then formal foster care and adoption, followed by foster homes, children's villages and community-based care and lastly, residential care. Kinship care is the second-best option, but many families do not have the capacity to take in more orphans.

People agree that the best place for children is in a family (UNICEF, 2006:19). "Foster and adoption care is to be encouraged because family-based care in a child's home community generally offers the best opportunities for positive psychosocial development" (Richter *et al.,* 2004:39). Guest (2001:12) agrees, but adds that if caring arrangements within the community cannot be made, the children could be placed in a loving family outside the community. At present, foster care is under-promoted and hence under-utilised in South Africa – especially for AIDS orphans – but it is more prevalent than adoption (Townsend & Dawes, 2004:71).

Many authors agree that replacement carers need to be prepared through training and support to look after children orphaned by AIDS: UNICEF (2006:24) state that "responding to the needs of children orphaned and made more vulnerable by AIDS requires an understanding of the wide range of possible impacts and the variables that mitigate them". Grainger (in Richter *et al.,* 2004:39) advises that caregivers should be trained in childcare, including health and psychosocial support. The International HIV/AIDS Alliance (2003b:17) observes that caregivers must be prepared "for the challenges of taking care of children who have lost their parents to AIDS". This must include sensitising them to the psychosocial needs of AIDS orphans. All these authors also mention that the caregivers themselves will need support too.

It has been found the world over that foster parents have a need for training and support in order to adequately parent the children in their care (Durand, 2007:2). In South Africa this need often goes unmet because of the vast number of cases the limited number of social workers have to deal with (Magome, 2008). This obstacle must be overcome in order to ensure that foster children are well cared for in their foster homes.

If foster care of AIDS orphans is to be utilised effectively, the foster carers must be thoroughly trained and supported to effectively parent them.

1.2 Problem statement and focus

At present there are an estimated 1 million AIDS orphans in South Africa. Foster care provides a viable means of caring for AIDS orphans and giving them a home. However, these children will have many specific needs that are likely to differ from those of other children in foster care. For foster parents to meet these needs and sufficiently parent AIDS orphans, they will need to be properly trained and supported. Internationally foster parents have indicated time and again that they have a need for training and support to meet the demands of foster care. In South Africa there is a shortage of social workers which leads to the current social workers being overwhelmed with the amount of work they have to do. They often do not have the time to train and support foster parents during in-depth pre- and post-placement services. This creates the problem of foster parents being unprepared to meet the needs of the children in their care.

For this reason the study is focused on the needs of AIDS orphans and on determining how/whether foster parents are being trained and supported to parent these children effectively.

1.4 Goals and objectives

The **goal** of the study is to shed light on the needs of children orphaned by AIDS as well as on the training and support that their foster parents will need, in order to provide guidelines for equipping foster parents to care for AIDS orphans.

The following **objectives** were formulated to meet the abovementioned goal:

- To make use of the Ecological Systems Perspective to explore the effects of parental death by AIDS on their children
- To give an overview of foster care with specific reference to the South African context
- To discuss foster parent cell groups as a means of training and supporting the foster parents of AIDS orphans for the parenting process
- To investigate by means of a situation analysis how and to what extent social workers are equipping foster parents to care for AIDS orphans
- To come to conclusions and make recommendations based on the results of the literature review and the empirical study that can be used as guidelines when equipping foster carers to parent AIDS orphans.

1.5 Research methodology

1.5.1 Research approach

A combined quantitative and qualitative approach was used to meet the research goal. It was a combined-method study because data were captured through semi-structured questionnaires consisting of closed questions (a quantitative method) and open questions (a more qualitative method) (De Vos, Strydom, Fouché & Delport, 2005:547).

Mouton and Marais (1990:155-156) describe the quantitative approach as highly formalised and controlled while the qualitative method "elicits the participants' accounts of meaning, experience or perception" (De Vos *et al.,* 2005:74). Questionnaires enable data collection procedures to be applied in a standardised manner (Fortune & Reid, 1999:93). The closed questions sketch an objective picture of reality, while the open-

ended questions, as the qualitative part, illuminate, and allow for interpretation of the participants' reality and experiences (Holliday, 2002:7).

1.4.2 Research design

The research was done as an exploratory-descriptive study. Descriptive research "presents a picture of the specific details of a situation" (Neuman, 2000:2) that is already well-defined. De Vos *et al.,* (2005:106) point out that an exploratory study is undertaken when more information is needed in a new area of interest, or when the researcher wants to understand a certain situation better. In the case of this study, much is known about the effects of orphanhood by AIDS on children, foster care and parenting, and these are the areas that will be described. The study also went on to explore how these three areas can be effectively synergised.

1.4.3 Research methods

i) Literature study

Literature studies are done to build a knowledge base and a logical framework into which the study can be embedded. Marshall and Rossman (1999:43) state that "a thoughtful discussion of related literature…sets [the study] within a tradition of inquiry and a context of related studies." Neuman (2000:446) agrees and adds that a literature review serves to show how a study is linked to work that has already been done on the topic.

The study's literature study creates a framework within which the study can be constructed and provides a means for the interpretation of data (Alston & Bowles, 2003:72). The literature study focuses on the following aspects – HIV/AIDS in the South African context, foster care and the process of parenting. International and local literature was consulted, as well as literature from fields other than social work, like sociology and psychology.

The questionnaires were based on the literature review, so they were developed in a deductive way.

ii) Population and sample

The universe of the study consisted of all social workers in South Africa who work for NGOs and specifically in the field of child and family care. They constitute the universe

because they are the sum total of potential subjects for the study (Arkava & Lane (1983:27).

Powers, Meenaghan and Toomey (1985:235) define a population as a group that narrows down the universe of the study by meeting all the set criteria of the researcher. The criteria forming the boundaries of the population are as follows:

- Social workers
- working for South African NGOs
- who have AIDS orphans in foster care as clients
- or who had AIDS orphans in foster care as clients in the past.

Social workers who met these criteria made up the population of the study.

A sample is a portion of the population (Seaberg, 1988:240) and serves to help explain a specific question about the population (De Vos *et al.,* 2005:194), and ultimately the universe. The sample thus consists of those people who are in the end asked to complete a questionnaire.

In the case of this study, a purposive sample was taken. The sample will be purposive in the sense that the researcher sets further criteria to narrow down the population (Singleton, Straits, Straits & McAllister,1988:153).

Originally, only one NGO operating in the Western and Northern Cape was approached to participate in the study. Various training days and conferences were scheduled for the month of May and the regional director of the NGO gave permission for the social workers working for this NGO to participate in the study, and personally undertook to give every social worker meeting the criteria for the population a questionnaire to complete. These social workers constituted the sample.

According to the regional director, 178 social workers work for this NGO in the Western Cape and the Northern Cape. Most of them attended either a conference or a day of training during May. Arkava and Lane (1983:162) are of the opinion that a researcher should obtain the largest sample possible and that is why every social worker who met the criteria was asked to participate in the study. Each social worker could decide whether he/she wanted to complete the questionnaire.

Complications set in however, when only ten questionnaires, all from the Western Cape, were received back. At least 20 respondents were needed for the study. The researcher therefore approached three more NGOs (two in the Western Cape and one in KwaZulu-Natal) and received permission from these NGOs to send questionnaires to the social workers employed there. In so doing a further ten respondents were acquired.

iii) Method of datacapturing

Information was gathered through questionnaires which were handed out by the regional director of one of the participating NGOs to those social workers who have or had AIDS orphans in foster care as clients and who have attended a conference or training day during May 2010. Circumstances on the day made it impossible for the questionnaires to be completed immediately, so the questionnaires were picked up from various offices of this NGO. The other questionnaires were either e-mailed or dropped off at the offices of the other participating NGOs, where they were picked up from the offices.

iv) Ethical considerations

An important ethical consideration is the fact that the term “AIDS orphan” is used in the study. AIDS is still somewhat of a taboo subject in South Africa and because of stigma and discrimination it is not wise to label someone as an AIDS orphan. However, in the context of this study, it was felt to be safe to use this term, the main reason being that the respondents are professional people, and that no child or lay-person will be involved in the study. It is also good for the sake of clarity to use this term, since the study is focused specifically on the needs of children orphaned by AIDS.

Considerations in terms of the empirical study:

- Participation will be voluntary.
- Confidentiality will be maintained.

The research was carried out by a registered social worker who submits to the ethical code of the Council of Social Service Professions.

1.4.4 Limitations of the study

Probable limitations of the study:

- There are only 20 respondents representing four NGOs. It is debatable whether the findings can be generalised to all social workers in the NGO sector in South Africa.
- The respondents represent only two provinces – the findings might not be generalisable to other provinces.
- Within the scope of this study there was no way to verify whether the respondents were truthful.

1.5 Chapter layout

Chapter 1 consists of the research proposal and was handed in on 31 October 2008. **Chapter 2** makes use of the Ecological Systems Perspective to focus on HIV/AIDS in the context of South Africa and specifically on the effect that parental death by AIDS has on children. **Chapter 3** gives an overview of foster care in South Africa, bearing in mind the Children's Act, no. 41 of 2005, the needs of foster parents and the challenges of the foster care system in South Africa. **Chapter 4** uses the parenting process as a framework for the content of foster parent training and also considers foster parent cell groups as a resource-friendly means of training and supporting foster parents. **Chapter 5** analyses the data obtained through questionnaires and in **chapter 6** conclusions are reached and recommendations offered.

CHAPTER 2: THE AIDS ORPHANS OF SOUTH AFRICA

2.1 Introduction

There were an estimated one million AIDS orphans in South Africa in 2006 (Dorrington, Johnson, Bradshaw & Daniel, 2006:30). This number would have grown from 2006 to 2010, resulting in an even greater number of children being affected by HIV/AIDS. As this study concerns the care of these children, the first step would be to understand how they are affected by the disease.

In order to meet the first objective of the study, the purpose of this chapter is to discuss in broad terms the occurrence of HIV/AIDS in South Africa and to look specifically at the effect that parents' death by AIDS have on their children. The ecological systems perspective is used to organise the information and to see the interplaying factors on the different system levels.

This chapter is foundational to the chapters following, in that it considers how children are affected by the pandemic. The subsequent chapters will focus on why and how foster parents can be equipped to care properly for children who are orphaned by AIDS.

The chapter starts with an overview of HIV/AIDS in the South African context and the definition of an AIDS orphan. The ecological systems theory is then used to discuss and organise the impact of HIV/AIDS on children, families and communities in South Africa. The discussion starts at the broadest system level (macro level) and moves in to the immediate reality of a child (micro level) and the impact that parental illness by HIV/AIDS has on the child. The last section deals with the psychosocial effects that HIV/AIDS has on orphaned and affected children.

2.2 HIV/AIDS in the South African context

The aim of this section is to give a short overview of the demographic impact of HIV/AIDS in South Africa. According to the National Strategic Plan (NSP) 2007-2011, the HIV prevalence in South Africa for the total population is 11.2% (SANAC, 2006). The national-level HIV prevalence varies by population group, sex, age and province.

2.2.1 Population group

Black South Africans are the most affected population group. According to the NSP (SANAC 2006:28), infection rates among black people are six to seven times higher than among the non-black population groups. Gouws and Abdool Karim (2005:63) supply the following statistics for prevalence according to population groups:

TABLE 2.1 HIV PREVALENCE BY POPULATION GROUP

Population group	Prevalence (%)
Black	12.9
White	6.2
Coloured	6.1
Indian	1.6

Source: Gouws & Abdool Karim, 2005:63

Given the fact that there are approximately 47 866 984 people in South Africa (Dorrington *et al.*, 2006:13) and that 75% of the population are black, 13% are white, 9% are coloured and 3% are Indian (Pembrey, 2009a: http://www.avert.org/aids-southafrica.htm), the following table can be drawn up, in conjunction with the table above, to give an idea of the number of HIV positive people in each population group:

TABLE 2.2 NUMBER OF HIV+ PEOPLE PER POPULATION GROUP

Population group	Number of people	Number of HIV+ people
Black	35 900 238	4 631 130
White	6 222 707	385 807
Coloured	4 308 028	262 789
Indian	1 436 009	22 976

Source: Derived from Dorrington *et al.*, 2006:13 and Pembrey, 2009a: http://www.avert.org/aids-southafrica.htm

From this table it can be seen that the prevalence among black people is the highest – with roughly one in seven black people being HIV positive.

One reason for the high prevalence among black South Africans is the clear correlation that has been found between poverty and high HIV prevalence (SANAC, 2006:28). Most

of South Africa's poorest and most vulnerable people live in informal urban and rural settlements. The vast majority of the people living in these settlements are black (SANAC, 2006:28).

However, even if the prevalence rate were the same for all the population groups, the HIV prevalence would still be higher among black people than among other population groups, because the majority of South Africans fall into this population group.

2.2.2 Sex and age

On the whole, women account for 55% of HIV infections in South Africa. In some age categories, the differences between male and female infection rates are very pronounced. In the age group 20 – 24, the prevalence rate for women is 23.9%, as opposed to the prevalence rate for men, which is 6.0%. In the age group 25 – 29, the prevalence rates are 33.3% for women, and 12.1% for men. The peak age for women to become infected with HIV is 25 – 29, while the peak age for men is 30 – 35 (Dorrington *et al.,* 2006:9; SANAC, 2006:28). This shows that children are most likely to lose their mothers rather than their fathers, to AIDS.

With children, the differences between the sexes are not so pronounced (SANAC, 2006:28). In the 2 – 4 age group, 5.3% of females and 4.9% of males are infected. In the 5 – 9 age group 4.8% of females and 4.2% of males are infected. Children in these two age groups would mostly have been infected through their mothers. What is very significant and sad, is that the next age group, 10 – 14, only have a prevalence of 1.8% for females and 1.6% for males. This indicates that children who were HIV positive from birth, or became infected very early in their lives, will rarely live to the age of 10. From there the prevalence rate starts climbing again as children become sexually active during adolescence.

2.2.3 Province

The HIV/AIDS prevalence and incidence vary noticeably across the eight provinces of South Africa. According to the NSP (SANAC: 2006:27), this geographical heterogeneity in HIV trends reflects, among other things:

- the degree of urbanisation
- sexual risk behaviours

- sexual networks
- population demographics
- unemployment
- social deprivation
- migration
- high population density
- unstable communities

In considering the history of HIV/AIDS in South Africa, it could be argued that the history of each province is another reason for varying prevalence and incidence rates. For instance, in 1990, KwaZulu-Natal (KZN) was the first province to show an HIV prevalence of more than 1% among pregnant women attending public sector antenatal clinics. By 1994, every province showed a prevalence of at least 1.00 - 4.99% among its population of pregnant women, but in KZN, the prevalence has risen to 10.00 - 14.99% (Abdool Karim, 2005:34).

In 2006, the prevalence among pregnant women in KZN was nearly 40% (Dorrington *et al.*, 2006:27). Together with the fact that the HIV/AIDS epidemic had a head start in KZN, it is also the most populous province in South Africa (Dorrington *et al.*, 2006:27), as well as one of the poorest. The population consists mostly of black people, and due to the inequitable distribution of resources during the Apartheid regime, this province is especially vulnerable to poverty-related diseases like HIV/AIDS and tuberculosis. The prevalence among the total population of KZN is 15.7% (SANAC, 2006:28).

HIV/AIDS prevalence is the lowest in the Western Cape, at 5.4% for the total population, even though it is the fourth most populous province (Dorrington *et al.*. 2006:27). The province is, however, relatively affluent, as well as being the province with the highest concentration of white South Africans. As noted in 2.2.1, HIV/AIDS is more prevalent among black people, as well as being strongly linked to poverty (SANAC, 2006:28).

In conclusion it can be noted that even though statistically the most likely person to become HIV positive is a young black woman, aged 25 – 29 who lives in KwaZulu-Natal, HIV does not play favourites. Many people of different age groups, race, gender and province are infected with HIV/AIDS and many more people are affected by it.

In the next section the definitions of an AIDS orphan are discussed..

2.3 Definition of an AIDS orphan

There are different definitions of what constitutes orphanhood, but the most commonly accepted definition is that of UNAIDS and UNICEF (2004:7). These organisations define an orphan as someone under the age of 18 who has lost his/her mother, father, or both parents. Further distinctions can be made between children whose mothers have died (maternal orphans), children whose fathers have died (paternal orphans) or children of whom both parents have died (double orphans). “AIDS orphan” is a term that specifies the reason for parental death.

Smart (2003:8) offers a broader definition for an AIDS orphan by also rendering orphan status to a child whose primary caregiver has died of AIDS. It is apparent in the literature that consensus has been reached among researchers that AIDS orphans are not the only children requiring concern by society (Smart, 2003:7-8; Foster, 2006:701). Many children affected by HIV/AIDS are becoming increasingly vulnerable and are also a cause for concern to society. As a result, new terms have been introduced – Orphaned and Vulnerable Children (OVC) and Children Affected by AIDS (CABA) (Smart, 2003:7), to refer to children who are orphaned or facing orphanhood. Lately it is sometimes seen as more “correct” to use these terms for children orphaned by AIDS. A paramount reason is the fear of labelling or stigmatising a child.

For this study, the terms “AIDS orphan” or “children orphaned by AIDS” will be used to refer to children whose parent(s)/primary caregiver have already died from AIDS. “Children affected by AIDS” will refer to children whose parent(s)/primary caregiver are HIV positive. The reason for not following the trend of referring to these children as OVC or CABA is because the study is aimed specifically at orphans or soon-to-be orphans. The far-reaching effects of HIV/AIDS are understood and also that most children are affected, but they fall outside the scope of this study. There is another, more subjective reason for not using those terms in this study – the view is held that using an acronym to refer to human beings strips them of their humanity.

In the next section the ecological systems perspective is used to organise and give an outline of the impact of HIV/AIDS on children, families and communities in South Africa.

2.4 The impact of HIV/AIDS on children, families and communities in South Africa: an ecological systems perspective

In this section the ecological systems perspective will be used to gain a better understanding of how various factors interact on various levels to ultimately have an impact on the life of an AIDS orphan. This sets the stage for the next section that deals with the resulting psychosocial issues that have been noted by various researchers as prevalent in AIDS orphans.

2.4.1 The ecological systems perspective

Compton, Galloway and Cournoyer (2005:7,24) emphasise the importance of any theory used in Social Work to reflect the interactions, transactions and organisational patterns within person-environment and person-situation interrelatedness. The system must be studied as a whole for these dynamics to become visible – the whole is always more than the sum of its parts. The same authors (Compton & Galloway, 1994:18) come to the conclusion that the ecological systems perspective offers a conceptual framework to this end.

The ecological systems perspective does not provide directives for action (Compton & Galloway, 1994:119). The perspective organises society by providing a theoretical foundation and a way of looking at systems that can be used as a starting point for constructing a model of action.

The core "logic" of this perspective is that "an intervention at any point in the system will affect the entire system" because all parts of the whole are interrelated and reciprocally influencing one another (Compton & Galloway, 1994:119).

Systems form part of a hierarchy. Bronfenbrenner (1979) identified four systems in this hierarchy – the macro-, exo-, meso- and microsystem. In order to gain a holistic view of children who are orphaned by HIV/AIDS, each system level is discussed and a glimpse is given into some of the interplaying factors at each level that ultimately shape and influence the immediate world of the AIDS orphan. The following figure gives a graphic illustration of the four system levels.

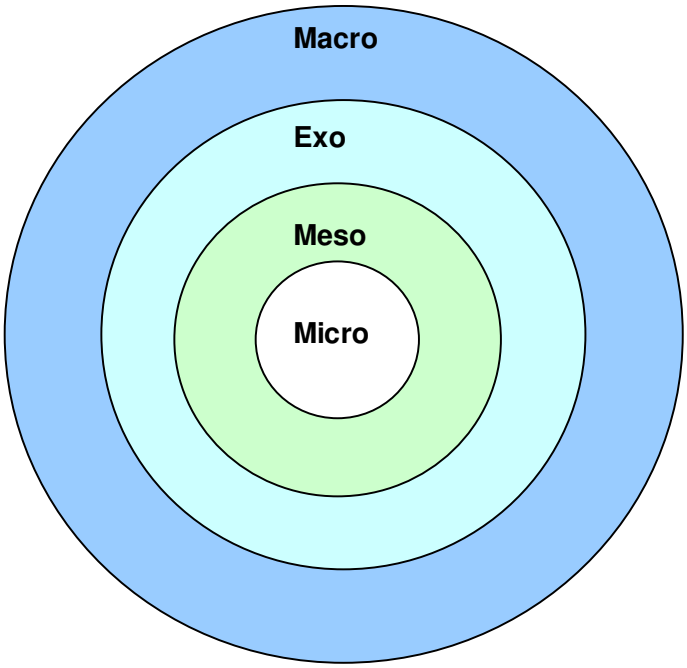


FIGURE 2.1 THE ECOLOGICAL SYSTEMS PERSPECTIVE

In the following four subsections, each level will be defined and discussed according to some of the factors that operate at each level. Each discussion will be further illustrated with a figure detailing the interplaying factors.

2.4.2 Macrosystem

The first and outer system level is the macrosystem. According to Bronfenbrenner (1979:26), "the macrosystem refers to consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies".

This means that the macrosystem is the blueprint of society. It is the worldview of a society and it shapes the ideologies and the organisation of that society. The way that society perceives the world determines the actions and behaviour that are deemed "right".

For a country, this level involves the ideologies that shape culture, macro-institutions (like the government) and public policy (Lerner, 2005:xiv). The outcomes of these overarching patterns are made manifest in the lower level exo-, meso- and microsystems (Bronfenbrenner, 1979:8).

However, it is not just the culture as a whole that is shaped by such a blueprint, but also the various subcultures. Bronfenbrenner (1979:26) states that the blueprints for the different subcultures differ from one another and in so doing predict and reflect the groups' different belief systems and lifestyles, causing similarities within different subcultural groups. It becomes evident in the characteristic patterns of ideology and lifestyles that are reflected in the goals and practices of socialisation, and in the resulting similarities in everyday experiences, ceremonies, customs and spiritual and religious values differentiating these groups (Bronfenbrenner, 1977:47, Bukatko & Daehler, 2004: 30).

As was stated above, the factors interplaying at this level are culture, the government and public policy (Lerner, 2005:xiv). Keeping HIV/AIDS in mind, these three factors will be discussed in greater detail in order to understand how they ultimately impact upon individual lives through shaping the way people think and act. The following figure displays where these factors fit into the ecological systems perspective.

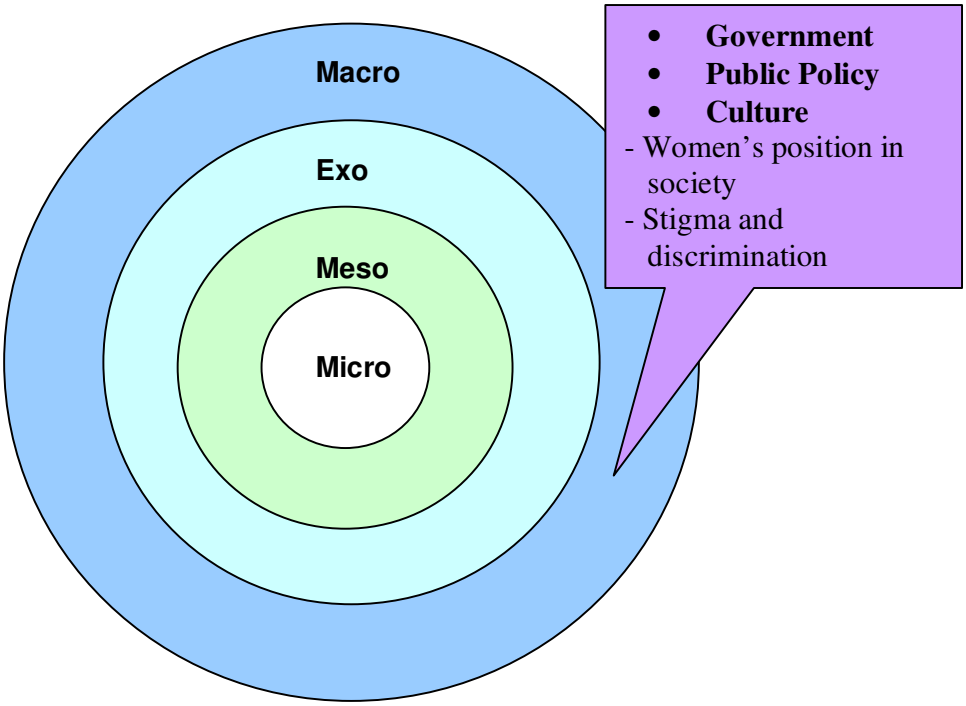


FIGURE 2.2 MACRO-LEVEL FACTORS

i) Government

The first of these factors at the macro level is the government. Since the government is the highest authority in a country, it determines to a great extent what is being thought, done and said by the people.

Zackie Achmat, the leader of the Treatment Action Campaign (TAC) said that "...the biggest problem we have in South Africa is that we [had] a president who does not believe that HIV causes AIDS" (Pembrey, 2009b:http://www.avert.org/aids-south-africa.htm). At the beginning of his term as president of South Africa, Thabo Mbeki went through an openly dissident stage by demonstrating a disregard for the orthodox scientific canon on AIDS. He chose to align himself with the theories of AIDS denialists – fringe scientists who carry no weight in the scientific community (Natrass, 2006:1-2, 5; Pembrey, 2009b:http://www.avert.org/aids-south-africa.htm). Between 1999 and October 2000 former president Mbeki openly questioned the link between HIV and AIDS and he denounced antiretroviral therapy as a treatment for AIDS (Pembrey, 2009b: http://www.avert.org/aids-south-africa.htm). Instead he called for an African solution to African problems (Fouché, 2005:55). In October 2000 Mbeki announced his withdrawal

from the public AIDS debate because the controversy was causing divisions within and between the ANC, COSATU and SACP (Natrass, 2006:12).

During this time, the former president's views were fully supported by the minister of health, Manto Tshabalala-Msimang. Together they undermined the authority of established science by portraying the orthodox understanding of AIDS as just another viewpoint, and they accused those who advocated for antiretroviral treatment of being salesmen for the large pharmaceutical companies. Mbeki and Tshabalala-Msimang claimed that antiretroviral medication was harmful, unsafe and toxic (Natrass, 2006:2; Fouché, 2005:55; Pembrey, 2009b http://www.avert.org/aids-south-africa.htm).

The Health Minister went on to refuse to make ARVs available to South Africans through government subsidies if further proof could not be given that it was safe to do so (Pembrey, 2009b: http://www.avert.org/aids-south-africa.htm). After losing a court challenge from the TAC, it was ruled that the minister should implement a national mother-to-child transmission prevention (MTCTP) programme (Natrass, 2006: 15). Tshabalala-Msimang also strongly resisted the introduction of antiretroviral treatment for people living with AIDS, but she was defeated by a carefully planned cabinet revolt. On 8 August 2003, the government committed itself to roll out antiretroviral treatment in the public health sector (Natrass, 2006:16). The Health Minister however, was not happy with this ruling, and made sure that the roll-out was as slow as possible by interfering in certain issues and not addressing others. The result was that the planned targets were not even closely reached. Instead of supporting the roll-out, Tshabalala-Msimang constantly pointed to the side effects, highlighted the benefits of nutrition and said that patients must exercise "choice" in their treatment strategies (Natrass, 2006:17).

This, together with Mbeki's stance at the beginning of his presidency, caused AIDS patients to be reluctant to take ARVs because they feared it was poisonous; it created widespread confusion and bewilderment which helped undo the success of past preventative work as well as heaping additional burdens on treatment counsellors to dispel myths about AIDS (Natrass, 2006: 17; Fouché, 2005:55). Most importantly, it contributed to many more AIDS deaths and many more children being orphaned. These deaths also had an adverse impact on the human capital of South Africa.

At present, the government provides free antiretroviral therapy through the public health sector and all HIV+ mothers receive nevirapine to prevent transmission to their babies. Recently, South Africa's current president, President Jacob Zuma, had been publicly tested for HIV and afterwards revealed his negative status publicly in an effort to encourage South Africans to be tested and to promote openness about the disease (News 24, 2010: http://www.news24.com/SouthAfrica/Politics/Zuma-shares-HIV-results-20100425).

ii) Public policy

The second important factor at the macro level is public policy. A policy is evidence of a government's commitment to a certain issue and it serves as a guideline for action and future decisions. It also sets out the long-term purpose(s) in order to establish unity among all the role players (WordNet, 2010: http://wordnetweb.princeton.edu/perl/webwn?s=policy).

South Africa's current response to the HIV/AIDS challenge takes the form of the National Strategic Plan (NSP) 2007 – 2011. This Plan builds on the previous NSP 2000 – 2005, as well as the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care and Support that was approved in 2003 (SANAC, 2006:4).

The NSP 2007 – 2011 represents the government's multisectoral approach (SANAC, 2006:7) to dealing with this challenge and its purpose is to guide the nation's response to the epidemic (SANAC, 2006:5). The following table offers a summary of this strategic plan.

TABLE 2.3 GOALS AND PRIORITY AREAS OF THE NSP

Goals	4 Priority Areas
1. Reducing new infections by 50%	1. Prevention 2. Treatment, Care, Support 3. Research, Monitoring, Surveillance 4. Human Rights and Access to Justice
2. Reducing the impact of HIV and AIDS on individuals, families and societies by expanding access to appropriate treatment, care and support to 80% of all HIV+ people and their families by 2011	

The NSP have two main goals that will be reached through interventions in four key priority areas (SANAC, 2006:10) as illustrated in table 2.3. Many policies and guidelines in South Africa have been developed since 1994 to support the country's HIV/AIDS strategies, like the NSP. The following are some examples of policies and guidelines found in SANAC (2006:18) that have supported and are supporting strategies like the NSP: The Reconstruction and Development Programme (1994); the Integrated Nutrition Programme (1995); Maternal, Child and Women's Health (1995); Development of the District Health System (1995); the Health Charter (2005); the National Action Plan for Orphans and Vulnerable Children (2009-2012); workplace policies in all government departments and the Social Assistance Act (2004). The number of policies on HIV/AIDS-related issues demonstrates that the fight against HIV/AIDS is a priority to the government.

iii) Culture

The third factor present at the macro level, is culture. Culture is a "...system of values, beliefs and attitudes that shapes and influences perception and behaviour" (Dahl, 2001: http://www2.eou.edu/~kdahl/cultdef.html). Culture at the macro level will permeate the lower levels and end up influencing individual lives and behaviour. It is learned, shared, patterned, mutually constructed, symbolic, arbitrary and internalised (Dahl, 2001: http://www2.eou.edu/~kdahl/cultdef.html). These values, beliefs and attitudes are characteristic of a particular social, ethnic or age group. Compton and Galloway (1994:120) say that "...the importance of culture is not only that it is a larger system that surrounds a person, but that culture is also a part of the individual".

There are three levels of culture: international, national, and subcultural. Culture on an **international level** refers to shared values, beliefs and attitudes that expand beyond national boundaries (Yohe, 2004: www.csub.edu/~ryohe/The%20Meaning%20of%20Culture.ppt). In the context of HIV/AIDS an example would be the global response to the crisis. Many nations, including South Africa, have made commitments and signed international declarations to make HIV/AIDS a matter of national priority.

On a **national level**, culture is "...the learned behavioural patterns, beliefs, values and institutions shared by the citizens of the nation" (Yohe, 2004: www.csub.edu/~ryohe/The%20Meaning%20of%20Culture.ppt). Examples of culture at a national level would be those behaviours, beliefs and values that "characterise" South Africans as a whole, or different racial groups nationally. One example would be the pattern of labour migration among black South Africans, along with other examples like women's position in society and stigma and discrimination.

On a **subcultural level** are found the values, beliefs, attitudes and traditions practiced by different groups within a larger culture and which set them apart from one another (Yohe, 2004: www.csub.edu/~ryohe/The%20Meaning%20of%20Culture.ppt). These subcultures divide the national culture into ever smaller units. Subcultures differ from one another and from the national culture with regards to their behavioural patterns, beliefs and values. Examples of subcultures are different communities, religious groups, traditional culture, ethnic groups and groups that speak the same language. A person can be part of more than one subculture at a time.

On the national and subcultural levels there are behavioural patterns, beliefs and values that differentiate groups from one another. Some of these behaviours, beliefs and values have a direct impact on the occurrence and effect of HIV/AIDS. Two of them will be discussed briefly below.

a) Women's position in society

As in most societies, there are great power imbalances between South African men and women, with men possessing more control and power, especially in sexual relationships. The sexist beliefs and negative attitudes towards women that are held by (some) men, increase a woman's risk to be sexually assaulted and infected with sexually transmitted

diseases. South Africa is one of the countries in the world with the highest rates of violence against women. This is born directly out of the attitudes and beliefs held by men – and women – that men have the power in sexual relationships and that a woman must comply with his expectations and demands. This power disparity creates the platform for men to have multiple sexual partners and to refuse to wear condoms (SANAC, 2006:30-31). These views and accompanying behaviour create conditions for the spread of HIV/AIDS.

b) Stigma and discrimination

South Africa's history of racism has formed a culture that is very susceptible to, and aware of, stigma and discrimination. It is still very much a part of many people's frame of reference. Deacon and Stephney (2007:6) define stigma as "...a blaming and othering response, a cognitive justification for an emotional reaction of fear". Stigma allows people to create distance between themselves and the "other" – be it the other race, the other sex, the other ethnic group or the other class. HIV/AIDS has long been branded as a disease of homosexuals and black people. People who wrongly view the disease in this way create a sense of "safety in superiority" for themselves by blaming the "other". Health-related stigmatisation is usually directed at fringe groups and they are blamed for the contraction of the disease because of certain characteristics associated with them as a group (Deacon & Stephney, 2007:6). Stigma is rooted in fear and is an outflow of the worldviews of the different cultures nested in society.

Peter Piot, the Executive Director of UNAIDS in 2000, declared combating stigma as the most pressing item on the agenda of the global community. He described stigma as "...a roadblock to concerted action, whether at local community, national or global level" (in Parker & Aggleton, 2003:14). Holzemer and Uys (2004:165) agree that stigma is an obstruction in the way of dealing with HIV/AIDS by keeping people from getting themselves tested and from accessing treatment.

It could be argued that stigma is caused by fear, but also that it causes fear in the people who are being stigmatised. People are afraid of discrimination, and often opt to keep their status a secret. This secrecy isolates people and families, forcing them to carry the weight of the disease and its implications alone.

The factors discussed in this section operate at the macro level of society and play an important part in shaping the everyday lives of South Africans through the ideologies, policies and culture that they promote.

The next system level is the exosystem.

2.4.3 Exosystem

Bronfenbrenner (1979:25) defined an exosystem as "...one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person". This means that an exosystem consists of settings that a person may never physically be a part of, but that have an effect on the person's immediate environment. Events occurring in these settings can have far-reaching effects. These settings (e.g. social, economic, political and religious) can have an explicit impact on someone who is directly involved in the person's life, and so influence the person through direct or indirect repercussions (Bronfenbrenner, 1979:7; Bukatko & Daehler, 2004: 30; Lerner, 2005:xiii). Another source of exosystem influence is the decisions made by any social institution that ultimately affect the conditions of family life (Bronfenbrenner, 1977:46).

Some of the exosystemic influences in South Africa on the occurrence and effect of HIV/AIDS are the public health sector coupled with the government and the pharmaceutical companies that manufacture ARVs; the Treatment Action Campaign (TAC) that lobbies for the provision of AIDS medicine to all infected South Africans; non-governmental organisations (NGOs) that implement programmes to address the occurrence and effect of HIV/AIDS and the demands that different religions make on their followers, specifically with regards to sexual behaviour and treatment. The first two of these exosystemic influences will be discussed in more detail in the next two sub-sections.

The following figure illustrates how these factors fit into the ecological systems perspective.

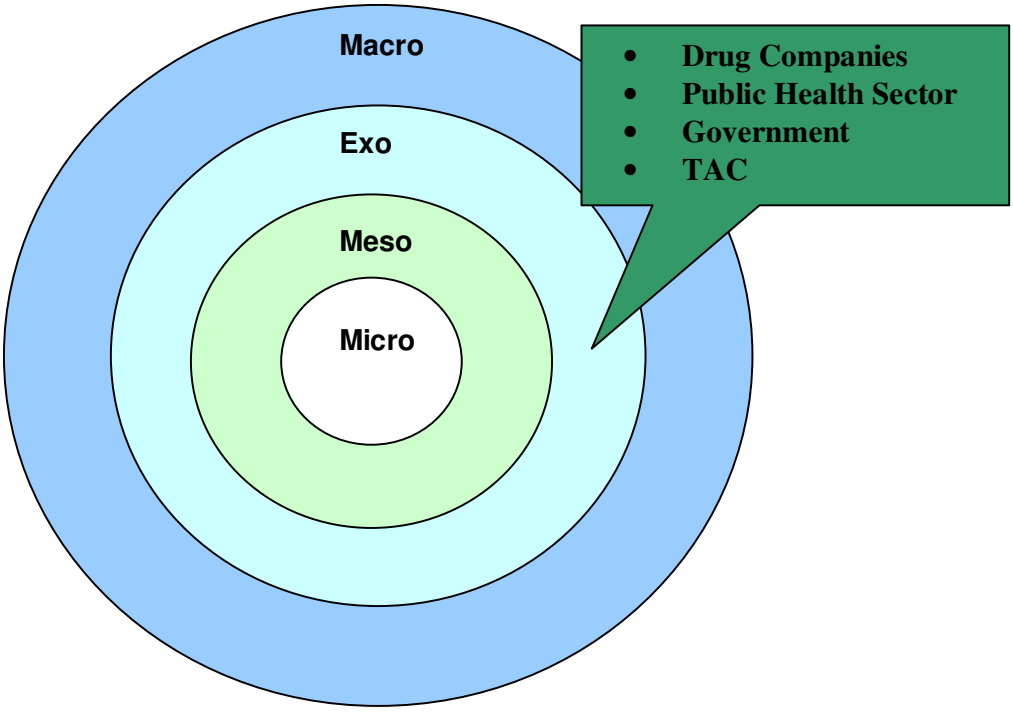


FIGURE 2.3 EXO-LEVEL FACTORS

i) Drug companies, the public health sector and the government

Treatment of HIV/AIDS is very expensive. This is especially problematic because HIV/AIDS is associated with poverty in South Africa. The South African government would not/could not subsidise treatment until drug companies dropped their prices. After extensive lobbying and legal action, discounts were achieved and the government was obligated to make antiretroviral therapy available to the people, free of charge, through the public health sector. In America, where treatment has been readily available, AIDS has become a chronic, manageable disease (Fouché, 2005: 56). Hopefully this will also become the reality in South Africa. Decisions made within and among the abovementioned role players in the past have caused many more people to die and many more children to become orphaned. Now that treatment is being provided however, lives are being prolonged, stalling the negative consequences of AIDS-related deaths on family life.

ii) Treatment Action Campaign

The Treatment Action Campaign is an important force behind the provision of health care services to people who are living with HIV/AIDS. The TAC is an advocacy group

aimed at increasing access to treatment, care and support for people who are HIV positive. The TAC is a national organisation that enjoys international recognition for its work. Its lobbying and advocacy have been imperative to secure the position where South Africa currently stands with regards to the treatment, care and support of HIV positive people. Through its work, the TAC has a direct impact on individual lives – to "hold the government accountable for health care services delivery, campaign against official AIDS denialism, challenge the world's leading pharmaceutical companies to make treatment more affordable and cultivate community leadership on HIV and AIDS" (TAC, 2009: http://www.tac.org.za/community/about). Two of the changes in South Africa's response to the HIV/AIDS pandemic are direct results of the TAC's advocacy. The first of these two changes was that all pregnant, infected mothers are now being given the drug nevirapine free of charge in order to prevent the transmission of HIV from the mother to the child. The second change was a country-wide roll-out of antiretroviral medication. The TAC is thus a good example of a social institution whose decisions have an impact upon family life and individual lives.

The next system level is the mesosystem.

2.4.4 Mesosystem

Bronfenbrenner's (1979:25) definition of a mesosystem is that it "comprises the interrelations among two or more settings in which the developing person actively participates e.g. for a child – the relations among home, school, and neighbourhood peer group". A mesosystem is a system of microsystems, and a microsystem is a setting within which a person is an active member. The mesosystem constitutes the relationships and connections between all the different microsystems. These settings make up a person's developmental niche within a given period of development (Lerner, 2005:xiii). Fouché (2005:51) is of the opinion that the mesosystem is very much indicative of the social support available to a person.

The main systems with which children interact are their family, school, community and friends. These systems will be touched on in more detail when the microsystem and its influences are discussed. The interactions between these settings are the concern of this section. The following figure illustrates how these factors fit into the ecological

systems perspective, after which the relationship between the school and the family will be considered.

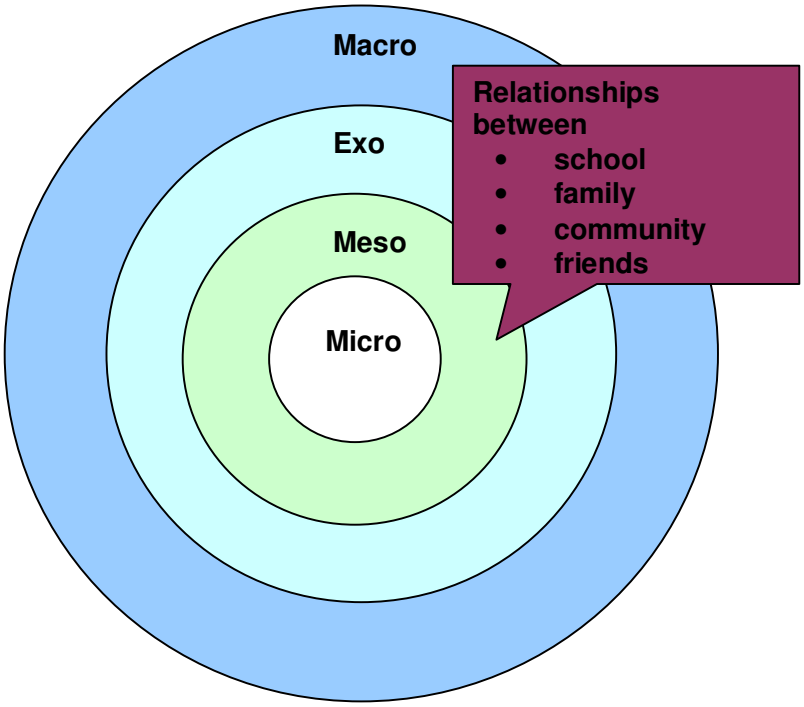


FIGURE 2.4 MESO-LEVEL FACTORS

i) The relationship between the school and the family

The relationship between a family and a school determines to a large extent how successful a child's schooling will be. Both parties in a relationship have expectations and whether or not those expectations are met determines the quality of the relationship.

UNICEF (2006:21) mentions some of the expectations that schools have – school fees are expected to be paid, the necessary books are to be bought, children are expected to wear uniforms, to attend school, to concentrate in class, to do their homework and parents are expected to be involved in, for instance, the child's studies and school events.

The child and his/her family have their own expectations. It is safe to assume that the following are some of their expectations of the school – they expect a child's rights to be respected, quality education, that the child would not be discriminated against, physical and emotional safety and understanding. Sometimes families have other expectations of

their children that directly contradict that of the school – e.g. when children are kept from school to perform economic activities or domestic responsibilities (The International HIV/AIDS Alliance, 2003c:4).

When schools are rigid in their expectations, school drop-out can ensue. Poverty is a major cause of drop-out (UNICEF, 2006:21) and some families simply cannot afford to send their children to school and to buy the uniforms and books required by the school. Sometimes children do not have enough to eat at home causing them to be unable to concentrate in class (Nemapare & Dow Tang, 2003:57). Children's home circumstances can make it difficult for parents to be involved in school events or in the child's studies. In some cases, parents just do not care enough about their child's education to want to be involved (Berns, 2007:242). When the school's expectations are not met, the relationship between the school and the family can become negative. The same is true for the child and his/her family's expectations. When a child is not respected, is discriminated against and endangered the relationship can turn sour quickly and could also lead to drop-out.

If schools would make an effort to understand the child's circumstances, much could be done to keep the relationship intact and the child in school (Duggan, 2000:146). The International HIV/AIDS Alliance (2003c:12-14) mentions a few things that are done by schools where the impact of HIV/AIDS on families is understood: some schools allow orphans to attend school free of charge or they offer discounts on school fees; children are allowed to come to school even if they do not have uniforms; some schools also have feeding schemes to ensure that children have at least one nutritious meal per day. With these actions schools compromise on their expectations because they understand the children's situations and they are willing to help.

In other cases schools rigidly enforce regulations and refuse children without books or uniforms or paid school fees access to the school (Subbarao & Coury, 2004:16-17). In many cases children are discriminated against by teachers and fellow pupils or stigmatised because of their association with HIV/AIDS (UNICEF, 2006:21).

From their side the parents or caregivers of the child can try and meet those expectations of the school that are within their reach. When the relationship between the school and the family and child is good, support is made available to the child. The

relationships making up the mesosystem have the power to shape the microsystems operating in a child's life. It can be argued that it is also indicative of the social support available to a child. It can impact negatively or positively upon a child's life.

2.4.5 Microsystem

The fourth and inner system level is the microsystem. The microsystem consists of those settings that directly affect a person. According to Bronfenbrenner's revised definition, a microsystem is "a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social, and symbolic features that invite, permit, or inhibit engagement in sustained, progressively more complex interaction with, and activity in, the immediate environment" (Lerner, 2005:xvii).

Every microsystem in a person's life will be characterised by different activities, social roles and relationships. The dynamics of each microsystem differ and each system has other expectations of the person in question. The person will be expected to engage in different activities, and to fulfil different roles, within the confines of the different relationships within the setting, depending on which setting is the primary one at a given time. These expectations are setting specific and are influenced by the higher level systems operating in the culture. Settings can be restrictive or supportive, with regards to the development of the person.

At the centre of the microsystem are the person's biological and psychological make-up, cognitive abilities and socio-emotional and motivational propensities like temperament and personality (Bukatko & Daehler, 2004:30). Coupled with past experiences and the way the world is viewed, these traits form the starting point for a person's interactions with the different settings in his/her environment.

In the previous three sections, the ecological systems perspective was discussed from the macrosystem inward to the microsystem. This discussion was elucidated with examples of the different factors influencing each level. The microsystem is the innermost level that directly impacts upon an individual. This level contains all the influences and factors that are closest to a person. It is important to gain an understanding of the microsystemic impacts that HIV/AIDS has on children whose

parent(s) are living with HIV/AIDS. To do so, the probable life path of such a child will be traced in order to see what, and how, different factors could influence the child's life during the parent(s) illness and after his/her death. The following figure indicates where these factors fit into the ecological systems perspective.

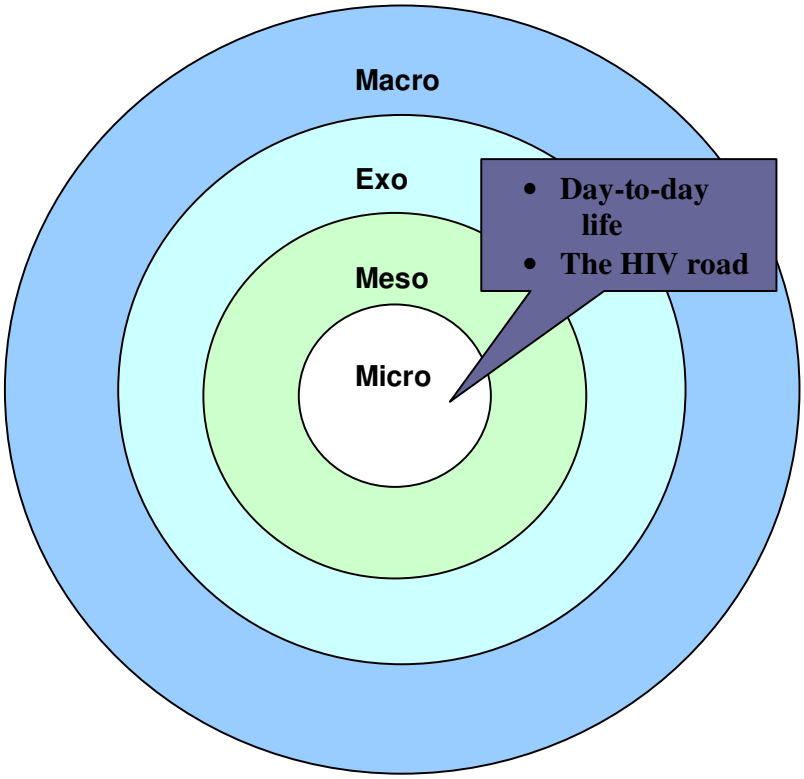


FIGURE 2.5 MICRO-LEVEL FACTORS

The HIV road referred to in figure 2.5 is the probable life path of an AIDS orphan. It will be discussed in an integrated manner with the day-to-day life of a child walking this road. Killian (2004:39-40) identified six stages in what she calls the "HIV road". These six steps are:

1. AIDS-related illness becomes personal
2. Children become involved in caring for someone who is ill
3. Children experience loss
4. Children adapt to the changes consequent to the death of a parent
5. Children adapt to new home and/or care arrangements
6. Children may themselves suffer the effects of the virus.

This author (Killian, 2004:39-40) notes that these steps are highly likely to be experienced by children walking the HIV road. These six steps will form the framework for this discussion.

i) Step 1: AIDS-related illness becomes personal

For a child, HIV/AIDS becomes personal when a loved one starts showing signs of the illness (Killian, 2004:39). For the purpose of this discussion, the "loved one" is a parent or primary caregiver.

When people find out that they are HIV+, they have to deal with the fact that they have a terminal illness and come to terms with what it means, while working through all the ensuing emotions and practical implications. The pressure of being infected can lead to dramatic mood swings. A parent with HIV may show less interest in his/her children than before. For a child, this can be very confusing. If the child does not understand what the problem is, he/she could feel that it is his or her fault. Children become anxious when one of their parents is ill. Changes in the rhythm of the daily life of the family make them unhappy and they become fearful when they realise that their parent is sick more and more often (Bezuidenhoudt, Elago, Kalenga, Klazen, Nghipondoka & Ashton, 2006:19). Mallmann (2002:10) observes that continual parental illness is the cause of many worries for children.

Sick parents often do not talk to their children about their disease – thinking that they are protecting them from distress. But not taking children into their confidence, causes more distress (Subbarao & Coury, 2004:20).

With the entry of HIV/AIDS into the family, a child's world suffers many changes. The normal daily routine changes because the sick parent cannot do the jobs around the house that he or she used to do and other members of the family must step in to help (Mallmann, 2002:10). The family structure can change – it is common practice for another relative to come and live with them to help out (Bezuidenhoudt *et al.*, 2006:19). Children are also frequently relocated between households. The reason for the move could be to help look after sick relatives, or to obtain better care in a household that does not have to deal with the pressure of caring for an HIV positive member. The children thus have to deal with and adapt to new caregivers and new routines, being away from

their families, and in some cases to a completely new environment, as they can be moved both within and between rural and urban areas (Richter, 2004:10).

Townsend and Dawes (2004:70) found that households with infected parent(s) are more prone to increasing poverty. The UNICEF report on Children Orphaned by AIDS (2006:10) states that household wealth declines when a member of the household falls ill. Richter (2004:9-10) agrees by quoting from a study that found that, on average, the income of a household that has an HIV+ member falls by 60%. Converse to the declining income, is health expenditure that quadruples. Families deplete their savings, sell their assets and fall into debt to care for infected members and to compensate for the loss in income. Since most of the family's money is spent on the sick person, it leaves less money to care for the needs of the rest of the family (UNICEF, 2006:10). Because of scarce financial resources, families often have no money for school fees, uniforms, materials, clothing and other necessities. It has been noted that food consumption can drop by as much as 41 % in affected households (Richter, 2004:10).

Households often take in children from relatives or friends, where parents have died of HIV/AIDS. It has an obvious effect on family composition, but more importantly, the dependency ratio in these households increases. A dependency ratio shows how many people are dependent on each adult for food and livelihood within one household. It is calculated by adding the number of people aged 0 – 17 to the number of people aged 60+, and dividing this by the number of adults aged 18 – 59. When households take in orphans, the number of dependent people increases, putting more strain on the family's financial resources. In the case of grandparent-headed households, there might not even be sufficient funds to begin with (UNICEF, 2006:11). When the breadwinner of the house falls ill, it has a detrimental effect on the economic stability of a family. Often the responsibility to earn money and provide food for the family will fall to the children.

The financial struggles of affected families further affect the children's education. Missed opportunities for schooling begin while the parents are ill. UNICEF (2006:22) reports that the children of HIV positive parents are less likely than the children of HIV negative parents to attend school, and their school performance deteriorates during the parent's illness. Children often go hungry and become malnourished, which makes it difficult for

them to concentrate in school. Hunger is a common cause of poor school performance and drop-out (Bezuidenhoudt *et al.*, 2006:20).

ii) Step 2: Children become involved in caring for someone who is terminally ill

When a parent becomes sick with HIV, it is usually the eldest child that takes over the parental role (Bezuidenhoudt *et al.*, 2006:19). New responsibilities and work increase dramatically as the parent's illness progresses and he or she is no longer able to perform their usual tasks. Work inside the households falls to the children, and they need to help out to a much greater extent with chores, subsistence agriculture and caregiving to the young, sick and old. Because of the loss of the parent's income, children also become involved in the economic activity of the family, through formal work, like farmwork, and informal work, like begging (Subbarao & Coury, 2004:18). As a result they are deprived of their childhood and their education invariably suffers while they are burdened with drastically premature parenting responsibilities (Frolich, 2005:358-359,361). Their education suffers, because they often stay away from school to care for sick parents, siblings and the household. Even if drop-out is not "forced" by circumstances or lack of finances, school becomes less important in comparison with the child's many other duties (Richter, 2004:11). Stigmatisation can also prompt them to stay away from school. Interrupted schooling has a detrimental effect on children, also because education is very important for their psychosocial development (The International HIV/AIDS Alliance, 2003c:5). It is important to remember that these caregiver-children have to witness and care for their dying parent (UNICEF, 2006:23), which has an immense impact on their psychosocial well-being.

iii) Step 3: Children experience loss

Because HIV/AIDS is a sexually transmitted disease, chances are that once a child has lost one parent to AIDS, he/she will lose the other parent as well. A child in a high prevalence community is likely to suffer repeated losses as family members, friends and community members die. A child's life could become a state of chronic, unrelenting loss and mourning. Loss can take many forms – a child can mourn for lost people, lost education, a lost home, the loss of the ideal family, a loss of dreams and hope for the future (Leal-Idrago, 2000: http://userwww.sfsu.edu/~ali1212/Psych.html).

Parental death is a profound loss for children. Fox and Parker (2003:120) pointed out that while adults spread their love among many meaningful relationships, children's love tends to be vested almost entirely in their parents. These authors (Fox & Parker, 2003:120) added that the consequences of bereavement depend on the age and social development of the child, while children's response to bereavement depends on the following aspects:

- their relationship with the person who died
- the nature of the death
- the child's own personality and previous experience with death
- the child's developmental and chronological age
- the availability of support from family and community
- the attitudes, behaviours and responsiveness of significant adults in the child's environment.

These aspects will determine the "health" of children's response to bereavement. For instance, if a child has lost a loved one for the third time, and witnessed a long and painful deathbed without receiving comfort from other significant people, the child will probably have difficulty in dealing with the loss.

Primary risk factors for poor adjustment after the loss of parents are a lack of social support, bereavement overload, secondary losses and concurrent stressors (Cook, Fritz & Mwonya, 2003:88); all of which are very probable in the lives of AIDS orphans. These factors will aggravate the intensity and duration of grieving (Cook *et al*., 2003:88) and can lead to internalising symptoms like anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Richter, 2004:23).

iv) Step 4: Children adjust to the changes consequent to the death of a parent

It is logical that, after the death of a parent, decisions will need to be made about the future of the children. In the case of a single-parent family, the children will need a new place to stay after the death of that parent. However, even if the child had been living with both parents, and one of them had died of AIDS, chances are that the remaining parent will also be infected because HIV/AIDS is sexually transmitted. It is therefore probable that any maternal or paternal orphan will become a double orphan in the foreseeable future.

It is understandable that the death of a parent will cause many disruptions in children's microsystem. Not only have they lost a very prominent presence in their microsystem, but they will probably need to move to a new family. Sometimes they will be exposed to multiple moves (UNICEF, 2006:13) in the process of finding a family that is able and willing to care for them. Because of the saturation of the traditional safety nets and poverty, siblings are sometimes separated and taken in by different families (Subbarao & Coury, 2004:29). Parental death can be seen as a catalyst for further losses and changes in the child's immediate environment.

A child's immediate environment consists of the home and school. The first issue to be discussed is that of caring, since the orphaned child will need a new home.

It has been found that the closer the orphans' new family is to the biological family, the better the chance that they will be well cared for, for example if the children are taken in by blood relatives or someone with whom the deceased parent had a close personal relationship (UNICEF, 2006:14). The traditional first choice for replacement carers used to be aunts and uncles, but this is changing. Reasons for the change include that they themselves could be victims of HIV/AIDS, or that they are not willing to care for the orphans (Subbarao & Coury, 2004:28), perhaps due to poverty and/or the presence of other children in their homes that are already being fostered by them. The responsibility of caregiving has shifted on a large scale to grandparents and older siblings (Subbarao & Coury, 2004:18).

Both caregiver grandparents and caregiver siblings face strong material constraints and receive little external support (Subbarao & Coury, 2004:29). Childheaded households are often mired in very bad circumstances because of increasing poverty and the lack of skills required to conduct household economic activities. Richter (2004:10) reports that children's vulnerability increases when they are cared for by a very aged relative. Subbarao and Coury (2004:28) reason that this may be the case where grandparents are old and may be sick and tired. They may find it difficult to respond to the psychological, legal, economic and basic needs of the children, even though they may provide a loving and secure environment in which the children can grow up.

Two other care-related concerns that will lead to changes in children's lives are that orphans are often passed from one relative to another when the caregivers become stretched beyond their capacity (Subbarao & Coury, 2004:45). Orphans are robbed of stability in their lives, and fall victim to property dispossession if their parents had not made proper wills (UNICEF, 2006:11).

The second issue pertains to the school. After the parent's death, the hazards for missing school are increased. School performance has been found to worsen after parental death. It has been noted that orphans sometimes acquire less schooling than non-orphans. Some of the reasons for drop-out or lack of enrolment are that there is not enough money to pay for schooling, children are needed to work to contribute to the household's finances, or caregivers do not regard the child's education as a priority (UNAIDS, 2006:21-22). It can be argued that this not only changes their day-to-day lives, but also their future prospects.

v) Step 5: Children adjust to new home and/or care arrangements

Even though some orphans are very happy in their new homes, it is not always the case. Subbarao and Coury (2004:19) are of the opinion that the lack of parental protection opens the door to the violation of the children's rights.

Some studies (UNICEF, 2006) report that children are treated as part of the family in their new homes, while others like Subbarao and Coury (2004) note that orphans are discriminated against in the new households, especially where poverty reigns and resources are scarce. In such cases parents usually distribute resources in favour of their biological children (UNICEF, 2006:13), and deny orphans access to basic needs such as education, health care and nutrition (Subbarao & Coury, 2004:15). Frolich's study (2005:254) confirms that orphans are often maltreated and exploited by their extended family. Frolich (2005) found that orphans were not treated the same as the biological children and were given excessive chores. Some orphans were forced to drop out of school because it was expected that they should work to contribute financially to the household. There is also the danger of physical and sexual abuse in the new homes.

Because of the overburdened safety net, children are at risk of, and vulnerable to malnutrition, poverty, child labour, homelessness and reduced access to education and

health care (Bezuidenhoudt *et al.*, 2006:20, Foster, 2006:700), neglect and migration (Foster 2006:700).

vi) Step 6: Children may themselves suffer the effects of the virus

As children grow older, they run the risk of becoming infected themselves. Since this study is specifically focussed on HIV negative children who are orphaned due to parental death by AIDS, a discussion of infected children would fall outside the scope of the study. It will suffice here to be aware that becoming infected with the virus will set off a whole new chain of events, repercussions and outcomes in the child's life. Such children will need particularly specialised help and guidance to learn to cope and to learn to live with the disease.

The six steps discussed above give valuable information on the realities of the lives of children affected and later orphaned by HIV/AIDS. Richter (2004:0) states that HIV has a psychosocial effect on the development and adjustment of children. A consideration of the different events and factors interplaying in their lives gives invaluable insight into the root causes of the psychosocial issues that these children will have to deal with.

2.5 Psychosocial effects of HIV/AIDS on affected and orphaned children

While the six steps of the "HIV road" (Killian, 2004) give an indication of the origin of psychosocial issues, this section is more concerned with what these psychosocial effects in children affected and orphaned by HIV/AIDS are.

Bezuidenhoudt *et al.* (2006:18) define psychological effects as "...thoughts, feelings and emotions that affect the mental state and well-being of infected and affected persons", while social effects concern the person's environment and situation. "Psychosocial effects" thus impact on the psychological development of a person in relation to his/her social environment.

Being affected or orphaned by HIV/AIDS leaves children traumatised. Subbarao and Coury (2004:20) observe that a lack of nurturance, guidance and a sense of attachment can mean additional trauma to the child. When a mother, father or both parents die, children are denied parental love, nurturing and protection. This is critical to their development, especially in early life (UNICEF, 2006:16). Children can suffer a variety of

psychological reactions to parental sickness and death, as well as to the negative circumstances and experiences they are exposed to as a result of the parent's sickness and death. Subbarao and Coury (2004:19) state that they may become withdrawn, passive, develop sadness, anger, fear, antisocial behaviours, and become violent and depressed. The children are exhausted and stressed because of the extra work they are required to do and constantly worrying about what is going to happen. Their lives are marked by insecurity and they will probably be the victim of stigmatisation. Being affected or orphaned by HIV/AIDS can impact upon the children's current and future mental health through the loss of their home, school drop-out, being separated from friends and siblings, increased workload and social isolation (Richter, 2004:11-12). Their socialisation process can be impeded through damaged self-confidence, social competencies and motivation (Subbarao & Coury, 2004:20).

There is prevailing concern among some researchers and analysts that the growing number of orphans can impact negatively on the security and stability of society (Pharoah, 2004:3). Barnett and Whiteside (2002:210) voice the fear that AIDS orphans could grow up as an "unsocialised, uneducated, and unloved" risk to society. This could have an increasingly adverse effect on human and economic capital, manifesting in growing socio-economic problems (Pharoah, 2004:2).

Bray (2003:6-7), however, critiques these predictions of the negative outcomes of orphanhood as an assumed direct causal relationship. According to Bray (2003:6-7) these predictions are based on the following logic – "parentless children will grow up without role-models, and hence will lack social skills, a moral framework and discipline. Large numbers of children and young adults who do not have these qualities will precipitate a breakdown in the moral order and social fabric". She argues that these predictions are based on too many assumptions and that it does not take into account the various protective factors that could be present in a child's life. The following two examples could serve as an illustration of the point she is making:

Children who do not have loving and caring adults in their lives that are committed to their well-being are at a higher risk to develop psychological problems. When children do not receive positive emotional care, they could develop a learned lack of empathy for others. Such children may develop antisocial behaviour. However, there are protective

factors that could lessen the effect of a home life with reduced love and nurturing, like a personality predisposition or compensating care from other people in the child's life (Richter, 2004:12).

The same author (Richter, 2004:21-22) quotes Mel Freeman (2003) who said that many orphans are likely to develop mental health problems, even if they are taken into caring homes, because they were not exposed to several formative influences:

- early bonding experiences critical for good, caring human relationships
- modelling, boundary setting and development of value systems necessary for moral development
- support, caring and discipline needed for emotional stability.

But since children have the tendency to seek out such positive experiences, even in the worst circumstances, it might only be absent in children who have no adult supervision or support.

There are three groups of determinants that can be associated with poor adjustment in children orphaned by AIDS: poverty; loss, separation and bereavement; and cruel and impersonal childcare. It could lead to deprivation syndromes, internalising psychological conditions and a range of psychological disorders (Richter, 2004:23).

Poverty is associated with deprivation syndromes in children. This includes poor growth and health, decreased motivation, increased passivity, impoverished experience and frames of reference and lower cognitive performance (Richter, 2004:23). Pre-existing conditions that could worsen the impact are, for example, substance abuse in the house, residential instability and displacement (Richter, 2004:23). These are widespread conditions in SA communities (Department of Welfare, 1997:60).

Loss, separation and bereavement are associated with internalising psychological conditions. These include anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Richter, 2004:23).

A child who is subjected to **cruel and impersonal childcare** are at risk of a wide range of psychological disorders, including a reduced capacity for affection and compassion, acting out and aggressive coping styles. If such conditions in the new home are

precipitated by similar conditions in the home of origin, the risk is much greater (Richter, 2004:24).

Richter (2004:11-12) states that studies have shown that affected and orphaned children mostly exhibit internalising symptoms (depression, anxiety, withdrawal) rather than externalising symptoms (aggression, antisocial behaviour). Only children exposed to cruel and impersonal childcare are likely to display more externalising symptoms.

The following table presents a summary of some of the internalising symptoms prevalent among orphans and affected children, as found by five authors in their various studies:

TABLE 2.4 INTERNALISING SYMPTOMS EXPERIENCED BY HIV/AIDS-AFFECTED CHILDREN

Internalising symptoms	
Depression	Lack of confidence
Anxiety	Isolation
Withdrawal	Bitterness
Anger	Guilt
Inactivity	Fear
Hopelessness	Loss
Suicidal thoughts	Denial
Emotional distress	Suicidal behaviour
Grief	Chronic stress
Low self-esteem	

Source: Derived from UNICEF, 2006:24; Alliance, 2003c:7; Foster, 2006:700; Bezuidenhoudt *et al*., 2006:18 and Richter, 2004:12

This table lists some of the internalising symptoms found in AIDS orphans. These symptoms are the result of the psychological effects that parental infection by HIV/AIDS has on their children.

Children affected and orphaned by AIDS are often stigmatised and discriminated against. Deacon and Stephney (2007:20) are of the opinion that HIV/AIDS-related stigma can aggravate the psychological effects of the disease on children. Discrimination can lead to behavioural disturbances in children, as well as to fatalism and increased opportunities for abuse. Children who are stigmatised may begin to internalise the stigma and make it part of their identity (Bezuidenhoudt *et al*., 2006:19) by coming to agree with society's perception of themselves as devalued (Deacon & Stephney, 2007:6). These same authors (2007:6) state that the children can also start living their lives in fear of possible stigmatisation or discrimination. Such children will make their decisions based on this perceived or expected threat. Fear of being stigmatised and discriminated against often keeps children orphaned or affected by HIV/AIDS from attending school – and the International HIV/AIDS Alliance (2003c:5) has found that education is very important for children's psychosocial development.

This section highlighted some of the psychosocial effects that HIV/AIDS has on orphaned and affected children. It is clear that these effects are numerous and impact negatively upon the child. It is important to have an idea of the psychosocial issues that are likely to present itself in a child orphaned by AIDS, because it is into this arena that the foster parents will step. They need to be prepared to deal with these issues, as well as be able to recognise them.

2.6 Summary

In conclusion it can be noted that HIV/AIDS is a massive problem in South Africa, and has far-reaching consequences for the country and for individuals' lives.

In this chapter the ecological systems perspective was employed to consider the bigger picture of HIV/AIDS in the South African context, narrowed down through the macro-, exo-, meso- and microsystem to understand the impact it has on the life of a child who are orphaned by HIV/AIDS. The psychosocial effects on children affected or orphaned by AIDS, were highlighted.

The next chapter will look at foster care in South Africa since foster parents are the likely carers for AIDS orphans.

CHAPTER 3: FOSTER CARE IN SOUTH AFRICA IN THE CONTEXT OF HIV/AIDS

3.1 Introduction

The previous chapter gave an outline of how the HIV/AIDS pandemic is ravaging families. The middle generation is dying and South Africa is left with an estimated 1 million orphans who need to be cared for. The best care option after adoption is foster care, because the best environment for a child to grow up in, is in a family.

This chapter therefore addresses the second objective of the study, which is to give an overview of foster care of AIDS orphans within the South African context. The chapter will start with a synopsis of foster care in general, followed by a discussion of the South African foster care system and its challenges within the context of the new Children's Act, and it will end with a specific focus on foster care of AIDS orphans.

3.2 Description of foster care

This section will provide a very general overview of foster care in order to set the stage for a more focused discussion of foster care in South Africa, and even more specifically, foster care of AIDS orphans. The purpose of foster care will be discussed first, followed by two foundational principles and a discussion of the different types of foster care that are being used. Next in line are three important aspects that must be kept in mind when considering foster care, namely the motivation of foster parents, the needs of foster parents and the roles that they are required to fulfil.

3.2.1 Purpose of foster care

The purpose of foster care is to provide substitute care within a family setting to children who cannot be cared for by their own parents. In many families, a sudden crisis, or a gradual family breakdown, causes parents to be unable to look after their children for longer or shorter periods (South African National Council for Child and Family Welfare, 1987:2). The ideal is that foster parents act as substitute parents to foster children, while a social worker renders services to the biological family in order to help them grow to a place where they can resume care of their own children.

The Children's Amendment Act, (no. 41 of 2007) emphasises three purposes of foster care in section 181:

1. "to protect and nurture children by providing a safe, healthy environment with positive support
2. to promote the goals of permanency planning, first towards family reunification, or by connecting children to other safe and nurturing family relationships intended to last a lifetime
3. to respect the individual and family by demonstrating a respect for cultural, ethnic and community diversity".

In other words, foster care purports to keep children in an edifying family environment that is safe, healthy, positive and supportive and that has the same roots as the children's previous environment until their parents can take care of them again. When reunification with the biological family is not possible, permanency will be pursued along another way.

Two foundational principles of foster care are also highlighted in this section of the Children's Amendment Act, no. 41 of 2007: The first principle is that of permanency and the second principle is the notion that the family is the best environment for a child to grow up in. These two principles will be discussed in further detail in the following subsection.

3.2.2 Foundational principles of foster care

i) Permanency

Permanency, the first principle, is a sought-after goal in foster care because children need stability and security in their lives in order to thrive. Permanency planning aims to reduce foster care placement disruptions and other threats to children's stability and security (South African National Council for Child and Family Welfare, 1987:6) through family reunification or permanent substitute family care.

Permanency planning is the second purpose of foster care highlighted by the Children's Amendment Act of South Africa, no. 41 of 2007 as quoted in the previous section. Family reunification is the primary goal of permanency planning, but the reality is that very few foster children are returned to their families (Philander, 2010). The secondary goal of permanency planning is to find a permanent substitute family for the foster child, either through adoption, or placing the child permanently with the foster family.

ii) Family-based care

Family-based care is the second principle of foster care. Foster care practices rest on the premise that "...a family setting still provides the best environment for the development of the innate potential of a child" (South African National Council for Child and Family Welfare, 1987:6). This is the dominant view in South Africa, and internationally. South African legislation prioritises a foster care placement as the first option of alternative care (Perumal & Kasiram, 2008:159).

These two principles run through all the legislation on foster care in South Africa and form the foundation on which foster care services are built. Foster care has many faces and the next section offers a discussion on different types of foster care models that could be used to fit each child and family's individual circumstances.

3.2.3 Types of foster care

It is a good idea to not take a too general approach to foster care – the families and their different circumstances and capacities vary too much. Because of these differentiating factors there are a variety of foster care models from which the most suitable one can be chosen and applied to each individual case. These differentiating factors are (South African National Council of Child and Family Welfare, 1987: 7-8):

- whether or not the placement takes place through a court order
- whether or not the foster carers are relatives of the child
- whether the foster child is mentally and physically normal, or a child with special needs
- whether the placement must be short-term, indeterminate, long-term or permanent (the duration of the placement)

When a placement occurs through a **court order**, it is referred to as "formal foster care", whereas a fostering arrangement outside the legal system is called "informal foster care". "Non-relative care" and "kinship care" refer to whether the *foster parents are related* to the child. A child with **special needs** can complicate the placement and be a challenge for the foster parents, but so can **mentally and physically normal children** – foster parents need to be equipped to care for their foster children. With the principle of permanency in mind, the **duration of placements** can vary.

It must be noted that the foster care models referred to here were conceptualised in 1987 – 23 years ago. However, the guidelines for foster care that are offered are still very much relevant today in terms of the new Children's Act no. 38 of 2005.

In the following subsections these different kinds of foster care will all be discussed.

i) Formal foster care

A foster care placement within the legal system is called "formal foster care". Section 180 (1)(a) of the Children's Amendment Act, no. 41 of 2007 is explicit about the requirements for formal foster care – it is stated that "...a child is in foster care if the child has been placed in the care of a person who is not the parent or guardian of the child as a result of an order of a children's court".

ii) Informal foster care

Informal foster care happens when a child is placed in the care of other people through an informal arrangement between the biological parents and the foster parents. The children's court is not involved.

iii) Kinship care

The term *kin* refers to any relative of the child, by blood or marriage (Hegar & Scannapieco, 1996:570). In kinship care, the child is placed in the care of relatives. Kinship placements are culturally sensitive and may be less traumatic than placement with strangers (Hegar & Scannapieco, 1996:568). An important advantage of kinship care is that it serves as a strategy for family preservation. Through kinship care children are generally able to live with people they know and trust. Staying with family allows the child's family identity to be transmitted and provides space for the child's cultural and ethnic identity. Kinship care prevents sibling relationships from breaking up, as well as helping children to maintain or form relationships with their extended family (Child Welfare League of America, in Hegar & Scannapieco, 1996:568).

iv) Non-relative family foster care

The placement of children with non-relatives should only be considered when no relatives are "available, willing and suitable" to care for the child (South African National Council for Child and Family Welfare, 1987:11). It is a voluntary decision for non-

relatives to act as foster carers, so they are at least willing to face the stresses and risks involved in foster parenting.

v) Children with special needs versus mentally and physically normal children

Foster parents looking after children with special needs will require a higher level of skills as well as specialised knowledge about the child's condition. These foster parents are often asked to provide homes for children with physical disabilities, emotional disturbances, behaviour difficulties or children who are to some extent mentally disabled (South African National Council for Child and Family Welfare, 1987:21) It is logical that such children will require specialised care and well-prepared foster parents.

However, depending on the reason for the child's removal from the home, many – or most – foster children are likely to manifest at least a low level of emotional disturbances and/or behaviour difficulties. All foster parents thus need to be thoroughly prepared for the placement and to meet the challenges of foster parenting. This is relevant for all foster children, not just those with special needs.

vi) Short-term placement

Short-term foster care is aimed at providing temporary care for children whose parents are unable to care for them for a limited time period. Children can be placed in short-term foster care as a result of a family crisis like serious illness or death. When the crisis has been resolved they are reunited with their parents. Short-term foster care can also serve as emergency placements in cases where children have to be removed from their families immediately, while the social worker is making more definite long-term plans (e.g. in cases of abuse, abandonment or neglect). Short-term foster care is also used to provide respite to the parents or caregivers of severely disabled children, or as holiday homes for children in children's homes (South African National Council for Child and Family Welfare, 1987:12-12).

vii) Indeterminate placement

This kind of placement does not have a specified length and can last a few months or a few years. The uncertainty is due to the fact that the parents are likely to be able to resume their parental responsibilities, but it is not known how long the restoration services will take. The goal remains family reunification within a reasonable time period.

The uncertainty associated with this kind of placement presents all the involved parties with serious difficulties (South African Council for Child and Family Welfare, 1987:14).

viii) Long term placement

Unplanned long-term foster care can have a negative effect on the children, whereas planned long-term foster care offers a high degree of permanence, security and certainty to the child, foster parents and biological parents. This kind of placement is made when the parent could eventually regain full parental responsibilities, but it could take time (South African National Council for Child and Family Welfare, 1987:15).

ix) Permanent placement

The purpose of permanent foster care is to provide the foster child with a home that offers continuous care and with parents who want the child and intend to raise him or her. This kind of placement is used for children whose chances of being returned to their biological parents are virtually naught. The goal of a permanent placement is to bring permanency to a child's life by avoiding multiple placements in shorter-term foster homes (South African Council for Child and Family Welfare, 1987:17-18).

The section served as a short elucidation of the fact that there is not just one way of "doing foster care". There are various types of placements, each with its own benefits and disadvantages. The social worker assigned to the case will consider the circumstances and decide which road to take.

The next section considers people's motivations to become foster parents.

3.2.4 The motivation of foster parents

In the case of non-relative family foster care, the foster parents usually volunteer to act as caregivers to children. Tyebjee (2003) conducted a study to determine what motivates people to become foster parents. The results pointed to two broad categories of motivations – being moved to action by the plight of children, and doing it for personal fulfilment. Foster parents said that the fact that there are so many children in need spurred them on to want to make a difference in a child's life by providing the child with a positive family experience (Tyebjee, 2003:701). Some foster parents are motivated by a desire to add meaning to their lives, or because they feel compelled by religious or

spiritual beliefs to take care of children. Others act on a desire to become parents, or to continue parenting once their own children have grown up (Tyebjee, 2003:701). These motivations point to a distinct willingness on the part of the foster parents to care for children.

With kinship care, circumstances frequently oblige family members to act as foster parents. The foster parents are often moved by a sense of family duty, or by affection for the child or the child's parents (Hegar & Scannapieco, 1995:204). Among Africans especially, there is an almost limitless sense of duty and responsibility between the members of the extended family, and the extended family remains the predominant caring unit for children (Foster, 2000:56).

People become foster parents for many reasons, and it is important to know what motivates them. The motivation of foster parents can predict the outcome of a placement to a large extent.

The needs and motivations of foster parents are closely correlated. Motivation can dwindle when needs are not met. The next section will consider the needs of foster parents.

3.2.5 The needs of foster parents

The two main needs of foster parents that have been identified internationally, is the need for training and the need for support. Foster parents are expected to be able to deal with any medical, emotional, developmental and behavioural issues that might surface while caring for their foster children (Rich, 1996:437-445). For this expectation to be fair, foster parents need to be sufficiently trained and supported.

Buehler, Rhodes, Orme and Cuddeback (2006:526-527) integrated four different schemata in order to provide a composite conceptualisation of the domains in which foster parents need to be competent. These domains are (Buehler *et al.,* 2006:526-527):

- "providing a safe and secure environment
- providing a nurturing care environment
- promoting educational attainment and success
- meeting mental and physical health care needs

- promoting social and emotional development
- valuing diversity and supporting children's cultural needs
- supporting permanency plans
- managing ambiguity and loss for the foster child and family
- growing as a foster carer – skill development and role clarification
- managing the demands of foster parenting on personal and family well-being
- supporting relationships between children and their families
- working as a team member".

In Buehler *et al.* (2006:527), Rycas and Hughes (1998) define the above competencies as the combination of the knowledge, skills and interests that are needed to perform the tasks of fostering successfully. These authors reason that a minimum standard of competency in each domain can be expected, while the desired standard is the goal that is being pursued. To enable a foster parent to develop his/her competencies to the desired standard will require additional support, training, time and experience.

Brown and Calder (2000:729) conducted a study in which foster parents were asked to identify their needs, by answering the question, "What do you need to be a good foster parent?" Five themes emerged from their answers – (1) Good working relationships with social workers and foster parents (2) Support from social services (3) Harmonious and stable family relationships (4) Cultural sensitivity (5) A range of personality characteristics and parenting skills. These themes and the domains illuminated by Buehler *et al.* (2006:526-527) complement one another and all of them can be enhanced through training and support.

3.2.6 The role of the foster parents

Competency in the abovementioned domains, will help foster parents to fulfil their various roles. The traditional roles of foster parents are nurturing the foster child, providing guidance and discipline to the child, and promoting his/her development. In America and other developed countries, foster care agencies have begun to recognise the strengths that foster parents could bring to the permanency planning process. Foster parents are increasingly valued as important members of agencies' fostering teams and they are taking more responsibilities on themselves. Dougherty (in Barbell & Freundlich, 2001:20) pointed out that, apart from nurturing, promoting child development and providing guidance and discipline, foster parents are beginning to assume the roles of

advocacy (on behalf of children with schools), mentoring (birthparents), facilitation (supporting the relationship between children and birthparents) and recruiting, training and mentoring new foster parents.

In summary it can be concluded that foster parents have four main roles to play – that of carer, facilitator, team member and biological parent. In order to fulfil these roles and ensure that foster children grow up in stable homes, foster parents need to be motivated and have their needs met – especially the need for training and support.

3.3 Foster care in South Africa

Through the discussion of foster care in general, a foundation was laid for a more detailed look at foster care. The next section is specifically focused on foster care in South Africa. It starts with the legal reasons and procedures for foster care as stipulated in the Children's Act, no. 38 of 2005; and ends with a look at some of the challenges in the South African foster care system.

3.3.1 The new Children's Act

The new Children's Act, no. 38 of 2005, was enacted and was set to replace the Child Care Act, no. 74 of 1983, once the regulations had been finalised. The new Children's Act has been pending for some time, but was enacted in full on 1 April 2010. From here on it will direct and shape foster care in South Africa. This discussion on the new Children's Act will start with why and how children are placed in foster care, before looking at what is legally expected from foster parents.

i) Reasons for being placed in foster care

Children can be removed from their homes when they are found to be in need of care and protection in the light of section 150(1) of the Children's Act, no. 38 of 2005. One of the possible placement options listed in section 156(1)(e) is foster care. According to the Children's Act, no. 38 of 2005, section 150(1), a child is in need of care and protection if the child:

- "has been abandoned or orphaned and is without any visible means of support
- displays behaviour which cannot be controlled by the parent or care-giver
- lives or works on the streets or begs for a living

- is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency
- has been exploited or lives in circumstances that expose the child to exploitation
- lives in or is exposed to circumstances which may seriously harm that child's physical, mental or social well-being
- may be at risk if returned to the custody of the parent, guardian or care-giver of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child
- is in a state of physical or mental neglect
- is being maltreated, abused, deliberately neglected or degraded by a parent, a care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is".

A child can only be placed in foster care because of one of the abovementioned reasons. It is important to note for this study, that orphans qualify for foster care.

ii) Procedures for being placed in foster care

According to section 180(1) of the Children's Amendment Act, no. 41 of 2007, a child can be placed in foster care in one of two ways – as a result of a children's court order, or as a result of a transfer by the provincial head of social development, from a more restrictive form of alternative care to foster care.

Section 184 of the Children's Amendment Act, no. 41 of 2007 determines that the court will base its decision to place a child in foster care in terms of section 156 on a report written by a social worker. This report will consist of a holistic consideration of the child's circumstances, as well as whether there is an available, suitable and willing person to act as a foster parent to the child. A "suitable" person is someone with a similar background to that of the child. There are certain provisions for allowing a child to be placed with foster parents from a different cultural, religious and linguistic background to that of the child; these being an existing bond between the prospective foster carer and the child, or the fact that there is not a suitable and willing person available to provide foster care to the child.

The court can place a child with a person who is not a family member, or with a family member who is not the parent or guardian of the child. The third option is to place a child in a registered cluster foster scheme.

iii) The foster parent – requirements, rights and responsibilities

Foster parents are by law expected to do certain things and the law also attributes certain rights to them. These rights and expectations will be discussed in this sub-section.

a) Requirements

Section 182(2) of the Children's Amendment Act no. 41 of 2007 stipulates that for someone to become a foster parent, that person must be properly assessed by a social worker to determine whether the prospective foster parent is a fit and proper person who can be entrusted with the responsibility to provide foster care, whether this person is willing and able to successfully undertake, exercise and maintain the responsibilities that come with foster parenting, and lastly, whether this person has the capacity to provide an environment that is conducive to the child's growth and development.

b) Rights and responsibilities

When the Children's Court issues a placement order, the rights and responsibilities of the foster parent will typically be set out in the court order. These rights and responsibilities are prescribed in detail in the draft regulations (Department of Social Development, 2008) to the Children's Act.

Section 70(1) of the draft regulations (Department of Social Development, 2008) asserts that a foster parent is primarily responsible for the day-to-day care of the foster child. A comprehensive definition for "care" is given in Section 1(1) of the Children's Act, no. 38 of 2005 to act as a guide for any caregiver. "Care" includes:

- "within available means, providing the child with –
  - a suitable place to live
  - living conditions that are conducive to the child's health, well-being and development - the necessary financial support
- safeguarding and promoting the well-being of the child

- protecting the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation and any other physical, emotional or moral harm or hazards
- respecting, protecting, promoting and securing the fulfilment of, and guarding against any infringement of, the child's rights set out in the Bill of Rights and the principles set out in Chapter 2 of the Child Care Act
- guiding, directing and securing the child's education and upbringing, including religious and cultural education and upbringing, in a manner appropriate to the child's age, maturity and stage of development
- guiding, advising and assisting the child in decisions to be taken by the child in a manner appropriate to the child's age, maturity and stage of development
- guiding the behaviour of the child in a humane manner
- maintaining a sound relationship with the child
- accommodating any special needs that the child may have
- generally, ensuring that the best interests of the child is the paramount concern in all matters affecting the child".

This definition stipulates what foster parents should do, and corresponds very closely with the domains identified by Buehler *et al.,* (2006:525-527) which describe what foster parents should be able to do. The essence of this definition is echoed by the domains and can be summed up as day-to-day protection, guidance, provision and love. The domains however, go further by stating that foster parents have the responsibility to grow as foster parents, to work as team members with the welfare organisation and to balance foster parenting with their personal and family well-being.

The draft regulations to the Children's Act further breaks down the rights and responsibilities of foster parents pertaining to caring for foster children:

Section 70 of the draft regulations (Department of Social Development, 2008) to the Children's Act, no. 38 of 2005 makes foster parents **responsible** for ensuring that any state grant or financial contribution from the child's parents is used towards the upbringing of the child. Foster parents must also encourage contact between the child and his/her biological parents (within the scope of the placement order) and with any person who is interested in the child's well-being and development. The foster parents

are responsible for the child's education – they must ensure that any child of school-going age attends school regularly. The allocated social worker or child protection agency will need access to the foster home and the child in order to monitor the placement, review the order or work towards reunification with the biological family – access must be granted by the foster parent. The foster parents are further more responsible for respecting the child, promoting his/her well-being and development, disciplining the child in a manner that is not violent, humiliating or degrading and for treating foster and biological children equally, except where a child (whether biological or foster) has special needs that require otherwise.

The purposes of foster care, as stated in section 181 of the Children's Amendment Act, no. 41 of 2007, are to protect and nurture the child, promote the goals of permanency planning and respect cultural, ethnic and community diversity. Most of the responsibilities outlined are connected to protecting and nurturing the child. Since the foster parents have demonstrated a willingness to pursue the purposes of foster care, they are also responsible for promoting the goals of permanency planning by co-operating with the plans for family reunification, as well as for ensuring that the child maintains links with his/her cultural, linguistic or religious background, should it differ from that of the foster parents. Finally, the foster parents must recognise that the child is a ward of the state and that it is their responsibility to keep the social worker informed of all matters concerning the child to assist the social worker in fulfilling his/her responsibilities towards the child, the agency and the state.

Section 71 of the draft regulations (Department of Social Development, 2008) to the Children's Act, no. 38 of 2005 gives foster parents the **right** to make all day-to-day decisions pertaining to the care, upbringing and development of the child. In certain instances, the foster parent may give consent for a surgical operation to be carried out on the child, and may apply for a passport to take the child out of the Republic. The foster parent has a right to financial support with respect to the foster child, as well as to adequate social services in support of the parenting role that the foster parent must fulfil. Another right of foster parent is the right to privacy, and to not be subjected to threats, harassment and undue intrusions on the part of the child's biological family. The foster parent also has the right to be informed by the social worker or the child protection

agency of any factor or happening that could potentially have an effect on the placement of the child in his/her care.

Many responsibilities are given to foster parents as set forth in the draft regulations (Department of Social Development, 2008), but they are also attributed rights to safeguard them.

iv) Foster care plans

Section 75(1) of the draft regulations (Department of Social Development, 2008) offers a definition of a foster care plan: "A foster care plan is a document recording the respective rights and responsibilities of the foster parent or parents, biological parent or parents, family members or other persons having an interest in the well-being of the foster child, and the role and responsibilities of the designated social worker or designated child protection organisation or management of a cluster foster scheme."

The purpose of a foster care plan is to provide all the relevant parties with a clear understanding of everyone's "musts", "mays" and "may nots". It must be made in consultation with the child protection agency or social worker and could be made an order of the court. If the child is of sufficient age and maturity, the child must also be consulted and his/her views must be respected and considered. "Of sufficient age and maturity" refers to when a child is deemed able to participate meaningfully. Such a plan may cover aspects like: personal identification details, contact with biological parents and family, financial contributions, details concerning consent for medical treatment, surgical operations, leaving the Republic, decisions concerning education and participation in cultural and religious activities, the projected permanency plan, steps to stabilise the child's life, proposed reunification and supervision services and how monitoring of the placement will work.

Every person who is a party to the co-operation agreement must have a copy of the foster care plan, including the child if the child is mature enough, so that the stipulations can be strictly adhered to.

This section discussed the stipulations for foster care in the Children's Act, no. 38 of 2005. It covered the procedures for placing a child in foster care as well as the rights,

responsibilities and expectations attributed to foster parents by the Children's Act (no. 38 of 2005). The next section is specifically focussed on the challenges in the South African foster care system and will discuss those challenges that are unique to the South African context.

3.3.2 Challenges in the South African foster care system

Wherever foster care is utilised, it is accompanied by the same kind of challenges – for example, foster children with problem behaviour, having to achieve positive outcomes for foster children when they leave care, and recruiting suitable foster parents. These challenges are all present in South Africa's foster care system too. There are, however, some challenges that are a result of the unique South African context. Some of them will be discussed below.

i) Lack of resources

South Africa lacks the resources to adequately carry out the stipulations of the Children's Act. It has been determined that 66 000 social workers, and R44 billion, are needed to implement the new Children's Act successfully. The reality is that there are currently only 15 000 social workers in South Africa (Theron, 2009). This shortage of social workers poses a huge challenge for the South African foster care system (Magome, 2008). Due to this shortage of workers, social workers are overburdened with big caseloads (Naidoo & Kasiram, 2006:119). One factor that increases the strain on them, is the over-reliance on social workers for the provision of welfare (Department of Social Development, 2009). The Department of Social Development has acknowledged this over-reliance, and is in the process of conferring on categories of social service professionals the authority to help with the social workers' load. The professionals that are being considered are, for example, social auxiliary workers, probation officers, child and youth care workers, as well as community development workers. This will enable social workers to concentrate more on developmental social work (Department of Social Development, 2009).

The former minister of Social Development, Zola Zkweyiya, identified the shortage of magistrates trained as commissioners of child welfare and the shortage of dedicated children's courts as further challenges to foster care (Magome, 2008).

There are 500 000 children in foster care in South Africa, with a further 157 000 awaiting placement finalisation (Magome, 2008). The minister is quoted in Magome (2008) as saying, "South Africa is facing a challenge of increasing numbers of orphaned children, abandoned babies, worrying levels of abuse, neglect and exploitation of children." Magome (2008) cites the main reasons as the high level of poverty, unemployment, unwanted pregnancies, family disintegration and the death of young parents and caregivers.

South Africa has lost many social workers to other countries and other sectors offering better work conditions and highly competitive salary packages (Department of Social Development, 2009). In response to this, the department has launched its "Retention and Recruitment Strategy" with the aim of recruiting students to the social work profession by offering them bursaries, and of improving the working conditions and remuneration of social workers. R210 million in the 2009/2010 financial year have been allocated to the social work bursary scheme and there are currently 3 529 students on the scholarship programme (Department of Social Development, 2009).

The shortage of social workers, children's courts, commissioners of child welfare and foster parents, coupled with the high caseloads facing social workers all contribute to the huge backlog in foster care cases.

ii) Families

The dominant view in South Africa and internationally is that the best environment for a child to grow up in is in a family. South African legislation supports this view, by prioritising a foster care placement as the first option for alternative care (Perumal & Kasiram, 2008:259).

Various factors in South Africa have a negative impact on family life, rendering the family in many cases as a less than ideal environment for optimal child development. Examples of these factors are HIV/AIDS, unemployment, poverty, substance abuse, inequality, family and gender violence, and crime. Perumal and Kasiram (2008:160) state that numerous families have a compromised ability to care for their children because they are under-resourced, oppressed and excluded.

Clough (1982:19) proclaims that "...there is a widely held belief that families are the ideal places in which to bring up children or indeed in which any of us, but particularly the dependent, should live. The myth that life is best in families persists in spite of the fact that families are not perfect..." It seems that Perumal and Kasiram (2008:160) are taking a valid stance in questioning how families will be able to fulfil their obligations towards children under the conditions of depravity many find themselves in.

The White Paper for Social Welfare (Department of Welfare, 1997:15, 60) recognises (1) families as the basic unit of society and (2) that the well-being of children depends on the family's ability to function effectively. The White Paper for Social Welfare (Department of Welfare, 1997:60) also expresses South Africa's support of the international viewpoint that children "...need to grow up in a nurturing and secure family that can ensure their survival, development, protection and participation in family and social life" because they are vulnerable. Families should impart values and life skills to their members while giving them a sense of belonging.

While the White Paper for Social Welfare (Department of Welfare, 1997) describes this ideal situation, it also gives a glimpse of the reality in South Africa:

Families are facing many problems inside the family as well as challenges pressing in from outside the family. Some examples of these internal problems are alcohol and drug abuse, communication and relationship problems, marital conflict, a lack of preparation for marriage, remarriage and family life, parenting problems, family violence, a lack of family and community support networks, and family breakdown. Violence and unsafe conditions in communities are two examples of outside challenges. Because of this pressure from inside and outside the family, many families are not able to fulfil their parenting and supporting roles without outside help (Department of Welfare, 1997:60).

A big challenge facing the foster care system is thus the fact that foster families will rarely be "perfect". Foster children are likely to be removed from a dysfunctional family and placed in another family facing other problems. Another family-related challenge facing the foster care system is the ideal end goal of foster care, namely family reunification. Two critical elements of foster care and child welfare are a successful placement and family reunification. As noted above, a successful placement could be

difficult to attain, while successful reunification is only possible if the relationship between the biological parents, the siblings and the child can be maintained during placement. Perumal and Kasiram (2008:161) maintain that reunification is difficult in the South African context, as biological families are rapidly disintegrating because of factors like migrant labour, divorce, teenage pregnancies, infertility, child abandonment, HIV/AIDS and death.

As is evident in the above discussion, the White Paper for Social Welfare (Department of Welfare, 1997) recognises the fact that families need support to cope with the increasing pressure and the Department for Social Development is committed to family-oriented policies and programmes. Part of the foster care process is training and support for foster families, but again, heavy workloads prevent social workers from giving it the necessary attention (Delport *et al*, 2008:319).

iii) Deluge in foster care cases

Another challenge is the deluge in foster care cases. According to the Annual Report of the Department of Social Development 2000-2001 (cited in the NWSSDF, 2007b:2) foster care grants were received for 49 843 foster children by foster parents in 2000. In 2009, there were 500 000 children in foster care in South Africa (The Centre for Child Law, 2008). According to Meintjies and Van Niekerk (2005:2) this disproportionate increase is to a large extent due to the HIV/AIDS pandemic and to a greater awareness of foster care among the general population. Orphans and abandoned children automatically qualify as "children in need of care" and are eligible for foster placements. The Department of Social Development is pushing foster care as a means to care for the increasing numbers of AIDS orphans. Section 71(6) of the draft regulations of the Children's Act (Department of Social Development, 2008) states that foster parents have the right to financial assistance with regards to the foster child/children in their care. In South Africa's budget for the financial year 2009/2010, the foster grant was increased to R680 per month per foster child (Manuel, 2009). More and more families are beginning to rely on grants for financial support and the foster care grant is particularly appealing, since it is almost three times the amount of the child support grant. The child support grant will increase to R250 per month per child, and is available to any primary caregiver who qualifies in terms of an income-based means test (Gordhan, 2010).

The danger here is for foster care to become a poverty alleviating measure, instead of a strategy for child protection. Meintjies and Van Niekerk (2005:2) are of the opinion that impoverished parents could see in the foster care grant an incentive to place their children in the care of others. These authors (Meintjies & Van Niekerk, 2005:2) also argue that "...it is inequitable for the state to provide greater financial support to poor relatives or other adults to care for children, without providing adequate and equal support to biological parents living in poverty to care for their own children".

Since foster care is a court-ordered process, there are many legal requirements. These requirements involve numerous professional people, continuous interventions and monitoring by social workers as well as a renewal process after designated time periods. According to Meintjies and Van Niekerk (2005:2) it is a waste of valuable resources to involve children and families in this process simply to gain access to the foster care grant.

The increase in foster care cases is leading to many challenges:

- The vast numbers of foster care cases are putting the child protection system in South Africa under strain, making it difficult to reach out and help those children who are abused and neglected and in need of services (Meintjies & Van Niekerk, 2005: 2).
- The legal system cannot cope with all the applications for foster care placements.
- Because of the bottlenecks in the system, those children in urgent need of financial assistance have to wait a long time for help (NWSSDF, 2007a:1).
- Social workers have no time for anything other than processing children through the children's courts and onto the foster care grant (NWSSDF, 2007a :2).
- Few foster care placements receive further meaningful social work services (NWSSDF, 2007a :2).
- The sheer numbers are exceeding social workers' capacity to process, monitor and support all the foster care placements (Meintjies & Van Niekerk, 2005:2).
- Government is aggressively recruiting social workers to address the foster care backlog, and in the process is depleting the human resources of NGOs

and affecting this sector's service delivery to vulnerable groups (NWSSDF, 2007a:2).

As can be seen from the above, the challenges in the South African foster care system are numerous and their consequences are far-reaching. They all have the same root – there are too few social workers, too many clients, too many problems and too little time. Self-sustaining and resource friendly ways to render the necessary services need to be created.

The next section specifically considers the foster care of AIDS orphans in South Africa.

3.4. Foster care in South Africa in the context of HIV/AIDS

There are many problems ingrained in the current foster care system in South Africa. A review of the foster care system in South Africa has been completed and new, in-depth, guidelines were created (Theron, 2009). It has not been made public yet, but will hopefully address some of the problems when it comes into operation.

This section will discuss foster care of AIDS-affected children and AIDS orphans by addressing each phase of the foster care process. The foster care process typically consists of eight phases, namely recruitment, preparation, assessment, matching and placement, post-placement support and training and reunification or permanency. (South African National Council for Child and Family Welfare, 1987; Triseliotis, Sellic & Short, 1995; Die Ondersteunersraad, in Delport, Roux & Rankin, 2008:311).

Since it is a given that there are problems in the system, but also a given that there are many children in foster care and that many more will come into the system, it is imperative that the best be done with the current situation.

3.4.1 Recruitment

The first step in the foster care process is recruitment. There are three types of foster care in South Africa – non-relative family foster care, kinship care and cluster foster care. The former two can be done formally, through a court order, or informally, through a private arrangement. A major problem in foster care is the limited number of people who are willing and available to act as foster parents (South African National Council for

Child and Family Welfare, 1987:97). When it comes to recruitment, a different approach is taken to each of the three types of foster care. Cluster foster care will not be discussed because it falls outside the scope of the study. The study is exclusively concerned with people who take foster children into their own homes in order to care for them. The goal of the study is to shed light on the needs of children orphaned by AIDS as well as on the training and support that their foster parents will need, in order to provide guidelines for equipping foster parents to care for AIDS orphans.

Non-relative family foster parents are recruited through other foster parents, through advertisements and through social workers identifying a family and asking them to consider becoming a fostering family (South African National Council for Children and Family Welfare, 1987:97-98).

Kinship care is almost four times more prevalent among black South Africans than among white South Africans (Harber, 2003:110). In traditional African cultures there is a saying that "there is no such thing as an orphan in Africa" (Foster, 2000:56). Traditionally there was no end to the sense of duty and responsibility that family members felt towards one another. "Extended families were the traditional social security system and its members were responsible for the protection of the vulnerable..." (Foster, 2000:56). These networks are organised as patrilineal kinship systems, in which the father's family is responsible for orphans. The traditional practice is that orphans are inherited by paternal aunts and uncles (Foster, 2000:56-57). This option is becoming less viable due to increasing numbers of orphans – aunts and uncles cannot accommodate all the orphans plus they could themselves die of AIDS. Alternate safety nets are grandparents and other relatives (Foster, 2000:57). Most kinship care placements are done by private arrangements – relatives take children in out of familial duty. When these informal foster parents seek to formalise the placement, it is usually to have access to the foster care grant. Recruitment is thus not really necessary, because relatives will probably already be taking care of the child. In cases where the child is not already resident with relatives, the social worker will seek out relatives who are willing to become formal or informal caregivers to the child.

In the context of HIV/AIDS, it is preferable that "recruitment" be done by the HIV positive parent(s), in the form of **custody planning**. An HIV positive person knows that he/she

will probably die sooner rather than later. When this person is a parent, it will have a positive psychological impact on the person as well as his/her children to plan for what will happen after his/her death. HIV positive mothers have identified several advantages to identifying and appointing a caregiver that will take care of their children after their death. These advantages are (Mason, 1998:164):

- it relieves pressure on the parent
- planning ensures a smooth transition to a new home
- the mother and her children can choose where the children will live
- the children will know where they are going
- the children will know that their mother cared enough about them to plan ahead for them.

Custody planning does not happen often. According to Mason (1998:164) there are two reasons for this: (1) it is too sharp a reminder of death, or (2) the parent has no potential caregiver in mind. However, a study was done in South Africa to determine whether family and community members would be willing to take in orphans and vulnerable children (Freeman & Nkomo, 2006: 308) and it was found that most partners, grandparents, parental siblings and best friends of the participants demonstrated willingness to become caregivers to the children of the participants, should he/she die of HIV/AIDS. It could be that the second reason for not making custody plans is based on ungrounded fears.

3.4.2 Preparation and training

The second step in the foster care process is preparation and training. After prospective foster parents have been recruited, it is essential that they receive full information on what it entails to be a foster carer (Triseliotis *et al.*, 1995:42). Preparation and training is therefore the next step in the foster care process. Prospective foster parents can use this information to decide whether or not fostering is for them. The preparation phase therefore acts as a self-selection procedure. Preparation often takes place as an informal meeting or a formal training session where prospective foster carers are invited to talk to social workers or practicing foster carers to obtain the relevant information. The preparation phase must dispel all illusions about foster care and prepare the prospective foster carers for the reality of the task. Inadequate pre-placement training can lead to undesirable consequences like failed placements, difficulty in parenting

foster children and the drop-out of much needed foster parents (Cuddeback & Orme, 2002:883).

In a review of foster carer pre-assessment/selection courses, Triseliotis *et al.,* (1995: 46-47) found a broad consensus with regards to the content of the courses, while the emphasis and depth varied from agency to agency. The following is a summary of the topics that could be covered during the preparation phase:

TABLE 3.1 TOPICS TO BE DISCUSSED DURING THE PREPARATION PHASE PERTAINING TO THE FOSTER CARE SYSTEM, THE FOSTER PARENT AND THE FOSTER CHILD

Foster care system	The child care system
	Working and planning as part of a team
	The role of social workers
Foster parent	The role of foster parents
	The impact of fostering on a foster family
	Attitudes and awareness with regard to issues such as race, gender and disability
	Awareness with regard to child sexual abuse (knowledge of signs and symptoms, how to make placements safe for the child and the family, handling disclosures)
Foster child	The role and significance of the child's birth family and origins, including the importance of racial and ethnic identity
	HIV and AIDS
	Child development
	The causes of low self-esteem/building self-esteem
	Attachment theory
	Socialisation and/or institutionalisation
	Managing difficult behaviour
	The effects of separation and loss

(Source: Triseliotis *et al*., 1995:46-47)

The topics in this table can be divided into three groups – those pertaining to the foster parent, to the foster care system and to the foster child. **Foster parents** need to be

thoroughly informed of their role and the accompanying rights and responsibilities as well as the possible impact that fostering could have on the biological family of the foster parent. During preparation it would be beneficial for the foster parent to confront his/her own attitudes, awareness and prejudices regarding things like race, gender and disabilities in order to be more open-minded and accepting. It is also very important for foster parents to be made aware of child sexual abuse – how to recognise when it is happening, how to protect children and the steps to take should it happen.

With regards to the **foster care system**, foster parents need to be informed and understand how the system works. They also need to know what the role of the social worker will be and what they as foster parents can expect from the social worker. After placement, the foster parents will be seen as team members with the social worker and they need to know what this entails and what will be expected of them.

An important part of pre-placement training is to prepare foster parents for caring for a **foster child**. There are many topics that they need information on before placement, like those mentioned in table 3.1, but they will also need continual training in order to accurately handle situations as they present themselves (South African National Council for Child and Family Welfare, 1987:101-102).

Once the preparation phase has been completed, and the prospective foster parents have indicated a willingness to continue with the process, they will be assessed according to section 182(2) of the Children's Act, no. 41 of 2007. The assessment phase will be discussed in the next section.

3.4.3 Assessment

The third step in the foster care process is assessment. Not all kinship carers will go through the same in-depth assessment as non-relative family foster carers. One of the reasons is that the child could already be living with the kinship carer.

Section 182(2) of the Children's Amendment Act, no. 41 of 2007 states that any prospective foster parent must be properly assessed by a social worker to determine whether the person is "a fit and proper person to be entrusted with the foster care of the child", whether the person is "willing and able to undertake, exercise and maintain the

responsibilities of such care" and lastly, whether the person has "the capacity to provide an environment that is conducive to the child's growth and development". There are no firm criteria of what attributes are required to be a successful foster parent. Research studies (Triseliotis *et al.,* 1995; Scannapieco & Hegar, 1996; South African National Council for Child and Family Welfare, 1987) have, however, been able to identify qualities in foster parents and foster families that could point to successful placements. This next section discusses these qualities within the prerequisites given by the Children's Amendment Act, no. 41 of 2007 in Section 182(2).

i) Qualities of foster parents

- *A fit and proper person*

The Children's Amendment Act, no. 41 of 2007 gives no definition for "fit and proper" person. For the purposes of this section, a fit and proper person will be considered to be someone who meets the other two requirements as set out by the Children's Amendment Act, no. 41 of 2007.

- *Willingness and ability to undertake, exercise and maintain responsibilities*

One focus of the assessment is to determine whether the prospective foster parent is willing to carry out the responsibilities of a foster parent and whether the prospective foster parent has the ability to put this willingness into action. The foster parent cannot have one without the other. The overarching responsibilities of a foster parent are to provide care, to partner with the child protection agency and to guarantee commitment and stability.

An in-depth definition of "care" is given in the Children's Act no. 38 of 2005, section 1(1), but it comes down to day-to-day protection, guidance, provision and love. The foster parent must understand what this entails and demonstrate that he/she is **willing** to care for a foster child to the full extent.

Partnering with the child protection agency is important for effectively carrying out the fostering role (Brown & Calder, 2000:729). Assessing the prospective foster parent's attitude and expectations concerning this is essential to avoid problems further along with the foster care process.

Foster parents must be willing to provide care for the full duration of the placement. Normally the placement will be terminated upon reunification, but when the child in question is an AIDS orphan, reunification is rarely an option. Because of a child's need for stability, it is important for the prospective foster carers of AIDS orphans to be willing to provide care for the child until at least the age of 18.

The prospective foster parents' motivation must also be considered when determining their willingness to take on the responsibilities of the fostering role. A family who fosters a child out of their own will are more likely to care well for a child than a family who are pressured, e.g. by family obligation, to take in a child (Subbarao & Coury, 2004:31). Once their willingness has been established, the social worker must assess their ability to care for the child, partner with the agency and commit to the placement.

To assess the prospective foster carers' **ability** to meet the responsibilities of foster parenthood, a holistic picture is needed of the applicants, their family and their way of life. Triseliotis *et al.* (1995:64) mention some characteristics that must be part of this holistic picture: age, accommodation, employment or occupation, standard of living, health, leisure activities, interests and details about other members of the household, personality and marital status of the applicants, particulars about religious persuasion, racial origin, and cultural and linguistic background, as well as criminal records of all family members over 18. Scannapieco and Hegar (1996:571) agree with these authors, but add a few extra characteristics that must be considered – the roles of family members, employment history, financial stability, background checks for child abuse, adults' families of origin, parenting experiences, approaches to parenting and discipline, the adjustment of any children in the home or reared to adulthood by the parents, and family composition. According to the South African National Council for Child and Family Welfare (1987:98) family composition "...is of the utmost importance, not only in selecting the foster parents, but also with regard to the placement of a specific child with a specific foster family. The different members of the foster family have an influence on the foster child, and therefore it is essential to investigate the family composition".

Triseliotis *et al.* (1995:68) conducted a literature review on fostering schemes and found that a relatively standard range of issues emerged to be addressed during assessment

that will help shed light on the foster parents' ability to undertake, exercise and maintain the responsibilities of foster parenthood. These issues are listed in the following table:

TABLE 3.2 ISSUES CONCERNING PROSPECTIVE FOSTER CARERS' ABILITY TO BE ADDRESSED DURING ASSESSMENT

Can the carers provide warmth and care without undue need for reciprocation in terms of affection or expectations of the foster child?
To what extent will they be able to accept and handle negative behaviour without rejecting the child?
Will they be able to empathise with the feelings likely to be experienced by the child?
Will they provide an appropriate standard of physical care?
Will they be able to help children develop a positive view of themselves and their families?
Will they provide a sufficiently stimulating environment for the child?
Will they be able to accept and support the child's relationship with his/her natural family?
Will they be able to work in positive partnership with the child's parents?
How good will they be at helping troubled children?
Do they have sufficient capacity to benefit from training and advice?
Do they have sufficient support networks?
Will they be able to use support available from the agency and other foster parents?
Are they sufficiently motivated to carry out the demands of the task, and do their motives fit with the task?
Are they sufficiently aware of their, and their family system's strengths and weaknesses?
Are they aware that fostering will change their family system?
Can they cope with stress, and conflict, and persist in the face of problems and crises?
Are they sufficiently aware of the need to keep placements safe?
Do their attitudes towards race, gender, disability and sexual orientation meet agency requirements?
Will they be able to work in partnership with the agency?
Will they work within agency policies?

(Source: Adjusted from Triseliotis *et a*l., 1995:68)

These questions are a good summary of what is required of foster parents. It will help social workers to determine whether the prospective foster parents will be able to meet the demands placed on foster carers and whether they will be able to provide a home to a foster child that is conducive to the child's growth and development.

- *Capacity to provide an environment that is conducive to the child's growth and development*

A conducive environment is one that will be contributing to the child's growth and development. Imbedded in every person's life, are risk and protective factors. Risk factors tip the scale in favour of negative outcomes, while protective factors tip the scale in favour of positive outcomes. If there are more risk than protective factors in a child's life, it will probably lead to negative outcomes for the child. If there are more protective factors than risk factors, positive outcomes become more likely. Risk and protective factors are present on every level of a child's ecology. Verhaagen (2005:45) uses a simple equation to illustrate how this works:

Sum of protective factors – Sum of risk factors = Prediction of outcome

Social workers can use this equation to determine whether the environment is conducive to the child's growth and development. During assessment the social worker must determine what risk factors are inherent in the prospective foster family and their environment, and weigh them up against the protective factors that he/she can identify. If the negatives outweigh the protective factors, chances are that the environment will be detrimental to the child's growth and development.

The assessment phase of the foster care process is very important. The social worker must determine the prospective foster parents' willingness and ability to be foster parents and to take good care of a foster child; as well as obtain in-depth background information to make an educated decision about which foster child to match and place with them.

3.4.4 Matching and placement

The fourth step in the foster care process is matching and placement. The decision has to place a child in foster care, is followed by the process of matching a child with a foster family (South African National Council for Child and Family Welfare, 1986:102).

Section 184 (1) of the Children's Amendment Act, no. 41 of 2007 stipulates that a child should preferably be placed in the care of a foster parent who has the same cultural, religious and linguistic background as the child. Once this legal requirement has been met, the child can be placed in that foster home, but ideally, the social worker should consider finer details to try and ensure a good match and a successful placement. The information obtained during assessment can prove valuable here. A positive aspect of kinship care is that the cultural, religious and linguistic background of the child and that of the foster carers are very likely to match (Child Welfare League of America, in Scannapieco & Hegar, 1996:568).

Placement with a foster family is a court-ordered process, and as discussed already, the courts are finding it hard to cope with all the applications for foster care. The huge increase in foster care applications is due to the number of family members caring for AIDS orphans who are applying for a foster care order and grant. According to the Alliance for Children's Entitlement to Social Security (ACESS, 2007) they are often motivated by: (1) access to the foster care grant (2) access for the child to the various services that are meant to come with a foster care placement (3) having the caregiver relationship formally recognised.

ACESS is made up of over 1200 children's sector organisations. "ACESS members are committed to realising a comprehensive social security system, which ensures the survival of all our children and a standard of living adequate for their development" (ACESS, 2007). They proposed an alternative method to court-ordered foster care to address the motives of informal kinship carers considering formal kinship care. They hope that this method will relieve the pressure on social workers, unclog the courts and equalise access to grants.

This alternative method proposes that an informal kinship carer can apply to have the caregiver relationship officially recognised through an administrative procedure. Social

workers need not be involved. The application will only go to court if there is a dispute about the suitability of the caregiver or about the relationship between the caregiver and the child. When this relationship has been registered, the kinship caregiver will have certain responsibilities and rights with regard to section 18 2(a, b and d) of the Children's Act, no. 38 of 2005 – the right to care for the child, to maintain contact with the child and to contribute to the maintenance of the child. Section 18 2(c) is deliberately left out, because this registered relationship will not make the caregiver the child's guardian. Since the caregiver has the responsibility to maintain and care for the child, the caregiver will have access to any relevant grant, should he/she not be able to afford the child's maintenance. The registration of the relationship will also automatically allow the child access to all support services aimed at vulnerable children. These services need not be provided by social workers.

This is one idea for trying to straighten out the system, but until a workable plan is finalised and implemented, all applications for care will be processed by the courts as foster care applications.

3.4.5 Post-placement support and training

This fifth step in the foster care process happens mostly in theory in South Africa. Delport *et al.* (2008:319) conducted a study in the North-West Province of South Africa and found that post-placement contact occurred on average once per year. It can be concluded that further training or support that only happens once a year will have very little value. The reason for the lack of post-placement services is once again the fact that social workers are overburdened with heavy caseloads and have no time to adequately support and train foster parents (Delport *et al.*,, 2008:314).

Triseliotis *et al.* (1995:44) state that "...foster parents [can] not be expected to undertake such demanding tasks without preparation, training, post-placement support and continued training". In the context of HIV/AIDS, training and support are especially important. Chapter 2 of this study discussed the effects of parental death from AIDS on children. Foster parents will need training to effectively and empathetically parent these children. The foster parents will also need to be supported in this role, especially if they are family members who are also affected by the loss of the child's parent(s).

Since training and support are imperative to successful placements, foster parent retention and positive outcomes for foster children, new strategies need to be found to bypass the resource restrictions in the foster care system. Delport *et al.* (2008:314) suggest that volunteers be recruited and trained to support and train foster carers, or that more auxiliary workers be trained to render these services. These authors (Delport *et al*., 2008:319) also found in their study that group work is considered as the best method of service delivery to foster parents. In Chapter 4 of this study, a possible strategy for supporting and training foster parents will be discussed in more detail.

3.4.6 Reunification or permanency

The fifth step in the foster care process is reunification or permanency. One of the purposes of foster care, as stated in section 181(b) of the Children's Amendment Act, no. 41 of 2007, is to establish permanency in a child's life – either through reunification with his/her biological parents, or through connecting the child with other family relationships intended to last a lifetime.

An AIDS orphan can be a double, paternal or maternal orphan. A double orphan is a child who lost both parents and a paternal/maternal orphan is a child whose father/mother died (UNAIDS & UNICEF, 2004:7). When a paternal/maternal orphan is in foster care, it logically means that the remaining parent has abandoned the child or is unfit to care for the child. In cases where the child is a double orphan, reunification is obviously impossible. When the child is a paternal or maternal orphan, reunification remains a possibility. Should the remaining parent wish to resume care of the child, he/she will have to commit to be a willing participator in the family reunification process. When reunification is not an option, it is desirable for the child to remain in the same foster family until at least the age of 18. Foster parents taking in AIDS orphans would have indicated that they are willing to take on a permanent placement.

Before having a child placed with them, non-kinship foster carers have to agree to work with birth families towards reunification. When reunification is not an option, it might still be in the best interest of the child to maintain contact with his/her extended family of origin. Contact with the extended family might have the same benefits for the child as kinship care: the child will be able to preserve and build connections with members of his/her extended family; siblings who were separated can remain connected; the child's

ethnic, cultural and family identity will not be lost; and the child will have more people in his/her life that care for him/her (Scannapieco & Hegar, 1996:568). HIV positive parents who have made custody plans can discuss extended family contact with the identified caregiver before their death and come to an agreement about how it should work. Otherwise the social worker can ensure that it is included in the foster care plan.

The ideal ending for the foster care process is permanency and stability in the child's life through being part of a caring family.

3.5 Summary

This chapter gave an overview of foster care, of the legal side to foster care, and specifically of foster care of AIDS orphans in the South African context. During this discussion, some points surfaced that have great implications for foster care and that are important to this study: foster parents need and want training and support to be equipped to fulfil their role properly and social workers do not have the time or the manpower to fulfil these needs. This suggests that the methods being used by social workers are time- and resource-consuming. Since there are 1 million AIDS orphans in South Africa and the government is pushing foster care as a means of caring for them, new ways will need to be found to care and support foster parents, especially in the light of the effect of parental death by AIDS on children, as discussed in Chapter 2.

The next chapter outlines the parenting process and offers a more detailed look at equipping foster parents through training and support. It also discusses foster parent cell groups as a self-sustaining and resource-friendly way of meeting foster parents' need for training and support.

CHAPTER 4: EQUIPPING THE FOSTER PARENTS OF AIDS ORPHANS FOR THE PARENTING PROCESS

4.1 Introduction

After children have been placed in foster care, the next steps in the foster care process are postplacement training and support. The previous chapter focused on the foster care process in its entirety, its legal aspects and the needs, roles and motivations of foster parents. This chapter picks up the foster care process after a child has been legally placed in foster care – whether with kinship foster parents or unrelated foster parents. The focal points will thus be the training and support of foster parents. Foster parents have often identified training and support as their two main, and largely unmet, needs. Since foster care is a legal process facilitated by social workers, it is mainly the responsibility of social workers to render post-placement services like training and support. However, the reality in South Africa is that social workers are too busy to provide foster parents with proper and ongoing training and support; mainly because there are too few social workers and too many social work clients.

This chapter will address the third objective of this study, which is "to discuss foster parent cell groups as a means of equipping the foster parents of AIDS orphans for the parenting process".

The three main concepts to be discussed in this chapter are foster parent cell groups, the parenting process and the equipping (training and support) of foster parents. Much is expected of foster parents during the parenting process. They are expected to build a relationship with their foster child, enhance and encourage his/her development, provide for, protect and guide the foster child, as well as be able to deal with any medical, emotional, developmental and behavioural issues that might surface while caring for this child. In order to live up to these demands, foster parents need to be properly equipped – trained and supported. Limited resources is one of the main stumbling blocks in the way of training and support and therefore this chapter offers an alternative way for equipping foster parents – through self-sustaining foster parent cell groups that do not need intensive social worker involvement.

The chapter offers a discussion of the three components of the parenting process, namely the functional areas of child care, parenting activities and the prerequisites for parenting. It integrates a discussion on foster parent cell groups as a means for training and supporting foster parents with the discussion on the prerequisites for parenting.

4.2 Equipping foster parents through training and support

Foster parents need to be thoroughly equipped to be effective foster parents. For the purposes of this study, "equip" is an overarching term used to refer to the **training** and **support** that a foster parent needs to become a "good enough" foster parent. The term "good enough" foster parent is based on, and borrowed from the work of Winnicott (1958). The idea behind "good enough" parenting is that perfect parenting is improbable and unnecessary for the successful raising of children (Hoghughi, 2004:4). Being a good enough parent is all that is needed for the healthy development of children and it is within the grasp of ordinary people (Bettelheim, 1987). A good enough foster parent will hence be successful and effective.

However, in order to be good enough, foster parents will need training and support as they take on the parenting process. The parenting process is the sum total of what parents do and are as they parent their children towards adulthood (Hoghughi, 2004:5). In the following sections the parenting process will be broken down and discussed.

4.3 The parenting process

The word "parenting" derives from a Latin word which means "to bring forth, develop or educate". It can be defined as "...purposive activities aimed at ensuring the survival and development of children" (Hoghughi, 2004:5). The focus is more on how the parenting is being done than on who does the parenting. The act and process of parenting will therefore be the same, regardless of whether it is being done by biological parents or foster parents or adoptive parents.

Another reason for the generic nature of the parenting act is that all children go through the same developmental stages and need to develop in the same domains (Wait, Meyer & Loxton, 2004). These are the physical, cognitive, social, emotional and moral domains (McFadden, 1984:36-37; Dougherty in Barbell & Freundlich, 2001).

Hoghughi (2004:6) identified three components of the parenting process, namely (1) the functional areas of child care (2) parenting activities and (3) prerequisites for parenting. These components and their subdivisions are presented in the following table.

TABLE 4.1(a) THE COMPONENTS OF THE PARENTING PROCESS

Functional areas of child care	**Parenting activities**	**Prerequisites for parenting**
1. Physical health 2. Intellectual/educational functioning 3. Social behaviour 4. Mental health	1. Care - *physical care* - *emotional care* - *social care* 2. Control 3. Development	1. Knowledge and understanding 2. Motivation 3. Resources - *Qualities* - *Skills* - *Social network* - *Material resources* 4. Opportunity

(Source: Derived from Hoghughi, 2004)

This table will be discussed in detail in the following subsections.

4.3.1 Functional areas of child care

The first component of the parenting process is the functional areas of child care. According to Hoghughi (2004:9), the functional areas are the main areas of child care that parents operate in. These four areas overarch all five domains in which children need to develop (physical, cognitive, social, emotional, moral), and for the most part, they need their parents' input. Hoghughi (2004:9) identified physical health, intellectual and educational functioning, social behaviour and mental health as the four major areas that best summarise and contain the areas of children's functioning that need parental attention, as well as the developmental domains. In other words, these areas make up the settings in which the parenting activities relating to the care, control and development of the child take place. The following subsections will briefly consider why parental input is so necessary in these functional areas.

i) Physical health

TABLE 4.2(a) PHYSICAL HEALTH

Functional areas of child care	Domains
1. Physical health	Physical
2. Intellectual/educational Functioning	Cognitive
3. Social behaviour	Social Moral
4. Mental health	Emotional

The first functional area is the area of physical health. This area also includes the physical domain of child development. Parents are responsible for the survival and development of their children. The younger a child, the more fully the child is dependent on his/her parents for survival. For example, parents, and more specifically for this study, foster parents, must take care of children when they are ill and ensure that they receive appropriate health care. Children need immunisations, nutritious food and exercise (The HIV/AIDS Alliance, 2003e:10).

Hoghughi (2004:9) is of the opinion that the focus of parental activity in this area is "... prevention of damage through neglect or harm, reactive care in the event of difficulty, and the provision of opportunities for positive growth". Foster parents must thus protect foster children from everything that might harm them physically, as well as promote their physical development (Buehler *et al*., 2006:529). "Reactive care" suggests that parents must be proactive on behalf of children to ensure their physical well-being.

The foster parents of AIDS orphans will need to pay particular attention to this area because their circumstances have probably prevented children from receiving optimum care in this area for some time (The HIV/AIDS Alliance, 2003e:7). Foster parents will need to make up the lost ground as far as possible as well as create opportunities for positive growth.

ii) Intellectual and educational functioning

TABLE 4.2(b) INETELLECTUAL/EDUCATIONAL FUNCTIONING

Functional areas of child care	Domains
1. Physical health	Physical
2. Intellectual/educational functioning	Cognitive
3. Social behaviour	Social Moral
4. Mental health	Emotional

The next functional area of child care is that of intellectual and educational functioning, which includes the domain for cognitive development. It has been found that the children of parents who are not interested or involved in their children's education have significantly less success educationally, than children whose parents are involved and interested (Jacobs & Harvey, 2005:432). Poor education has been linked to many undesirable outcomes for children, while good education will decrease a child's vulnerability to unemployment and will lessen the chance that a child becomes involved in offending behaviour (Farrington, in Libscombe, Farmer & Moyers, 2003:250). These findings demonstrate why parental input is important when it comes to children's education.

It often happens that AIDS orphans' schooling has been interrupted (UNAIDS, 2006:21-22). When they are placed in foster care in terms of Section 156 of the Children's Amendment Act no. 41, of 2007, foster parents have the important responsibility of promoting their educational attainment and success (Buehler *et al*., 2006:526; Department of Social Development, 2008: s70). The reason this is so important is that education will open doors for the child in the future and, as stated above, will lessen the chance of certain undesirable outcomes. Once children leave the care system, they should have the ability to assume care of themselves and education will help make this possible.

Foster parents – regardless of who they are – can contribute significantly to a foster child's school achievement through being interested and involved. Jacobs and Harvey

(2005:432) quote many authors who through the years have found that students who come from a low-income, broken family have significantly less success in schools than children from a high socio-economic, intact family. The reasons for this seem to be that the parents in the low-income families did not have high academic expectations for their children, they did not monitor their work, and were on the whole not very involved in their children's lives. Marjoribanks (1977:385-403) claims that variables like socio-economic status and family structure can be mediated by parental interest, expectations, attitudes and aspirations for their children's education. Through being involved and employing simple strategies, foster parents can be a positive force in their foster child's education. Examples of these strategies are encouraging children to go to school, showing an interest in their achievements, giving practical help and support, keeping in contact with school teachers and in so doing remaining aware of educational progress and problems at school (Jacobs & Harvey, 2005:251). If the foster child has dropped out of school, foster parents can actively find alternative educational provision for them (Jacobs & Harvey, 2005:251).

In other words, parental interest and involvement in a child's school career can go a long way towards ensuring success. Foster parents can invest in their foster children's futures by being interested and involved.

iii) Social behaviour

TABLE 4.2(c) SOCIAL BEHAVIOUR

Functional areas of child care	**Domains**
1. Physical health	Physical
2. Intellectual/educational Functioning	Cognitive
3. Social behaviour	Social Moral
4. Mental health	Emotional

The third functional area is that of social behaviour. This area of child care encompasses two developmental domains – the social and moral domains. Hoghughi (2004:9) describes three components of social behaviour. The first two correspond with the social

domain and the third one with the moral domain. The first component is understanding and responding to social cues, the second component is building social relationships and knowing how to act appropriately in different kinds of relationships and the third component has to do with coming in agreement with the cultural and legal norms of behaviour – knowing and agreeing with what is accepted culturally and legally, and what is not.

Children learn from their parents how to relate to other people and social circumstances (social domain), as well as what is acceptable and what is not (moral domain). It is therefore understandable that there is a specific fear that surfaces in literature time and again – the fear that AIDS orphans pose a threat to society because their socialisation process was interrupted by the sickness and death of their parents as well as all the resulting circumstances (Grainger, Webb & Elliot, 2001:38; Hunter, 1990:687; Barnett & Whiteside, 2002:210; Oni, Obi, Okorie, Thabede & Jordan, 2002:28). The assumptions in this regard are that if left to their own devices these children are likely to become delinquents because they lack the "social behaviour training" usually given by parents/caregivers to children that are meant to protect them from negative outcomes like delinquency. "Social behaviour training" happens within the context of early bonding experiences, modelling, boundary setting, the development of value systems, support, caring and discipline. Through these aspects children are taught how to form good caring relationships, they develop morally and they enjoy emotional stability (Freeman in Richter, 2003:12). These aspects are therefore of the utmost importance for healthy social behaviour.

If a child whose socialisation process was interrupted, should enter a new family where good examples are set and positive social behaviour is modelled and encouraged, the negative outcomes might be sidestepped. That is why it is important for foster parents to specifically focus on their foster children's social and moral behaviour and to direct many of their parenting activities in this area.

iv) Mental health

TABLE 4.2(d) MENTAL HEALTH

Functional areas of child care	Domains
1. Physical health	Physical
2. Intellectual/educational Functioning	Cognitive
3. Social behaviour	Social Moral
4. Mental health	Emotional

Mental health is the fourth functional area of child care. It includes the domain of emotional development. This area of children's functioning "encompasses all aspects of children's thoughts, feelings and behavioural tendencies towards themselves and others" (Hoghughi, 2004:9). Being affected by HIV/AIDS can lead to many negative emotional states in a child, like helplessness, hopelessness, decreasing self-esteem, depression, anxiety (Townsend & Dawes, 2004:70), fear of the future and psychological distress caused by stigma and discrimination (Richter *et al*., 2004:10). Being affected and orphaned by HIV/AIDS is likely to lead to multiple losses, stigma and poverty, all of which can have serious implications for the children's emotional well-being. Two of the main causes for mental health issues in children orphaned by AIDS are posed by bereavement and stigma.

Because of the stigma attached to HIV/AIDS, children whose parents have died of AIDS are likely to be stigmatised and discriminated against. When a child is exposed to stigma and discrimination, it may cause a variety of internalised conditions like fear, fatalism, internalised stigma, behavioural disturbances (Deacon & Stephney, 2007:20), self-doubt, low self-esteem and depression (Deacon, Stephney & Prosalendis, 2005:31). When stigma becomes internalised, it lowers self-esteem and causes self-doubt because the person comes to agree with society's perception of him/her (Deacon & Stephney, 2007:6). It can also result in self-stigmatisation – suffering disadvantage without direct discrimination by avoiding situations that they think will be discriminating (Deacon *et al*., 2005:31).

Parental death is a profound loss for children. Fox and Parker (2003:120) state that one of the main reasons for the depth of the loss is that children's love tends to be vested almost entirely in their parents, while adults spread their love among many meaningful relationships. These authors also state that the consequences of bereavement depend on the age and social development of the child, while children's response to bereavement depends on the following aspects:

- their relationship with the person who died
- the nature of the death
- the child's own personality and previous experience with death
- the child's developmental and chronological age
- the availability of support from family and community
- the attitudes, behaviours and responsiveness of significant adults in the child's environment.

This list sheds light on some aspects that could complicate the bereavement process. AIDS orphans have lost their parents, with whom they shared a significant relationship, to a stigmatised disease that slowly kills the sufferer. It is also likely that it is not the first or the last time that the child will be faced with losing someone to AIDS. Statistics show that people are most likely to become infected with HIV between the ages of 25 – 35, which suggests that their children will still be young when they die (Dorrington *et al.*, 2006:9; SANAC, 2006:28). Death is more difficult to comprehend and deal with by a young child. Support from the family and community depends on how prevalent the disease is in the particular community, but many communities and families have been struck too often by AIDS to have the resources to adequately support the child. Since there is great stigma attached to AIDS, the chances are that the child will be stigmatised as a result of the parent's illness. It is evident that bereavement could be very complicated, and very difficult.

Primary risk factors for poor adjustment after the loss of parents are a lack of social support, bereavement overload, secondary losses and concurrent stressors. These factors will exacerbate the intensity and duration of grieving (Cook, Fritz & Mwonya, 2003:88) and could result in anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Richter, 2004:23).

Given the circumstances of HIV/AIDS affected children as discussed within the context of mental health, it is obvious that when an AIDS orphan enters foster care, the foster parents need to be physically and emotionally available to protect, nurture and care for the child. Richter (2006:10,49) maintains that the optimum family setting is one that exhibits commitment, stability and individualised affectionate care and that is where the heart of psychosocial care is to be found. Foster parents can play a major role in helping their foster children towards mental health.

It is evident that foster parents have a key role to play in these four areas of their foster children's functioning. It has merely been touched upon but it is clear that AIDS orphans have unique needs that must be met by their foster parents. In the next section parenting activities will be discussed.

4.3.2 Parenting activities

A wide range of parenting activities take place within the functional areas of child care, as discussed in the previous section. Hoghughi (2004:7) identified three groups of core activities that are *necessary* and *sufficient* for good enough parenting. These three groups are (1) care (2) control and (3) development, and they are depicted in the following table.

TABLE 4.1(b) THE COMPONENTS OF THE PARENTING PROCESS

Functional areas of child care	**Parenting activities**	**Prerequisites for parenting**
1. Physical health 2. Intellectual/educational functioning 3. Social behaviour 4. Mental health	1. Care - *physical care* - *emotional care* - *social care* 2. Control 3. Development	1. Knowledge and understanding 2. Motivation 3. Resources - *Qualities* - *Skills* - *Social network* - *Material resources* 4. Opportunity

(Source: Derived from Hoghughi, 2004)

Each core group of parenting activities has two sides: "...the prevention of adversity and anything that might harm the child; and the promotion of the positive and anything that might help the child" (Hoghughi, 2004:7). This correlates very strongly with the work that has been done in the field of resiliency. The concurrent idea is that protective factors should be enhanced, while risk factors are to be reduced in order to ensure positive outcomes (Kaplan & Owens, 2004:72).

These risk and protective factors are imbedded in every person's life. It has been found that they are present on every level of a person's ecology – there are personal, family and community risk and protective factors (Benard, 1991:2). The premise underscoring resiliency work is that the presence of risk factors will not necessarily lead to negative outcomes for a person if there are compensating protective factors present in the person's life. The more risk factors there are in a person's life, the greater the chance of negative outcomes, while protective factors tip the scale in favour of positive outcomes.

Resilience itself is defined as the ability to overcome adverse circumstances in life (Kaplan & Owens, 2004: 74), while the work that is based on this research field, is defined by Wong and Lee (2005:316) as "...the combined preventive-promotive orientation of primary prevention efforts that have the potential to stop risk factors from affecting the behaviours of young people who are at risk". Schofield and Beek (2005:2) see resiliency work as an active process and suggest that it can "...include increasing felt security, building self-esteem, promoting competence and working towards a range of often modest developmental goals that nevertheless reduce risk and increase resilience". The aforementioned authors specifically refer to foster parents as agents in this process.

The following subsections will look at what the three groups of core activities, namely care, control and development, encompass. It will be discussed with specific reference to the parenting activities of the foster parents of AIDS orphans and to the five developmental domains common to all children.

i) Care

TABLE 4.3(a) CARE

Parenting activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

Care activities are defined by Hoghughi (2004:7) as "...a cluster of activities aimed at meeting the survival needs of children" and are the first group of parenting activities to be discussed. Children have physical, emotional and social needs. These needs differ across the different developmental stages (Wait *et al.*, 2004). Section 70(1) of the draft regulations of South Africa's Children's Act, no. 38 of 2005 (Department of Social Development, 2008) makes foster parents legally responsible for the care of foster children and section 1(1) of the Children's Act, no. 38 of 2005 defines in great detail what is meant with "care". It basically comes down to protecting children from physical, emotional and social harm while enhancing their well-being and development, through day-to-day protection, guidance, provision and love. This legislation corresponds with Hoghughi's (2004:7) statement that care "...is concerned with factors that increase the child's resilience in the face of adversity and promote positive development". Any child needs threefold care – physical care, emotional care and social care (Hoghughi, 2004: 7). Each of these three forms of care will now be explained.

a) Physical care

TABLE 4.3(b) PHYSICAL CARE

Parenting activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

The first form of care that children need is physical care. Foster parents need to address a wide spectrum of foster children's physical care needs. Physiological needs and safety needs make up the two bottom rungs of Maslow's hierarchy of needs (Maslow, 1943). According to Maslow's theory (1943), the lower level needs have to be fulfilled in order to get to the higher level needs of love, esteem and self-actualisation. This theory thus attaches great importance to the physical care of children. Hoghughi (2004:7) as well as the definition for "care" in the Children's Act, no. 38 of 2005 explain what physical care entails. Through combining these explanations, a comprehensive picture of physical care as meeting physiological and safety needs, emerges. The different elements are depicted in the following list:

- Provision of basic necessities

The basic needs of AIDS orphans and other children can be summarised as food, warmth, cleanliness, sleep and satisfactory sanitation (Hoghughi, 2004:7). Before coming to live with their foster parents, AIDS orphans' basic needs have probably not been met for some time (The International HIV/AIDS Alliance, 2003e:7). They often present many physical care needs upon entering foster care because of exposure to inadequate environmental and sanitary living conditions, malnutrition, and inadequate access to health care (The International HIV/AIDS Alliance, 2003e:3). Poverty and a lack of care, two major repercussions of parental illness due to HIV/AIDS (The International HIV/AIDS Alliance, 2003e:3), create these circumstances.

The orphans' new caregivers should aim to meet their basic needs to the best of their ability. They should also be made aware of what exactly these needs could be and how to fulfil them. For example, if their foster child is malnourished, the foster parents should be equipped with knowledge on how to prepare nutritious meals and how to ensure that the child becomes healthy again. Other important information that they need, is that a child made vulnerable by HIV/AIDS can be protected from ill health through routine immunisation, good nutrition and basic hygiene (for example, safe food preparation, safe disposal of faeces, hand washing before preparing and eating food, clean clothes and bedding, bathing) (The International HIV/AIDS Alliance, 2003e: 10). The social worker assigned to the foster care case is in a good position to relay this information.

- Conducive living conditions; a suitable place to live and protection from physical harm, hazards and accidents

Foster parents should ensure that the home environment is nurturing and stimulating for the foster child (Buehler *et al.*, 2006:526; Triseliotis *et al.*, 1995:68). Section 1(1) of the Children's Act, no. 38 of 2005 states that the home environment should be contributing to the child's health, well-being and development. Children need attention and stimulation in order to help them learn and develop positively (The International HIV/AIDS Alliance, 2003d: 7).

According to Buehler *et al.* (2006:528) a safe and secure environment is very important and includes the following aspects: "freedom from abuse, freedom from neglect, a home that diminishes the chance of accidents and injury, a safe neighbourhood and school or built-in protections when there are safety concerns and an environment that promotes emotional security". Favourable conditions like these are conducive to a child's well-being and development. Foster parents should also be made aware of what constitutes unfavourable conditions so that they do not unknowingly expose their foster children to it. Foster parents have the responsibility to shelter foster children from every form of danger in their new environment (Buehler *et al.*, 2006:529).

- Financial support

Foster parents receive a foster care grant to assist them in caring financially for their foster children. Section 70(1) of the Draft Regulations (Department of Social Development, 2008) to the Children's Act, no. 38 of 2005 requires this grant to be spent

solely on the foster child in question, to ensure that the child is properly fed, clothed and educated. Learning to budget will prove a valuable skill for foster parents.

Foster parents will need much information in order to adequately meet the needs of the children in their care (Durand, 2007:41). Social workers are in the optimum position to provide them with this information and to offer their professional opinion as a resource for the foster parents to use in their parenting (Durand, 2007:60). Social workers can bring awareness and guidance with regards to the child's physical care, as well as link the foster parent with other helpful services like food parcels if necessary. The social worker assigned to the case has to write a report when the court order expires to advise the placement to be renewed if he/she regards it as being in the best interest of the child (Children's Act, no. 38 of 2005, Section 159). Together with this report, the social worker must compile a foster care plan for the child, as stipulated by section 75(1) of the draft regulations (Department of Social Development, 2008). This care plan will, amongst other things, address the physical care of the child. The social worker must ensure that the stipulations in the care plan are carried out by the foster parent and all other parties that are mentioned in the care plan as being responsible for some aspect of the child's physical care.

b) Emotional care

TABLE 4.3(c) EMOTIONAL CARE

Parenting activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

Emotional care is the second component of care and takes place at and has an impact on various levels. Emotional care can again be better understood if the explanations of Hoghughi (2004:7) and section 1(1) of the Children's Act, no. 38 of 2005 are combined. From this combination, it is clear that emotional care encompasses the following: dealing

with negative emotions, respecting the child, maintaining a sound relationship with the child and loving him/her unconditionally, providing opportunities for managed risk taking and exercising choice, creating optimism and protecting the child from emotional harm and hazards like degradation, discrimination and exploitation. This corresponds with the love and esteem needs as presented by Maslow (1943). Children have a need to receive and give love and affection, as well as an intense need to belong. A lack of love is the most common core reason for maladjustment in people. Esteem needs are one rung higher than love needs in Maslow's hierarchy of basic needs. Children have a need for healthy self-esteem and to be esteemed and respected by other people. Should this need be met, it will lead to feelings of self-confidence, worth, strength, capability, adequacy, and feeling useful and necessary to the world (Maslow, 1943:382).

Two of the components of emotional care that are especially important, will be elaborated on:

- Dealing with negative emotions

Emotional care takes on extra dimensions when the foster children are AIDS orphans. An important factor that distinguishes AIDS orphans from other orphans is that the former have gone through the process of parental HIV infection and death by AIDS. This process will often entail caring for the sick parent, the economic impact of the disease in the family, facing stigma and discrimination and having to deal with the death of one or both parents (Mallmann, 2002:9-11). The foster parents will need to help them through the process of bereavement and loss, as well as through the feelings that could arise should they suffer stigmatisation and discrimination.

- Maintaining a sound relationship and unconditional love

Relationship building is an important part of foster parenting. Foster parents must build an unconditional relationship with their foster children. Such a relationship will make a foster child feel safe, secure, loved and accepted. A parent is the leader in a family with the purpose of "leading" children along the way to a healthy and happy adulthood. It is important for foster parents to maintain a sound relationship with their foster children, because foster children will only "follow" their foster parents as far as they can trust them, and they will only trust them as far as their foster parents care for them (Swart, Esser & Opperman, 2009:23).

Foster parents can use very simple strategies to build a sound and unconditional relationship with their foster children. Examples of these strategies are given in the following table:

TABLE 4.4 STRATEGIES FOR BUILDING POSITIVE RELATIONSHIPS

Ways to build positive relationships	Guidelines
Listen so that children will talk	1. Be interested 2. Be available 3. Give undivided attention 4. Be patient and encourage talking 5. Watch your body language 6. Be empathic 7. Help clarify and relate experiences 8. Reflect feelings 9. Listen to nonverbal messages
Listening with the third ear	Listen "between the lines" for clues as to thoughts and feelings
Talk so that children will listen	1. Be brief 2. Use simple, concrete words 3. Be respectful 4. Be animated 5. Be direct 6. Self-disclose 7. Enjoy talking to children 8. Be relevant 9. Select the right time 10. Avoid arguments
Celebrate with rituals and ceremonies	*Rituals*: make use of regular events which are observed at certain times – generate feelings of togetherness, joy and a sense of belonging *Ceremonies*: use this to honour family members – It can be used to reward children, or to show approval or caring

Ways to build positive relationships	Guidelines
Show empathy	Show children that you understand them from their point of view
Love your children	1. Have an unconditional positive attitude 2. Value the uniqueness of the child 3. Be interested in everything about the child
Love your spouse	
Show affection	Express warm feelings of liking for your child Show physical signs of affection
Comfort	1. Cheering 2. Calming 3. Sympathising
Establish mutual trust	1. Be honest and reliable 2. Be genuine 3. Admit mistakes 4. Be consistent
Be a companion	Spend mutually enjoyable time alone with the child
Create an enjoyable home atmosphere	
Develop family spirit	Enhance family pride (liking, respect, and admiration for each other) and family cohesiveness (tendency to stick together)
Conduct family councils	Promote open discussions of family concerns and problems
Individualise	Treat each child as a unique person

Ways to build positive relationships	Guidelines
Develop positive personal characteristics	1. Be agreeable 2. Seek self-knowledge 3. Be patient 4. Show cheerfulness 5. Be a positive leader 6. Be sensitive to a child's needs 7. Keep a sense of humour

(Source: Schaefer, 1978:135-176).

This table contains simple and practical guidelines that a foster parent can use to build a good relationship with his/her foster child. It is a valuable resource that social workers can use to equip foster parents. These guidelines can be introduced during post-placement services, whichever form the services take.

c) Social care

TABLE 4.3(d) SOCIAL CARE

Parenting activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

The third component of care is social care. It has been identified time and again as a very important protective factor in children's lives because positive social relationships shape their views of themselves and have a big effect on their emotional state (Hoghughi, 2004:7).

The needs of children in this area are to be socially connected to peers and significant adults in their lives, to find their place at home and in school and learn to regulate

themselves within the social world (Hoghughi, 2004:7). Foster parents need to take "social care" of their foster children by encouraging them to connect with others and by providing opportunities for such connections (Hoghughi, 2004:7). Simple ways of doing this is to encourage friendships and to make children's friends welcome at home (Libscombe *et al*., 2003:249). They should also encourage and support children to participate in sports and other social activities (Libscombe *et al*., 2003:250). Another important role of foster parents, is to guide their foster children towards appropriate behaviour in social settings. They can, amongst other ways, do this through modelling the appropriate behaviour. Social workers can make them aware of their role and how to fulfil it.

ii) Control

TABLE 4.3(e): CONTROL

Parenting Activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

The second group of core parenting activities has to do with control. A big part of parenting revolves around the control (in a positive sense) of children. Four different parenting styles have been identified that parents use to control their children (Parenting, 2008). These four styles are authoritarian, authoritative, permissive and uninvolved. The uninvolved style is rather a lack of parenting than a parenting style and will be left out of the following discussion.

A parenting style is made up of two components – parental demandingness and parental responsiveness (Darling, 1999). **Parental demandingness** refers to "the claims parents make on children to become integrated into the family whole, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys" (Baumrind, 1991:61-61). **Parental responsiveness** is "the extent to which parents

intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands" (Baumrind, 1991:62). In other words, a parenting style is made up of a type of "give and take" – what the parent asks of the child and what the parent will do for the child.

Authoritarian parents demand absolute obedience from children while permissive parents are overly lenient. Authoritative parenting finds its place in the middle of this range. It "...balances clear, high parental demands with emotional responsiveness and recognition of child autonomy" (Darling, 1999). Authoritative parenting has consistently been found as the best parenting style.

The following is a short summary of what authoritative parenting means in practice. It is based on Darling (1999) and on an article at www.goodparentinghelp.com that aims to give practical guidance to parents.

Authoritative parents demand behavioural obedience while respecting a child's uniqueness. They do not exert psychological control by expecting a child to accept their values, judgements and beliefs without question.

Structure is important to children because of the stability and security it provides. Authoritative parents have definite rules, limits and boundaries and a child will suffer consequences for infractions. Authoritative parents are responsive and flexible. Children are given a voice and their input is listened to. This flexibility means that rules, limits and boundaries should not be rigid – rules could be bent occasionally if the situation calls for it. Parents are engaged and flexible and children can make choices up to a point, but the bottom line is that the final decision rests with the parents and they remain the highest authority in the home.

This parenting style is attributed to be "...one of the most consistent family predictors of competence from early childhood through adolescence" (Darling, 1999). Social workers can make foster parents aware of their particular style of parenting and suggest how their parenting can become more authoritative. It would be beneficial for foster children and foster parents' biological children if foster parents were to adopt this style.

iii) Development

TABLE 4.3(f) DEVELOPMENT

Parenting activities
1. Care
- *physical care*
- *emotional care*
- *social care*
2. Control
3. Development

The third group of parenting activities concerns development. Consensus exists among various authors (Buehler *et al.*, 2006; Dougherty in Barbell & Freundlich, 2001) that foster parents should be actively involved in promoting the child's social, emotional, moral, physical and cognitive development. Buehler *et al.* (2006:538) elaborate on this point by saying that foster carers must have knowledge and understanding of the various stages of human development and of what is considered to be normal at each stage in order to effectively promote development. Although there are certain stages of growth that all children go through in the same sequence, every child will complete those stages at his/her own developmental rate (Schaefer, 1979:184). If foster parents have an understanding of these stages and its corresponding developmental tasks (Newman & Newman, 1999:41) and what each stage entails, they will be able to identify a child's current stage of development as well as know what the next level is. In so doing, foster parents can encourage the child to progress by providing the child with appropriate challenges (Schaefer, 1979:184). Maturation (development as a function of age or time) cannot produce the highest level of development on its own. It is the interaction between maturation and environmental stimulation that leads to optimal development. Foster parents will thus need knowledge of the different developmental stages, as well as understand what they can do during each stage to enhance the child's development. Equipped foster parents can effectively provide environmental stimulation geared to the child's developmental level (Schaefer, 1979:184).

Any child coming into foster care is likely to have some developmental lags or manifest some form of regression (McFadden, 1984:46). A developmental lag manifests when a

child is slow at accomplishing a developmental task, while regression happens when a child moves backward to a previous developmental stage (McFadden, 1984:42). This happens because of their life experiences before coming into foster care. Children who are affected and orphaned by HIV/AIDS are left traumatised. Without a proper chance to grieve and adapt, trauma can cause children to become "stuck" developmentally, a.k.a. regression (McFadden, 1984: 61). As discussed previously, parental illness by HIV/AIDS can lead to inadequate food provision, a lack of attention and security and a lack of stimulation. These factors respectively can cause developmental problems like being physically small and delayed, being afraid and mistrustful and having an impaired ability to learn (McFadden, 1984:61). These are just a few examples, but it is clear that AIDS orphans will have a developmental disadvantage, which can manifest in all five developmental domains – physical, social, emotional, cognitive and moral. However, when children enter foster care, foster parents can help them grow in the areas where they are behind and they often make noticeable progress in the areas that the foster parents focus on (McFadden, 1984:42).

Since these developmental lags and regression are to be expected, foster parents should only become concerned or look for outside help when:

- Problematic behaviours are: extreme
  frequent
  dangerous
  long-lasting
- Regression is severe and prolonged
- A developmental lag does not respond to nurture
- Blocks in one area of development affect development in other dimensions (the child is so upset, withdrawn or angry that learning, social development, physical health or safety are impaired) (McFadden, 1984: 46)

In other words, chances are good that the foster care placement will not be smooth sailing from the start. Problems are very likely and should be expected, but they are not supposed to be long-lasting or pose a threat. If they do persist or become dangerous, foster parents should contact their social worker.

It is important for foster parents to be knowledgeable about child development. The following table contains six important principles that will help them to understand the children in their care.

TABLE 4.5 DEVELOPMENTAL PRINCIPLES

1.	The stages of development are orderly and sequential and cannot be skipped
2.	As individuals, children move through the same general stages at their own pace and in a unique way
3.	Physical, cognitive, social, moral development go together with emotional development
4.	It is possible to become stuck or lag at any stage
5.	Trauma can slow down progression
6.	The child's developmental level rather than his chronological age is key to understanding his behaviour

(McFadden, 1984:61)

Knowledge of the principles in this table forms the foundation for understanding child development and will guide foster parents' efforts to enhance and aid their foster children's development.

Another summary was taken from the work of McFadden (1984:36-37) in order to demonstrate how foster parents can contribute towards development in each of the five domains of development:

TABLE 4.6 FOSTER PARENT CONTRIBUTION TO DEVELOPMENTAL DOMAINS

Dimension	Importance	What foster parents do
Physical	If a child is to survive, biological needs must be met. Child must develop coordination, the ability to handle his/her body, as well as physical skills.	Provide food, clothing and shelter. Encourage the child to move about and explore the environment. Care for the child when immature or ill. Be physically affectionate – touch and hold the child.
Cognitive	Child needs to think, talk, solve problems and interpret the world.	Help child acquire speech. Talk with the child about his/her experiences. Ask questions and explain things and concepts that the child is not familiar with. Provide educational opportunities like school, games and books.
Social	The child needs to get along with others, develop relationships, make friends and deal constructively with others.	Provide examples of relationship skills. Entertain friends of the child. Encourage the child to participate in clubs and activities.
Emotional	The child needs to feel close to others and to develop trust. The child needs a sense of him/herself as unique. The child needs self-esteem and needs to label feelings and the appropriate behaviour for each feeling.	Provide consistency and security. Give the child a name and personal belongings. Provide feedback and praise with regards to the child's behaviour. Help the child to learn and label feelings. Teach the child how to handle different feelings.
Moral	The child develops a sense of right and wrong, feelings of responsibility for his/her own behaviour and the need for rules. The child needs to develop a conscience.	Provide rules for living. Teach by example. Establish consequences for behaviour. Discuss moral applications of TV, movies, etc. Provide religious training.

(Source: McFadden, 1984:36-37)

The contents in this table provide a practical and helpful tool for foster parents and social workers because it a complex and overwhelming demand placed on foster parents is broken down into practical guidelines.

With regards to parenting activities, social workers can mainly offer information and guidance to foster parents, as well as direction through the foster care plan (Department of Social Development, 2008: Section 75(1) Draft Regulations). It is much needed and can make a big difference to the well-being of the child if the foster parent is informed, knowledgeable and purposeful. Social workers can also offer more practical help like counselling and referrals to other service providers.

The next section looks at the last component of the parenting process and introduces foster parent cell groups as a means for equipping foster parents.

4.3.3 Prerequisites

TABLE 4.1(c) COMPONENTS OF THE PARENTING PROCESS

Functional areas of child care	**Parenting activities**	**Prerequisites for parenting**
1. Physical health 2. Intellectual/educational functioning 3. Social behaviour 4. Mental health	1. Care - *physical care* - *emotional care* - *social care* 2. Control 3. Development	1. Knowledge and understanding 2. Motivation 3. Resources - *Qualities* - *Skills* - *Social network* - *Material resources* 4. Opportunity

The prerequisites for the parenting process refer to everything parents need in order to do the job. Hoghughi (2004:10) lists four indispensable prerequisites for good enough parenting, namely (1) knowledge and understanding, (2) motivation, (3) resources and (4) opportunity. These four prerequisites remain the same for foster parents. This discussion will introduce an idea for training and supporting foster parents that combines social work groups with the cell structure used for small groups in many churches. The

researcher had this idea based on her experience and involvement with church small groups and being a witness of its effectiveness. The main part of the discussion will look at what these prerequisites entail, as well as point out how these groups could provide a platform for its realisation. In the first part of the discussion, the workings of the groups will be explained in order to facilitate understanding later on.

The logic behind a church cell group is based on biology. In biology, a cell is a living organism that grows through multiplication. In cell groups, "multiplication" (one cell group becoming two cell groups) is evidence of a healthy cell group. The fact that a cell group is "alive" makes it very useful for group work – a social work intervention method – and in particular for foster parent groups. Something that is alive is self-sustaining, suggesting that it is very resource friendly. That is the first big advantage. In South Africa, social workers do not get around to rendering all the post-placement services that foster parents need (NWSSDF, 2007a :2). In truth, the indications in the previous section of what social workers can do to help foster parents, are fairly unrealistic, because there is very little time for it. The fact that there is little time, however, does not take away the need for action. If these groups are to be self-sustaining, needing little social worker involvement, then it might be an answer to the problem. The aim of a cell group is "growth within relationship". This concept corresponds strongly with foster parents' two main needs – training and support (Durand, 2007:2), suggesting that these needs might be met within foster parent cell groups.

- *The functioning of foster parent cell groups*

The first group will be started with the social worker as facilitator and a few foster parents as members (between two and five). The members and the social worker will invite other foster parents to the group meetings that will take place on a regular basis (once every week or two weeks). During these meetings are and while the group is growing, the social worker will identify one person (or a husband and wife) as potential facilitators of their own group and will begin training them through some personal attention, giving them responsibilities in the group and opportunities to practice facilitation. Once the group has reached eight members, the group will multiply (break up into two groups). The social worker will take one group and the new facilitators will take the other group. The process will then be repeated, with both groups' facilitators identifying new leaders and both groups growing through the addition of new members.

When everything is well established, the social worker can train someone in his/her place and the groups can go on without the social worker. The social worker could still have occasional meetings with the facilitators to ensure that everyone is doing okay. The social worker could also take the time to create a manual containing important and applicable information to be used by the foster parents in the groups, in the event of difficult questions or situations.

- *The relation between foster parent cell groups and support groups and self-help groups*

After a consideration of literature, the researcher has come to the conclusion that these foster parent cell groups correspond strongly with both self-help groups and support groups. Self-help groups will be discussed first, followed by support groups. It will then be pointed out how foster parent cell groups are a combination of the two.

Self-help groups refer to the combination of "self-help" and "mutual aid" (Borkman, 1999:5). This author defines self-help as the process by which an individual takes action to help him/herself by taking ownership of a troubling situation, while mutual aid happens when people with the same problem come together to reciprocally assist one another emotionally, socially and materially. When self-help and mutual aid become integrated within self-help groups, an interdependent dynamic is created in which individuals accept self-responsibility while reaching out to others. An often quoted statement sheds light on the concept underlying self-help groups: "You alone can do it but you cannot do it alone" (Borkman, 1999:5).

A consideration of Borkman's work (1999), has led to the following characteristics of self-help groups being identified. Self-help groups consist of people who have some issue or problem in common. The group come together often and a sharing circle is created in which people can build relationships and share their stories. The sharing circle and narratives are the tools for change. The main purpose of the group is to support one another. The support is based on true empathy because all the members are going through the same kind of experiences and they can use their experiential knowledge to offer guidance. They rely on experiential learning rather than professional opinion to overcome difficulties. Membership is voluntary and members are on the same level. The number of group meetings is not limited – it can continue for as long as the members

want. Professionals are not in charge of the group. Borman (1982) mentions some positive by-products of self-help groups – instant identity, helping one another, networking and developing community, acquiring experientially based wisdom, and sharing information. Alcoholics Anonymous is a well-known example of a self-help group.

Philippi Trust (Undated:12) defines **support groups** as "...a structure/meeting wherein people with common challenges, concerns and needs come together to support one another in various aspects of daily living and functioning – emotional, spiritual, physical and psychological – and to share information, knowledge, ideas and experiences. Members are bound by group norms, goals and objectives, as agreed upon by the group". It is therefore a group in which people can share life issues openly with people having similar experiences. It offers holistic support – members feel free to share details about any area of their life, whether it be emotional, spiritual, physical or psychological. The main differences between a support group and a self-help group are that self-help groups do not make use of professionals as facilitators, and they do not have a limited number of sessions. Professionals are only, in some cases, involved with starting the group or referring possible members to the group. Support groups on the other hand are much more structured. A professional person, e.g. a social worker, starts the group, recruits members, plans the sessions and acts as facilitator. There are a set number of sessions, usually about 10 to 12, and different topics are prepared by the facilitator to be discussed in the group. In these groups, people receive support because of their shared experiences, but they are also supported through the new information received through the topics prepared by the facilitator. When the group sessions come to an end, the social worker can start a new group. The group has a limited duration to prevent dependency and to give other people the chance to be part of the group. It is much more structured than self-help groups and offers both support and "training" through professional opinion and input. It also relies on more formal group work techniques like contracting (Becker & Duncan, 2005:35) and collective group norms, goals and objectives (Corey, Corey & Corey, 2006: 147,150).

The following table is a graphic illustration of how foster parent cell groups are a combination of self-help groups and support groups. A discussion of the table will follow.

TABLE. 4.7 THE ASPECTS THAT FOSTER PARENT CELL GROUPS HAVE IN COMMON WITH SELF-HELP GROUPS AND SUPPORT GROUPS

Support groups	Self-help groups
Members have similar problems/challenges	Members have similar problems/challenges
Purpose – support and guidance	Purpose – support and guidance
Experiential learning and professional input	Experiential learning
Professional person began the group	Professional person probably began the group
Facilitator is a professional	Facilitator is a group member
Prepared topics	Sessions deal with the "here and now"
Fixed number of sessions	Number of sessions is not limited
Group contract	Might, or might not, have a contract

(Source: Derived from Borkman, 1999 and Phillipi Trust, Undated)

Foster parent cell groups, support groups and self-help groups have the same foundation – these groups are for people with similar problems/challenges. Foster parent cell groups have the same purpose as self-help groups and support groups, namely support and guidance. It adds "training" to the guidance aspect, in that members are meant to learn from one another's experiences and from the social worker's professional input when it is relevant. Foster parents will receive guidance from each others' experiences, but the social worker's professional opinion will also be available as a resource. There will thus be a mixture of the sharing circle of a self-help group and the professional input of a support group.

Foster parent cell groups will be started by a professional, as will support groups, and the social worker will act as facilitator until there are group members who can take over the role of facilitator, as in the case of self-help groups. Since foster care is a legal procedure facilitated by social workers, social workers will continue to oversee the groups. These groups will be started by social workers in order to satisfy the demand placed on them to support and train foster parents and it remains their responsibility to ensure that it is properly done. The facilitators of foster parent cell groups will not prepare specific informational topics for the group sessions. The reason for this is two-fold – group members will eventually be the facilitators and the idea is to provide foster parents with a space where they can discuss the current happenings at home. To

explain further – it cannot be expected of a non-professional person to teach/train other group members on certain topics; and even though topics will be helpful, it will draw the attention away from the “hear and now”.

Foster parent cell groups will not have a limited number of sessions. Because of their structure however, foster parent cell groups will have an unlimited number of sessions for the same reasons that support groups have limited sessions. It has been explained already that cell groups are considered to be “alive” because they grow through multiplication. If groups multiply and grow, dependency on certain facilitators will not be possible and there will continually be space for new people. Foster parents will have an enduring support system, as well as be part of a healthy support network that will grow and reach out to more people. Foster parent cell groups should preferably have a group contract because, even though the content of the groups will not be structured, it is important for the network of foster parent cell groups to be structured to prevent chaos (Hepworth, Rooney, Dewberry Rooney, Stron-Gottfried & Larsen, 2009:497).

One of the main advantages of foster parent cell groups is that it fulfils the two main needs of foster parents that have been identified in research, namely training and support (Durand, 2007:2). There are also many other advantages to foster parent groups.

TABLE 4.8 ADVANTAGES OF FOSTER PARENT CELL GROUPS

Foster parent cell groups are:
Resource friendly - it merely needs a social worker to start it off - training and support happen simultaneously
A safe place for foster parents to gain knowledge through asking for information and advice and through listening to the experiences of other foster parents caring for AIDS orphans
An empathic space for sharing successes, feelings, frustrations and worries
A way for foster parents to keep on having hope through motivating each other
Foster parent cell groups offer:
Support through all kinds of life situations
"Safety in numbers" in cases of stigma and discrimination
Satisfaction from seeing how you are helping other people
More leverage in their communities to ask for further help and support should they need it
The opportunity and space for accountability

These advantages make foster parent cell groups seem like a worthy idea, and as this discussion continues, it will become evident how the four prerequisites for good enough parenting can be acquired and developed within these groups.

i) Prerequisite 1: Knowledge and understanding

TABLE 4.9(a) KNOWLEDGE AND UNDERSTANDING

Prerequisites for parenting
1. Knowledge and understanding
2. Motivation
3. Resources
- *Qualities*
- *Skills*
- *Social network*
- *Material resources*
4. Opportunity

The first prerequisite for parenting, is knowledge and understanding. In order to be good enough, foster parents need knowledge and understanding in many areas. The following are a few examples:

Foster parents need information on the care, control and development of children, as well as to be knowledgeable about the functional areas of child care. Foster parents need knowledge of the developmental phases of children, so that they can know what they can legitimately expect of their foster child (McFadden, 1984:61). Foster parents of AIDS orphans specifically need to know and understand what the impact of HIV is on children so that they can treat them with empathy. Foster parents further need to know where they can gain help and support should they need it. Another important aspect of which foster parents need to have thorough knowledge and understanding, is what is required of them as foster parents. They need to understand that they are basically expected to fulfil four roles – that of partner to the welfare organisation, facilitator between the child and his/her biological family and other significant people in his/her life, biological parent to the foster parent's own children and carer to the foster child (derived from Triseliotis *et al.*, 1995; Rich, 1996; Children's Act, no. 38 of 2005: section1(1)).

These are just a few of the areas of which foster parents need knowledge, and all of them can be broken down into much greater detail. However, foster parents can gain knowledge and understanding of these topics and any other topic related to their foster parenting, during discussions with other foster parents in a safe and relaxed group context. Through sharing experiences and knowledge, and looking for answers together they will help each one another to meet this prerequisite. Foster parent cell groups will provide the opportunity for informational support among the foster parent members. The following are two definitions of informational support found in literature:

- "Cognitive guidance consists of advice, counsel and normative information about the individual's handling of his or her situation or about his or her plans for handling situations" (Gottlieb & Pancer, 1988:241).
- "Providing a person with information that the person can use in coping with personal and environmental problems" (House, 1981:25).

Foster parent cell groups give the members the opportunity to discuss different situations and to give and receive experiential knowledge in order to handle the situation correctly. This contains the crux of informational support. Erik Erikson (1950) said that

people need and want information and guidance on how things need to be done. If this information and guidance come from fellow foster parents, it will be less intrusive and more readily accepted, as opposed to being told what to do by a social worker (Heath, 2004:316).

However, important as they are, knowledge and understanding are not enough. Without motivation, all the knowledge that a foster parent might have through experience and socialisation is dead (Hoghughi, 2004:11).

ii) Prerequisite 2: Motivation

TABLE 4.9(b) MOTIVATION

Prerequisites for parenting
1. Knowledge and understanding
2. Motivation
3. Resources
- *Qualities*
- *Skills*
- *Social network*
- *Material resources*
4. Opportunity

The second prerequisite for parenting is motivation, which is very important, because motivation puts knowledge into action. Hoghughi (2004:11) defines motivation as follows: “Motivation concerns [foster] parents’ wishes and commitment to do whatever is necessary to maintain or improve their children’s state”. It suggests a willingness to go beyond the call of duty.

Tyebjee (2003:701) identified two main categories of motivations that spur people on to become foster parents, namely personal fulfilment and the plight of children. People doing it for these reasons will probably become foster parents out of their own free will and they are likely to be more motivated and committed to the well-being of their foster children. A further distinction can be made between these two groups of foster parents: Becoming a foster parent for personal fulfilment is more “selfish” in a sense than doing it

for the sake of the child and therefore these foster parents might struggle with their motivations should the child's needs conflicts with their own (Hoghughi,2004:11).

There are other people who become foster parents to relatives' children because of a sense of family obligation. It might be that they do it rather because they have to and not necessarily because they want to. As a result, some of them might not be as motivated to go the extra mile for their foster children.

Foster parent groups can be a place where foster parents are motivated for the task at hand. It could cultivate a desire in foster parents to "...do whatever is necessary to maintain or improve their children's state" (Hoghughi, 2004:11). Motivation can happen on various levels and also as a function of support. Within a foster parent group, support can, amongst other things, take the form of altruism and appraisal.

Altruism refers to caring for the needs of others (Cutrona, 1984:379). Within a foster parent cell group members can meet one another's need for appraisal. Appraisal has to do with acknowledging someone's efforts and successes (Cutrona, 1984:378), and can be used powerfully as a means of motivating someone. People are motivated when they feel valued, noticed and worthwhile because of what they do for others. Foster parents can be motivated through reminding one another that they are doing a remarkable thing by caring for an orphaned child, something not many people would do. Appraisal can also motivate them to go the extra mile with their foster children through the good feelings they get from being praised by other foster parents.

iii) Prerequisite 3: Resources

TABLE 4.9(d) RESOURCES

Prerequisites for parenting
1. Knowledge and understanding
2. Motivation
3. Resources
- *Qualities*
- *Skills*
- *Social network*
- *Material resources*
4. Opportunity

The third prerequisite for parenting is resources, referring "...everything that parents need, want or desire to deploy in raising their children" (Hoghughi, 2004:12). There are four core resources for parenting, namely qualities, skills, social network and material resources.

a) Qualities

The first resource that foster parents will need is the right qualities to be a good parent. Qualities are "parental behaviour tendencies that arise from fundamental personality characteristics" (Hoghughi, 2004:12). In other words, qualities predict how foster parents will approach their task and how they will react to situations. "Good" qualities that have been identified in parenting literature are warmth, intelligence, stability and communicative ability and freedom from serious physical and mental health problems (Hoghughi, 2004:13). During the discussion on the assessment phase of the foster care process in Chapter 3 of the study, the qualities required of a foster parent, as stipulated by the Children's Amendment Act, no. 41 of 2007, were considered. The Children's Amendment Act, no. 41 of 2007, requires a foster parent to be a fit and proper person who is willing and able to undertake, exercise and maintain the responsibilities associated with foster care and who has the capacity to provide an environment that is conducive to the foster child's growth and development. Foster parent cell groups are a safe place where others can point out a foster parent's strengths and weaknesses. It also provides the opportunity for foster parents to hear and practice alternative reactions

to specific situations and for giving feedback to help others acquire the qualities they need.

b) Skills

The second resource that parents cannot do without, is skills. People are not born with the skills to parent. Parenting skills are acquired through experience, observation and parenting programmes (Hoghughi, 2004:13). According to Hoghughi (2004:13), there are a wide range of necessary parenting skills, for instance, skills to establish behavioural boundaries, communication skills and the skills that a foster parent will need to meet the physical, emotional and social care needs of a foster child. This author (Hoghughi, 2004:13) highlights an important aspect – "...the more specialised the needs of children, the more complex and specialised the parenting skills necessary". AIDS orphans have specialised needs, and therefore it is very important for their foster parents to develop the necessary skills. Foster parent cell groups will help foster parents to develop these skills through the advice and guidance given by other foster parents, based on their experiental knowledge and through witnessing the consequences of one another's actions.

c) Social network

A foster parent cell group will provide foster parents with a social network of supportive people. A social network is the third resource that parents need. Parents who are accountable to a social network have much better child outcomes than parents who do not have such a supportive social network (Hoghughi, 2004:13). Foster parent cell groups create the opportunity for accountability and for foster parents to receive and give emotional support. Emotional support has many faces. At the root it means letting someone know that they are cared for and loved (Cooke, Rossman, McCubbin & Patterson, 1988:213). Cutrona and Russell (1990:322) define emotional support as "comfort and security during times of stress". In other words, emotional support happens when a person does not have to face difficult times alone. Gottlieb and Pancer (1988:241) observe that emotional support has to do with expressing attachment and esteem for a person, as well as allowing a person to share feelings in a safe place. The context of a foster parent cell group offers the opportunity for emotional support because a safe place was created for venting feelings through the relationships and trusts that exist in such groups.

A foster parent cell group, as a type of social network (Tracy & Whittaker, 1990:462), will also provide foster parents with the support, care and comfort of other people going through the same experiences. In addition, these groups will combat the isolation that stigma and discrimination can cause (The International HIV/AIDS Alliance, 2003f:6) by providing members with a sense of belonging. Research have indicated that foster parents have a big need for this kind of support and that social workers do not have the time to try and provide it (Kohler Durand, 2007:2). Through these groups they can support one another.

d) Material resources

Money, goods and services are necessary for raising children (Hoghughi, 2004:13). These are the material resources that foster parents need for parenting. Hoghughi (2004:13) adds that inadequate material resources have an impact on parenting practices and child outcomes and "is the single most powerful predictor of subsequent disadvantage and vulnerability in health, education, family stability, antisocial behaviour and mental health of children". Sometimes foster parents will need tangible support in order to take good care of their children.

According to House (1981:24-25) tangible support consist of any form of direct help like money, labour, time or aid in kind. Gottlieb and Pancer (1988:241) define it as "...services and material resources that are extended by network members free of charge". Tangible aid also means giving people the resources they need to cope with a stressful event (Cutrona and Russell, 1990:322).

In the case of foster parent cell groups, members can offer each other free tangible support during stressful times, whether it be money or respite care, knowing that they will be helped in turn when they go through a difficult time.

iv) Prerequisite 4: Opportunity

TABLE 4.9(d) OPPORTUNITY

Prerequisites for parenting
1. Knowledge and understanding
2. Motivation
3. Resources
- *Qualities*
- *Skills*
- *Social network*
- *Material resources*
4. Opportunity

Foster parents need the opportunity to parent well (Hoghughi, 2004:14), and for this they need the opportunity for training and support so that they can be equipped to care for their foster children. The foster parent cell groups offer a simple way to equip foster parents.

This section briefly demonstrated the prerequisites for parenting, and how they could be met through foster parent cell groups.

4.4 Summary

In conclusion it can be stated that much is expected of the foster parents of AIDS orphans and that they will need training and support in order to be good enough at their parenting.

This chapter started with a discussion of the parenting process that foster parents will have to engage in as they care for their foster children. It became evident that foster parents will need training and support in order to be good enough at their parenting. Training will provide them with the knowledge and direction and practical wisdom to approach the task, while support is especially needed to carry them through difficult times. The chapter ended by proposing that foster parent cell groups provide a way for equipping foster parents to meet the demands of the parenting process in a way that is

resource friendly and self-sustaining. These two points make foster parent cell groups very appealing in the South African context.

CHAPTER 5: AN EXPLORATION OF FOSTER CARE FOR AIDS ORPHANS

5.1 Introduction

There are currently an estimated 1 million AIDS orphans in South Africa. Because of the circumstances surrounding the death of their parents, and because HIV/AIDS is a stigmatised disease, these children have special needs. If these orphans enter foster care, their foster parents will need to be specifically prepared by social workers to meet the AIDS orphans' needs. The reality in South Africa is that there are too few social workers, caseloads are very high, and as a result, the social workers do not have the time to manage their cases effectively.

The goal of this study is to shed light on the needs of children orphaned by AIDS as well as on the training and support that their foster parents will need, in order to provide guidelines for equipping foster parents to care for AIDS orphans. These guidelines are to be feasible within the South African foster care system that is overburdened.

In order to begin to realise this goal, a literature review was conducted about the needs of AIDS orphans, the training and support needs of foster parents and the foster care system in South Africa, within the context of HIV/AIDS. Towards further realisation of this goal, this chapter is investigates, by means of a situation analysis **how** and **to what extent** social workers are equipping foster parents **to care for AIDS orphans**.

5.2 Empirical study

5.2.1 Research method

The universe of this study consisted of all the social workers in South Africa who work for an NGO in the field of child and family care. The population was made up of social workers working for a South African NGO and who have, or had, AIDS orphans in foster care as clients. The sample was purposive, in that the researcher set further criteria to narrow down the population.

Due to some complications that set in during the time of data collection, the final sample consisted of:

- Ten respondents from a particular NGO in the Western Cape – they received and completed their questionnaires during training days that were held in May 2010
- Five respondents from two NGOs in KwaZulu-Natal. They received and completed their questionnaires via e-mail
- Four respondents from an NGO in the Western Cape – their questionnaires were delivered and picked up by the researcher
- One respondent from an NGO in the Western Cape – the questionnaire were received and completed via e-mail.

5.3 Results of the investigation

The results of the study will be presented and discussed in the following sections:

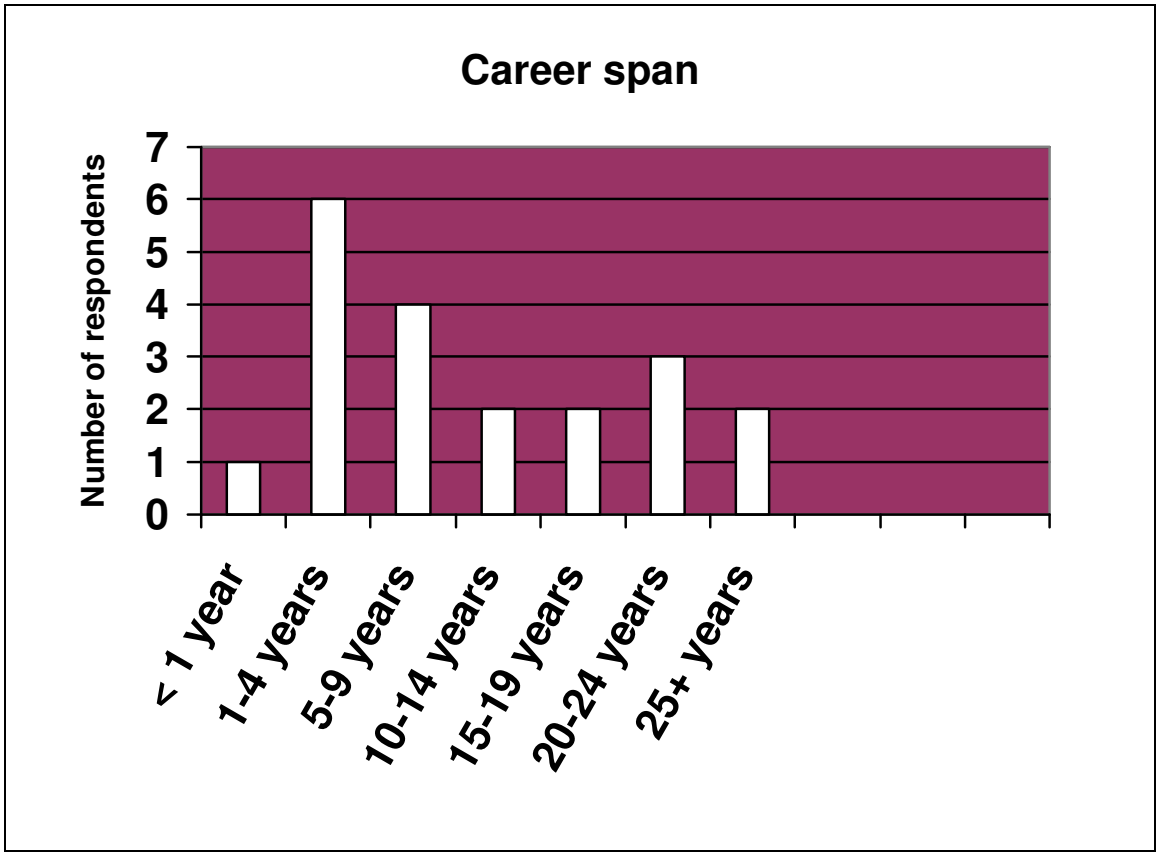
- Profile of the respondent
- Background
- The foster care process
- Foster parent training
- Profile of the foster parents
- The needs of foster parents
- The needs of AIDS orphans
- Challenges

5.4 Profile of respondent

A profile of the respondents was drawn up by considering their career span and the organisations for which they work.

5.4.1 Career span

The first area of investigation pertained to the career span of the respondents. The findings are presented in figure 5.1.



n=20

FIGURE 5.1: CAREER SPAN

From figure 5.1 it is clear that most of the respondents were experienced social workers. Thirteen (65%) of the respondents have been working as social workers for longer than five years. Nine (69%) of the 13 respondents have been working for longer than ten years. Seven (27%) of the respondents have less than five years' experience, while only one of them was in her first year as a social worker.

The level of experience lends legitimacy to the answers given by the respondents.

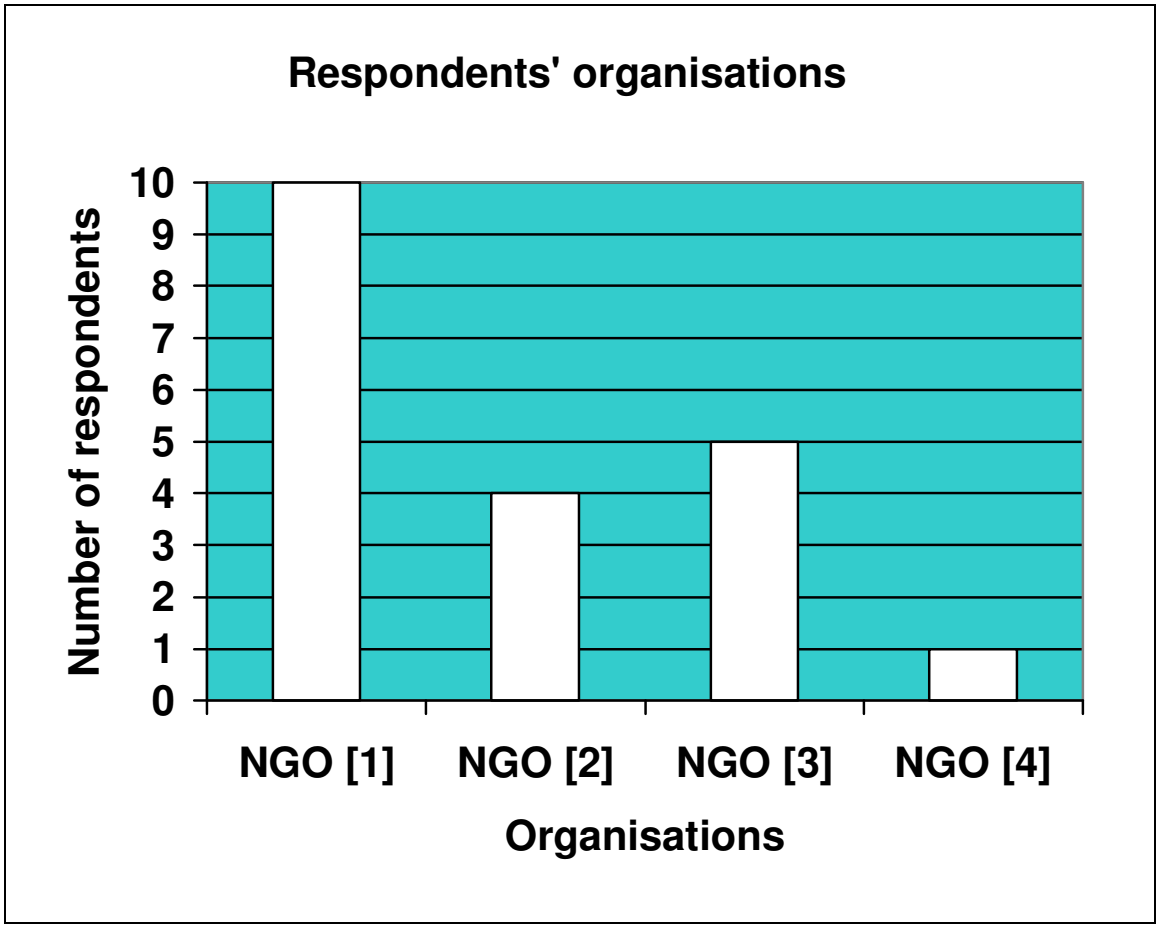
5.4.2 Organisation

In the second place, enquiries were made as to the organisation that each respondent represented. For ethical reasons the names of the organisations will not be relayed. This information is presented in table 5.1 and figure 5.2.

The respondents represented four different organisations – NGO [1], NGO [2], NGO [3], NGO [4] – and two provinces – Western Cape and KwaZulu-Natal. NGO [1] and [2] are family and child welfare organisations, while NGO [3] and [4] are faith-based organisations.

TABLE 5.1 LOCATION OF ORGANISATIONS

Western Cape	• NGO [1] • NGO [2] • NGO [4]	**KwaZulu-Natal**	• NGO [3]



n=20

FIGURE 5.2 RESPONDENTS' ORGANISATIONS

As shown in figure 5.2, ten (50%) respondents work for NGO [1], four (20%) respondents work for NGO [2] and one (5%) respondent works for NGO [4]. Table 5.1

shows that the branches representing these three organisations are located in the Western Cape. Five (20%) respondents represented NGO [3] in KwaZulu-Natal.

The respondents represented four well-established NGOs in South Africa, as well as two different provinces, one of which is the province with the highest HIV prevalence in South Africa (SANAC, 2006:28).

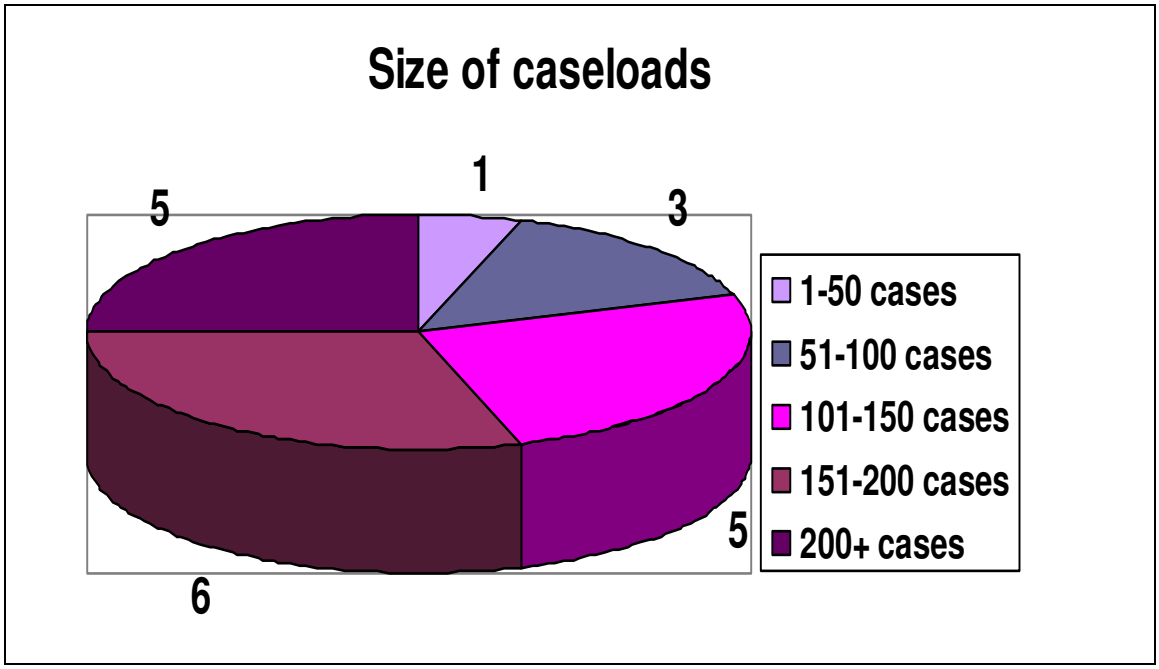
5.5 Background information

The size of social workers' caseloads is a big concern in South Africa, since there are too few social workers for the amount of work (Theron, 2009). Many authors mention the vast numbers of foster care cases in South Africa and how this is preventing social workers from rendering in-depth services to any of their clients (Meintjies & Van Niekerk, 2005; NWSSDF, 2007).

To gain an understanding of their workload, the respondents were asked about the size of their caseload, the number of foster care cases in their caseloads and how many of the foster care cases involved AIDS orphans. This information will prove valuable in interpreting the rest of the questionnaire.

5.5.1 Size of caseloads

The following pie chart illustrates the size of the respondents' caseloads:



n=20

FIGURE 5.3 SIZE OF CASELOADS

One (5%) respondent has a caseload that ranges between 21-30. Three (15%) respondents have caseloads ranging between 51-100. Five (25%) respondents have between 101-150 cases, while six (30%) respondents' caseloads range between 151-200. The last five (25%) respondents have caseloads of more than 200. One of these respondents indicated that her caseload is 300.

This means that 17 out of the 20 (85%) respondents have caseloads bigger than 100; 11 out of the 20 (55%) respondents have caseloads bigger than 150 and five out of the 20 (25%) respondents have caseloads surpassing 200. These numbers are very high.

The following table contains the average size of each respondent's caseload, the number of foster care cases of the individual respondents, how many of the foster care cases involve AIDS orphans and in which province the respondent works.

TABLE 5.2 CASELOAD BREAKDOWN

Respondent nr.	Caseload	Foster care cases	Cases involving AIDS orphans	Province
1	125.5	97	2	Western Cape
2	125.5	75	5	Western Cape
3	125.5	65	2	Western Cape
4	125.5	63	6	Western Cape
5	175.5	95	10	Western Cape
6	125.5	75	6	Western Cape
7	220	200	?	Western Cape
8	220	202	165	Western Cape
9	175.5	20	0	Western Cape
10	175.5	1	1	Western Cape
11	220	60	1	Western Cape
12	75.5	75	8	Western Cape
13	175.5	123	5	Western Cape
14	75.5	20	0	KwaZulu-Natal
15	35.5	1	0	KwaZulu-Natal
16	175.5	78	70	Western Cape
17	300	300	300	KwaZulu-Natal
18	75.5	26	22	KwaZulu-Natal
19	220	146	60	KwaZulu-Natal
20	175.5	140	10	Western Cape
	3122.5	**1862**	**642**	

This table shows that the 20 respondents have a collective caseload of 3122.5, of which 1862 are foster care cases, while 642 foster care cases involve AIDS orphans. Since there can be more than one child per foster care case, chances are that the number of AIDS orphans placed in foster care by the respondents is much higher than 642.

5.6 The foster care process

This section of the questionnaire focused on the foster care process and its outcomes.

5.6.1 Steps followed in the foster care process

The foster care process ideally consists of eight phases, namely recruitment, preparation, assessment, matching and placement, post-placement support and training and reunification or permanency (South African National Council for Child and Family Welfare, 1987; Triseliotis *et al.*, 1995; Die Ondersteunersraad, in Delport, Roux & Rankin, 2008:311). Many factors can come into play to influence the order or inclusion of certain steps. One can expect time constraints to be a main determinant in this regard.

The respondents were given a table listing the steps in the foster care process and were asked to mark the steps that they usually follow. Where they did not follow certain steps, they were asked to give a reason. Only 19 of the respondents completed this question. The green blocks in the following table indicate which steps in the foster care process are followed by each respondent.

TABLE 5.3: STEPS IN THE FOSTER CARE PROCESS

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Recruitment	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■
Preparatory training	■	■				■		■	■	■	■		■	■				■	■	■
Assessment	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■		■	■
Matching	■					■	■	■	■	■	■	■	■	■		■				■
Placement	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■		■	■
Post-placement support	■	■	■	■		■	■	■	■	■	■	■	■	■	■		■		■	■
Post-placement training						■	■	■	■	■	■		■	■		■	■			■
Permanency planning				■		■	■	■	■	■	■	■	■	■	■	■	■	■		■

n=19

Reasons for not following some of the steps were given only for four steps of the foster care process, namely recruitment, preparatory training, matching and post-placement training. The same reasons were consistently given:

- **Not enough time** was held up as a reason five times.
- The fact that **orphans were already living with families** before the process started, was also mentioned five times.
- The other big reason seemed to be that **information is conveyed informally** to foster parents.
- The last two reasons offered were that **foster parents give little co-operation once the placement has been finalised,**
- and that the **caseloads are too big**.

Looking back to table 5.2, it is significant to note that most of the respondents who indicated that they followed all the steps in the foster care process presented in table 5.3 were either employed as a foster care worker, or were working for NGO [2]. Further on in Chapter 5, in section 5.7.4, the social workers from this NGO all mentioned that they made use of a certain formal foster care programme, developed by this NGO. It can thus be concluded that having a designated social worker to focus only on foster care could be beneficial to an organisation, as well as having a formally structured programme to guide the social worker and the foster parent through the process.

5.6.2 Outcome of foster care placements for AIDS orphans

One of the purposes of foster care, as stated in section 181(b) of the Children's Amendment Act, no. 41 of 2007, is to establish permanency in a child's life.

In the questionnaire, the aim of this question was to determine the most common outcome for a foster care placement where the child is an AIDS orphan. Three options were given – placement failure, permanent placement/continuous renewal and adoption. Respondents had to mark how often each option was an outcome – never, rarely, often or always. The following table contains the results:

TABLE 5.4 FOSTER PLACEMENT OUTCOMES

	Never	Rarely	Often	Always
Placement failure	4	**9**	1	0
Permanent placement Continuous renewal	2	2	4	**6**
Adoption	**10**	3	1	0

n=14

According to the results in the table above, placement failure is not a common outcome, while successful placements seem to be very common. Ten of the 14 respondents (71%) who answered this question marked adoption as something that never happened, while four (29%) indicated that it happened sometimes. This suggests that AIDS orphans do achieve stability and permanency in their lives after having been placed in foster care and that the purpose of foster care is being realised.

Townsend and Dawes (2004:71) conducted a study and found that adoption is under-promoted and under-utilised in South Africa. This correlates with the finding that adoption rarely happens.

5.7 Foster parent training

This section was concerned with the training that foster parents need, training that they currently receive as well as about the respondents' opinion on the need for this training.

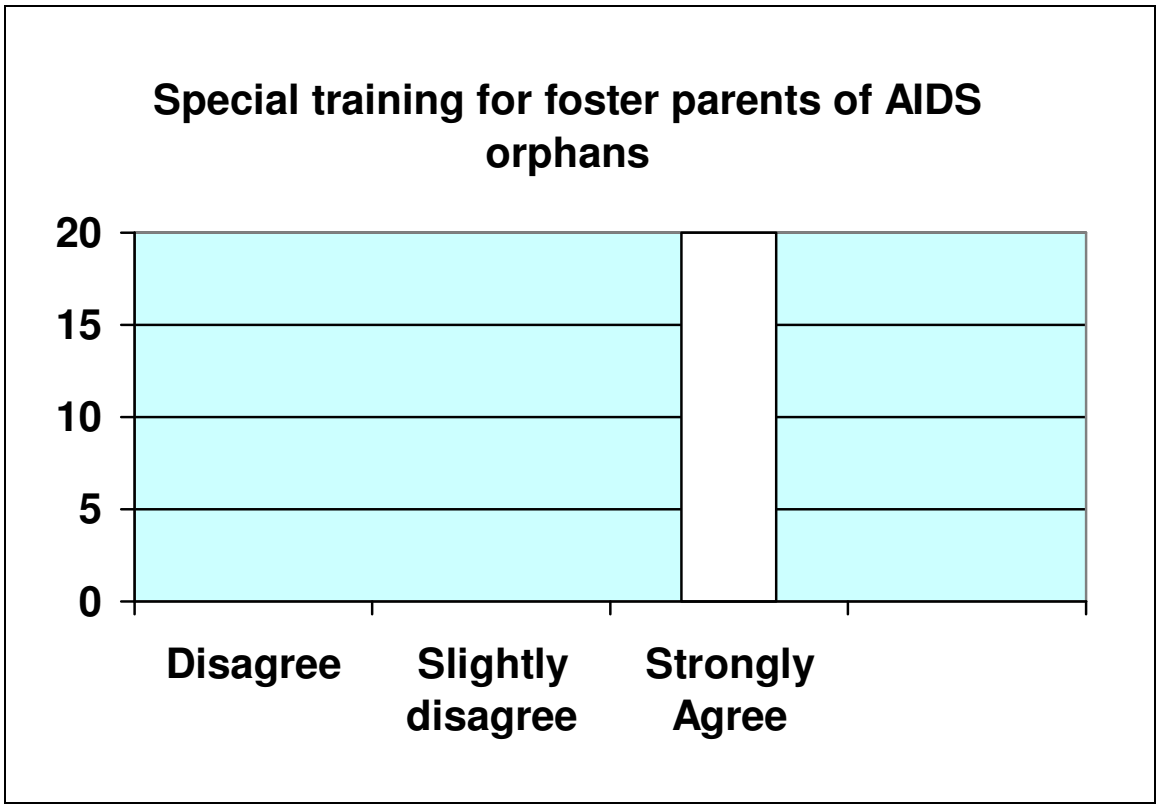
5.7.1 Special training for the foster parents of AIDS orphans

It has been found the world over that foster parents need training in order to adequately parent the children in their care (Durand, 2007:2). Many authors concerned with AIDS orphans have pointed out that foster parents will need to be made aware of the specific challenges inherent in caring for a child orphaned by AIDS, in order to meet the child's special needs (The International AIDS Alliance, 2003b:17; Grainger in Richter *et al.*, 2004:39; UNICEF, 2006:24).

Respondents were asked to consider the following statement and to indicate their level of agreement:

"Foster parents of AIDS orphans need special training to meet the AIDS orphans' special needs."

Their responses are portrayed in figure 5.4.



n=20

FIGURE 5.4: SPECIAL TRAINING FOR FOSTER PARENTS OF AIDS ORPHANS

As can be seen in figure 5.4, all 20 respondents (100%) chose the "strongly agree" option. This response implies three things:

1. All the respondents indicated that AIDS orphans have special needs.
2. All the respondents are convinced that the foster parents need **special** training to meet the AIDS orphans' needs, in other words, training that differs from that of other foster parents.
3. All the respondents think that foster parents need training in general, since the foster parents of AIDS orphans would need "special" training.

There is thus agreement between these findings and current literature (The International AIDS Alliance, 2003b; Grainger in Richter *et al.*, 2004; UNICEF, 2006; Durand, 2007).

5.7.2 Motivation for level of agreement

In addition the respondents were asked to explain and motivate their level of agreement with the abovementioned statement. When their answers were analysed, three main themes emerged.

TABLE 5.5 REASONS FOR THE FELT NEED OF SPECIAL TRAINING

Theme: Foster parents of AIDS orphans need special training to meet the AIDS orphans' special needs		
Sub-theme	**Category**	**Special needs expressed by participants**
Strongly agree	AIDS orphans are unique	• These children need special care and protection • Foster parents need special training to meet their special needs • AIDS orphans have slightly different needs than other foster children have
	Foster parents need guidance and skills	• To guide child when there are questions • To deal with the emotional needs of the traumatised children • To assist children through the grieving process • To equip foster parents with the needed skills and knowledge to deal with any issues or needs they themselves might have
	Foster parents need information	• Will obtain knowledge to understand the context of their needs • Important to educate prospective and current foster parents as to the special needs and care that AIDS orphans require • Foster parents and children are mostly unaware of the emotional strain that would be involved in caring for an AIDS orphan • Foster parents must understand the bereavement process

The respondents' answers fall into three categories: that AIDS orphans have unique needs and that foster parents need guidance and skills, as well as information in order to meet these unique needs. Most of the respondents agreed that foster parents will need special training to care for AIDS orphans.

i) Category: AIDS orphans are unique

The respondents indicated that AIDS orphans need special care *(These children need special care and protection)* because they have different needs than other children have *(AIDS orphans have slightly different needs than other foster children)*, and as a result, foster parents will need special training to meet these needs *(Foster parents need special training to meet their special needs)*. Various authors have also pointed to the uniqueness of AIDS orphans (International AIDS Alliance, 2003b; Richter, 2004; Subbarao & Coury, 2004; UNICEF, 2006:24).

ii) Category: Foster parents need guidance and skills

The respondents' reasons indicated that they felt foster parents need special training to obtain guidance and skills to care for AIDS orphans. The guidance that foster parents need ranges from *guiding the child when there are questions*, to *assisting the child through the grieving process* and *dealing with the traumatised child's emotional needs*. Foster parents also need to be *equipped with the skills and knowledge* to handle any presenting issues. This is supported by the International HIV/AIDS Alliance (2003b) who states that the caregivers of AIDS orphans must be prepared for all the challenges associated with taking care of children who have lost their parents to AIDS. One factor that is associated strongly with AIDS orphans by both the respondents and current literature (Richter, 2004; Townsend & Dawes, 2006) is the AIDS orphans' emotional needs. The importance for these needs to be met is also emphasised in literature (Cook *et al.,* 2003:88; Grainger in Richter *et al.,* 2004:39).

iii) Foster parents need information

The last category that emerged from the respondents' reasons is that foster parents need information. The findings ranged from the value that training will add *(will obtain knowledge to understand their needs)*, to the importance of training *(important to educate prospective and current foster parents as to the special needs and care that AIDS orphans require),* to bringing awareness *(Foster parents and children are mostly*

unaware of the emotional strain that would be involved in caring for an AIDS orphan) and understanding *(foster parents must understand the bereavement process)* in foster parents.

One aspect that stands out in all three categories is that many of the respondents mentioned grief and bereavement. The trauma surrounding the illness and death of the parent seems to be one of the important differentiations between an AIDS orphan as a foster child and another foster child. The respondents seem to feel that a specific focus on dealing with grief and bereavement is necessary when it comes to AIDS orphans as foster children.

5.7.3 Topics for foster parent training

Upon consideration of all the tasks that foster parents are required to do, it becomes evident that they have to fulfil four roles – that of partner, facilitator, carer and biological parent (Based on Brown & Calder, 2000:729; Dougherty in Barbell & Freundlich, 2001:20; Buehler *et al*., 2008:527). Triseliotis *et al.* (1995:46-47) conducted a review of foster parent training courses and found a broad consensus with regards to content. It seems that the same topics are regarded as important in different countries. The most common topics also illuminate the four main roles of the foster parents mentioned above.

The respondents were asked to indicate which of a list of topics presented to them were covered when they train foster parents. Their responses are portrayed in table 5.6. The respondents were also asked to list any additional topics that they might be covering in their training programmes.

TABLE 5.6 TOPICS IN FOSTER PARENT TRAINING

Training topics	Yes		No	
The foster parent as Partner	**Number**	**Percentage**	**Number**	**Percentage**
The foster care system	18	**100%**	0	**0%**
Working and planning in a team	13	**72%**	0	**28%**
The role of foster parents	17	**94%**	1	**6%**
The role of social workers	17	**94%**	1	**6%**
The foster parent as Parent to biological children	**Number**	**Percentage**	**Number**	**Percentage**
The impact of fostering on the fostering family	17	**94%**	1	**6%**
The foster parent as Facilitator	**Number**	**Percentage**	**Number**	**Percentage**
The role and significance of the child's birth family and origins	14	**78%**	4	**22%**
The foster parent as Carer	**Number**	**Percentage**	**Number**	**Percentage**
Knowledge and understanding of HIV/AIDS	17	**94%**	1	**6%**
Dealing with grief, bereavement and loss as experienced by foster child	18	**100%**	0	**0%**
Dealing with stigma and discrimination as experienced by foster child	15	**83%**	3	**17%**
Child development	16	**89%**	2	**11%**
Building self-esteem of foster child	14	**78%**	4	**22%**
Building a caring relationship with the foster child	15	**83%**	3	**17%**
Socialisation of the foster child	11	**61%**	7	**39%**
Managing difficult behaviour of the foster child	17	**94%**	1	**6%**
Awareness of the symptoms of child sexual abuse	15	**83%**	3	**17%**

n=18

From table 5.6 it is clear that two topics scored a 100% (18 respondents) inclusion rate, namely “the foster care system” and “dealing with grief, bereavement and loss as experienced by foster child”. Five topics tied for a 94% (17 respondents) inclusion rate – “the role of foster parents”, “the role of social workers”, “the impact of fostering on the fostering family”, “knowledge and understanding of HIV/AIDS” and “managing difficult behaviour of the foster child”. “Child development” came third with 89% (16 respondents).

The topic least likely to be included, with an inclusion rate of 61% (11 respondents), was “socialisation of the foster child”. “Working and planning as part of a team” scored an inclusion rate of 72% (13 respondents), which made it second least likely to be included. Two topics tied for third place with 78% (14 respondents) – “the role and significance of the child’s birth family and origins” and “building self-esteem of foster child”. In the fourth place for least likely to be included, with 83% (15 respondents) is “dealing with stigma and discrimination as experienced by the foster child”, “building a caring relationship with the foster child” and “awareness of the symptoms of child sexual abuse”.

The topic least likely to be included still scored a 61% inclusion rate. The other “least likely” topics all ranged between 61% and 78% – it is clear that most respondents do find them important.

i) Partner

Three of the topics that are meant to prepare foster parents for the role of partner scored very high inclusion rates. The fourth topic (working and planning as part of a team) was second least likely to be included.

The respondents indicated that information about **the foster care system** is always included in their training of foster parents. This is in agreement with Triseliotis *et a.l* (1995:42) who state that it is of the utmost importance for the foster parent to be fully informed about exactly what foster care is and how the system works. These authors (Triseliotis *et al*., 1995:42) maintain that prospective foster parents need this information to determine whether fostering is for them. This information will also prepare them for what can be expected during the duration of the placement. **Foster parents need to know what their role is** and what is expected of them within that role. Foster parents

must also be informed about **the role of the social worker** so that they will know what to expect from the social worker (Triseliotis *et al.*, 1995:42).

The practice for foster parents **to work and plan as part of a team** has become very mainstream in the USA and in England (Dougherty in Barbell & Freundlich, 2001:20). It seems that this approach is not yet commonplace in South Africa.

ii) Parent

Foster parents are likely to have children of their own already, and one of the roles that they are required to fulfil, is that of parent. **The impact of fostering on the fostering family** scored a 94% inclusion rate, making it one of the second most important topics in the respondents' opinion. Fostering children has a big impact on the biological children in the family. Younes and Harp (2007) state that "potential foster parents must determine whether their family possess the necessary commitment, dedication, time, economic stability and parenting skills to care for vulnerable children". In other words, the potential foster parents must determine whether their family will be able to withstand the impact of fostering. The foster parents must be made aware of any ways in which their family can be impacted, in order to make an informed decision. The foster parents must decide whether they want to expose their biological children to potentially troublesome behaviour (Younes & Harp, 2007) Some of the impacts are that biological children could be exposed to potentially troublesome behaviour (Younes & Harp, 2007); biological children could have trouble adjusting to the presence of the foster child and the resulting changes in their relationship with their parents (Wilkes, 1974). Sometimes biological children also come to resent the foster child (Poland & Groze, 1993) because they are receiving less of their parents' time and attention (Heger, 2004).

iii) Facilitator

Another role that foster parents are required to fulfil, is that of facilitator. **The role and significance of the child's birth family and origins** scored a 78% inclusion rate in foster care training programmes. It is understandable that emphasis is put on the child's family roots since section 70 of the draft regulations (Department of Social Development, 2008) to the Children's Act, no. 38 of 2005 makes foster parents responsible for encouraging contact between the foster child and the biological family (within the scope of the placement order). For a foster parent to actively encourage this contact an

understanding of the necessity of such contact for e.g. the child's sense of belonging and identity is crucial.

iv) Carer

The fourth role of a foster parent is that of carer. The circumstances surrounding the death of the parent and the accompanying loss and bereavement experienced by the child are one of the main distinctions between an AIDS orphan and another child. Many factors can complicate the grieving process (Fox & Parker, 2003:210) and without the comfort and support of a significant person poor adjustment on the part of the child is very likely after the loss of the parent (Cook *et al*., 2003:88). The respondents' inclusion of **"dealing with grief, bereavement and loss as experienced by the foster child"** in their training programmes underscores their view that it is an important topic to be addressed.

Foster parents need to have **an accurate understanding of HIV/AIDS** in order to empathise with the foster child and to be able to answer questions truthfully. It has been noted in literature that the experiences of an AIDS orphan can aggravate the "normal" difficult behaviour of a child (Richter, 2004). Foster parents must be prepared to handle it. The fact that this topic ties with those topics identified as second most important by the respondents, suggests that the respondents have experienced AIDS orphans as exhibiting difficult behaviour.

Child development was identified as the third most important topic. Again literature emphasises the importance of including this topic in foster parent training. AIDS orphans are likely to have a developmental disadvantage, but foster parents who are knowledgeable about child development will be able to identify those areas in which they are behind and help them grow (McFadden, 1984:42).

Literature refers to the proper **socialisation of children** as a very important protective factor because positive social relationships have an impact on their emotional state and shape their view of themselves (Hoghughi, 2004:7). When considering the relationship problems evident in many South African families (Department of Welfare, 1997:60) it seems puzzling that this topic is not viewed as more important.

Richter (2004) has identified low self-esteem in AIDS orphans as a common internalising condition associated with the loss, separation and bereavement that these children go through upon the death of their parent(s). Foster parents need to be trained on how to **build self-esteem** (Triseliotis *et al.*, 1995).

"Dealing with stigma and discrimination as experienced by the foster child", "building a caring relationship with the foster child" and **"awareness of the symptoms of child sexual abuse"** scored an 83% inclusion rate, which is quite high, but it does seem surprising that it did not score higher. Stigma and discrimination are associated so strongly with HIV/AIDS and it is such a commonplace occurrence that all foster parents should be trained on this topic (The International HIV/AIDS Alliance, 2003c; Bezuidenhoudt *et al.*, 2006). A caring relationship forms the basis of a successful foster care placement. The White Paper for Social Welfare (Department of Welfare, 1997:60) describes the relationship problems in many South African families and from this description it becomes evident that relationship building skills should be regarded as a very important topic to be addressed in foster parent training. Given the reality of the unsafe nature of many communities in South Africa (Department of Welfare, 1997:60), it is very important for foster parents to be aware of the signs and symptoms of child sexual abuse.

In addition, some of the respondents indicated other topics that they include in their training programmes, and regard as particularly important:

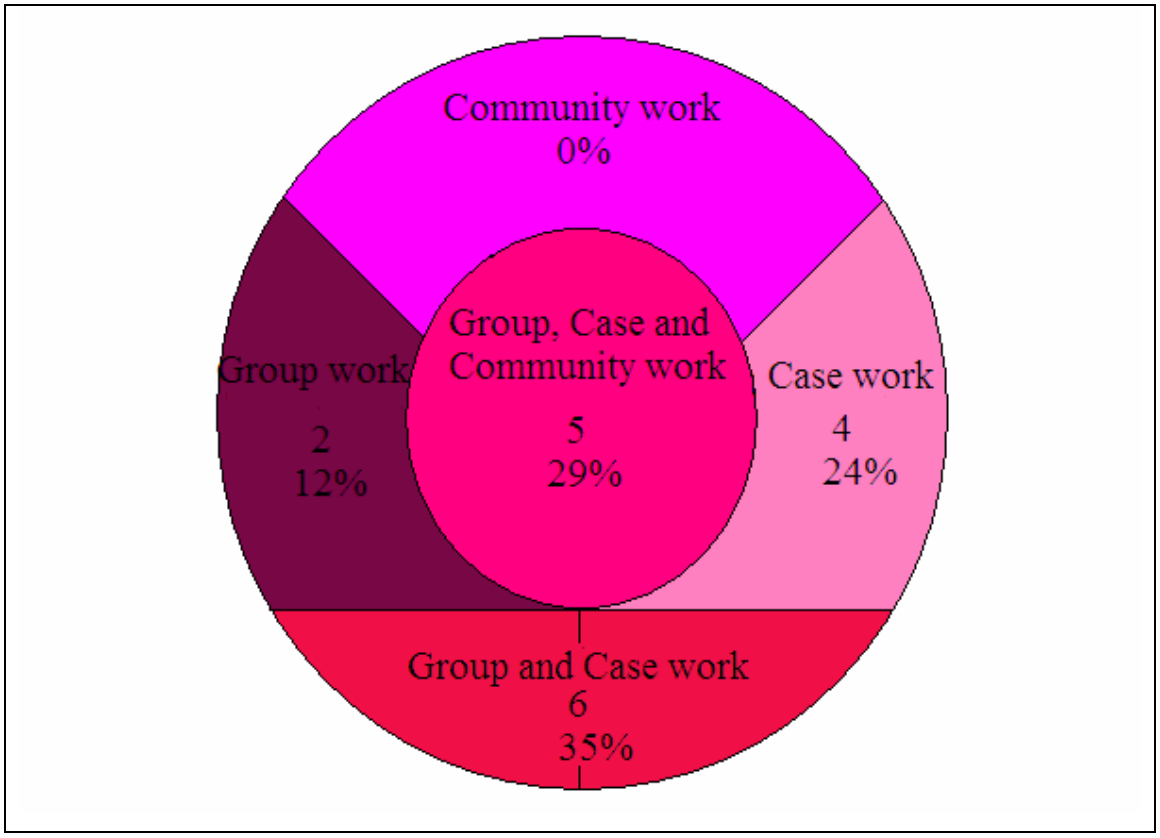
- "Importance of the life circle"
- "The impact of substance abuse on the human body"
- "Isolabantwana".

The fact that these topics were specifically mentioned indicated that the particular respondents found them especially important.

5.7.4 Social work intervention programmes

The respondents were asked to give a detailed explanation of the following four aspects – the social work intervention method that is used, how the foster parents are trained, how often the training takes place and what resources are used. The purpose of this question was to gain an understanding of the nature of intervention and how often the respondents conducted training for foster parents.

i) Social work intervention method



n=17

FIGURE 5.5 SOCIAL WORK INTERVENTION METHODS USED FOR TRAINING FOSTER PARENTS

Five of the respondents (29%) are using group, case and community work to train foster parents, while six respondents (35%) are only making use of group and case work. It seems as if none of the respondents do training primarily as a function of community work, while four respondents (24%) use only case work and two respondents (12%) use only group work. In other words, case work is used 88% of the time, followed by group work (76%), which makes it the two most probable methods to be used.

a) Case work

In question 5.6.1, 37% and 42% of the respondents respectively indicated that they are not doing pre- or post-placement training. The reasons they gave were time constraints and high caseloads, correlating with the research done by Delport *et al.* (2008). In light

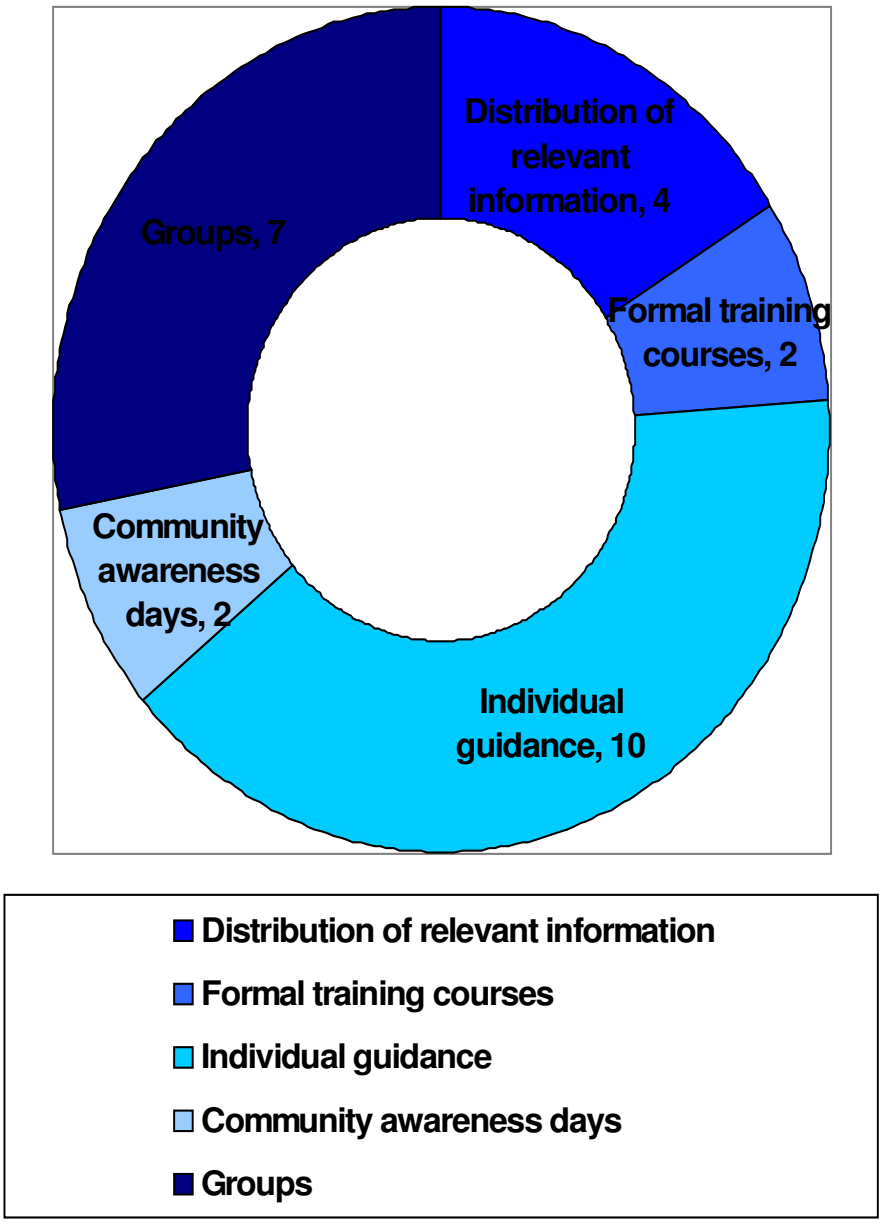
of this it seems strange that the social work method of choice among the respondents to do training is case work, since it is very time-consuming to render services to clients on an individual basis.

b) Group work

Delport *et al.* (2008:314) pointed out that social workers are often unable to train foster parents because they are overburdened with heavy caseloads and thus have no time to do training. They also found that group work is considered to be the best method of service delivery to foster parents because it is so resource friendly.

ii) Training structure

The foster parents were asked to explain how they train the foster parents. Their answers are displayed in figure 5.6.



n=19

FIGURE 5.6 TRAINING STRUCTURE

Nineteen respondents answered this question. Some respondents made use of only one training method, while others used two or more – therefore the percentages do not add up to 100%.

It became evident however that five main methods are primarily used. Figure 5.6 indicates how many respondents use each method. Seven respondents (37%) conducted their foster parent training in groups. Four respondents (21%) distributed relevant information as a means of equipping foster parents with knowledge and information. Two respondents (11%) implemented formal training courses. Ten respondents (53%) guided foster parents on a one-to-one basis, while two respondents (11%) imparted knowledge and information through community awareness days. Individual guidance is thus the most prevalent training method used by the respondents.

The fact that individual guidance is the most prevalent training method is surprising, since social workers are reputed to have big caseloads and too little time *(*Delport *et al.,* 2008:314*)*.

iii) Frequency of training

The respondents were asked to specify how many times per year they trained foster parents.

TABLE 5.7 FREQUENCY OF TRAINING

Frequency of training – Times per year	**Number of respondents**	**Percentage**
1	2	18%
3	1	9%
4	4	36%
12	3	27%
6	1	9%

n=11

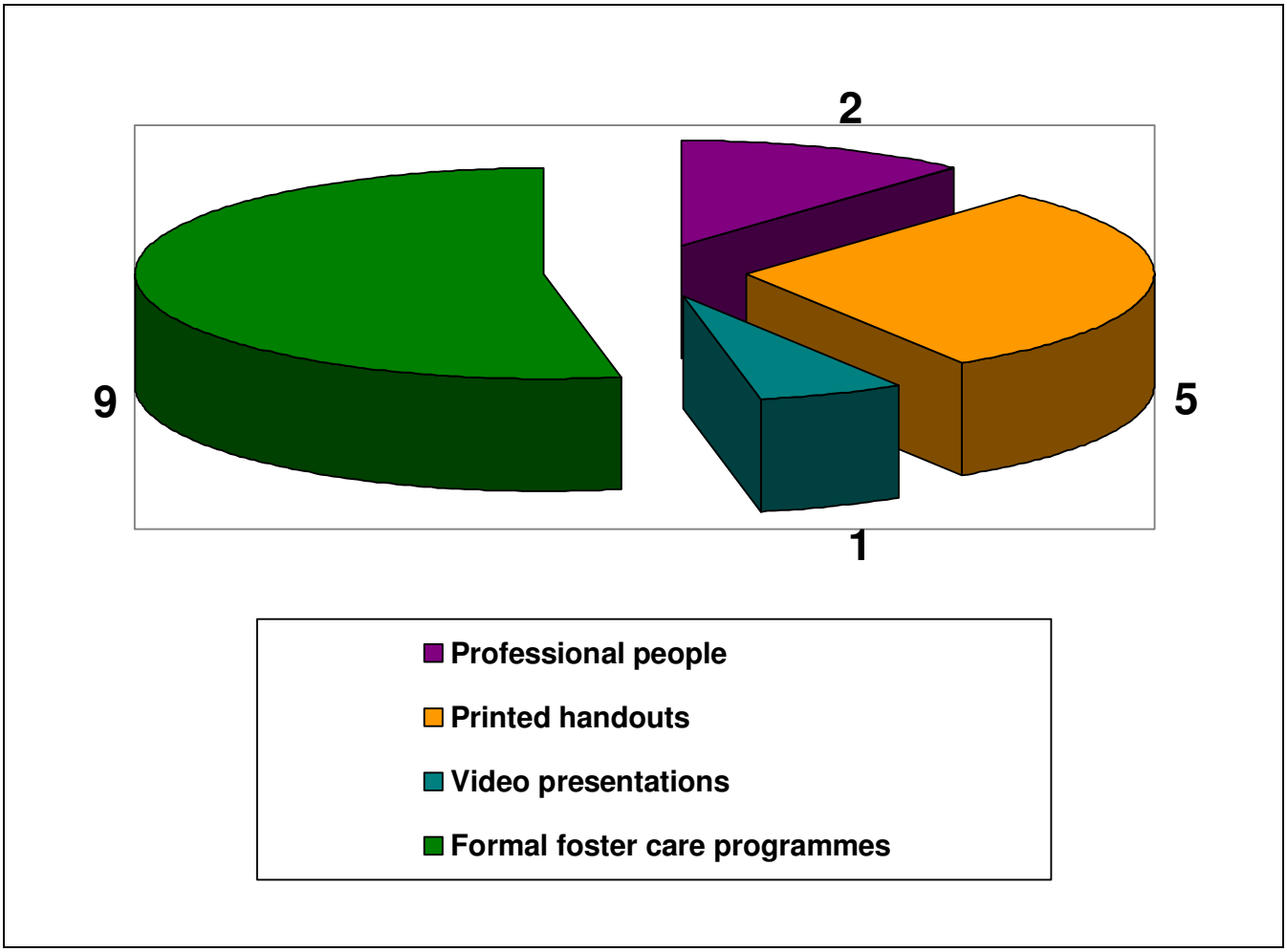
As can be seen from table 5.6, two respondents (18%) conducted training once a year, one respondent (9%) did training three times per year and another respondent (9%) conducted training six times per year. Four respondents (36%) offered training four times per year, while three respondents (27%) managed to have monthly training. One other respondent said that training did not happen often because of a heavy workload, while another respondent said that his/her organisation made use of another organisation to train their foster parents.

Based on table 5.6, training happened on average two times per year among the respondents, and probably within their organisations. Delport *et al.* (2008) conducted a study in the North-West Province of South Africa and found that foster parent training happened on average once per year. The averages of Delport *et al.*'s study and this study are quite similar and therefore the conclusion reached by Delport *et al.* (2008) can be regarded as valid in both instances. Delport *et al.* (2008) concluded that training that happens so infrequently will be of very little value.

The most prevailing training method was individual guidance which makes sense within a case work framework. It is puzzling however, that these are the chosen methods of operation, given the fact that social workers have big caseloads and little time. It makes more sense when it is taken into consideration that training seems to happen on average twice per year. Individual guidance will only be time-consuming if it is a regular occurrence. If it only happens twice per year, it is probably the most time-economical training method. It is safe therefore to presume that the need for training that foster parents are said to have is not fulfilled.

iv) Resources and teaching aids

In answer to what resources and teaching aids they used, the respondents listed the input of professional people, video presentations, printed handouts and formal foster care programmes.



n=17

FIGURE 5.7 RESOURCES AND TEACHING AIDS

The majority of the respondents (53%) make use of formal foster care programmes to train foster parents. Five respondents (29%) use printed handouts to train foster parents and one respondent (6%) utilises video presentations. Two respondents (12%) make use of input from professional people.

a) Professional people; Printed handouts; Video presentations

Durand (2007:49) mentions training techniques that social workers use to train foster parents. Guest speakers, video presentations and printed handouts are specifically mentioned, suggesting agreement between the respondents and literature.

ii) Formal foster care programmes

A discrepancy creeps in here, where the most used resource is identified as formal foster care programmes. Foster care programmes, like Wolalani and Botswadi, are not meant to be implemented in a case work setting or in two contacts per year. It might be however that the respondents are using the information in these programmes as guidelines for their individual sessions with the foster parents.

5.8 Profile of the foster parents

The first part of the questionnaire was aimed at discovering who the respondents were and what their involvement was in the foster care process. From there the questionnaire moved on to cover the foster parents. This section of the questionnaire was aimed at casting light on who the most prevalent foster parents were and what their motivation was for fostering.

5.8.1 Most prevalent foster parents

This question posed some difficulties for the respondents. They were given a table containing five options for foster parents and were asked to rate the list from 1 to 5 to indicate who the most prevalent foster parents of AIDS orphans were in their experience; 1 being the most prevalent. Many of the respondents did not complete this question correctly – for example, some of them did not rate all five options, or only indicated who they felt were the most prevalent. As a result of this, the answers to this question could not be analysed in a scientific way – it is also not possible to give percentages. Table 5.8 however gives an indication of how many times each foster parent option was given a specific rating:

TABLE 5.8 PREVALENCE OF DIFFERENT FOSTER PARENTS

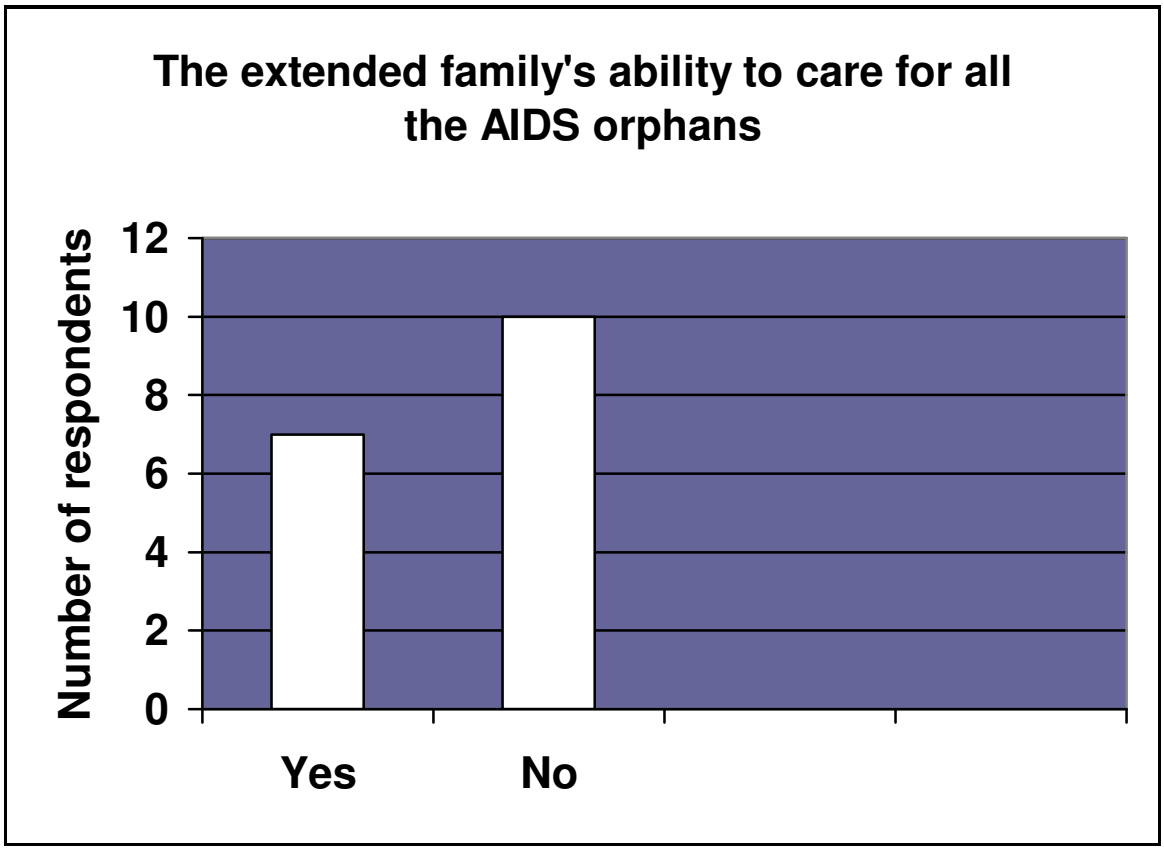
	Foster parent options	Rating				
		1st	2nd	3rd	4th	5th
n=17	**Grandparents**	**10**	3	1	2	1
n=16	**Aunts and uncles**	6	**6**	3	1	0
n=12	**Siblings**	4	0	**5**	3	0
n=12	**Other relatives**	4	1	1	**6**	0
n=13	**Non-relatives**	2	2	0	2	**7**

Ten respondents rated grandparents as the most prevalent foster parents for AIDS orphans. Six respondents rated aunts and uncles as second most prevalent. Siblings were rated as third, other relatives as fourth, and seven respondents felt that non-relatives were the fifth most prevalent foster parents for AIDS orphans.

The findings are presented because they do reflect current literature. According to Foster (2000) the traditional first choice for replacement carers were aunts and uncles. This dynamic changed however, because of the number of orphans and because aunts and uncles are themselves likely to contract HIV. Foster (2000) notes that grandparents, followed by other relatives, became alternative options. This supposition is supported by table 5.7, in that grandparents were rated as most prevalent, followed by aunts and uncles, siblings and then other relatives. According to table 5.7 non-relatives seem to be the least likely to become the foster parents of AIDS orphans. This is an unexpected finding, but it is understandable because of two reasons: It is **unexpected** because literature (Townsend & Dawes, 2004:71; Booysen & Arnst, 2002:172; Derbyshire & Derbyshire, 2002:2) time and again points to the fact that the number of orphans surpasses the capacity of the extended family to care for them. It is **understandable** because many of the orphans are already living with family members when an application is made for foster care. This is confirmed by the respondents who indicated in section 5.6.1 of this chapter that the recruitment of foster parents is often not necessary because children are already living with their family.

5.8.2 The ability of the extended family to take in orphans

This question was aimed at determining the respondents' opinions regarding the ability of the extended family to care for all their orphans. They were also asked to give reasons for their answer. Their answers are portrayed in figure 5.8.



n=17

FIGURE 5.8 THE EXTENDED FAMILY'S ABILITY TO CARE FOR ALL THE AIDS ORPHANS

Seventeen respondents answered this question. Ten respondents (58%) said that they did not think that the extended family had the needed capacity, while seven respondents (42%) believed that the extended family did have the capacity to take in and care for their orphans. It is significant that more respondents thought that the extended family did not have the necessary ability, while most of the respondents rated family members as the most prevalent foster parents in section 5.8.1.

Table 5.9 illustrates their answers by depicting the reasons for their assertions.

TABLE 5.9 REASONS FOR AND AGAINST THE ASSERTION THAT THE EXTENDED FAMILY WILL BE ABLE TO CARE FOR ALL THE AIDS ORPHANS

Theme: The extended family will be able to take in and care for all the AIDS orphans		
Sub-theme	**Category**	**Reasons**
Positive	Family responsibility	• Currently most orphans are cared for by the extended family • Parents made arrangements • If they really care for the child
Negative	Lack of concrete resources	• Finances • Lack of space
	Lack of human resources	• Aunts and uncles all died • Social circumstances

i) Positive responses

The reasons given by the ten respondents who said that the extended family would be able to take care of all the orphans all had one theme in common – that of family responsibility. They mentioned the fact that most orphans were currently being cared for by their families, as is reflected again in section 5.8.1; they referred to custody planning and stated that if the family truly cared for the orphan, they would make a plan to take care of the child. These findings correlate with Hegar and Scannapieco (1995:204) who pointed out that family foster parents are mostly motivated by a sense of family duty and/or by love for the child or his/her parents. The respondents seemed to feel that "love will conquer all" and that the families would plan around all the presenting difficulties in caring for the AIDS orphans.

ii) Negative responses

The reasons given by the seven respondents who said that the extended family would not be able to take care of all the orphans had two related themes in common – **a lack of concrete resources** like finances and space, and **a lack of human resources**. The respondents stated that in many cases all the aunts and uncles have died and that the social circumstances of the family did not allow for the taking in of more children. These findings echo other research findings that indicate that potential caregivers are dying (The International HIV/AIDS Alliance, 2003a:5; UNICEF, 2006:17); dependency ratios

are increasing (UNICEF, 2006:11); families who take in children face strong material constraints, rendering them unable to care for more children (Subbarao & Coury, 2004:28-29).

5.8.3 Motivation for fostering

Literature states that foster parents are largely motivated by four categories of motivations: personal fulfilment, a desire to help children (Tyebjee, 2003), family obligation (Hegar & Scannapieco, 1995:204) and the foster care grant (ACESS, 2003). The respondents were given a table containing these four motivations for fostering that have been identified by research studies. They were asked what they thought the motivations were of the different "types" of foster parents. In retrospect, the researcher realised that the question was asked in an unnecessarily complicated manner. The data obtained are presented in table 5.9, but then summarised for clarity's sake in table 5.10.

TABLE 5.10 THE MOTIVATIONS OF THE DIFFERENT FOSTER PARENTS

	Personal fulfilment			**Desire to help**			**Family obligation**			**Foster care grant**		
	Disagree	AgreE	Strongly Agree	Disagree	Agree	Strongly Agree	Disagree	AgreE	Strongly Agree	Disagree	Agree	Strongly AgreE
Non-relatives	5	8	1	1	8	5	3	6	4	3	7	4
	n=14			n=14			n=13			n=14		
	36%	57%	7%	7%	57%	36%	23%	46%	31%	21%	50%	29%
Grandparents	9	4	1	2	10	3	0	7	10	3	8	6
	n=14			n=15			n=17			n=17		
	64%	29%	7%	13%	67%	20%	0%	41%	59%	18%	47%	35%
Aunts & uncles	7	7	2	2	11	2	1	11	6	1	8	10
	n=16			n=15			n=18			n=19		
	44%	44%	12%	13%	73%	13%	6%	61%	33%	5%	42%	53%
Siblings	6	6	0	2	8	3	0	7	8	3	6	5
	n=12			n=13			n=15			n=14		
	50%	50%	0%	15%	62%	23%	0%	47%	53%	21%	43%	36%

TABLE 5.11 SUMMARY OF THE MOTIVATIONS OF FOSTER PARENTS

	Personal fulfilment	**Desire to help**	**Family obligation**	**Foster care grant**
Non-relatives	64%	93%	77%	79%
Grandparents	36%	87%	100%	82%
Aunts & uncles	58%	86%	94%	95%
Siblings	50%	85%	100%	79%

Table 5.10 makes it clear that most of the respondents (93%) concluded that non-relatives become foster parents out of a desire to help children. All of the respondents (100%) thought that grandparents and siblings become foster parents out of a sense of family obligation while the majority of the respondents (95%) concluded that aunts and uncles are primarily motivated by the foster care grant.

The motivation of the foster parent is an important indication of the success of the placement. One of the prerequisites for becoming a foster parent is a distinct willingness to care for the child (Children's Amendment Act, no. 41 of 2007, Section 182(2)).

i) Personal fulfillment

According to table 5.10, none of the types of foster parents is primarily motivated by personal fulfillment. This disagrees with Tyebjee (2003) who observed that non-relatives are mostly motivated by personal fulfillment or a desire to help. According to table 5.10 non-relative foster parents are motivated least by personal fulfillment.

ii) Desire to help

The information gained by this question is in agreement with research studies conducted by Hegar and Scannapieco (1995) and Tyebjee (2003). Tyebjee (2003) found that non-relative foster parents are usually motivated by two broad categories of motivations – a desire to help children and personal fulfillment. The respondents are thus in line with research by indicating that the main motivation for non-relative foster parents is a desire to help children. This motivation points to a distinct willingness to care for children.

iii) Family obligation

According to the respondents, grandparents and siblings are always motivated by a sense of family obligation when they take on the role of foster parents. Family obligation can take the form of affection for the child or his/her parents, or family obligation can be the result of circumstances "forcing" a family member to become a foster parent. The first instance also points to a willingness to foster, while family members who feel "forced" will probably do it more as a duty than out of willingness. This is an important distinction for social workers to keep in mind because a willing foster parent is more likely to take good care of a child than one who feels pressured (Subbarao & Coury, 2004:31). Many researchers have found that foster children are discriminated against,

maltreated and exploited in their new families (Subbarao & Coury, 2004; Frolich, 2005; UNICEF, 2006). These authors found that this happens especially in poor households where resources are scarce. It is safe to deduct that foster parents in situations like this were motivated more by a sense of duty than by a willingness to foster.

iv) Foster care grant

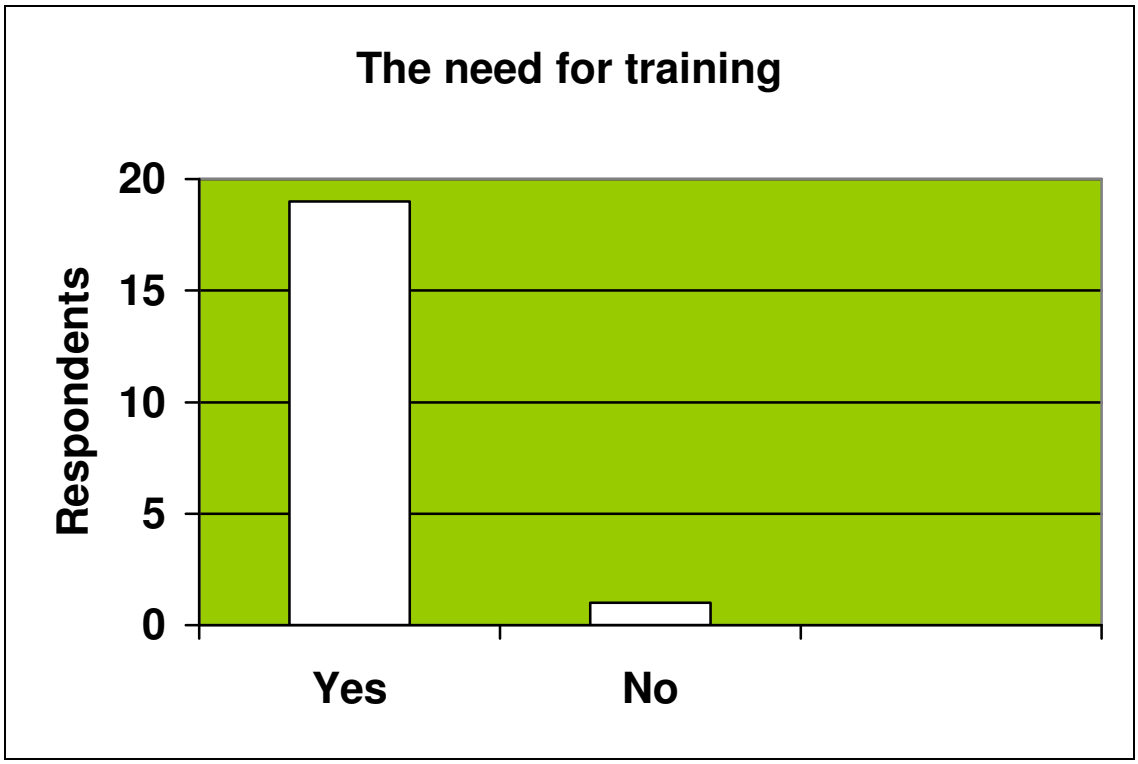
Most of the respondents (95%) indicated that aunts and uncles are motivated largely by the foster care grant. ACESS (2007) confirms that relatives are often motivated by the foster care grant. This can point to the generally held belief that the foster care system is misused by some foster parents as a poverty alleviating method (Meintjies & Van Niekerk, 2005).

5.9 The needs of foster parents

This section of the questionnaire was based on the documented need that foster parents the world over seem to have for both training and support (Durand, 2007:2).

5.9.1 Foster parents' need for training

In this section, the respondents were first asked whether they thought that foster parents needed training.



n=20

FIGURE 5.8 THE NEED FOR TRAINING

The vast majority of the respondents (19 out of 20; 95%) are of the opinion that foster parents do need training in order to care for foster children. Only one respondent said that foster parents do not need training and her reason was that "many have children....can teach you more about motherhood than you can them, but training can be useful in handling e.g. emotional problems". Table 5.12 contains the reasons that the respondents gave for their answers.

TABLE 5.12 FOSTER PARENTS NEED TRAINING IN ORDER TO CARE FOR FOSTER CHILDREN

Theme: Foster parents need training in order to care for foster children		
Sub-theme	**Categories**	**Responses of participants**
Yes, foster parents need training in order to care for foster children	To gain knowledge & information	• Do not know that background impacts on behaviour • Information on the development of children's behavioural problems • How to treat children from broken families • To learn better ways of caring for children
	For guidance and advice	• Foster children have special needs and emotional problems. Foster parents need training to help them deal with those issues and needs • They are wounded children who need emotional and physical care • Foster children need special attention and care because of origin • Because they treat foster children differently from their own
	To develop parenting skills	• Do not possess the necessary parenting skills because of a lack of education • All people always need parenting training – especially when dealing with someone else's child
	To understand the foster care system	• Legal aspects
	To understand what foster care is	• Foster parents do it for money and not for the children • Huge responsibility to take care of someone else's child – many challenges come with it; need to be informed and have training on the pros and cons

The respondents' answers all fell into five categories – Foster parents need training (1) to gain knowledge and information, (2) for guidance and advice, (3) to develop parenting skills, (4) to understand the foster care system, and (5) to understand what foster care is.

i) Training – to gain knowledge and information

The respondents indicated certain areas in which foster parents are likely to need more information once a child is placed in their care *(Do not know that background impacts on behaviour; information on the development of children's behavioural problems)*. It can be deduced from the respondents' reasons that all parents become knowledgeable about those areas which they are exposed to through parenting their own children. When a person becomes a foster parent, he/she will have to care for a child who comes from a different background, and as a result the foster parent will need information and knowledge about areas of which he/she might not have experiential knowledge *(How to treat children from broken families; to learn better ways of caring for children)*. These findings are in agreement with Hoghughi (2004:10) who identified knowledge and understanding as a prerequisite for parenting.

ii) Training – for guidance and advice

Many of the reasons that the respondents gave centred on the fact that foster children have special needs and emotional problems because of their background, and that foster parents would need training to help them handle the situations correctly, since, once again, they probably have not had to deal with similar situations previously *(Foster children have special needs and emotional problems. Foster parents need training to help them deal with those issues and needs)*. It seems from the reasons given (table 5.11) that the respondents suspect that foster parents will need more than information and knowledge – they will need to be trained in how to apply their newfound knowledge *(They are wounded children who need emotional and physical care)*. In other words, they will need guidance and advice to direct them. These findings echo Hoghughi's (2004:10) observation that both knowledge *and understanding* are prerequisites for parenting.

iii) Training – to develop parenting skills

The respondents indicated that many foster parents, as well as parents in general, lack adequate parenting skills *(Do not possess the necessary parenting skills because of a lack of education)*. The White Paper for Social Welfare (Department of Welfare, 1997:60) states that families in South Africa are facing many problems, amongst others parenting, communication and relationship problems. It can be concluded that foster parents will need training to develop their parenting skills *(All people always need parenting training…)* – it will benefit their foster children as well as their biological children.

iv) Training – to understand the foster care system

The respondents indicated that foster parents need training in order to understand the *legal aspects* of the foster care system. Triseliotis *et al.* (1995:46-47) conducted a review of foster parent training programmes the world over and found that most training programmes specifically addressed the foster care system. It is important for foster parents to understand how the system works, what they can expect of the social workers and what the social workers expect of them.

v) Training – to understand what foster care is

The findings agree with Triseliotis *et al.* (1995:42) that foster parents need full information on what it entails to be a foster parent *(Huge responsibility to take care of someone else's child – many challenges come with it, need to be informed and have training on the pros and cons)*. The respondents specifically pointed out that many foster parents are motivated by the foster care grant *(Foster parents do it for money and not for the children)*. It is thus necessary to clarify what foster care is, to dispel illusions and to try and prevent a misuse of the system.

The respondents' reasons for foster parents' need for training are very much in line with what has been written in literature (Triseliotis *et al.*, 1995; Department of Welfare, 1997; Hoghughi, 2004).

5.9.2 Topics in foster parent training programmes

The second question dealt with the respondents' experience as to the topics that the foster parents of AIDS orphans need training in. The respondents were given a table listing various topics that are included in foster parent training programmes globally

(McFadden, 1984; Children's Act, no. 38 of 2005: Section 1(1); Buehler *et al.*, 2006). The respondents were asked to choose those training-areas that in their experience the foster parents of AIDS orphans need training in.

TABLE 5.13 TRAINING TOPICS

Training topics	Number of respondents	Percentage
Development of the foster child		
Social development	**16**	84%
Moral development	**12**	63%
Emotional development	**15**	79%
Physical development	**13**	68%
Needs of the foster child		
Mental/emotional care	**15**	79%
Physical care	**14**	74%
Cultural needs	**11**	58%
Educational attainment and success	**14**	74%
Religious education and upbringing	**10**	53%
Caring for the foster child		
Using the foster grant wisely	**15**	79%
Creating a safe, secure, nurturing and stimulating home environment	**16**	84%
Building a sound relationship	**16**	84%
Ensuring the child's rights and responsibilities	**13**	68%
Dealing with the stigma and discrimination associated with HIV/AIDS	**16**	84%
Dealing with the effects of grief, bereavement and loss	**16**	84%
Recognising and dealing with internalising symptoms like depression, withdrawal and bitterness	**15**	79%
Development of the foster parent		
Growing as a foster parent	**16**	84%
Working as part of the fostering team	**14**	74%

n=19

Nineteen respondents answered this question. The respondents marked those topics that they considered important, meaning that the topics that were chosen most often were deemed to be most important.

Table 5.12 illustrates the data, showing that the respondents chose seven topics as the most important, with all seven scoring 84%. The topics are “growing as a foster parent”, “dealing with the effects of grief, bereavement and loss”, “dealing with stigma and discrimination associated with HIV/AIDS”, “creating a safe, secure, nurturing and stimulating home environment”, “building a sound relationship” and “social development”.

The topics with the lowest scores are “religious education and upbringing” (53%), cultural needs (58%) and moral development (63%).

The respondents were asked to give reasons when they felt strongly about a topic, but no reasons were given.

i) Development of the foster child

Under topics pertaining to the development of the foster child, 16 of the respondents (84%) indicated that they train foster parents on the social development of the foster child. 15 respondents (79%) gave training on emotional development. Physical and moral development received much lower scores.

Consensus exists among various authors that foster parents should be actively involved in their foster children’s development (Buehler *et al.*, 2006; Dougherty in Barbell & Freundlich, 2001). Newman and Newman (1999) call for foster parents to have an understanding of developmental stages and tasks. It is evident that the respondents are in agreement with these authors (Buehler *et al.*, 2006; Dougherty in Barbell & Freundlich, 2001; Newman & Newman, 1999) that foster parents need training to gain understanding about development in order to contribute to their foster children’s development. However, the respondents seem to place a high level of importance on only social and emotional development. McFadden (1984) specifically mentions the importance of social and emotional development as well as the importance of physical and moral development.

ii) Needs of the foster child

None of the seven topics mentioned above that scored the highest inclusion rate, falls into this category. This is surprising, since it would make sense for the needs of the foster child to form an important part of any foster parent training. The topic with the highest score in this category is the needs of the foster child regarding emotional care. 15 respondents (79%) indicated that they include this topic in their training programmes. This corresponds with the emphasis placed on AIDS orphans' emotional needs in literature (Townsend & Dawes, 2004; Richter *et al.*, 2004).

iii) Caring for the foster child

Four of the seven topics that scored the highest inclusion rate fall into this category, suggesting that the respondents emphasise caring for the foster child in their training programmes. 16 respondents (84%) prioritised dealing with stigma and discrimination and the effects of grief, bereavement and loss. 16 respondents (84%) also prioritised creating a safe, secure, nurturing and stimulating home environment and building a sound relationship. These two priority areas correlate with Hoghughi (2004), section 1(1) of the Children's Act, no. 38 of 1005 and with Swart *et al.* (2009) stating that foster parents must be equipped to deal with negative emotions and to love their foster children unconditionally.

iv) Development of the foster parent

16 respondents (84%) indicated that growing as a foster parent is an important topic to include in foster parent training programmes. Rycas and Hughes (in Buehler *et al.*, 2006) note that foster parents need a combination of skills, knowledge and interest to manage the tasks of fostering successfully. These authors (Rycas & Hughes, 1998) argue that foster parents will have basic competencies, but that there is a desired standard that should be their goal. The development of their competencies will require support, training, time and experience.

5.9.3 Foster parent support

The third question concerned their opinion on the source of the needed support. The respondents were given the following statement to consider: "Foster parents need support from their social worker as well as from other foster parents." They were asked to indicate their level of agreement. Their answers are summarised in table 5.14:

TABLE 5.14 THE NEED FOR SUPPORT FROM OTHER FOSTER PARENTS AND FROM SOCIAL WORKERS

Foster parents			Social workers		
Disagree	**Agree**	**Strongly agree**	**Disagree**	**Agree**	**Strongly agree**
0 0%	12 63%	7 37%	0 0%	11 58%	8 42%

n=19

None of the respondents (0%) disagreed with the statement. All of them (100%) felt that foster parents need support from both social workers and from other foster parents.

5.9.4 Reasons for the need for support

This question followed on the previous one, asking the respondents to elaborate on their answer. The reasons that they gave for the foster parents' need for support from both other foster parents and social workers are summarised in table 5.15:

TABLE 5.15 REASONS FOR NEEDING SUPPORT FROM SOCIAL WORKERS AND OTHER FOSTER PARENTS

Theme: Foster parents need support from social workers and other foster parents		
Sub-theme	**Category**	**Reasons**
Support from foster parents	Support through learning from people in a similar situation	• Foster parents can use the support of persons in a situation similar to theirs by learning from the mistakes of others • Support is education and building of skills. Sharing with other foster parents helps to deal with difficult cases and to learn from each other • Foster parents need all the support and encouragement they can get. Other foster parents are a great support for foster parents. They learn from one another's experiences
	Support through identifying with people in a similar situation	• Foster parents can identify with one another. Not in isolation • Foster parents have a common denominator. They can support and guide • Much strength in acquiring knowledge from someone who has the same experiences
	Continual support	• Foster parents need sustainable support • To cope with life's difficulties
Support from social workers	Support through guidance from an involved professional	• Social worker as professional can guide and facilitate the aspects of concern • Social workers can give strong guidance and monitor the child's well-being

n=18

i) Support from foster parents

The respondents indicated that foster parents gain support from other foster parents through learning from people in a similar situation, through identifying with people in a similar situation and by having a continual support system.

a) Support through learning from people in a similar situation

The respondents explained that foster parents can gain support from each other through learning from the mistakes and experiences from people in similar situations *(Foster parents can use the support of persons in a situation similar to theirs by learning from the mistakes of others).*

b) Support through identifying with people in a similar situation

According to the respondents foster parents can gain support from one another through acknowledging the common denominator *(Much strength in acquiring knowledge from someone who has the same experiences).*

c) Continual support

The respondents indicated that foster parents need a constant support system *(Foster parents need sustainable support…To cope with life's difficulties).*

The three ways in which the respondents envisioned the foster parents gaining support from one another correlates precisely with the purpose of self-help groups. According to Borkman (1999) a self-help group is a group of people **sharing a certain commonality** who come together to **learn from one another** and to **be there for one another**. Social workers can create the opportunity for foster parents to support each other in this way through the foster parent cell groups discussed in Chapter 4.

ii) Support from social workers

The respondents indicated that foster parents gain support through guidance from an involved professional.

a) Support through guidance from an involved professional

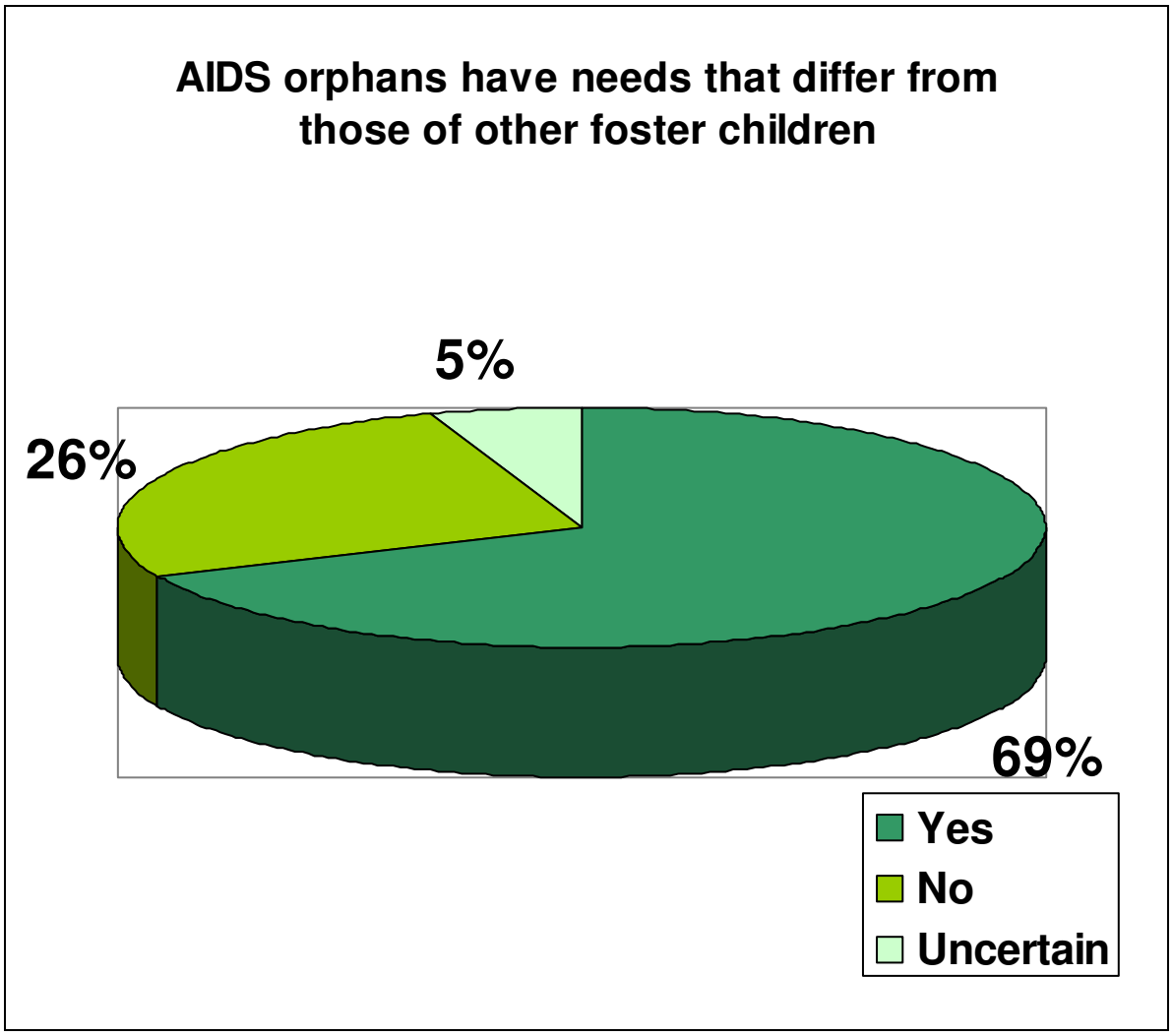
Foster parents gain support from social workers through their professional input (Philippi Trust, Undated:12) and guidance *(Social worker as professional can guide and facilitate…).*

5.10 The needs of AIDS orphans

The purpose of this section was to gain an understanding of the respondents' perception of the needs of AIDS orphans.

5.10.1 The needs of AIDS orphans as opposed to the needs of other foster children

This first question dealt with whether the respondents thought that AIDS orphans had needs that were different from those of other foster children. The respondents' answers are contained in figure 5.10.



n=19

FIGURE 5.10 AIDS ORPHANS HAVE NEEDS THAT DIFFER FROM THOSE OF OTHER FOSTER CHILDREN

Thirteen respondents (69%) stated that the needs of AIDS orphans differ from those of other foster children. Five respondents (26%) were of the opinion that AIDS orphans do not have different needs, while one respondent (5%) was uncertain. The vast majority of the respondents were thus convinced that the needs of AIDS orphans were unique. The respondents were also asked to explain their answers. Their answers are contained in table 5.16.

TABLE 5.16 REASONS FOR OR AGAINST DIFFERENT NEEDS

Theme: AIDS orphans have needs that differ from that of other foster children		
Sub-theme	**Category**	**Reasons**
Positive response	AIDS orphans have special needs	• Often accompanying long suffering and a stigmatised disease • Need more and special attention than other children • Need to understand and talk about the death of their parents as well as the trauma of seeing the suffering of their parents in the process of dying • Have the same needs, but also special emotional needs • Traumatised children who do not always understand what happened with them or their parents • They lost their parents and they have to deal more with emotional, mental and physical challenges than other children
Negative response	All children have the same needs	• Orphans all have the same needs • Just like other children • All children who are traumatised by the death of a parent have needs specific to their experiences and developmental level • Need the same attention, care, love and security • Other foster children also have emotional scars and needs. They all need love, security and a feeling of belonging

i) Positive response

Most of the respondents were of the opinion that AIDS orphans have needs that differ from those of other foster children.

a) AIDS orphans have special needs

All the reasons given had one common theme – AIDS orphans have special emotional needs *(Need more and special attention than other children)* because of the suffering of their parents in the process of dying and because of the stigma attached to the disease *(Often accompanying long suffering and a stigmatised disease)*. The uniqueness of AIDS orphans' needs is verified by literature – Subbarao and Coury (2004) state that children suffer a variety of psychosocial reactions to parental illness and death, as well to the circumstances surrounding the death. AIDS-related stigma and discrimination can aggravate these psychosocial reactions (Deacon & Stephney, 2007), leading to behavioural disturbances, internalised symptoms (Bezuidenhoudt *et al*., 2006; Richter, 2004) and a sense of worthlessness (Deacon & Stephney, 2007).

ii) Negative responses

Some of the respondents felt strongly that other foster children have the same needs as AIDS orphans.

a) All children have the same needs

These reasons also had one common theme – AIDS orphans have the same needs as other children *(Just like other children)*. All children taken from their families or whose parents died are traumatised and thus AIDS orphans are not unique *(Need the same attention, care, love and security)*. This is in opposition with research that points out that AIDS orphans have different needs than other children have (Subbarao & Coury, 2004; Richter, 2004; Bezuidenhoudt *et al*, 2007; Deacon & Stephney, 2007).

5.10.2 Needs unique to AIDS orphans

The respondents were asked to list those needs that they have been able to identify and regard as unique to AIDS orphans. As a guideline, they were given four areas – school, family, personal, other.

Certain themes emerged from their answers in the four areas. The findings are presented in table 5.17 according to common themes.

TABLE 5.17 UNIQUE NEEDS OF AIDS ORPHANS

Theme: Unique needs of AIDS orphans		
Sub-theme	**Category**	**Responses of the respondents**
School	**Vision for the future**	• Need to have a dream for the future • Chances for higher education and development needs attention
	Difficulties with school work	• Late entering school • Sometimes they are not up to standard with their school work; parent was not able to give the necessary support; had to stay out of school sometimes to care for parents and other children • They learn slowly
	Stigma	• Want to be accepted by the learners and teachers • Children don't always admit that their parents died of HIV/AIDS (scared of being stigmatised)
Family	**Stigma**	• Family often label them as HIV positive
	Belonging	• Great need for belonging and acceptance • Want to be part of a family • Often feel like they do not fit in • Extended family are sometimes not aware of what happened – leads to a lack of support • Some foster families dishonour the parents in the presence of the child • Important to them
	Role models	• Need positive role models and a feeling of belonging • No father role models
Personal	**Belonging**	• Support and belonging • A lot of love and belonging • Has difficulty to form a sense of belonging
	Grief and bereavement	• Need to grieve and get inner healing • Emotional feelings that did not receive attention

n=10

i) School

Three themes emerged in the respondents' answers – AIDS orphans need to have a vision for the future, which implies that they often do not have such a vision, AIDS orphans often experience difficulties with their school work and they are often the victims of stigma. These themes are very much in agreement with research done on AIDS orphans. With regards to school problems, UNICEF (2006:22) wrote that the children of HIV positive parents are less likely to attend school than the children of HIV negative parents plus their school performance deteriorates during the parent's illness. Home circumstances like caring for a sick parent, financial struggles and hunger are common causes of poor school performance and drop-out (Richter, 2004:11; Bezuidenhoudt *et al.*, 2006:20). UNAIDS (2006:21-22) also found that school performance worsens after a child orphaned. Reasons for this are, not enough money to pay school fees, children need to work to contribute to the family's income or new caregivers do not see the child's education as a priority. Stigma also has an effect on schooling (The International HIV/AIDS Alliance, 2003c:5); because children orphaned by AIDS often stay away from school for fear of being stigmatised. Stigmatisation leads to, amongst other things a fear of the future (Richter *et al.*, 2004:10) and fatalism (Deacon & Stephney, 2007:20). Fatalism is defined by Garbarino, Dubrow, Kostelny and Purdo (in Bowman, 1999:182) as futurelessness or terminal thinking. In other words – no vision.

ii) Family

The respondents' answers had another three themes in common – stigma, belonging and role models. Orphans are frequently stigmatised by their family members or members of the community who are uneducated about HIV/AIDS and wrongly assume that the child is also HIV positive because his/her parents died of AIDS. The writings of Richter (2004:12) confirm this. The respondents noted that AIDS orphans need role models and a feeling of belonging. Corcoran and Nichols-Casebolt (2004:212) conducted extensive research on risk and resiliency and developed a Risk and Resiliency Ecological Framework. Many of the protective factors that they identified have the same core as the need for role models and belonging, for instance, attachment, involved father figures and caring neighbours. Protective factors can protect a child against risk (Corcoran & Nichols-Casebolt, 2004:212).

iii) Personal

Two themes surfaced in the respondent's answers to what needs they could identify in this area. The first one is again belonging, and the second one is grief and bereavement. AIDS orphans need to go through a process of grief and bereavement. The respondents specifically identified it as a need of these children, suggesting that this need is not always met. One of the most important ways of meeting this need is to create the opportunity for the child to talk openly and freely about the deceased parent (Bauman & Germann, 2005). The secrecy surrounding HIV/AIDS can make it difficult for children to mourn openly (Bauman & Germann, 2005: 123). This potential for stigma and discrimination could be a contributing factor to this unmet need. When grief cannot be openly acknowledged and socially supported, it can lead to a state of disenfranchised grief (Doka, 1994) which is a primary risk factor for poor adjustment after the loss of parents (Cook *et al.*, 2003:88).

5.10.3 Thoughts, feelings, behaviour and reactions experienced by AIDS orphans

The purpose of this question was to investigate whether the respondents agreed with the psychosocial effects that parental illness and death by AIDS have on AIDS orphans as identified in literature (Alliance, 2003c:7; Richter, 2004:12; Foster, 2006:700; Bezuidenhoudt *et al*, 2006:18; UNICEF, 2006:24). They were given a table listing some of the most common of these psychosocial effects. The psychosocial effects were divided into four categories according to the way they manifest in a child's life. The categories were thoughts, feelings, psychosocial reactions and behaviour. The respondents had to choose those psychosocial effects that they have noted in the AIDS orphans they have worked with. Their answers are contained in table 5.18.

TABLE 5.18 PARTICULAR THOUGHTS, FEELINGS, BEHAVIOUR AND REACTIONS IN AIDS ORPHANS

Thoughts	**Number of participants**	**Percentage**
Suicidal thoughts	1	7%
Rumination	2	13%
Feelings		
Anxiety	4	27%
Emotional distress	9	60%
Low self-esteem	10	67%
Lack of confidence	9	60%
Bitterness	3	20%
Guilt	2	13%
Fear	9	60%
Psychosocial reactions		
Depression	7	47%
Chronic stress	2	13%
Behaviour		
Withdrawal	7	47%
Anger	8	53%
Denial	7	47%
Decreased motivation	4	27%
Increased passivity	5	33%
Acting out	9	60%
Aggressive coping styles	8	53%
Reduced capacity for affection and compassion	4	27%

n=15

For clarity's sake, the psychosocial effects are rearranged in table 5.19, from most to least prevalent.

TABLE 5.19 PSYCHOSOCIAL EFFECTS IN ORDER OF PREVALENCE

Psychosocial effect	Respondents	Percentage
low self-esteem	10	67%
emotional distress; lack of confidence; fear; acting out	9	60%
anger; aggressive coping styles	8	53%
depression; withdrawal; denial	7	47%
increased passivity	5	33%
anxiety; decreased motivation; reduced capacity for affection and compassion	4	27%
Bitterness	3	20%
rumination; guilt; chronic stress	2	13%
suicidal thoughts	1	7%

n=15

Ten of the respondents (67%) indicated that low self-esteem is the most prevalent psychosocial effect that they have noted in the AIDS orphans that they work with. Nine respondents (60%) identified emotional distress, lack of confidence, fear and acting out as the second most common psychosocial effects. Eight respondents (53%) have often come across anger and aggressive coping styles in AIDS orphans. This paints the picture of children who are afraid, unsure of themselves, filled with negative feelings and who are hiding it behind anger, aggression and misbehaviour. The remaining psychosocial effects have been noted by less than half of the respondents (<50%). It can be deduced that they are not so common.

i) Thoughts

Only one respondent (7%) has come across suicidal thoughts in the AIDS orphans he/she work with. Two respondents (13%) have noted rumination or "running thoughts" in the children they know that have been orphaned by HIV/AIDS. Richter (2004:23) attributes rumination to loss, separation and bereavement – it is one of the associated psychological conditions. Apparently the respondents do not detect psychosocial effects manifesting as negative thoughts among AIDS orphans.

ii) Feelings

Low self-esteem is the most common psychosocial reaction identified by the respondents. Emotional distress, lack of confidence and fear are second most prevalent. All these factors have been attributed to stigma in literature (Deacon *et al*., 2007; Deacon & Stephney, 2007). Since these four psychosocial reactions are commonly come across by the respondents, it can be assumed that the AIDS orphans are being stigmatised.

iii) Psychosocial reactions

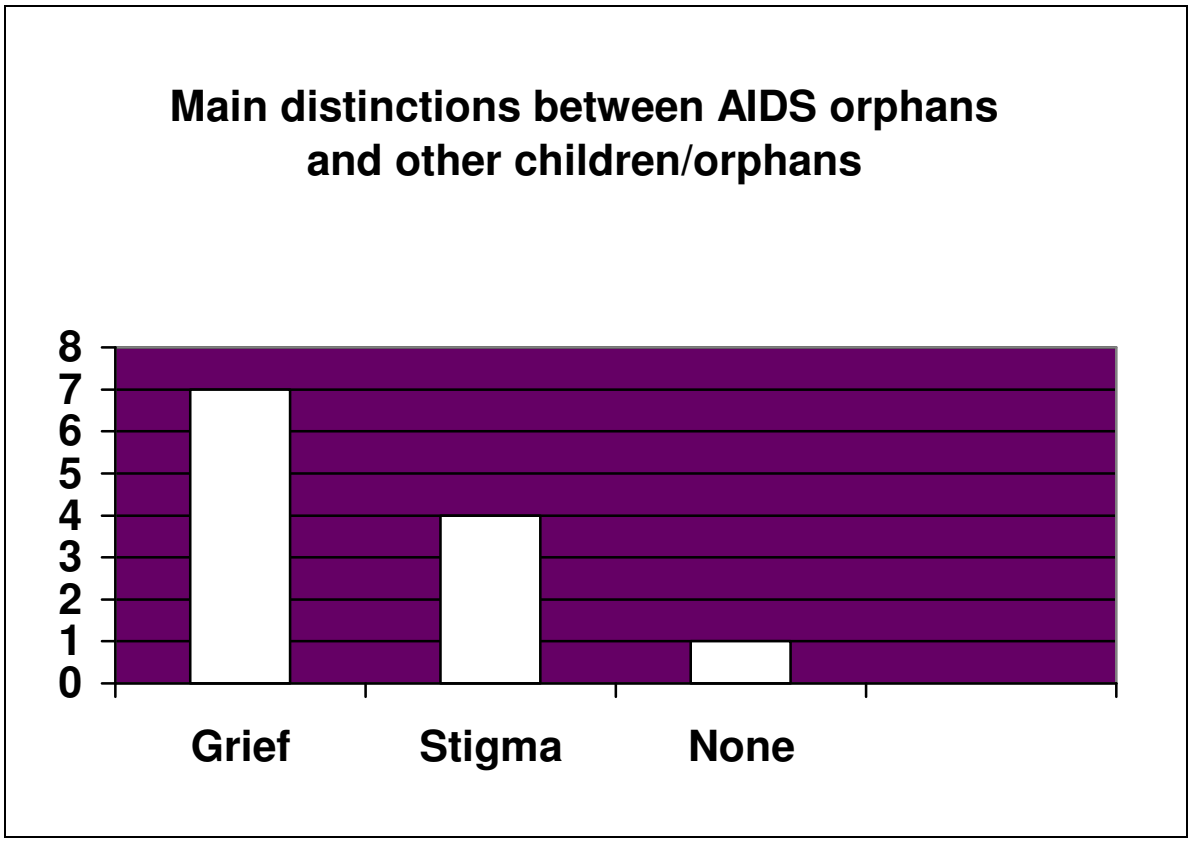
The respondents identified depression as the most common psychosocial reactions they have come across. Depression is linked to loss, separation and bereavement by Richter (2004:23). It is evidence of poor adjustment after the loss of the parent – reasons for this poor adjustment include a lack of social support, bereavement overload, secondary losses and concurrent stressors (Cook, Fritz & Mwonya, 2003:88).

iv) Behaviour

Three types of behaviour have been noticed by more than 50% of the respondents, namely anger, acting out and aggressive coping styles. Richter (2004:23) states that cruel and impersonal childcare are associated with poor adjustment in children orphaned by AIDS. When AIDS orphans are subjected to cruel and impersonal childcare, they are likely to exhibit externalising symptoms like anger, acting out and aggressive coping styles (Richter, 2004:24). There is evidence in literature that AIDS orphans are subjected to cruel and impersonal childcare in the new households that they join (Subbarao & Coury, 2004; Frolich, 2005; UNICEF, 2006). The fact that the respondents often come across these types of behaviour in the AIDS orphans they work with, is a reason for concern.

5.10.4 The difference between AIDS orphans and other children/orphans

The respondents were asked to point out what they thought the main distinctions were between AIDS orphans and other children/orphans. Figure 5.11 graphically illustrates their answers.



n=12

FIGURE 5.11 MAIN DISTINCTIONS BETWEEN AIDS ORPHANS AND OTHER CHILDREN/ORPHANS

Twelve respondents answered this question. Seven of them (58%) felt that the **grief** and accompanying factors surrounding parental death by AIDS were the main distinction between AIDS orphans and other children/orphans. Four respondents (33%) were of the opinion that **stigma** was the main differentiating factor; while one respondent (8%) said that there is no difference between an AIDS orphan and other orphans/children. [Rounding explains the fact that the percentages do not add up to 100%.] It is very significant that 92% of the respondents chose either grief or stigma as the main distinction. No other factors were mentioned. In section 5.7.2, the respondents also made mention of the unique needs of AIDS orphans and they particularly mentioned grief and stigma as two reasons for the foster parents of AIDS orphans to have special training.

i) Grief

Most foster children will probably be traumatised and experience grief due to the loss of their biological families – whether through the death of their parents or through being removed from their families. However, the grief that AIDS orphans experience is exacerbated by the circumstances prior to the parent's death, like having to watch the parent suffer for a long time before dying from a stigmatised disease. The stigma associated with HIV/AIDS increases the likelihood of persistent and unresolved grief (Pivnick & Villegas, 2000:103).

ii) Stigma

Because HIV/AIDS is a highly stigmatised disease, the children of parents who died of HIV/AIDS are likely to be stigmatised and suffer discrimination. If a child is stigmatised, there is likely to be a psychosocial effect on the child by causing internalised conditions like fear, fatalism, internalised stigma and behavioural disturbances (Deacon & Stephney, 2007:20). When stigma becomes internalised it has an even deeper impact on the child by causing low self-esteem and self-doubt; and it could lead to self-stigmatisation (Deacon & Stephney, 2007:6). AIDS orphans are differentiated by the probability of stigma, because other foster children are not likely to be exposed to it to the same extent.

5.11 Challenges

The respondents were asked to identify the main challenges that they are experiencing within the foster care system and when offering training and support to foster parents. Their answers are depicted in table 5.20.

5.11.1 Main challenges in the foster care system in South Africa within the context of HIV/AIDS

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TABLE 5.20 MAIN CHALLENGES IN THE FOSTER CARE SYSTEM IN SOUTH AFRICA WITHIN THE CONTEXT OF HIV/AIDS

Theme: Main challenges in the foster care system in South Africa within the context of HIV/AIDS		
Sub-Theme	**Categories**	**Responses of participants**
Limited resources	Fitting foster families	• People don't usually want to care for AIDS orphans on a long-term basis • To have the appropriate family for foster care placement • Not enough families
	Lack of social workers	• To have enough social workers to do the task • Not enough preventative services • Too many children to be placed in foster care • No proper supervision of placements
	Financial challenges	• The foster care grant does not make provision for the child's special needs • Financial support • Expensive to the taxpayer
	High caseloads	• High caseloads of orphans • Big general caseloads
	Operational challenges	• To assimilate the foster child into the foster family • Language barrier, time, money, some government officials and social workers with no compassion

n=16

Table 5.19 contains the main challenges that the respondents are experiencing within the foster care system in South Africa within the context of HIV/AIDS. Five common themes have emerged from their responses.

i) Fitting foster families

The first theme was that the respondents find it difficult to find a fitting foster family for an AIDS orphan. Their responses ranged from unwillingness on the part of potential foster parents *(People don't usually want to care for AIDS orphans on a long-term basis)* to the availability of foster parents *(To have the appropriate family for foster care placement; Not enough families).* The traditional first choice for foster parents of AIDS orphans was aunts and uncles, followed by other family members (Subbarao & Coury, 2004:28). Many research studies have found that the extended families are saturated and will not be able to keep on taking in orphans (Booysen & Arnst, 2002:172; Derbyshire & Derbyshire, 2002:2; Townsend & Dawes, 2004:71). The fact that respondents are finding it difficult to find willing foster families might be indicative of this saturation. Two other reasons could be the stigma attached to HIV/AIDS and that potential caregivers are themselves dying of AIDS (International HIV/AIDS Alliance, 2003a:5; UNICEF, 2006:17).

ii) Lack of social workers

The second theme that emerged was the lack of social workers. The respondents' responses centred on the size of the task *(To have enough social workers to do the task; Too many children to be placed in foster care)* and the results of too few social workers *(Not enough preventative services; No proper supervision of services)*. Research supports the fact that there are too few social workers (Magome, 2008) to handle the high caseloads (Meintjies & Van Niekerk, 2005:2) and as a result, not enough services are being rendered to foster parents (NWSSDF, 2007a:2).

iii) Financial challenges

The third theme pertained to financial challenges. The respondents indicated that foster care was a financial burden to the foster parents *(The foster grant does not make provision for the child's special needs)* and to the South African citizens *(Expensive to the taxpayer)*. Currently, the foster care grant is R680 per month per foster child (Manuel, 2009). That amount can hardly be expected to extend beyond the child's basic needs. More and more families are coming to rely on the grants and there is the danger

that some families view the foster care grant as a poverty alleviating measure (Meintjies & Van Niekerk, 2005:2), which would be a misuse of taxpayer money.

iv) High caseloads

The respondents stated that high caseloads are a big challenge to them within the foster care system. The NWSSDF (2007a:2) note that social workers do not have the time to do anything else than process children through the children's courts and Meintjies and Van Niekerk (2005:2) observe that the numbers of foster care applications are exceeding the social workers' capacity to process, monitor and support all the foster care cases.

v) Operational challenges

The respondents reported experiencing many operational challenges, ranging from challenges with the foster care process *(To assimilate the foster child into the foster family)*, to concrete challenges with the day-to-day execution of tasks *(Language barrier, time, money, some government officials and social workers with no compassion).* These concrete challenges are personal experiences of the respondents; however, the time-challenge has often been mentioned in literature (NWSSDF, 2007a:2). One reason for the indicated challenge of assimilating the foster child into the foster family might be the fact that social workers do not have the time to adequately support and train the foster parents after a child has been placed with them (Delport *et al.*, 2008:314).

5.11.2 Main challenges to training foster parents

TABLE 5.21 CHALLENGES TO TRAINING FOSTER PARENTS

Theme: Challenges to training foster parents		
Sub-theme	**Category**	**Responses of participants**
Challenges	Training attendance	• Not all foster parents are open to training after the children's court inquiry has been finalised • Many foster parents are already employed, and cannot always attend training sessions • The foster fathers are not always available or involved • Commitment • Supporting the training • Full co-operation • Motivation • Foster parents don't always show up for training/support groups
	Training content	• Personal hygiene, ways of life and certain cultural and religious beliefs that you cannot change
	Limited resources	• High caseloads • Time • Money

n=15

Three themes stood out among the challenges pertaining to foster parent training that the respondents listed – training attendance, training content, limited resources.

i) Training attendance

The respondents experienced foster parents as lacking in commitment, co-operation and motivation when it came to attending training *(Not all foster parents are open for training after the children's court enquiry has been finalised)*. Some foster parents are also unable to attend training that is scheduled during office hours because of work responsibilities. There is a disparity between the respondents' experience and research studies in which foster parents have indicated that they have a need for training (Durand,

2007:2). If foster parents had such a need, it makes sense that they would make use of opportunities to meet the need. One explanation might be that training is not presented in a way that resonates with them. Combining training and support might be an answer. Contracting with foster parents before placement could also be a means to breach this problem.

ii) Training content

The respondents identified sensitive training content as another challenge to training. The respondents indicated that culture, religion and hygiene are sensitive topics to broach during training *(Personal hygiene, ways of life and certain cultural and religious beliefs that you cannot change)*.

iii) Limited resources

Limited resources like time, money and manpower pose a challenge to the respondents when they want to implement training programmes. There are too few social workers and their caseloads are too high to render all the necessary services to their clients (NWSSDF, 2007a:2). Social workers do not have the time for in-depth services like post-placement training (Delport *et al*., 2008:314).

5.11.3 Main challenges to supporting foster parents

TABLE 5.22 CHALLENGES TO SUPPORTING FOSTER PARENTS

Theme: Challenges to supporting foster parents		
Sub-theme	**Category**	**Narrative responses of participants**
Challenges	Foster parent attendance	• Co-operation – coming for all appointments • The foster parents are not always available due to working circumstances • Lack of co-operation from foster parents – as soon as they receive the grant, they disappear
	Limited resources	• Caseloads are still to large to be able to give appropriate attention to all foster care cases • Time • Regular contact • Money • Support groups • Teamwork • Too few social workers with HEART • Not enough therapeutic services available for foster parents and foster children • Not enough resources available to social workers

n=17

The respondents identified various challenges to supporting foster parents. The two themes that emerged from their responses corresponded with the challenges to training foster parents. The two themes pertained to **foster parent attendance** and **limited resources**.

i) Foster parent attendance

The co-operation and availability of foster parents *(Lack of co-operation from the foster parents – as soon as they receive the grant they disappear)* makes it difficult for the respondents to support the foster care placements. The same disparity exists here, as it

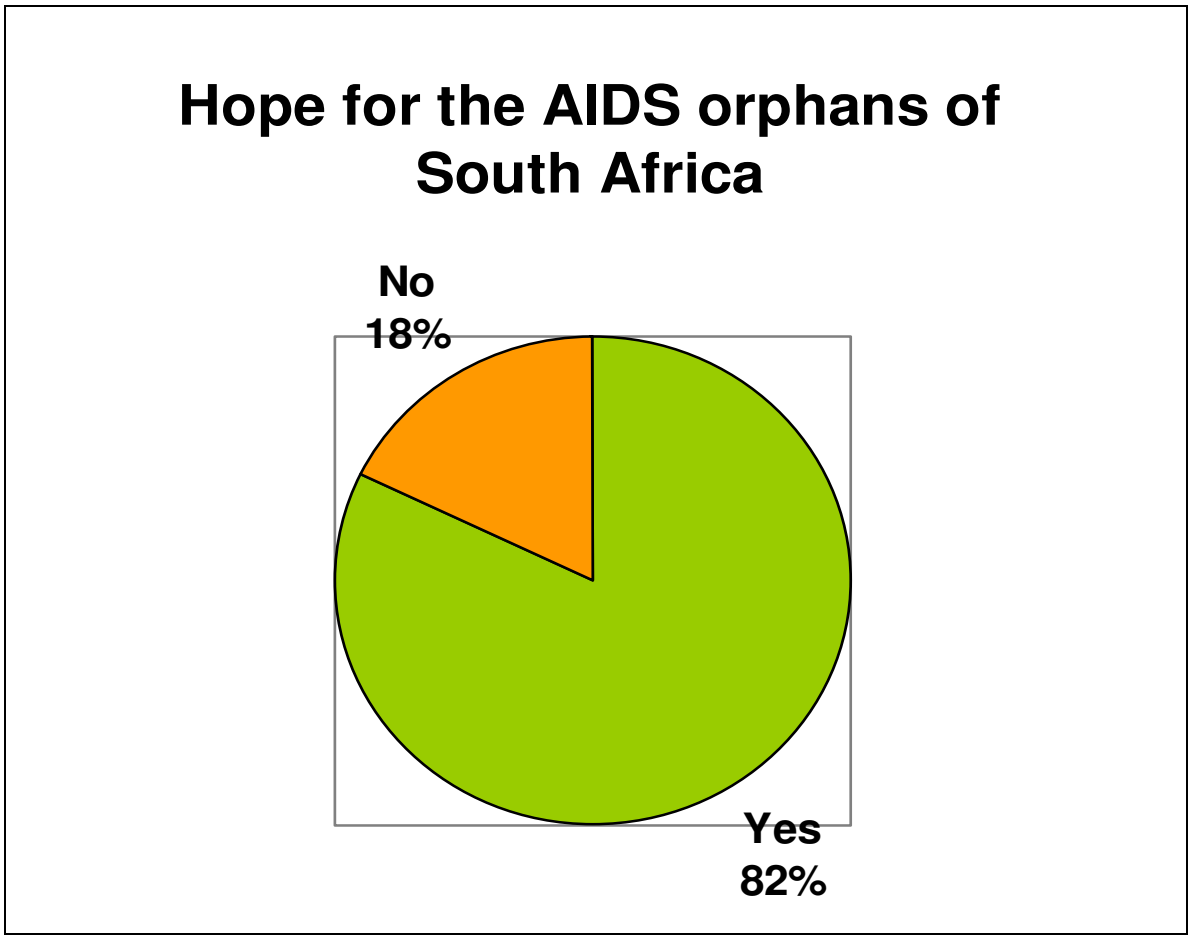
does with foster parents' reluctance to attend training. If the foster parents had the need for support that literature says they have (Durand, 2007:2), it is surprising that they do not give their co-operation. If literature correctly identified their need, there must be other factors at play.

ii) Limited resources

The respondents indicated that large caseloads *(Caseloads are still too large to be able to give appropriate attention to all foster cases)*, few services available and a lack of time and money make it difficult for them to support foster parents. Delport *et al.* (2008) also found limited resources, especially limited time, as a major stumbling block in the way of training foster parents.

5.11.4 Hope

To end this section as well as the questionnaire, the respondents were asked whether they have hope for the children in South Africa who have been orphaned by HIV/AIDS. Their answers are graphically illustrated in figure 5.12 and the reasons that they gave are portrayed in table 5.23.



n=17

FIGURE 5.12 HOPE FOR THE AIDS ORPHANS OF SOUTH AFRICA

Fourteen respondents (82%) stated that they do have hope for the AIDS orphans of South Africa. Only three respondents (18%) declared that they do not have hope. The respondents without hope did not give any reasons.

TABLE 5.23 REASONS FOR HOPE

Theme: Reasons for hope		
Sub-theme	**Category**	**Reasons**
Love will conquer all	Love and care will lead to positive development	• With the right care and support they will develop into well-balanced adults, and they will break the cycle of AIDS • With the understanding and love of a substitute carer, these children can develop positively
	There are people willing to love and care for foster children	• There are still parents who care about other people's children • The extended families are accepting the challenge and responsibility

n=17

It is very encouraging that 82% of the respondents still have hope for the current situation in South Africa regarding AIDS orphans and foster care, despite all the daily challenges and struggles that they face. Hope is defined by TheFreeDictionary (2010: http://www.thefreedictionary.com/Hope) as "the theological virtue defined as the desire and search for a future good, difficult but not impossible to attain with God's help".

The respondents' reasons ranged from a belief that love and care will lead to positive development *(With the understanding and love of a substitute carer, these children can develop positively)*, to the conviction that there are still people who are willing to love and care for foster children *(There are still parents who care about other people's children)*. All the reasons they gave for their hope reflected a commonly-held belief – "love will conquer all'. The reason for their hope seems to be that they cling to the belief that goodness will triumph. This reason for hope is also recorded in Psalm 27:13:

"I would have lost heart unless I had believed that I would see the goodness of the Lord in the land of the living."

5.11.5 Summary

This chapter contains the results of an empirical study that was carried out through asking 20 social workers from four NGOs in two provinces to complete a questionnaire. The questionnaire contained both open- and closed-ended questions.

The purpose of this chapter was to gain an understanding of social workers' experiences in the foster care system in South Africa within the context of HIV/AIDS. There was also a specific aim to investigate how and to what extent social workers are equipping (training and supporting) foster parents to parent AIDS orphans.

The chapter followed the outline of the questionnaire and covered the profile and background of the respondents – the size of their caseloads, how long they have been working and for which organisation. The respondents' implementation of the foster care process and foster parent training was also considered. An understanding was sought as to the "kind" of foster parents who parent AIDS orphans and therefore enquiries were made about the prevalence of certain people to act as foster parents, the motivations of foster parents and the extended family's ability to care for AIDS orphans. Emphasis was further placed on the needs of foster parents and AIDS orphans and the challenges that the respondents face while facilitating foster care.

It was found that the respondents' answers reflected current literature in many instances. This lends validation to the generalisation of certain findings.

In Chapter 6 the conclusions that were reached based on the empirical and literature study will be presented. Recommendations will also be offered, based on the conclusions, in an effort to provide guidelines for social workers for the equipping of foster parents to parent AIDS orphans in South Africa and within the context of HIV/AIDS.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The **goal** of the study was to shed light on the needs of children orphaned by AIDS as well as on the training and support that their foster parents will need, in order to provide guidelines for equipping foster parents to care for AIDS orphans. Except for the last part, this goal was achieved in the previous chapters of the study. The purpose of this chapter is to meet the final objective of the study, which is to come to conclusions and make recommendations based on the results of the literature review and the empirical study, that can be used as guidelines when equipping foster carers to parent AIDS orphans.

6.2 Conclusions and recommendations

The following conclusions and recommendations are based on the findings of the study.

6.2.1 Profile of the respondents and background

The respondents were mostly experienced social workers who worked for four different, established NGOs in the Western Cape and in KwaZulu-Natal. The 20 respondents had a collective caseload of 3122.5, of which 1862 were foster cases. Of these foster care cases, 640 involved AIDS orphans.

It can be concluded that because the social workers have high caseloads, they do not have enough time to render in-depth services.

Recommendation:

- Social workers should consider using other methods such as group work that is less time consuming, together with case work.

6.2.2 The foster care process

The steps of the foster care process and the outcomes of foster care placements were investigated in this study. The findings show that pre- and post-placement training are the least likely steps of the foster care process to be followed. The second least likely step is matching of the foster child with the prospective foster family. The respondents explained their omission of these steps by stating that they do not have enough time, orphans are already living with the prospective foster parent, information is conveyed

informally, foster parents give little co-operation and the social workers have big caseloads.

When training is done through the informal conveyance of information it results in a lack or non-use of a formal foster care programme. When foster parents give little co-operation, it might be as a result of inadequate contracting. It suggests that the foster parents are not aware of what is expected of them.

Most of the respondents indicated that they do support the foster parents. However, the meaning of this statement is completely dependent on each respondent's definition of what constitutes support.

Matching between the foster parent and the foster child is the second least likely step of the foster care process to be followed. When matching does not happen, it can result in an unsuccessful placement, especially in the absence of training and support.

It can be concluded that a lack of resources (time, human resources), and a lack of structure in the intervention process are the main stumbling blocks to implementing all the steps of the foster care process.

With regards to the common outcomes of foster care placements, the respondents indicated that placement failure is very rare, while successful placements are common. For one respondent however, placement failure was a regular occurrence. Adoption is indicated to be very rare. Successful placements merely become permanent placements, maybe for fear of losing the foster care grant or because of cultural issues. The downside of a permanent placement is that it remains the responsibility of the social worker to support the placement.

It can therefore be concluded that adoption is underutilised while successful foster care placements become permanent placements, continuing the strain on social workers and the foster care system.

Recommendations:

- Social workers should employ foster parent cell groups to train and support foster parents, because the support and training (pre- and post-placement) of foster parents are very important. The lack of resources that seems to prevent its proper implementation can be combated by social workers finding a way to render these services in a resource-friendly manner.
- Social workers should create structure in the way that the foster care process is facilitated. One way of doing this is to contract with prospective foster parents from the first contact so that they are completely aware of what is expected of them. The contract can stipulate, for example, that the foster parents are required to attend a foster parent cell group as well as how often it will take place. If they do not agree with the conditions, then placement is not possible. If they fail to adhere to the terms of the contract after the placement has been finalised, then the placement will be terminated. These are extreme measures, but the well-being of the child is at stake.
- Social workers should enforce matching between the child and the foster family. If the applicant does not meet the requirements for a foster parent, then the social worker must try and find alternative placement – preferably regardless of whether the child is already staying with the applicant. If it is not possible, a strict contract must be drawn up.
- Social workers should promote adoption by non-relatives in order to lessen the burden on social workers and the foster care system.

6.2.3 Foster parent training

All the respondents agreed that foster parents need special training in order to parent AIDS orphans successfully, and that AIDS orphans are unique – with specific reference to the circumstances leading to their orphanhood and to their special needs.

It can be concluded that foster parents need to be informed about and prepared for the uniqueness of an AIDS-orphan foster child and they need to be guided to meet the child's needs resulting from this uniqueness.

The respondents were also largely in agreement about training topics for foster parents that have been identified internationally in research studies. All the respondents

indicated that they include information about the foster care system and about grief, bereavement and loss as experienced by the foster child in their training programmes. Most of the respondents found another five topics very important. These topics are the role of the foster parents, the role of social workers, the impact of fostering on the fostering family, knowledge and understanding of HIV/AIDS and managing difficult behaviour of the foster child.

It can be concluded that South African foster parents have the same training needs as foster parents in other countries. Therefore research done on this topic in other countries will also be applicable for South African foster parents.

With regards to the form of their training programmes, it became clear that most of the respondents make use of case work and individual guidance, followed by group work, to do training. Training seems to happen on average twice per year and the respondents make use of input from professional people, printed handouts, videos and formal foster care programmes.

It can be concluded that social workers are using case work that is very time consuming, to do training irrespective of the fact that they are pressured for time. **It can further be concluded** that, even though social workers are also making use of group work, it is not done in such a way that the frequency of training is increased.

Recommendations

- Social workers should move away from case work as a means for training foster parents.
- Social workers should move away from formal training sessions – it is unnecessarily resources intensive.
- Social workers should use foster parent cell groups as a way of doing group work because it is both resource-friendly and self-sustainable.
- Social workers should offer training to foster parents more often.
- Social workers should use foster parent cell groups to employ the experiential knowledge of the foster parents as a training resource.

6.2.4 Profile of the foster parents

It was found that the most prevalent foster parents for AIDS orphans are their grandparents, followed by aunts and uncles and then siblings. Non-relatives are the least likely foster parents.

It can be concluded that families are still managing to care for their family members who are orphaned. The burden however, is falling more and more on the grandparents, because aunts and uncles are not willing or able to take in more children. **It can further be concluded** that non-relatives are under-utilised as foster parents.

Most of the respondents are of the opinion that the extended families do not have the ability to care for all their family members who might be orphaned by AIDS. It contradicts the fact that most AIDS orphans are currently being cared for by family members. **It can be concluded** however that the social workers have become aware that the extended families will soon reach their saturation point.

Family obligation is the main motivation for fostering AIDS orphans. This can be both positive and negative – it is positive if the foster parents want to take care of their family, but negative if they do it because they have to. The foster care grant is also a major motivation that can once again be positive if the foster parents know that they need the money to care for the child, but negative if they care for the child because they want the money. Non-relatives on the other hand are likely to be motivated by a desire to help children.

Recommendations:

- Social workers should recruit non-relatives to foster AIDS orphans by tailoring recruitment strategies to address the desire to help children.
- Social workers should encourage and facilitate custody planning so that a relationship can be formed between the child and the future foster parent before the biological parent dies.
- Social workers should offer training and support to grandparents who become foster parents because of their need for support and training from the social worker and other foster parents.

- Social workers should make an effort to understand the prospective foster parents' motivation for fostering during screening, to determine what the effect will be on the child.

6.2.5 The needs of foster parents

Most of the respondents indicated that foster parents do have a need for training. From the reasons given it can be concluded that foster parents need training for guidance and advice, to gain knowledge and understanding, to develop parenting skills, to understand the foster care system and to understand what foster care is.

The findings concur with international research studies about the topics that foster parents need training in. **The conclusion can be reached** that all foster parents have the same basic training needs. International research done in the field of foster parenting will therefore be applicable to foster parents in South Africa.

All the respondents said that foster parents need support from social workers and from other foster parents. From these findings **it can be concluded** that foster parents gain support from other foster parents through learning from people in a similar situation, through identifying with people in a similar situation and through having a continual support system. Foster parents also gain support from social workers through the professional guidance that they can provide.

Recommendations:

- Social workers should find a way to train and support foster parents.
- Social workers should use research that has been done in the field to guide them when training and supporting foster parents.
- Social workers should place an emphasis on equipping foster parents to see to their foster children's moral development, cultural needs and religious education and upbringing, since the findings indicate that these topics are the least likely to be included by the respondents in a training programme.
- Social workers should begin to make use of foster parent cell groups. It offers a way of supporting and training foster parents that allows them to identify with and learn from one another while forming a continual support system. These cell

groups also offer social workers the platform to give professional guidance and input.

6.2.6 The needs of AIDS orphans

Most of the respondents were in agreement that AIDS orphans have needs that are different from those of other foster children. When considering these findings, **the conclusion can be reached** that AIDS orphans have special needs and need special attention because of the emotional distress and trauma caused by their parents' illness and death and the associated stigma.

AIDS orphans have unique needs. The respondents identified some of these needs with regards to their education and families as well as to the AIDS orphans personally. AIDS orphans need a vision for their future, they have difficulty with their school work and they are being stigmatised at school. Within families they can also suffer from stigmatisation; they have a strong need to feel that they belong and there is a lack of role models in families to guide them toward healthy adulthood. Personal needs of AIDS orphans relate to the need for belonging and for dealing with grief and bereavement as well as with feelings of rejection and loss.

It can be concluded that these needs are a direct outflow of their parents' illness and death and that this makes them different from other foster children, obliging their foster parents to receive special training to meet their special needs.

Agreement exists between the findings of the study and international research studies that identified the psychosocial effects of parental death by AIDS on their children. **It can be concluded** that this research will prove a valuable tool that social workers can use in their work with AIDS orphans and their foster parents.

The respondents were all in agreement about the difference between AIDS orphans and other orphans/children, and based on their reasons **it can be concluded** that the main distinction between AIDS orphans and other children/orphans is the grief that they go through and the probability of being stigmatised and discriminated against.

Recommendations:

- Foster parents should be equipped by social workers to guide the AIDS orphans in their care through the grieving process.
- Foster parents should be offered the opportunity to debrief by social workers because it will be emotionally taxing to facilitate the grieving process. Foster parent cell groups create the space where they can debrief among people who can identify with what they are going through.
- Community projects should be used to deal with the unique needs of AIDS orphans.
- Social workers should use research as guidelines to meet the needs of AIDS orphans.

6.2.7 Challenges

The respondents listed many challenges that they face in the foster care system and when training and supporting foster parents. **It can be concluded** that their main challenges are a lack of resources, a lack of co-operation from the foster parents and the content of training programmes. The majority of respondents indicated however that they still have hope for the AIDS orphans of South Africa.

Recommendations:

- Social workers should find resource-friendly ways of equipping foster parents through training and support to parent AIDS orphans.
- Social workers should focus on formally contracting with prospective foster parents to try and avoid co-operation problems later on.
- Social workers should make use of the literature in the field of foster care as well as the experiential knowledge of the foster parents, to overcome the problems that training programme content can cause.

6.3 Future research

In view of the results of this study, it is recommended that further research regarding foster care for AIDS orphans should focus on:

- The practical application of foster parent cell groups
- The recruitment and use of non-relatives as foster parents for AIDS orphans
- Establishing community projects that could meet the needs of AIDS orphans.

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ANNEXURE A: QUESTIONNAIRE

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

SEMI-STRUCTURED QUESTIONNAIRE

Foster care of AIDS orphans: Social Workers' Perspectives

All the information recorded in this questionnaire will be regarded as confidential. Individual views or respondents' names will not be made known.

FOR THE PURPOSES OF THIS STUDY, AN "AIDS ORPHAN" REFERS TO A CHILD WHOSE PARENT(S) DIED OF HIV/AIDS. THE CHILD IS NOT NECESSARILY INFECTED WITH HIV.

Instructions

There are four types of questions in this questionnaire:

1. Yes/no questions – the respondent chooses between yes and no, and in some cases it is requested that the respondent explains his/her answer.

2. Scaling questions – the respondent indicates the level of his/her agreement with a particular statement.

3. Lists – the respondent is given a number of possible answers to a question and is requested to choose the answers that are applicable to the respondent's situation.

4. Open-ended questions – the respondent is asked to answer a question in his/her own words. Answers will vary from one word to a paragraph.

The first three types of questions needs to be answered by marking the chosen answer **with an "x"**.

All the places where a longer answer is required are indicated **with an arrow**.

---

1. Profile of respondent

1.1 How long have you been a social worker?

➔ _____

1.2 Please indicate the area in which you work

➔ _____

2. Background

2.1 How big is your caseload?

Mark with an "x"	Size of caseload
	1 – 20
	21 – 50
	51 – 100
	101 – 150
	151 – 200
	200 +

2.2 How many of these cases are foster care cases?

➔ _____

2.3 How many of your foster care cases involve AIDS orphans?

➔ _____

3. The foster care process

3.1 The following list contains the steps in the foster care process.

(i) Choose from the list the steps that you usually follow, by marking it with an "x".

(ii) If there are certain steps that you **do not follow**, please give the reason in the column on the right.

Mark with an "x"	Steps in the foster care process	Reason
	Recruitment	
	Preparatory training	
	Assessment	
	Matching	
	Placement	
	Post-placement support	
	Post-placement training	
	Permanency planning	

3.2 The following table contains some of the possible outcomes of a foster care placement in terms of the Children's Amendment Act no. 41 of 2007.

(i) Please indicate with an "x" how often each one is the outcome of a foster placement where the foster child is an AIDS orphan:

Outcomes	Never	Rarely	Often	Always
Placement failure				
Permanent placement or continuous renewal of placement *[Section 186 of the Children's Amendment Act no. 41 of 2007]*				
Adoption				

4. Foster parent training

4.1 Consider the following statement:
"Foster parents of AIDS orphans need special training to meet the AIDS orphans' special needs"

(i) Please indicate your level of agreement with an "x":

Disagree	Slightly disagree	Strongly Agree

4.2 Please explain and motivate your answer:

➔ _____

_____

_____

_____

4.3 The following list contains topics that you are possibly including in the training that you provide to the foster parents of AIDS orphans (regardless of whether it differs from the training that you provide to other foster parents).

(i) Please indicate which of these topics you cover when training these foster parents.

(ii) If you include topics in your training that is not mentioned here, please list them underneath the table.

Mark with an "x"	Training topics
	*The foster parent as **PARTNER***
	The foster care system
	Working and planning in a team
	The role of foster parents
	The role of social workers
	*The foster parent as **PARENT** to biological children*
	The impact of fostering on the fostering family

	*The foster parent as **FACILITATOR***
	The role and significance of the child's birth family and origins
	*The foster parent as **CARER***
	Knowledge and understanding of HIV/AIDS
	Dealing with grief, bereavement and loss as experienced by foster child
	Dealing with stigma and discrimination as experienced by foster child
	Child development
	Building self-esteem of foster child
	Building a caring relationship with the foster child
	Socialisation of the foster child
	Managing difficult behaviour of the foster child
	Awareness of the symptoms of child sexual abuse

Other topics:

➔ _____

_____

_____

4.4 Please give a detailed explanation of

(i) the social work intervention method you use to do the training (e.g. case work, group work or community work)

_____

_____

_____

(ii) how you train the foster parents

_____

_____

_____

(iii) how often training takes place

_____

_____

_____

iv) resources and teaching aids that you use for training

_____

_____

_____

5. Profile of the foster parents

5.1 Please rate the following list from 1 to 5 to indicate who the most prevalent foster carers of AIDS orphans are **(1 = most prevalent)**.

Rating	Foster carer options
	Non-relatives
	Grandparents
	Aunts and uncles
	Siblings
	Other relatives

5.2 Do you think that extended families will be able to take in and care for all the AIDS orphans?

Yes	No

Please explain your answer

➔ _____

_____

_____

5.3 The following tables contain four motivations for fostering that has been identified by research studies.

(i) Please indicate how you regard the motivations of the different foster carers, by marking it with an "x"

The motivation for fostering AIDS orphans are:

	NON-RELATIVES			GRAND-PARENTS			AUNTS AND UNCLES			SIBLINGS		
	Disagree	Agree	Strongly Agree	Disagree	Agree	Strongly Agree	Disagree	Agree	Strongly Agree	Disagree	Agree	Strongly Agree
Personal fulfilment												
Desire to help children												
Sense of family obligation												
Foster care grant												

6. The needs of foster parents

6.1 Do you feel that foster parents need training in order to care for foster children?

Yes	No

Please explain your answer:

➔ _____

_____

6.2 The following list contains various topics that have been included in foster parent training programmes all over the world.

(i) Choose from this list those areas which your experience has taught you that the foster parents of AIDS orphans need training in.

(ii) If you feel strongly about some of the topics, please elaborate on your reasons for including them.

Mark with an "x"	Training topics	Reasons
	Development of the foster child	
	Social development	
	Moral development	
	Emotional development	
	Physical development	
	Needs of the foster child	
	Mental/emotional care	
	Physical care	
	Cultural needs	
	Educational attainment and success	
	Religious education and upbringing	
	Caring for the foster child	
	Using the foster grant wisely	
	Creating a safe, secure, nurturing and stimulating home environment	
	Building a sound relationship	
	Ensuring the child's rights and responsibilities	
	Dealing with the stigma and discrimination associated with HIV/AIDS	
	Dealing with the effects of grief, bereavement and loss	
	Recognising and dealing with internalising symptoms like depression, withdrawal and bitterness	
	Development of the foster parent	
	Growing as a foster carer	
	Working as part of the foster care team	

6.3 Consider the following statement:
"Foster parents need support from their social worker as well as from other foster parents".

(i) Please indicate your level of agreement with an "x":

	Disagree	**Agree**	**Strongly agree**
Foster parents			
Social workers			

6.4 Please explain and motivate your answer:

➔ _____

_____

_____

_____

7. The needs of AIDS orphans

7.1 Do AIDS orphans have needs that are different than that of other foster children?

Yes	**No**	**Uncertain**

Please explain your answer:

➔ _____

_____

_____

_____

_____

7.2 In your work with AIDS orphans, you have probably been able to identify various needs that are rather unique to them. Using the following list as a guideline, what needs, in relation to the areas mentioned below, have you been able to identify through working with these children?

➔ School:

_____

_____

➔ Family:

_____

_____

➔ Personal:

_____

_____

➔ Other:

_____

7.3 Which of the following thoughts, feelings, behaviour and reactions have you noted in the AIDS orphans that you work with?

Mark with an "x"			
	Thoughts		***Psychosocial reactions***
	Suicidal thoughts		Depression
	Rumination		Chronic stress
	Feelings		***Behaviour***
	Anxiety		Withdrawal
	Emotional distress		Anger
	Low self-esteem		Denial
	Lack of confidence		Decreased motivation
	Bitterness		Increased passivity
	Guilt		Acting out
	Fear		Aggressive coping styles
			Reduced capacity for affection and compassion

7.4 What do you think are the main distinctions between AIDS orphans and other children/orphans?

➔ _____

_____

_____

8. Challenges

8.1 What are the main challenges that you experience in the foster care system in South Africa within the context of HIV/AIDS?

➔ _____

_____

_____

8.2 What are the main challenges to training foster parents?

➔ _____

_____

_____

8.3 What are the main challenges to supporting foster parents?

➔ _____

_____

_____

8.4 Do you have hope for the children in South Africa who have been orphaned and affected by HIV/AIDS?

➔ _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE!