

The Capacity Needs of Extended Family and Community Members in
the Care and Support of Orphans and Vulnerable Children in
uMgungundlovu and uThukela districts

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DECLARATION

Submitted in partial fulfilment of the requirements for the degree of Master of Social Science (Psychology), in the Graduate Programme in Counselling Psychology, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I, Vusumuzi M. Penyane, hereby declare that:

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DEDICATION

This work is dedicated:

- To my late mother, Pauline S. Mbatha, who sacrificed so much for me; my uncle Bernard M. Phenyane, my sister Bhesana Sibisi, nieces, nephews and cousins; and the Mbatha and Phenyane's families.
- Missionary Oblate of Mary Immaculate; and
- Friends and Umndeni Oyigwele Catholic Parish.

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ABSTRACT

The aim of this study was to explore and describe experiences and capacity needs of extended family and community members that care for and support orphans and vulnerable children (OVC) in UMgungundlovu and uThukela districts. This study was qualitative in nature and was guided by bio-ecological theoretical framework. Purposeful sampling was used to recruit 45 participants. Semi-structured interviews were conducted with four focus group discussions. Data was analysed using Interpretative Phenomenology Analysis. The results indicate that the capacity needs of extended family and community members to care for OVC was remarkably weak; OVC caregivers face numerous challenges such as providing basic material needs, educational needs and emotional needs albeit with limited financial and emotional support. Government social grants were identified as the main source of income although they were regarded as grossly insufficient. The study found that motivation to care for OVC for extended family was based on responsibility embedded in traditional childcare arrangement, while for community members emanated from love and compassion. The study further highlighted ways in which extended family and community members would like to be assisted in order to strengthen their capacity to care for and support OVC. This study provide firstly a new perspective on what it means to be an OVC caregiver and secondly a baseline for further studies to be pursued on a larger scale in the majority, if not all provinces of South Africa.

Key words: extended family, community members, capacity needs, orphans and vulnerable children

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Chapter 1

Introduction

1.1 Introduction and Background to the Study

2.01 million orphans were reportedly in South Africa by 2011 (StatsSA, 2011), most of them as a direct result of HIV/AIDS. These orphans have basic needs such as food, clothing and shelter which must be met. The Gap Report published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2014 reported that, at the end of 2013, there were 35 million people living with HIV and the majority of those affected are aged between 15 years and older. Of the 35 million people living with HIV, 24.7 million are living in sub-Saharan Africa, the region hardest hit by the epidemic. Of the 24.7 million in Sub-Saharan, South Africa account for 18% of people living with HIV in the region and it has largest number of people living with HIV; and there were 1.5 million AIDS-related deaths and sub-Saharan Africa accounted for 74% of all AIDS-related deaths. HIV/AIDS prevalence rate in South Africa in 2014 was 29%, based on those who attended ante-natal clinics across the country. In the same period under review, the HIV/AIDS prevalence rate in uMgungundlovu and uThukela districts were 40.1% and 39% respectively, above the national prevalence rate (Department of Health, 2012).

HIV/AIDS has become a critical challenge facing the world. South Africa, in particular the province of KwaZulu-Natal, has not been spared from this challenge, recording one of the highest infection rates in the country (Department of Health, 2012). HIV/AIDS is reconfiguring family units more than the apartheid system. Child-headed households, youth-headed households, houses headed by grandparents and street children are the results of HIV/AIDS (Foster, 2004). As one or both parents die, children are faced, not only with the emotional trauma of losing parents, but also their uncertain future (Foster, 2004). Children are left at the mercy of extended family and community members, and at times they struggled alone without help from external help (Foster, 2004).

AIDS-related deaths have resulted in a numbers of orphans and vulnerable children (OVC), especially in KwaZulu-Natal, and a majority of OVC were cared for and supported within families and communities (Madhavan, 2004; Nyasani, Sterberg, & Smith, 2009; Phiri & Tolfree,

2005; Richter & Desmond, 2008; Richter et al., 2009; Tamasane & Head, 2010; UNAIDS, UNICEF, & USAID, 2004). The extended family and community members are the solution to OVC problem and demands placed by HIV/AIDS related-deaths (Littrell, Murphy, Kumwenda & Macintyre, 2012), and are willing to care for OVC and to create a protective environment for OVC and other children (Abebe & Aase, 2007; Chirwa, 2002; Madhavan, 2004).

The extended family and community members that provide care for OVC are faced with numerous challenges that are political and economic in nature (Department of Welfare, 1997). The White Paper on Social Welfare Service in South Africa (Department of Welfare, 1997) in its situational analysis on social and economic impact on families, noted problems and challenges faced by families. It noted that families are affected by social, economic and political policies of the past. Apartheid policies such as influx control and lack of housing, redefined household structures in South Africa. It further acknowledged that a major contribution to family problems and breakdown in family functioning is increasing economic stress and poverty facing households. It acknowledged that families also face internal family problems such as alcohol and drug abuse, communication and relationship problems, parenting problems, lack of family and community support networks, and housing.

However, faced with such a situation, several authors (Abebe & Aase, 2007; Chirwa, 2002; Foster, 2004; Madhavan, 2004; Mathambo & Gibbs, 2009) have argued that the extended family and community members are losing battle to HIV/AIDS and collapsing; they cannot cope with the demand currently placed on them by childcare due to AIDS (Mathambo & Gibbs, 2009). Families are disintegrating and child care, of especially orphans, is not assured (Ayieko, 1997; Mathambo & Gibbs, 2009). Contrary to this, other authors (Foster, Levine & Williamson, 2005; Madhavan, 2004; Nyamukapa & Gregson, 2005 as cited in Mathambo & Gibbs, 2009) have argued that the extended family and community members are not losing the battle to HIV/AIDS but can continue to absorb and care for OVC. However, it is worth noting that families and communities still and will continue to care and support orphans as they have done it before the HIV/AIDS crisis (Abebe & Aase, 2007; Madhavan, 2004; Mathambo & Gibbs, 2009). Indeed, the family structure is changing and adapting to broader social and economic shifts (Mathambo & Gibbs, 2009); orphans are living in, or with, extended families (Ansell & Young,

2004; Foster, Makufa, Drew & Kralovec, 1997; Foster, Makufa, Drew, Mashumba & Kambeu, 1997; Foster, 2000; Malinga, 2002; Ntozi, 1997; UNICEF, 2003; Urassa et al., 1997 as cited in Freeman & Nkomo, 2006); and roles and responsibilities are being rearranged (Kuo & Operario, 2009).

Due to the high rate of HIV/AIDS in South Africa and the increasing number of orphans, the extended family and community members that care for OVC face an increasingly high level of poverty and the huge negative effect of socio-economic problems, such as an inability to provide material needs to OVC and the inability to find employment (Nyasani et al., 2009). Challenges faced by OVC and interventions directed towards orphans are well documented, however, little has been documented concerning capacity needs of extended family and community members that care for OVC (Kiggundu & Oldewage-Theron, 2009; Nyanisa et al., 2009). This study therefore seeks to explore and understand in depth the capacity needs of extended family and community members that provide care to OVC in uMgungundlovu and uThukela districts.

1.1.1 Research Field

This research was conducted at uMgungundlovu and uThukela districts, KwaZulu-Natal as these districts are severely affected by HIV/AIDS and other socio-economic problems such as unemployment. uMgungundlovu has a million inhabitants (StatsSA, 2011) and predominantly urban. It is the economic hub of KZN because of its status as the capital city. It is located in the south-western region of KZN. uMgungundlovu district comprises seven municipalities. It has the highest HIV prevalence rate of 40.7% in 2012, above the provincial and national average (Department of Health, 2012). In 2012, an estimate of 6.1 million South Africans were living with HIV and 240, 000 people in South Africa were dying of AIDS-related illnesses (UNAIDS, 2013)

UThukela district has ten municipalities and is located in the western boundaries of KwaZulu-Natal. It is predominately rural, with three of the five municipalities, rural based. It has high unemployment rate. It has a HIV prevalence rate of 39% in 2012, above the provincial and national average (Department of Health, 2012). The two districts were chosen in the hope that

they will offer diverse and rich experiences of extended family and community members' involvement in the care and support of OVC.

1.2 Motivation for the Study

The author, as a priest and a social worker, has vast experience of working with extended family and community members particularly those that provide care and support to OVC. The author observed from families, especially in his own family, the challenges and problems surrounding care and support of OVC; and that families had to provide care to orphans, although unprepared for such responsibility. The vast body of literature have documented and investigated the experiences of orphans living with kinship (Perumal, 2011; Govender, Penning, George & Quinlan, 2011; Hearle & Ruwanpura, 2009), and in this study it became necessary to explore in depth the experiences of extended family and community members that care and support OVC, especially their capacity. Therefore the aim of this study is to explore the capacity needs of extended family and community members that provide care for and support OVC. The researcher, after observing the phenomena of caring and supporting OVC, hypothesised that the capacity to care for OVC is weak and remain financially and emotionally unsupported.

1.3 Aims and Rationale of the Study

The study sought to explore the experience of the extended family and community members that care for and support OVC. Therefore, it has two aims: (a) to explore and describe experiences and capacity of extended family and community members that care for OVC in uMgungundlovu and uThukela districts and (b), to make recommendations to decision makers on designing and developing interventions that would assist extended family and community members that provide care and support to OVC.

This study seeks to inform all stakeholders on the capacity needs of extended family and community members that care for OVC. This study argued that extended family and community members remain psychologically and socially unsupported, and have been overlooked in AIDS policies because literature, as well as policy and programs, have focused overwhelmingly on children, outside the context of their families and communities. Few systematic efforts have documented the experiences and lessons learned regarding extended family and community

members' ability to provide care to OVC (Foster, 2004; Kiggundu & Oldewage-Theron, 2009; Nyanisa et al., 2009). Research on this topic is sporadic and scanty and because of this, little is known about the capacity needs of extended family and community members that provide care to OVC. This thesis tries to bridge the gap and provide information from perspective of extended family and community members that provide care and support to OVC of how they want to be assisted.

1.4 Objectives of this Study

Objectives of the study were:

- to explore reasons extended family and community members assume responsibility to provide care to OVC;
- to explore challenges and coping resources for extended family and community members that provide care and support to OVC;
- to explore support systems available to extended family and community members that provide care and support to OVC;
- to explore capacity needs of extended family and community members that provide care and support to OVC in uMgungundlovu and uThukela districts; and
- to make recommendations based on findings of this study on interventions that can be undertaken in order to assist extended family and community members that provide care and support to OVC.

1.5 Research Questions

Research questions for this study were:

- What are the experiences of extended family and community members that provide care and support to OVC in uMgungundlovu and uThukela districts?
- What are the capacity needs of extended family and community members that provide care and support to OVC in uMgungundlovu and uThukela districts?
- What are the challenges and coping mechanism of extended family and community members that provide care and support to OVC?

- What are the physical and emotional issues that extended family and community members are experiencing?

1.6 Methodology

1.6.1 Research design.

A qualitative research design was adopted in this study because it guides researcher in collecting, analysing and interpreting observed phenomena. Qualitative research refers to any type of research that produces findings not arrived at by statistical procedures or other means of quantification (Creswell, 2013) and it is concerned with exploring and describing phenomena as experienced by individuals (Smith & Osborn, 2003). It allows for a greater in-depth investigation and understanding of individual human experience (Creswell, 2013). This design is therefore deemed suitable to investigate the capacity needs of extended family and community members that provide care for and support OVC, because little is known about their experience and informants are believed to have rich experience of caring for OVC.

1.6.2 Population and sample.

Population is understood as being the large pool of cases from which a sample is drawn (Durrheim & Painter, 2006). The population for this study was drawn from members of extended families and communities that provide care and support to OVC. Non-probability purposive sampling was used to recruit participants. Durrheim and Painter (2006) defined non-probability sampling as any kind of sampling where the selection of elements is not determined by the statistical principle of randomness. Purposive sampling is based on careful selection of cases that are typical of population that is being studied. The advantage of purposive sample approach is that people who are knowledgeable about the subject are recruited so that they can share their experiences. The extended family and community members were purposefully selected because they are increasingly caring for OVC.

1.6.3 Data collection.

Data was collected using focus group interviews. Focus group is a general term given to a research interview conducted with a group of people who share a similar experience, and it allows people with similar experience to be brought together for guided interview on a specific

topic (Kelly, 2006). The method was employed because multiple voices can be studied at one sitting and participants could remind each other of important events (Wilkinson, 2003).

1.6.4 Instrument of data collection.

A semi-structured interview schedule was employed. This technique is used to elicit from participants rich and detailed data, and it helps to enter as far as possible the psychological and social world of participants (Creswell, 2013). It also allowed the researcher and participants to engage in a dialogue where initial questions were modified in the light of participants' response (Creswell, 2009; Smith & Osborn, 2003).

1.6.5 Data analysis.

Interpretative Phenomenology Analysis (IPA) was utilized in this study. IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences and their personal and social world (Smith, Flowers & Larkin, 2009). It is concerned with the lived experiences through sharing and talking to people experiencing particular phenomena. This approach was chosen because the researcher was not only interested in describing in detail the lived experiences of people but also what meaning people attach to these experiences.

1.7 Definition of Terms

1.7.1 Extended family.

The White Paper on Families in South Africa (Department of Social Development, 2012) defines the extended family as “a multigenerational family that may or may not share the same household” (p. 3). Richter and Desmond (2008) argue that the relationship between members of the extended family is clearly defined and there is a long term commitment among members; members have mutual obligations and responsibilities towards each other and they share a sense of togetherness. Therefore, in this thesis, “extended family” will be defined as a multigenerational family that may or may not share the same household where relationships between members are clearly defined; there is a long term commitment; and members have mutual obligations and responsibilities towards each other.

1.7.2 Community members.

“Community” is defined as a group of people who relate to each other as members living and belonging in a specific geographical area (SADC, 2008). The Oxford dictionary defines “community” as a social group of any size whose members reside in a specific locality, share government and often have a same cultural or historical heritage. Notwithstanding, the SADC definition will be adopted for this study.

1.7.3 Orphans and vulnerable children.

1.7.3.1 Orphan.

Literature defines an orphan as a child below the age of 18 years who has lost one or both parents to HIV/AIDS (SADC, 2008; UNAID, UNICEF, & USAID, 2004; USAID & UNICEF, 2004). There appears to be a discrepancy in how the local and the international society use the terms OVC. Sessions (2006) argued that, internationally, the term sometimes refers only to children with increased vulnerabilities because of HIV/AIDS and other times it refers to all vulnerable children, regardless of the cause; while locally, it describes mainly the socio-economic status of children who have lost one or both of their parents, due to various causes (Abebe, 2005; Foster et al., 2005; Freeman & Nkomo, 2006; Tamasane & Head, 2010). An orphan in this study is defined as a child below the age of 18 years who has lost one or both parents to HIV/AIDS.

1.7.3.2 Vulnerable children.

The *Policy Framework for Orphans and Other Children Made Vulnerable by HIV/AIDS in South* (Department of Social Development, 2005) defined vulnerable children as “children whose survival, care, protection or development may be compromised, due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights” (p. 8). In this study, “vulnerable children” will mean children whose developmental has been compromised due to conditions beyond their circumstances.

1.8 Structure of the Thesis

Chapter 1 contains the introduction and background, motivation, aims and rationale, objectives, key research questions, methodology, as well as definitions of terms. Chapter 2

contains a review of literature on the research topic. It presents the theoretical framework underpinning the study, and it presents a review of literature on extended family and community members that care for and support OVC, motives to provide care and support to OVC, capacity needs of extended family and community members, and coping resources, as well as government response and intervention. Chapter 3 outlines the research methodology employed for this study. It includes the research design, sampling method and sampling procedures, data collection, data analysis, and ethical considerations. Chapter 4 presents the results of this study. Chapter 5 discusses the results as well as limitations of this study. Finally, chapter 6 presents conclusions and recommendations for possible interventions.

1.9 Conclusion

In conclusion, this chapter laid the foundations for this thesis. It introduced the research problem and research questions. The aims and objectives of this study were presented, as well as brief account of methodology and definitions of terms. On these foundations, this thesis can now proceed to explore the capacity of extended family and community members to care for OVC.

Chapter 2

Literature Review

2.1 Introduction

This chapter explores the body of literature around the research topic. This chapter also presents the theoretical framework guiding this study, the overview of the traditional caring arrangement among African families, motives to provide care and support to OVC, capacity to care for OVC, coping resources and government support system.

By the year 2011, there were reportedly 2.01 million orphans in South Africa (StatsSA, 2011) and the majority of these orphans were cared by their immediate and extended families or communities (Madhavan, 2004; Phiri & Tolfree, 2005; Richter & Desmond, 2008; Richter et al., 2009). The extended family absorbs these orphans, despite limited resources and lack of external support (Madhavan, 2004; Richter et al., 2009). The advantage of caring for orphans within the family is that it allows OVC to live as part of the family (Kuo & Operario, 2009).

However, recently, South Africa has aligned itself with the ideology that children are better cared for by the family or community (Department of Social Development, 2012). This chapter explores research that has been carried out in areas such as care within the extended family and community and how the South African government has supported families and communities that care for OVC. The literature review sets the context for this thesis in that it is clear that very little qualitative research has been carried out concerning the capacity needs of extended families and communities that provide care and support to OVC.

2.2 Theoretical Framework

The bio-ecological theory of Bronfenbrenner is the theoretical framework that guided this study. Bronfenbrenner's (1979, 2005 as cited in Swick & Williams, 2006) bio-ecological perspective offers an insightful lens for enhancing an understanding of the experiences of extended family and community members that care for OVC and it is inclusive of all of the systems in which families are enmeshed because it reflects the dynamic nature of actual family relations. This approach emphasizes the multiple contextual influences on human behaviour and the concept of reciprocating between the individual and the environment (Hill & Madhere, 1996;

Whittaker, Schinke & Gilchrist, 1986). It is also based on the idea of empowering families through understanding their strengths and needs because extended family and community members, although they continue to provide care to OVC, are struggling, and, in other cases, are disrupted.

Four defining properties of the model are presented: (i) Process: It includes the forms of interaction that take place between individuals and environment called proximal processes; (ii) Person: includes the individual biological, temperamental, intellectual and personality characteristics of the child and significant others in the child's life, such as parents, caregivers and educators; (iii) Context: Includes families, communities, cultures and ideologies; and (iv) Time: takes into account changes that occur over time. It has five basic systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 2005).

The microsystem focuses on the individual's needs, problems and strengths. It consists of the child's most immediate environment (physically, socially and psychologically) and stands as the child's venue for initially learning about the world (Berk & Churchill, 1996). In the interrelations of a child with family, the child develops trust and mutuality (Pipher, 1996 as cited in Swick & Williams, 2006). The family is clearly the child's early microsystem for learning how to live. In this study, the microsystem includes OVC, siblings and the household where OVC reside.

The mesosystem consists of the linkages that exist between two or more micro systems in which a child plays an active role (Berk & Churchill, 1996). It includes the extended family and relatives, schools, teachers, work groups, other social groups. However, in order for families to flourish and offer the best care, 'community' must become a concrete reality for young children and their parents (Pipher, 1996 as cited in Swick & Williams, 2006) and this will lead to having loving adults beyond parents who engage in caring for orphans. The relationships or the lack thereof, within the mesosystem will become apparent in this study.

The exosystem includes social settings that influence children's development but in which they do not play an active role. This could include health and welfare services as well as informal

social networks that may provide support and possibly financial assistance to extended family and community members (Berk & Churchill, 1996). An example of an exosystem is support groups that are informally formed to support caregivers.

The macrosystem consists of cultural beliefs, laws, societal values, customs and resources, and focuses on the social, political and economic conditions, and policies that affect people's overall access to resources and quality of life (Berk & Churchill, 1996). It influences what, how, when and where people carry out their relations (Bronfenbrenner, 2005 as cited in Swick & Williams, 2006). Without an umbrella of beliefs, services, and supports for families, children and their parents are open to great harm and deterioration. Cultural beliefs and legislation that govern the care and support of children will be apparent in this study.

The chronosystem consists of the historical context as it occurs within the different systems (Bronfenbrenner, 1989). For example, the history of relationships in families may explain more about parent-child relations than is evident in existing dynamics. Another example is the powerful influence that historical influences in the macrosystem have on how families can respond to providing care to OVC. These systems or environments are defined as including "not only actual situations in which one finds oneself but also includes socio-cultural and socio-economic events that shape the psychosocial context within which one lives. These events include such things as the general political climate of the day, the socio-economic status of one's concepts "person" and "environment" were inseparable and that behaviours must be viewed within the person-environment interaction.

The bio-ecological theory is useful for this study because it attempts to view and appreciate extended family and community members and OVC in their interaction with the environment. Extended family and community members and OVC are viewed in transition with the environment (McKendrick, 1990). Caregivers and OVC do not exist in isolation but they interact with many systems within their environment and in turn are influence by these systems. This theory proposes that a more encouraging and nurturing environment will have a positive effect on the development of a child because it accommodates a broad spectrum of problems and needs, that OVC caregivers faces in their interaction with the environment. Whittaker, Schinke &

Gilchrist (1986) outlined the value of this paradigm in designing service programmes for children, and how various forms of environment help in designing and increasing social support

This model allows not only the researcher but all stakeholders to assess the family's functioning at various levels and identify the strength and supportive nature of each family that provides care and support to OVC (Swick & Williams, 2006). Therefore, this approach will assist in examining the capacity needs of extended family and community members that provide care and support to OVC, and view resources available to them.

2.3 Traditional Caring Arrangement Among African Families

2.3.1 Overview of caring of orphans within the extended family.

Caring for orphans before the advent of HIV/AIDS was a normal activity and was governed by cultural norms. The study conducted by Oleke, Blystad and Rekdal, (2005) gives examples of how childcare would customarily be arranged in the event of parents' death. It was the older brother/sister of a deceased parent that was customarily obligated to take primary responsibility to provide care to his/her deceased brother/sister's children. The capacity of that person to provided care or support to an orphan was not considered. The main motivation of this childcare arrangement was to keep a child within the family (Abebe & Aase, 2007; Foster, 2004; Madhavan, 2004). This customary obligation does not take into account financial situation of each family in determining who should care for orphans.

Children were also sent to families that were better off either financially or materially, so that they could benefit from skills transfer or could obtain education (Abebe & Aase, 2007; Oleke, Blystad and Rekdal, 2005). For example this was a case in Ethiopia where children who were not necessarily orphaned or impoverished were sent to live with relatives (Abebe & Aase, 2007). Likewise, Oleke, Blystad and Rekdal (2005) give an example of children in Uganda who were cared for by the extended family because they belonged to a lineage or kinship group. This kind of caring offered many kinds of opportunities like strengthening social and kinship ties and children were not cared for in this way on a permanent basis (Oleke, Blystad and Rekdal, 2005).

In South Africa, Madhavan (2004) asserts that the situation of caring was different due to apartheid. He argued that apartheid resulted in the breakdown of African family structures due to migration and forced segregation both in rural and urban areas. Migration of males to mines severely disrupted family life, resulting in children being cared for by extended families (Madhavan, 2004). This further disrupted the capacity for extended families to care for orphans. Extended families, during this time, performed a crucial role in caring for all children, including orphans, with or without external support.

Caring for orphans today has changed. Some caring today is due to ‘crisis-led caring’ (Madhavan, 2004) due to HIV/AIDS, where members of the extended family find themselves caring for and supporting OVC without any financial, physical or psychological support. HIV/AIDS seems to have wiped out the nuclear family, and extended families or communities are the first line of defence in caring for orphans (Foster, 2004). HIV/AIDS knows no limitation or financial resources; some families lack the financial capacity to care for orphans but they continue to welcome AIDS orphans so as to keep children within a family environment (Foster et al., 2005). It is often the family that is not financially and materially well off that is willing to care for OVC and its capacity is already weak (Abebe & Aase, 2007).

Finally, it is clear that caring for children, whether orphans or not, before the advent of HIV/AIDS was geared to benefit children and families. The extended family has played a role of caring for children including orphans since the beginning and there was a strong support system that existed within families and communities. No child or family went hungry and the needs of children or orphans were fulfilled by the extended family or communities. Even today families and communities continue to care and support OVC although HIV/AIDS has disrupted the very structure that care and support children.

2.3.2 Overview of care by community members.

Given the situation of extended family caring for orphans described above, community members were also found to play a pivotal role in caring for orphans. Care and support of orphans by community members before the advent of HIV/AIDS was geared to support children and strengthen community ties rather than haphazardly responding to the HIV/AIDS crisis (Phiri

& Tolfree, 2005). Families formed close knit communities that cared for and supported each other especially during difficult times, and communities spontaneously joined together to support and assisted orphans. Community response to orphans crisis can be divided into two categories, that is, formal (foster care homes) and informal (indigenous or grassroots responses). Formal categories are financially supported by outside agencies such as NGOs, international development agencies and governments. They depend on outside donors for their assistance, and they will continue to assist OVC as long as they get funding. Once funding dried out, their assistance also stops (Phiri & Tolfree, 2005). However, Thomas and Mabusela (1991, as cited in Madhavan, 2007) accused apartheid of directly breaking down the community structures and with it, the capabilities of providing proper care for non-biological.

Grassroots responses by community members focus on different crises such as providing shelter, clothes and food for children who are orphaned. For example, communities have traditional voluntary associations that provided essential support to families in time of need. Phiri & Tolfree (2005) argued that the voluntary associations, such as burial societies, grain loan schemes, self-help groups, labour sharing groups, and stokvels offered a short term relief to OVC. They continue to assert that these associations were poor people's insurance policies. Communities also provided moral and material support, not only to orphans, but to all community members (Phiri & Tolfree, 2005). Urbanisation and technology have reconfigured informal structures and have ceased to exist in most communities.

Informal groups observed and monitored the well-being of OVC. These groups understood the psychosocial and emotional distress of the time and how children coped with these challenges. They frequently visited OVC or families that were struggling with daily necessities such as food. They provided space and opportunity for spiritual, emotional and cultural support (Phiri & Tolfree, 2005). Spiritual exercises such as prayer, scripture reading, and praise songs provided a powerful support to children who were parentless and members of extended family that cared for and supported OVC. The caring for children including orphans was a community affair, rather than for individual families (Phiri & Tolfree, 2005).

HIV/AIDS and urbanisation with its insistence on children's rights brought with it a new crisis, a new challenge to community care of orphans. HIV/AIDS has ravaged the community safety net leaving the community disrupted and not able to care for its own people (Foster, 2004). Orphans, instead of being supported and cared for, are discriminated against and stigmatized. Urbanisation and apartheid destroyed the communities' safety net and communities were not relying on each other to care and support children (Madhavan, 2004). The loss of land and the constant reliance on employment brought new challenges for communities (Phiri & Tolfree, 2005). Communities, because of limited financial resources, struggle to care for orphans. Those who continued to care for orphans did it with limited or no financial resources (Foster, 2004).

In brief the traditional care arrangement of children and orphans have recently been challenged by HIV/AIDS pandemic and community members seems are unwilling to care for orphans without substantial financial support (Freeman & Nkomo, 2006).

2.4 Motives to Provide Care and Support to OVC

If HIV/AIDS and urbanisation keep disrupting and destroying family life what then could be the motive for extended family and community members to keep accepting to care for OVC? The motive for providing care therefore lies in the traditional childcare arrangement and love some community members have for children. For example, the study conducted in Richards Bay by Nyasani et al. (2009) found that the majority of rural foster carers care for orphans out of obligation because they have no other choice, while for community members it was out of love, although their capacity to do so was limited. Sometimes age, HIV status and limited financial resources have a bearing in a decision to care for OVC and this was confirmed in the study conducted by Townsend and Dawes (2007) in South Africa. Freeman and Nkomo (2006) confirmed this finding in their study and added that potential carers were more willing to care for OVC if offered substantial financial assistance. The reason to care for OVC, therefore, flows from the traditional childcare arrangement.

Some people, like a social worker interviewed in the study by Nyasani et al. (2009), hold a view that the extended family and community members are motivated by foster care or social

support grants to care for orphans. However, this view is disputed by Freeman and Nkomo (2006), who found that adults who care for OVC were not motivated by money; financial assistance could help them care for OVC. The study further found that community members would not be influenced by a social grant to care for OVC. Therefore it seems the motivation to care for OVC is not money, but the desire to keep OVC within family environment (Department of Welfare, 1997).

2.5 Capacity to Care for OVC

Turning from the traditional childcare arrangement and motives, to capacity to care for OVC, the White Paper on Social Welfare Service (Department of Welfare, 1997), painted a picture of families and communities that are faced with challenges and unable to care for children. Chapter 8 of this White Paper particularly focuses on families and the life-cycle, and it addresses the needs and problems of women and disabled people, and the following sections is from chapter 8 of the source. It acknowledges that families are faced with numerous problems such as social, political and economic. It notes that families have been particularly affected by social, economic and political policies of the past such as influx control and lack of housing. Economic stress and poverty are major contributions to family problems and the breakdown in family functioning (Department of Welfare, 1997).

Families are faced with internal family problems such as alcohol and drug abuse, communication and relationship problems, parenting problems, a lack of family and community support networks, overcrowding, lack of housing, as they attempt to meet the needs of their members. Children are traumatised by violence in communities and women have joined labour market for economic reasons and have to rely on child care outside of the home. It further acknowledges that families and children live in unhealthy, unsafe and disadvantaged communities. Families are therefore unable to fulfil their parental and social support roles effectively without the active support from the community, the State and private sector.

The capacity to care for OVC is determined by social stability, material needs and health status. Concerning social stability, age, gender, marital status and composition of extended family and community members are some of the determinants of social stability and ability of

household to effectively care for and support OVC. For example, it has been found that 90% of OVC caregivers were members of extended families; and 68% were females, of which 23% were over age 60 years (Freeman & Nkomo, 2006; Sternberg, Johnson, Scheirhout & Ndagwa, 2002 as cited in Nyasani et al., 2009). Some of these caregivers had at least a primary school education, had no formal employment or had no income-producing occupation and had no means to feed themselves. The social status of caregivers makes it difficult for them to provide care to OVC.

The capacity to care is also determined by material needs of each household. Their capacity seems unable to meet their basic needs and that of OVC. For example, Msomi (2009) found that 40% of caregivers are reported to have insufficient food and 60% spend their pension and foster care grant (FCG) on food. The study further found that half of the respondents could not provide clothes for OVC. About 57% of caregivers did not have enough accommodation for their family members; 63% had poor roofing, and 57% shared accommodation or sleeping facilities with children (Msomi, 2009). Kiggundu and Oldewage-Theron (2009) found that half of the respondents in their study could only afford one-bedroomed or two-bedroomed houses and had no space for children.

Education, unemployment and ability to discipline children are some of factors that are considered in determining the capacity to care for OVC. The level of education may limit the capacity to comprehend, internalise and practice some of the practices of OVC's care, especially those that require specialized skills (Chirwa & Chizimbi, 2007). Unemployment affects their sources of income because they cannot raise income from a stable or multiple sources. Their capacity to discipline children is weak. The difficulty stems from what Nyasani et al. (2009) calls a generation gap.

Lastly, the health status of caregivers has been found to be one determinant to judge the capacity needs of extended family and community members. Caregivers were found to be sick and suffered from illness such as high blood pressure, diabetes, arthritis, blindness, cancer and some were HIV positive (Maundeni & Malinga-Musamba, 2013). The sicker the members are, the less capacity they have to provide care for OVC (Kiggundu & Oldewage-Theron, 2009;

Maundeni & Malinga-Musamba, 2013). Kuo and Operario (2009) found that OVC caregivers experienced high levels of depression (35.16%), anxiety (74.10%) and posttraumatic stress disorder (4.51%), compared to caregivers of non-orphaned children, which was significantly lower. Sickness or chronic illness reduces the capacity of the household to earn a living and it drains the little available resources through payment of medical expenses and continued consumption without replenishment (Ritcher & Desmond, 2008).

In summary the capacity to care for caregivers is weakened by political, social, material and health status of caregivers. Challenges are enormous and families seem to struggle to deal with them while at the same time caring for OVC.

2.6 Coping Resources Available to Caregivers

After considering the capacity to care for OVC, the support systems available to caregivers need to be investigated. Their spirituality is an anchor in their lives, and God or the Supreme Being is a source of strength and support in their lives. For example, the study conducted by Shaibu (2013) in Botswana found that grandmothers drew strength to care for OVC from their spirituality. Participants in the study conducted by Shaibu (2013) made reference to God in their lives and acknowledged Him as the One who has seen them through hard times, especially in times of trouble. The study concluded that many grandmothers look up to God to guide them.

In South Africa, studies have found that caregivers formed support groups with or without assistance from NGOs (Hearle & Ruwanpura, 2009). The study conducted by Kiggundu & Oldewage-Theron (2009) concluded that participants found support groups to be restorative and therapeutic and NGOs were singled out as a support system. The study further found that NGOs supported caregivers financially and assisted them in starting income generating projects, participated in mutual counselling and provided material support to destitute individuals and families.

In brief their spirituality and support groups play vital role in assisting caregivers to face challenges of caring for OVC. Participants could rely on God and each other in order to help each other to care for OVC

2.7 Government's support

In addition to the support available to caregivers, the support from government needs to be explored. The main government's response to families is in terms of grants to caregivers of orphans, accompanied by eligibility for a specific grant. Grants in South African, like Latin America are given with certain condition viz. caring and supporting orphans, attending to their healthy and school needs, and nutrition monitoring (Aguero, Carter, & Woolard, 2006). The aim of the grants, according to National Development Plan (NDP), vision 2030, is to ensure that primary caregivers living in poverty are able to finance the basic needs of children (National Planning Commission, 2011). Social grants in South Africa changed a little in basic structure up to the year 1996, where new policy targeting poverty alleviation among children and families, and trying to address the inequalities of the past was designed and introduced (Aguero et al., 2006). The system was still dominated by means-tests which were determination of whether an individual is eligible for government assistance, based upon whether that individual possesses the means to do without that help (Meintjes, Budlender, Giese, & Johnson, 2003).

2.7.1 Foster Care Grant (FCG).

The processes involved in accessing the Foster Care Grant (FCG) are far more complex than those for the Child Support Grant (CSG), and are currently governed by two Acts: the Child Care Act, No. 74 of 1983 (RSA, 1983) and the Social Assistance Act, No. 59 of 1992 (RSA, 1992). In order to qualify for a FCG, children are required to be placed in formal 'foster care'. Sections 13–15 of the Child Care Act make provision for the courts, with the support of social workers, to place children considered to be "in need of care" in the custody of a so-called foster parent with the additional legal requirement that foster parent be under the supervision of a social worker (RSA, 1983). Section 14(4) of the Act outlines a set of criteria for children to be found "in need of care", and once a child has been found by courts to be "in need of care" they can be placed in the care of a foster parent (RSA, 2005). The foster parent is then eligible in terms of the Social Assistance Act to apply for a FCG, and at a time of this study, the FCG was an amount of R830 per month, per fostered child up to the maximum age of 18 years old (Meintjes et al., 2003).

However, informal foster caregivers (extended family and community members) experience difficulty accessing the FCG because a child is put in foster care through a court order. Extended families or communities foster OVC without any court order because of traditional childcare arrangement. They also find it difficult to access the FCG based on erroneous interpretation of section 150 (1) (a) of the Children's Act, No. 38 of 2005, 'a child in need' of care because the law regard extended family as having a common law duty to support OVC. In 2011, the South Gauteng High court, in Johannesburg, ruled that those who have a common law duty to care for OVC can foster orphans and receive a FCG (*Mono Cynthia Manana vs. the presiding officer of the children's court, district of Krugersdorp, 2011*). Although the court has found in favour of extended families, this has not translated into reality where the caregiver's visible means of support is assessed, rather than those of the child (*Meintjes et al., 2003*).

2.7.2 Child Support Grant (CSG).

The CSG is governed by the Social Assistance Act, No. 59 of 1992 (*Meintjes et al., 2003*). Under the Social Assistance Act, children under the age of 18 in South Africa living in poor conditions are eligible to receive a CSG whether they live with their biological parents or with other caregivers. Access to the CSG is through an administrative procedure managed by the Department of Social Development, and does not require a court order or the services of social workers as FCG. In 1995, the South African government established the Lund Committee to evaluate state support and come up with new alternatives targeting children and families (*Aguero et al., 2006*). In 1998, the committee proposed the CSG and emphasised that the grant should "follow the child", meaning that the benefit should be independent of the child's family. In 1998 a means test was changed to consider only the income of the primary caregiver, plus that of his/her spouse.

The above-mentioned approach proposed by the Lund Committee represented a move from a family-based benefit to a child-focused benefit (*Aguero et al., 2006*). Legally, however, the grant must be paid over to caregiver on behalf of the child. In cases where the applicant is not the biological parent of the child, a sworn affidavit from the parents or guardians is required to confirm that the applicant is indeed the primary caregiver (*Aguero et al., 2006*). In practice, the

designation of the primary caregiver as the grant recipient has effectively targeted women who are primary caregivers. The government has increased the age limit for eligibility from initial 7 years to 18years (Meintjes et al., 2003). The amount granted has also changed from R100 in 1998 to R320 in 2014 (Gordon, 2014; Meintjes et al., 2003). Access to the grant is facilitated easily by social workers (RSA, 1992).

However, the 1990 reform abandoned State Maintenance Grant (SMG) that was payable to biological parents who could not, for a number of reasons, rely on the support of the second parent (Aguero et al., 2006); if the second parent was alive, it was necessary to apply for a private maintenance order through the courts and only if this failed (or the amount awarded was very low) was the child eligible for the grant. The pre-1990 grants were family-centred rather than the post-1990 grants that are child-centred (Aguero et al., 2006). The move towards the family-centred approach to assisting OVC is necessary in order to face and defeat problems related to grants offered to OVC (RSA, 1997). Some studies (Nkomo & Freeman, 2006a) indirectly assert that this money is insufficient to meet OVC needs. Therefore the State does not support families that care for OVC directly but the State supports them by supporting OVC. The money is for children or orphans but received by caregivers and should be used in relation to the child. The money granted is reportedly insufficient and can hardly meet household needs for families that care for OVC (Nyasani et al., 2009; Kiggundu & Oldewage-Theron, 2009). This money in most families is only their source of income (Shaibu, 2013).

2.8 Conclusion

This chapter provides the literature review of the capacity needs of extended family and community members that provide care for and support OVC. Literatures showed that community members, particularly, extended family are increasingly taking care of OVC and are more likely to be females, single, living below the poverty line. They are more likely to be experiencing challenges with limited financial and emotional support. Social Welfare services in South Africa have reportedly done little to support OVC caregivers; instead the focus has exclusively been on orphans. Support has been directed at OVC, rather than families and families have acted as intermediaries. The next chapter will discuss methodology.

Chapter 3

Methodology

3.1 Introduction

This chapter describes the methodology used to investigate the research questions. An account of the research design, sampling procedure, data collection, data analysis, ethical issues, as well as credibility and trustworthiness of the findings are presented.

3.2 Research Design

The research design refers to the researcher's overall plan for obtaining answers to the research questions and testing the research hypothesis (Pilot & Hungler, 1999). A qualitative research design was chosen for this study because it is flexible and a lot of information could be gathered during the research. The qualitative research design deals with how individuals interpret particular phenomena (Smith et al., 2009). In order to understand this meaning making of individuals, the qualitative research approach explores and describes personal and social experiences of participants (Smith, 2003a). It tries to understand participants' frame of reference, especially how they make sense of their world. The aim of qualitative approach is to provide rich descriptive accounts of the phenomena under investigation by describing, making sense, and interpreting people's feelings and experiences (Smith & Osborn, 2003). Qualitative approach also explores participants' belief systems and values that underline the phenomena experienced by people (Creswell, 2013). This approach which includes structural procedures, data collection and analysis procedures was considered the best suited for this design (Pilot & Hungler, 1999). The characteristics of qualitative research approach which makes it most suitable for this research are:

- It uses interview as a way of data collection. The researcher used semi-structure interviews as data collection for focus group discussions.
- It uses open ended questions. The researcher used the same semi-structure interviews for all four focus group discussions.
- The researcher used digital recorder to capture the experiences of participants. The researcher then enlisted the assistance of a professional to transcribed and translate the interviews (Pilot & Hungler, 1999).

3.3 Focus Groups

Data was collected using focus groups interviews. Four focus groups were conducted. This method of data collection was chosen firstly because (a) participants are likely to trigger memories, stimulate debate, facilitate disclosure and generally encourage the production of elaborate accounts of their experience (Wilkinson, 2003); and (b) multiple voices can be studied at one sitting according to (Smith et al., 2009). In this way participants interacted with one another and in that interaction they offered a rich, detailed first-person account of their experience. The interaction takes place in an informal manner because focus group prefers discussion to be informal rather than formal (Wilkinson, 2003).

This approach uses focus group discussions/interviews (FGD) or individual interviews to collect data and face-to-face methods of data collection are preferable (Creswell, 2013; Smith et al., 2009). Therefore, data is collected in a form of naturalistic verbal reports and individuals are interviewed in their natural setting (Terre Blanche, Kelly & Durrheim, 2006). Interpretation is conveyed through detailed narrative reports of participants' perceptions, their understanding and their interpretation (Smith, 2003a). Qualitative research emphasised the value of analytic strategies and it remains close to the symbolic system in which "sense-making" occurs (Smith, 2003a). In collecting data, structured or semi-structured interviews are used and there are used as instrument of data collection.

3.4 The Sample method

A sampling method is a process of selecting a sample from the population in order to gain knowledge about the population that is being studied. It is thus a way that is designed to select a population suitable for the research study (Terre Blanche, Kelly & Durrheim, 2006).

The sample used in this study is purposive sample as indicated above as the researcher consciously selected certain participants to take part in the study. The purposive sampling procedure was regarded as the most suitable method for this research, as the researcher could apply the knowledge about the subject in order to handpick participants. The burden of judgement of who should be included remained with the researcher.

3.4.1 Advantage of purposive sampling method

- The purposive sample only includes participants who are knowledgeable about the subject being investigated. The researcher was able to judge the participants that were knowledgeable about the phenomena being studied and were included in the study;
- The data collected could be very informative of the research (Terre Blanche, Kelly & Durrheim, 2006);
- It is convenient and economical because the researcher was the only one involved in collecting data (Pilot & hunger, 1999);
- And the researcher was able to judge the participants that were typical or representative of the phenomena being studied (Terre Blanche, Kelly & Durrheim, 2006).

3.4.2 Disadvantage of purposive sampling method

The disadvantage of this sampling method is that it did not contribute to generalisation. The researcher knew that the population selected may not represent the entire population of extended family and community members that care and support OVC and that it will limit the generalisation of the findings. There was also a possibility for sampling bias. The researcher however decided it would be the most suitable method to use and that the inclusion criteria set for participants would be followed closely (Terre Blanche, Kelly & Durrheim, 2006).

3.5 Sample size

A total of 45 participants (43 females and 2 males) were recruited for this study. Males were included in the study because caring for orphans is not exclusively the responsibility of females. Some of the orphans are entrusted to males although females take care of orphans' daily needs, males remain primary caregivers. Of the 45 participants, 42 were extended family members and 3 were community members. The majority of extended family cared for orphans because they either accepted their responsibility within a family matrix, were coerced by other family members or they honoured the deceased's wishes; while community members voluntary cared for OVC without following a formally adopting process. The caring of OVC was a voluntary process based on cultural beliefs and expectations rather than on formal adoption procedures set out by government. Three FGD were conducted in uMgungundlovu district and one was conducted at Colenso, uThukela district. uMgungundlovu is more populated than

uThukela, which is why more focus group discussions were conducted in uMgungundlovu. The age range was 21 to 65 years for females and 35 and 55 years for males, therefore the mean age was 40 years old. Focus group discussions were conducted in isiZulu and the service of a professional translator was enlisted to help with translating the interviews from IsiZulu to English.

Of the 45 participants, 10 were married and the majority of the participants were maternal caregivers. The majority of participants had a primary school level education. Two of the 45 participants are formally employed and six are doing piece jobs. At the time of this study, the majority of participants were recipients of social grants. Participants were caring for OVC ranging in number from 1-10. The majority of orphans were in primary school, while some were in secondary school. Most OVC were born out of wedlock. Half of the participants reportedly care for more children other than OVC. These were either children belonging to OVC, or children left behind by female parents that got married to other man not fathering their children. The participants care for these children without financial assistance.

A basic set of criteria for selecting participants was followed: participants had to be: (a) a member of an extended family or community; (b) an adult caring for one or more OVC for at least a year; and (c) residing either in uMgungundlovu or uThukela districts for at least five years. These criteria were used in order to adhere to the objectives of the study. The assumption made was that participants who met these criteria will be able to share rich information about their experiences of providing care and support to OVC.

3.6 Sampling Procedure

The researcher approached local councillors for permission to conduct the study and to direct the researcher to possible participants (Appendix A). Permission was granted and local councillors introduced the researcher to community care-givers (CCG), who in turn assisted the researcher in recruiting the extended family and community members that provide care and support to OVC. The help of CCG was enlisted because they visit and assist families and communities that care for OVC and people affected by HIV/AIDS pandemic. However, prior to

seeking gatekeepers' permission, an ethical clearance had already been sought and obtained from the university research ethics committee.

Non-probability purposive sampling technique was used to ensure knowledgeable participants were selected for the study. The intention was to have two focus groups of extended families and two groups of community members; it was also the intention of the researcher to divide equally the number of participants from rural and urban areas. However, it was not possible to recruit an equal number of participants, as some participants did not meet the inclusion criteria. It was also not possible to balance the gender, as more females were found to be caring for OVC than males.

3.7 Data Collection

Data was collected using focus group interviews (Appendix B). The advantage of using focus groups interviews is twofold: (a) participants are likely to recall memories, stimulate debate, facilitate disclosure and generally encourage the production of elaborate accounts of their experience (Wilkinson, 2003); and (b), multiple voices can be studied at one sitting (Smith et al., 2009). In this way, participants interacted with one another and in that interaction they offered rich, detailed first-person account of their experience. Interaction took place in an informal manner (Wilkinson, 2003).

A semi-structured interview schedule for collecting data was used. It was developed by the researcher in the following way: (a) information from literature was used to identify key content areas that are of relevance in understanding capacity needs of extended family and community members that provide care to OVC; (b) themes that emerged during the literature review were used to devise a one hour semi-structured interview schedule; (c) and CCG were consulted because the researcher regarded them as experts on the field. Semi-structured interviews contained four major themes, i.e. motivation to assume the responsibility to care for OVC; challenges and coping resources; how they like to be assisted; and who should support them (Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009; Nyasani et al., 2009).

3.8 Data Collection Procedure

The procedure stated here was followed when conducting this study: participants were recruited through the help of CCG. Entry into households was facilitated by CCG from whose client's list participants were selected. The dates for focus groups interviews were set and CCG accompanied the researcher to an agreed venue. Participants were debriefed by the researcher after sessions and were thereafter encouraged to seek further help from local social workers. Informed consent (Appendix C) was distributed to participants and it contained information about the study. Focus group interviews were recorded using a digital voice recorder with the consent of participants. The researcher also took notes during the discussions. In general, participants co-operated and the discussions flowed freely and smoothly.

3.9 Data Analysis

Data was analysed using Interpretative Phenomenology Analysis (IPA). This way of analysing data required that seven steps outlined below be followed as outlined by Smith and Osborn (2003) as well as Smith et al. (2009):

- (i) Reading and re-reading data: This step involves immersing and familiarising oneself with the original data by listening to the audio-tape while reading the transcript.
- (ii) Initial noting: This step examines semantic content and language. Everything of interest like thoughts, observations and reflections are noted and commented upon.
- (iii) Developing emergent themes: The main aim during this stage is to turn notes into possible themes. Themes are named and coded.
- (iv) Searching for connections across emergent themes: This stage aims at grouping themes together as cluster, those themes that are of particular concern to participants.
- (v) Moving to the next phase: A master list of themes obtained from the first focus group interview is created. This is done in order to identify more instances of these themes in subsequent focus group interviews, while being aware of the possibility of new themes emerging from other focus group interviews and noting what is new and different. New themes that emerged are tested against early data. This process is repeated for all interviews.

- (vi) Looking for patterns across cases: This step looks for patterns, connections and potent themes across transcripts in order to cluster them together in a meaningful way. The master list is created and later modified.
- (vii) Writing up: Themes are translated to narrative account and are supported by verbatim.

Transcripts were analysed in conjunction with the original audio recordings in order to suffice themes that were relevant to this research. Transcribed scripts were given to some of the participants in order for them to read and comment on the themes and the stories for accuracy and representation (Smith et al., 2009). The file containing transcription notes will be store in the secure cabinet, in the supervisor's office.

3.10 Ethical Considerations

3.10.1 Permission from authorities.

Ethical clearance for the study was obtained from the University of KwaZulu-Natal's Humanities Research Ethics Committee (Appendix D). Once the clearance was received, the researcher began with data collection. Verbal permission was received from relevant local authorities.

3.10.2 Ethical principles.

Participants' rights were honoured through the informed consent. Informed consent means that participants have adequate information regarding the research, are capable of comprehending information and have the power of free choice that enables them to consent voluntarily to participate in the research or decline participation (Speziale, Streubert, & Carpenter, 2003). Information about the research was communicated to all participants (Appendix E). The title of the research, aims and objectives, name of the supervisor, how long interview will last, what will happen to data collected, concept of confidentiality and anonymity, and autonomy were all explained (Speziale et al., 2003; Terre Blanche et al., 2006). Participants were also informed that they could ask questions at any time during the research, refuse to give information, or terminate their participation at any time. Participants who could read, signed the consent form, and those who could not gave verbal consent which the researcher noted.

Regarding confidentiality, the researcher explained to participants that their identity will be kept secret. Pseudonyms were used and the list containing real names will be stored away in the secure cabinet (Terre Blanche et al., 2006). Finally harm during the research was avoided by treating sensitive topics with respect and discontinuing line of questioning when participants were uncomfortable (Smith et al., 2009).

3.11 Trustworthiness

Qualitative research prefers concepts such as trustworthiness, rather than reliability and validity (Morse 1997). The aim of trustworthiness in qualitative research is to ascertain whether findings are worth paying attention to (Lincoln & Guba, 1985 as cited in Averyard, 2007). In qualitative research, each step of the research process is evaluated to ensure trustworthiness. The term 'trustworthiness' is based on four constructs: credibility, dependability, transferability and confirmability (Morse et al., 2002; Lincoln & Guba, 1985 as cited in Averyard, 2007).

Credibility refers to the ability of the researcher to produce results from the study that are believable and convincing (Lincoln & Guba, 1985 as cited in Averyard, 2007). In addressing credibility, the researcher used focus group interviews, took notes and observed interactions within the groups. In addition, the researcher did a verbatim transcription of audio recorded data, and finally, the researcher gave participants the results of the study in order to check for accuracy (Smith, 2003b).

Dependability is the same as 'reliability' in quantitative research and, it refers to whether the findings will be consistent if the research was conducted with the same people or in a similar context (Morse et al., 2002 as cited in Averyard, 2007). But it must be noted that ensuring consistency of results in qualitative research is not guaranteed as qualitative data is subjective and contextual – might change due to various factors (Smith, 2003b). In addressing dependability, the researcher kept the file containing transcription, notes, observation, draft reports and the final report. This file can be consulted at any time by anyone who wants to satisfy himself/herself about the process and procedure of data collection (Smith, 2003b).

Transferability refers to whether the findings of the study can be applied to other settings (Lincoln & Guba, 1985 as cited in Averyard, 2007). For this, the researcher provided an interview schedule to enable anyone to determine if conclusions, interpretations and recommendations can be traced to their sources; and in addition, rich and thick descriptions of extended family and community members' experience was obtained, and was also reported in sufficient detail in order to allow anyone to decide on transferability (Morse et al., 2002). Due to sample size and the qualitative nature of this study, the findings can only be transferable to populations with characteristics and contexts similar to those of the participants (Creswell, 2013).

Confirmability refers to freedom from the researcher's bias in the research procedures and results (Smith, 2003b). This means that data interpretations and outcomes are rooted in contexts of participants apart from the researcher (Averyard, 2007). This was achieved by being close to participants and giving participants the draft report in order for them to check accuracy of the interpretation and whether their views were accurately represented (Morse et al., 2002; Smith et al., 2009).

3.12 Conclusion

This chapter provided a description of the research methodology employed in this study to investigate the research questions. A qualitative approach was deemed necessary to investigate the experiences of extended family and community members that care for OVC. The next chapter presents the research findings.

Chapter 4

Results

4.1 Introduction

In presenting the findings of the current study, this chapter is organised around five major themes, viz., challenges concerning the behaviour of OVC¹ and neighbours; difficulty associated with accessing the foster care grant (FCG) and child support grants (CSG); corruption; motivation to provide care for and support to OVC; and the needs of extended family and community members that provide care to OVC. Participants' responses (verbatim quotes) are presented in *italics* and their real names are omitted to protect their identity (P + number refers to a participant and TR + number refers to a transcript number).

4.2 Challenges Concerning the Behaviour of OVC and Neighbours

This theme discussed the capacity of extended family and community members in relation to challenges encountered in executing their duties. Sub-themes that mostly emerged were behaviour of teenage OVC, respect, discipline and interference by outside people. These are discussed below:

4.2.1 Behaviour of teenage OVC.

The source of stress for participants was applying disciplinary measures to orphaned and vulnerable girls and boys and their lack of respect. A lack of respect was experienced with behaviour of both girls and boys, who were described as ill-disciplined, stubborn, extremely demanding and choosy. Participants complained about girls' behaviour, stating that girls disappear at night or for the weekend, sleep with boys, abuse alcohol and smoke. Some girls get themselves pregnant, hide their pregnancy and refuse to say who is responsible for pregnancy. Participants found caring for OVC girls a daunting task. The child support grant (CSG) received by teenage OVC on behalf of their children is not used for children's needs but of teenage OVC themselves, such as getting their hair done. Participants take responsibility of caring for OVC's

¹ The focus group participants referred to the OVC as "my child, my children, these children, orphans". The researcher will make it clear when participants refer to their biological children. Therefore, in this session, when the researcher reports on the results, the word as used by participant, "my child, my children and these children" will refer to OVC.

children, including the OVC themselves. The behaviour of some boys was reportedly challenging for most participants. Boys sleep with girls, abuse alcohol and drugs, refuse to do household chores, and some are criminals. Some boys were accused of smoking drugs and turning to criminal activities such as hijacking cars, stealing money, in order to feed their habit. OVC were disrespectful and refused to listen to caregivers. OVC demand their FCG or CSG from guardians.

When you ask her where she is going, you get a response, 'I was not in your youth granny or you are not my mother.' She will then bang the door. She does not say where she is going. Sometimes she visits her boyfriend. She will go for 2 or 3 days. (P11-TR2)

He smokes wunga and steals. He steals everything in the house. Our fridge is empty because he takes everything. We cannot lock the house because he stole the key... (P6-TR4)

Children's rights are perceived by participants as obstacles in disciplining OVC. Participants reported that they could not physically punish OVC because OVC will cite their rights and threaten to report them to social workers or police for abuse. Participants hated children's rights and social workers who would normally take OVC's side. They were also very angry that OVC have protectors and advocates like social workers, and are left with no one to advocate for them as caregivers. Participants felt that they were left at the mercy of OVC without anyone to assist them.

These children are like kings and queens. Izimbali siyanunuselwa bheka wena! (They are like flowers). I can do nothing to them because they will report me. (P12-TR1)

Police intervene by locking you up if you beat a child. (P9-TR2)

4.2.2 Basic material needs.

4.2.2.1 Food.

Participants' main concern in both districts was their capacity to provide food for their family, including OVC. Participants in the uThukela district seemed to be worse off than their counterparts in the uMgungundlovu district regarding the capacity to provide food. Participants in uThukela district expressed that they find it difficult to provide enough food for OVC, while those in uMgungundlovu reported that OVC were wasteful. Most participants rely on FCG/CSG for income. However, it was clear that social grants alone were insufficient to provide food for the whole family. Participants in uMgungundlovu complained that OVC were wasteful – eating everything within a week. Councillors in both districts assisted with food parcels and Christmas parcels, although apparently they give it only to those who attend their meetings.

I think only about where and how to get food. Other things like shoes come after. I buy 6 loaves of bread every day. They would not eat this bread unless there is polony... Food is expensive! And we do not have enough money. (P11-TR2)

I just need help with food. I just need to feed these children. (P4-TR2)

4.2.2.2 Clothes.

OVC reportedly demand branded clothes. The FCG/CSG is insufficient to buy these branded clothes. Participants had to find money in order to buy branded clothes.

He wanted a cavella. It is expensive. It takes time to save money in order to buy it. (P5-TR2)

4.2.2.3 Shelter.

Accommodation in both districts was reported by participants to be inadequate and in some instances unsatisfactory. The majority of participants live in RDP (Reconstruction and Development Plan) houses; sleeping arrangements were reported to be more challenging. Some RDP houses were not properly constructed, and others were left unfinished. In uThukela district, some participants reported that some OVC choose to live in old, unsafe, and rundown houses.

We do not have enough space to sleep. I have an RDP house. They sleep everywhere and this is not healthy. I could be arrested. (P5-TR3)

He sleeps in an old house, with a leaking roof and no door. That house was built by our grandmother. I live in an unfinished RDP house with my child and some members of the family (P3-TR4).

Shelter was not just inadequate but also municipalities' services were expensive. Electricity was mentioned as the most expensive item and participants feel that municipalities should give them discounts when buying electricity. Keeping the household running was the most stressful, challenging and demanding activity for caregivers.

I buy food, pay for water and rates, no one is helping me. (P9-TR3)

Electricity is very expensive and someone must tell municipalities to give pensioners and those caring for OVC discount. They do give us free water, why they can't give us discounted electricity. (P6-TR1)

4.2.3 Violence against caregivers.

Majority of participants, especially in the uMgungundlovu area, felt unsafe in their homes. They expressed that they are afraid of OVC because they have displayed aggressive attitudes towards them; orphaned and vulnerable boys have threatened to kill them, manhandled them, and shouted at them demanding the FCG/CSG. Participants' anger and frustration were evident during discussions. Participants reported that they were afraid of orphaned and vulnerable teenagers, thus choosing their words carefully when speaking to them. Orphaned and vulnerable dating teenage girls were aggressive and disrespectful (talking back). These girls threatened to report caregivers to their boyfriends who were known to be criminals, for refusing to grant them permission to visit them. Participants evidently fear for their lives and regarded life as hell in their homes. They reported that social workers – instead of monitoring and helping OVC to be responsible – take their sides, blaming participants for not being responsible parents and threatening to remove OVC from their care.

He carries his gun around. H pointed his gun at me; I was sitting on my sofa. I told him that I do not have money...he went outside shouting. He fired his gun outside. I was so afraid. He wanted to kill me... life is hell and we are not safe. (P11-TR1)

They will turn against you and beat you up or the girl might tell her boyfriend and the boyfriend might stab you because you refused to let her visit him. (P7-TR2)

Social workers and police are perceived to take OVC's side. They protect the rights of OVC and advice participants to love these children. Participants were angry, especially in uMgungundlovu district, concerning the suggestion to love OVC, despite the fact that they are being abused and disrespected. They felt that their efforts of caring for these children are unappreciated. Councillors at times take the caregivers' side, but OVC caregivers were afraid of being arrested.

Social workers tell us to love these children. How can you love someone who does not respect you? They must respect us and we will love them. (P7-TR3)

Children's rights are a problem and social workers take their side. We are left to fight the battle alone. (P2-TR3)

4.2.4 Negative outside interference.

Participants expressed anger and frustration towards other members of extended families, neighbours, and social workers for what they felt is unnecessary interference. This interference was described as destructive. Outside interference was experienced when other people tell OVC to demand FCG/CSG from caregivers, coached them on what to demand and what action they could take if their material needs were not met. Neighbours and social workers were reported to monitor the kind of clothes OVC wear (need branded clothes), kind of food they eat (need 100% juice), question their disciplinary methods and accuse them of discriminating against OVC. Participants were angry and accused these people of negative interference without understanding budgetary constraints that they face every day. Interference centred on money and material needs

of OVC. Interference was also experienced as indirectly calling their parental skills to question. This way of behaving was regarded as a major source of stress.

We have the problem of people in our community, especially neighbours, who tell these children to demand the grant money from us because that money belongs to them. At home we give him his money because he was told by our neighbours and social workers that this money belongs to him.... (P10-TR2)

I built him a room using his FCG because we were crowded. The neighbour told him that I was abusing his money by building my house. They went to report me to social workers. I have to budget every month but these people do not understand that. (P2-TR1)

4.2.5 Education.

Participants reported a number of challenges when it comes to the education of OVC. Challenges mentioned were: (i) OVC refusing to go to school because they did not have branded clothes and had no pocket money or transport money; (ii) slow learners and repeating grades; (iii) dropping out of school; (iv) lack of financial resources to assist OVC further their education at higher institutions of learning; and (v) lack of cooperation between educators and caregivers.

He can do anything you ask him to do but school! School is difficult for him. ... Some of these children are slow learners and teachers need to attend to them immediately. They cannot go to special school because other children laugh at them. ... They told me to take him there but I refused. (P8-TR2)

She was accepted at uNgoye University but was there last year without paying university fees. She had no food and she phoned me asking for money to buy food and clothes. I had no money because I am buying food for 13 children here. (P8-TR3)

Participants felt that the government was not doing enough to assist OVC to further their tertiary education. When participants were asked about bursaries and National Student Financial Aid Scheme (NSFAS), they responded that they heard about it but OVC could not access it because of their matric results and some have not even passed Grade 12. They need to upgrade

their symbols. They suggested that a special fund for OVC should be set up. They were more concerned about those who did not pass matric well and needed to upgrade their symbols. This costs money – money they did not have because these children had reached 18 years and are no longer eligible for the FCG/CSG but they still need to go to school. Some were above 18 years but were still at primary school.

I do not know what I will do next year because he will be 18 years and will not be eligible for a grant. He is doing Grade 6. (P8-TR2)

Government must do something about children who are slow learners and those who have finished matric but did not pass well. They should continue to receive the FCG/CSG as long as they are still at school (P2-TR4)

4.2.6 Health.

Deteriorating health was experienced as a challenge to the capacity of extended family and community members to care for OVC. Participants reportedly suffered from physical illnesses such as headache, hypertension, diabetes, and arthritis. They blamed OVC for their poor health.

We go to the clinic because of BP and stress. We are sick because we live under difficult conditions. (P1-TR2)

I was admitted at Mariannahill hospital, I was admitted with the other child, on the first day I spent the night sleeping on benches. (P14-TR1)

They also reported to suffer from stress, anxiety and depression.

I suffer from stress. My doctor told me to stop worrying too much. (P5-TR3).

I worry especially about girls. She goes with her boyfriend for the whole weekend. I do not know whether she is dead or alive. I have to wait until she comes back. (P6-TR1)

Moreover, because of their weak health, they still have to cope with the loss of their support system (their children) while at the same time caring for OVC. HIV/AIDS further

weakens the family resources. This practice of separating orphans among family members normally lead to psychological trauma and grief for OVC.

I lost my child and the house she was building is left unfinished. No one will finish it (P4-TR2)

4.3 Difficulties Associated with the Accessing of FCG/CSG

4.3.1 The FCG.

Difficulties associated with accessing the FCG were discussed by participants at length. All participants mentioned two obstacles in trying to access the FCG: (i) OVC documentation, such as an abridged birth certificate and death certificate of biological fathers, and (ii) their husband's pay slip. Participants mentioned that they are excluded from applying for the FCG based on their husbands' income, who refuse to support their family *and* an orphan that is not from his family house. Participants also complained that it takes longer to register for the FCG than it is for the CSG. They also mentioned that OVC above 18 years that have no documentation cannot find employment and they cannot take funeral covers for them.

You will never get a FCG. It is better to apply for CSG. They need documentations like an abridged birth certificate. You wait for 7 months for it and then it comes back with wrong information. (P8-TR2)

...They asked for the death certificate, especially of his father. We do not have it because we do not know who his father is. (P6-TR1)

4.3.2 Biological fathers.

Participants reported that the requirement to try and find a biological father or his death certificate were absurd. They do not know where to find OVC's biological fathers. Participants, particularly in the uThukela district, reported that their daughters went either to Durban or Gauteng, and they came back sick carrying a child. For them, they did not know where Durban or Gauteng was. Some were advised by social workers to publish details of child's biological father in local newspapers. This made them angry and protested, saying: they never met their daughter's boyfriend/s and they do not know how to contact the media.

After the death of my daughter...I went to apply for the FCG and they told me to find the biological father. Where could I find him, he was dating my daughter? (P4-TR3)

They told me to publish his details on Ilanga. Would you agree? How would the child react if he finds his details on a newspaper? His classmate will laugh at him. (P5-TR2)

4.3.3 Orphans over 18 years.

Participants were frustrated about the stipulation that a child over 18 years old is not eligible to receive financial support from the State. This stipulation denies OVC a better education. They want government to support OVC financially, even when they have reached 18 years, as long as they are still under parental supervision and are still studying. The age of 18 years as a cut-off age was perceived by all participants as unfair and unrealistic.

Mine is 16 years old and is doing Grade 4. He will not get his FCG in two years from now and I would struggle to support him. The government must continue to support him as long as he is at school. (P4-TR2)

Our orphans are above 18 years old. We cannot give them basic needs...this is difficult because a child can even drop out of school. (P1-TR4)

4.3.4 Lack of Financial Resources.

Lack of financial resources is based on the fact that social grants are insufficient to meet OVC's material needs. They live below the poverty line. Family income, whether from social grants or from piece jobs, is used to buy households needs including branded clothes for OVC, educational needs and municipality's services. Despite above challenges they are encouraged by social workers to save some money for OVC. Majority of participants rely on social grants for their income that has to support the family. They urged government to raise grants substantially.

Lemali incane yona kodwa ngeke sisho ukuth ayisisizi ngoba yona imali. Iyaphesha la iphesha khona kodwa siyakhala incane (The grants are inadequate but we would not say the money doesn't help because it is money. It does help us where it can, but it is insufficient). (P12-TR2)

When they were asked about income-generating projects or the government's project of one garden, one family, participants responded that they cannot participate in those projects because they are sick. They in turn encouraged OVC to participate in these projects but apparently OVC refuse, saying that the government gives them money. In uMgungundlovu, participants complained about the lack of space as most of them live in RDP houses with no space even to extend their house.

We have heard about those projects from Radio but our councillor has not done anything to help us (P2-TR1).

We live in RDP houses and there is no space. Where do you think I can have a garden there because I can't even extend my house to accommodate all of us? The government is mad they must just give us more money (P7-TR1).

Social grants cannot take care of OVC's health needs. OVC get sick, some take chronic medication, but there is no money to take them to doctors. The state hospitals and clinics supply chronic medication, but at times they have to buy it. The grants money is also used to pay school transport (*omalume*).

They get sick, especially in winter and I had to take them to the doctor. Where do I get the money because I have to pay for school transport every month? (P5-TR3)

Clinics sometimes they do not have chronic medication and we have to buy it. We need money to buy it and grants are insufficient (P7-TR2).

4.4 Corruption

4.4.1 Community care-givers (CCG).

The community caregivers (CCG [*some are volunteers and others are employed either by the Department of Social Development or by the Department of Health*]), especially in uThukela district, were described as corrupt and treating people differently. CCG reportedly gave assistance such as food vouchers, food parcels and school uniforms to their friends, family or those who bribed them. 'You have to pay R30 for a food voucher', lamented one participant.

Caregivers that had televisions or spacious houses were discriminated against and were not visited by the CCG. They could not report them to authorities, because they are afraid of victimization.

I don't know what is a CCG? I decided to go to the councillor and I asked him what kind of an animal is CCG. (P14-TR1)

They will not visit your house if you have a TV... my daughter died while she was building that house and the CCG refuse to enter my house. (P8-TR1)

CCG must stop being corrupt e.g. orphans are given free uniforms but CCG divert it to their friends. They use friendship in given help...if you ask for a uniform you are told to wait...people who are corrupt are those called home-base who are contracted by DSD to help us...they take things for orphans and give them to their friends who have no orphans. (P6-TR1)

4.4.2 Social workers.

Participants in both districts were angry and embarrassed by the attitude of some social workers. Social workers were described as lazy, corrupt, disrespectful, and inaccessible (either too far or too busy), fail to monitor OVC placement, and refuse to assist caregivers. They take OVC's side against their caregivers and threaten to remove OVC from their care. They described some social workers as devils that were not prepared to help.

The scarcity of social workers was also noted during the discussions, urging government to act quickly. Participants also complained that social workers do not do their job; they are seen in town during working hours doing their shopping. The arrangement by social workers to see people on different days was criticized as not practical and inconsiderate. Participants suggested that this system needs to change. If they come on any day other than the day assigned to them, they will be chased like a dog. The manners and respect for elders by social workers was also criticised.

Social workers must do their job. The last time you see a social worker is when you go and register a child for grant. You will never see social workers after that. But they come if a child reports you for abuse. (P5-TR2)

We must have social workers in our area. If you want social workers you need to take 2 or 3 taxis. (P3-TR4)

4.4.3 Councillors.

Councillors, especially in uThukela district, were regarded as corrupt, useless, serving only their clan, or friends and refuse to side with caregivers. RDP houses and food parcels are apparently given to their clan or friends. In fact, some participants did not even want to mention the names of political counsellors for fear of victimization.

A list of pensioners and those who care for OVC should be established in each ward, so that food could be distributed evenly. (P5-TR3)

Oh! Do not talk about him (councillor) that is another issue for another day. You receive nothing if you don't have incision. (P11-TR3)

4.5 Motivation to Provide Care for and Support to OVC

4.5.1 Having no choice.

Extended families indicated that the reason they care for OVC is based on the fact that they had no choice, enforced by culture and their love for OVC. Participants cared for their grandchildren because they were left in the family home after their parents' death and uses maternal surname, their status within the family, or were coerced by other family members. They did not approach paternal family (if known) for help because they were afraid to be embarrassed and insulted by biological fathers.

It was not my choice. I felt trapped. So the decision to care for these children was not my choice, they were at home and I am the eldest. I had to take care of them. (P6-TR1)

...These children use my surname; they use it because their mother was not married. So, should I take these children and give them to that woman? (P3-TR2)

Some participants undertook parental responsibility because they were honouring the last wishes of the deceased sister/brother. In some cases, the wishes of the deceased were facilitated by hospital staff or social workers.

She was very sick and she said to me, 'my sister, please take care of my children because I am weak and I will die soon. (P5-TR1)

My sister was very sick. She had a stroke. She could do nothing for herself and she gave me the children that time. My sisters do not help me to care for these children. (P3-TR2)

4.5.2 Compassion.

Community members, rather than the extended family, were motivated by love and fervour to care for OVC. Community members observed poor conditions which OVC were forced to endure. Neglect by caregivers was the reason why they took pity of these children and decided to foster them.

This child stayed with his granny. I found him one day after work sitting outside naked. The granny had gone away. I took the child to his mother. I knew where she was. She died and I took the child. (P6-TR2)

4.6 Needs of Extended Family and Community Members that Care for OVC

Participants discussed the way they would like to be assisted. They preferred the government to directly assist them, rather than assisting OVC. They expect to be assisted with household needs, an advocate, workshops, counselling, support groups, employment, financial assistance and educating OVC.

4.6.1 Household needs.

Participants expressed that they need help with household needs such as food, clothes, and paying municipality rates. Providing food was their priority. Municipality services were regarded as expensive, especially electricity. They would like for their pension card to give them discounts when buying electricity. Others suggested food vouchers instead of cash. They appreciated free water.

“Government must give us food vouchers instead of money. Money will always create trouble. (P10-TR2)

I also do not agree with branded clothes. I buy whatever. But I need help with food... right now I just need help with food...and we also need help with water, electricity and municipality rates. (P6-TR3)

4.6.2 An advocate.

Participants, especially in uMgungundlovu district, pointed out that no one was advocating for their issues relating to the lack of capacity to care for OVC. They reported that no organisation, social workers or NGO has created awareness about challenges extended family and community members that care for OVC are facing. They need someone who could speak on their behalf, advise them and fight for their rights. There are many organizations that advocate for children’s right without advocating parental rights, although the task of caring for OVC is challenging.

The only thing that we ask for is that we need an advocate, someone who could sympathize and speak on our behalf. OVC! They have advocate like social workers.”(P5-TR2)

“We would not have stress or BP if we have someone advocating for our rights as elderly people and parents...there is no one who sympathize with us or advocating for us. Those in authority must speak for us. (P9-TR2)

4.6.3 Workshops.

In order to strengthen their capacity, participants expressed the need to have regular workshops. The aim of these workshops/camps would be: to share their experiences, debriefing, to be educated about how best to care for OVC, and to learn how to deal with possible conflict between OVC and themselves. Participants are aware that laws are changing and they cannot keep abreast with all the changes. Workshops/camps would help them to deal with themselves and rethink strategies to deal better with OVC. Workshops/camps were also suggested for OVC. They felt that the aim of the workshop/camps for OVC would be to educate them about respect

and how to live life in general. Social workers could take up the task of organising workshops/camps.

Social workers should arrange workshops for us. We want to sit as we are sitting right now and discuss what we can do and how to handle OVC. (P2-TR1)

Government must have a workshop for orphans every 6 months; and must not leave everything in our hands because we do not know how to deal with orphans. (P6-TR2)

4.6.4 Counselling.

Counselling was discussed and suggested by the majority of participants as a way to strengthen their capacity and help them deal with psychological trauma and grief (trauma of being abused by OVC and grief for losing their children). They also suggested counselling for OVC because they face child developmental stages, bereavement and grief, and adjustment problems.

We also need counselling in order to cope with this daunting task. The life is not nice in your own house. (P7-TR1)

We need counselling and social workers must counsel us. (P1-TR2)

4.6.5 Support groups.

No support groups for carers of OVC were found existing in both districts. Support groups were suggested by participants for caregivers, OVC. Another suggestion was having a support group that will combine the caregivers and OVC. Support groups were seen as an important tool to help them deal with bereavement and share their experiences with other caregivers. Social workers and NGOs were identified by participants as people who could help to establish these support groups.

We want groups where we can share our experiences and learn from each other. We want to sit as we are sitting right now and discuss our problems. You must call us again because this will help us. (P6-TR3)

Social workers need to call OVC together and give them advice about life. They also need to call them and us together so that we can discuss issues that affect us. (P5-TR3)

4.6.6 Employment.

Participants younger than 40 years, particularly in uMgungundlovu district, suggested that they need employment opportunities for them as caregivers and for OVC. They are not able to meet the household needs because they rely on the CSG. The grant is not enough to cover households' needs, therefore they need employment. They also suggested that OVC, those over 18 years, need employment.

We want work, even sweeping roads, anything that will help. (P5-TR2)

We want work for our children. Some are over 18 years and are not at school any more. They stay at home doing nothing. (P10-TR3)

4.6.7 Financial assistance.

The FCG/CSG is reportedly insufficient to meet OVC's needs like transport, school fees, and material needs. If the government is serious about helping these children, then it will need to increase this money substantially. They want to help orphans to further their studies at universities and those who want to upgrade their symbols to do so. The grant is also used to meet the family households' needs. Grants should be directed to families rather than just to OVC because they demand it for themselves. Thus, if it is directed to families rather than to OVC, problems associated with grants will be solved. Some participants suggested food vouchers rather than receiving money. They suggested that government create cards like pension card that will be loaded with food, clothes and school uniform money.

Government must increase the FCG/CSG not just put R10 every year. What can you do with R10 increment? We need money so that we can able to care for these children (P1-TR3)

I think the government must start thinking about food vouchers because these children demand this money for themselves. (P9-TR3)

4.6.8 Help educating OVC.

Participants expressed that they need help concerning the education of OVC, especially for OVC that are slow learners. They would like educators to be fully involved in assisting orphans with school-related work. They also would like the government to help with bursaries for OVC who have passed matric well, and those who need to upgrade their matric. The concern was more on helping to educate OVC than dealing with their education.

Government must have bursaries specifically for OVC. We do not have money to take them to universities. Government must help. (P1-TR4)

Educators must help children who are slow learners. We cannot take them to special schools because other children will laugh at them. (P7-TR4)

4.7 Conclusion

The findings of this chapter demonstrate that the capacity of extended family and community members to care for is weak and shows the type of challenges and psychosocial needs that OVC caregivers in this study confront. The findings show the effect that these challenges and psychosocial needs have on OVC caregivers. Surely caring for OVC with limited support must be difficult. The next chapter will focus on discussions.

Chapter 5

Discussion

5.1 Introduction

The purpose of this chapter is to present discussions on the findings and highlight the limitations. This study was designed to understand the capacity needs of extended family and community members that provide care and support OVC in uMgungundlovu and uThukela districts. Extended family and community members are increasingly caring for OVC, it is vital to explore their capacity needs and ways in which those needs can be met.

In summary, about results of this study, it was found that capacity needs of extended family and community members was remarkably weak; OVC caregivers are facing numerous challenges such as providing basic household, educational and emotional needs with limited financial and emotional support. The study further found that motivation to care for OVC for the extended family was based on responsibility embedded in traditional child-care arrangements, while for community members it emanated from love and compassion; and lastly it highlighted ways OVC caregivers and OVC would like to be assisted as families.

5.1.1 Profile of OVC caregivers.

This study found that extended families are increasingly taking on the parental role of OVC. The majority of the participants were extended family members; a few of them were formally employed and did not receive the FCG or the CSG. The number of women caring for OVC was notably high in both districts. These findings held true for the study carried out in Amajuba district, in KwaZulu-Natal, which highlighted that grandmothers or aunts were likely to be OVC's caregivers, unemployed by virtue of their age and gender and have less access to assistance from other adults (Govendera, Penninga, Georgea & Quinlana, 2012). The same was found in the study carried out in Richards Bay by Nyasani et al. (2009). The fact that the study found that majority of participants were members of extended families can firstly be attributed to traditional childcare arrangements where family members are culturally expected to care for OVC, and to HIV/AIDS which has reconfigured family structures leading to the extended family increasingly playing a role of caregivers to OVC (Govendera et al., 2012; Madhavan, 2004). Therefore, extended family is increasingly taking on the parental role (Govendera et al., 2012;

Madhavan, 2004) as HIV/AIDS continue to destroy nuclear families, and they will need to be substantially supported in their new role.

However, it was interesting to note in both districts that there were few community members that care for OVC. It was not the scope of this study to explore why few community members are caring for OVC. In fact, Zagheni (2011) argued that OVC are expensive to care for, and this seems to have deterred community members from caring for OVC. The study conducted by Freeman and Nkomo (2006) found that community members were willing to care for orphans if offered a substantial financial support, especially in this current generation when one is dealing with 'crisis-caring'. Taking in orphans seems to be a strain rather than a reciprocal idea to help families and children (Abebe & Aase, 2007; Madhavan, 2004). The absence of community members in the care and support of OVC can be attributed to the disruption of family and community life by HIV/AIDS, urbanisation and the harsh economic climate (Govendera et al., 2012; Madhavan, 2004). Harsh economic conditions, such as the high unemployment rate seem to have deterred community members from taking on the responsibility to care for OVC. It seems community members are not willing to care for orphans unless offered a substantial financial support (Freeman & Nkomo, 2006). Therefore the burden to care for OVC remains with the extended family that seems to have no option but to care for their grandchildren.

5.1.2 Challenges and coping resources.

Extended family members taking care of OVC is a major breakthrough, but not without consequences. This study has highlighted some factors surrounding the care-giving activities that have an impact on capacity needs of extended family and community members that care for OVC.

One of the findings of this study is the expressed concern by extended family and community members over meeting basic material needs of OVC, such as food, clothing, shelter and education; but the main concern was a challenge of providing food for dependents within their family compound. Their major source of income was social grants and was deemed insufficient. At the time of this study the old age pension was R1050, FCG was R830 and CSG was R320 (Gordon, 2014). These findings are consistent with literature that found that social

grants in South Africa changed little in basic structure up to the year 1996, where new policy targeting poverty alleviation among children and families, and trying to address the inequalities of the past was designed and introduced (Aguero et al., 2006) but the income of participants act as a determinant whether government financially support them (Meintjes et al., 2003). In 1995, the new government established the Lund Committee to evaluate state supports and come up with new alternatives (Aguero et al., 2006). In 1998, the committee proposed the CSG and emphasised that the grant should 'follow a child'; meaning the benefit should be independent of the child's family. In 1998 a means test was changed to consider only the income of the primary caregiver, plus that of his/her spouse. Instead, FCG was given to orphans who were in the care of adults who were not biological parents and the cause of death was AIDS (Foster, 2005). Its purpose was to ensure that the orphaned child lives in adequate housing, is fed and given clothing, receives necessary medical care and attends school regularly (Hearle & Ruwanpura, 2009). In 2011 the South Gauteng High Court in the matter between Mono Cynthia vs. the presiding officer of the children's court clarified section 150 (1) (a) of children's Act, 38 of 2005 that deals with a child in need of care (Mono Cynthia vs. the presiding officer of the children's court, district of Krugersdorp, 2011). The court ruled that it is the child visible means of support that need to be taken into consideration, not of a primary caregivers, thus changing the battle field and relieving primary caregiver of the burden to prove whether they can or cannot support OVC.

Though some are recipients of social grants, participants felt that it was not sufficient to meet household needs, particularly the needs of OVC. Social grants were spent on food, clothing, education, municipal rates and other basic household needs (Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009; Nyasani et al., 2009). For example, in the matter between Mono Cynthia Manana vs. the presiding officer of the children's court, the social worker concluded that the appellant had a clear shortfall and did not have sufficient means to support children (total income was R2, 470, while total expenses was R2, 850 per month). Therefore social grants alone barely meet household needs and one can understand why there is a constant call from participants for government to substantially increase social grants, particularly that which is directed to orphans. Call for increase in social grants makes sense in light of their expenses.

The introduction of social grants to South Africans is laudable and necessary and it can assist families to move out of the poverty trap, but literature warns that it can also create a state of dependency on the government social system. For example, Ruiters, (2007 as cited in Hearle & Ruwanpura, 2009) argues that grants are a way for government to assert its class power while suppressing any opportunity for the transfer of power to local communities, as they become passive recipients of money. Recognizing the possibility of permanent state dependency, young participants suggested employment opportunities be created for themselves and OVC. This is a long term solution that will finally help families break free from state dependency and enable them to meet their needs, and that of OVC.

The struggle that caregivers have in providing orphans with adequate primary and tertiary education was unsettling. For example, South African government offers grants to orphans until they turn 18 years old (Aguero et al., 2006; Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009). Beyond 18 years, caregivers have to find means to support orphans and pay for their education. Cessation of grants comes at a crucial time when a child's career path start. This study found that caregivers in uMgungundlovu cared for OVC even though they were experiencing difficulty with their education. Most orphans were at primary school at age 18. Some had dropped out of primary school, others took a gap year and the rest had no money for registration at universities. These findings held true for a study conducted in Botswana that highlighted the educational problems experienced by OVC. It was found that the cessation of social welfare grants came at a time when most orphans were unemployed, had completed high school at 18 years and were looking for tertiary education opportunities while other spent time at home because they had no money to pay for application fees (Shaibu, 2013). In South Africa, the study conducted in Richards Bay found that the lack of access for OVC to tertiary education was disquieting for both rural and urban foster-carers (Nyasani et al., 2009). The concern was either that the FCG would terminate when a child reached age 18, or were anxious about OVC achieving a career and self-sustainability. As long as participants lack financial capacity and are preoccupied with meeting household needs, the educational needs of OVC will take a back seat.

OVC particularly adolescents perpetrated violence against their caregivers. Participants in this study identified lack of respect and FCG/CSG as the main cause of conflict (Hearle &

Ruwanpura, 2009). Participants mentioned how they were fearful of OVC. This was a source of constant stress and a cause of sleepless nights. These findings are consistent with the study conducted by Hearle and Ruwanpura (2009) who found that OVC perpetrated physical violence against their caregivers; their study also argued that conflict between OVC and their caregivers can be conceptualized in terms of power, and OVC used FCG/CSG to exert power over their caregivers. The study conducted by Nyasani et al. (2009) in Richards Bay concluded that the conflict between OVC and their caregivers is based on the generation gap. Caregivers come from a generation that believes in corporal punishment, while OVC belong to a generation where human rights are commonly advocated. Difficulty in controlling and disciplining OVC illustrates how the values of respect flowing from the child to caregiver and the channels of authority from caregiver to child seem to have been reversed. Unlike the study of Hearle and Ruwanpura (2009), this study did not find that physical violence towards caregivers translated to resentment. There seems to be no strategy from participants to deal with violence towards them.

It is interesting to note that focus group discussions, particularly in uMgungundlovu district, were used as a platform to vent participants' emotions. OVC were reported to lack respect, sleep with boys/girls, drink alcohol, and participants could not discipline them because of rights' rhetoric that is used to defend their actions. The study conducted by Hearle and Ruwanpura (2009) found that children's rights were a problem for caregivers. The 'rights' of OVC are held in high esteem while their roles and responsibilities are not mentioned. Van Rensburg and Human (2005 as cited in Hearle & Ruwanpura, 2009) argued that the problem that most families experience about children's rights is that the discourse on children's rights fails to mention that children have an obligation to treat others with dignity and respect, even while realizing their basic rights. Children's rights override parental rights and the fact that it is the family that socializes, naturalizes and cares for children takes a back seat. Because of this, caregivers resent children's rights, social workers and police who, instead of taking their side, are seen to protect and support orphans. They are furious about the perceived treatment meted by social workers on them.

In addition, there seems to be resentment towards neighbours for negatively interfering in their duty to care for OVC. This clash calls into question the community cohesion which has

been promoted. The friction emanates from the FCG/CSG and the expected role that participants are supposed to play. Neighbours accused caregivers of not providing everything OVC need such as food and clothes, although they receive their FCG/CSG. This interference negatively affects their relationship with neighbours and OVC, which is at odds with the principle of *ubuntu* that guides the relationships between neighbours (Hearle & Ruwanpura, 2009), and the fact that a child belongs to the village. However, participants feel betrayed by people who collaborated with OVC. It seems as long as there is no awareness about the responsibility of caregivers, conflict and resentment between caregivers and neighbours will continue.

Besides conflict with neighbours, corruption particularly of CCG and councillors was specially mentioned by participants in uThukela districts. CCG divert the most needed assistance to their friends and clan, so as ward councillors, leaving participants to struggle alone (Shaibu, 2013). Corruption is widely reported in the media but this does not mean it is something that should be accepted as normal. Corruption destroys the morale and religious fibre of a nation. CCG and councillors are part of the mesosystem that need to play a supportive role to participants, but it seems they fail to play their role (Swick & Williams, 2006). Department of Social Development will need to strengthen monitoring systems for CCG, so that the service they offer to caregivers will be appreciated.

Caregivers in uThukela district were found worse off than their counterparts in uMgungundlovu district. Their concern was to meet the household needs and that social workers, councillors and CCG, discriminated against them (Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009; Nyasani et al., 2009). In contrast, the experience of participants in uMgungundlovu district was different. Their concerns were quality of relationships between themselves and OVC, meeting household needs, providing quality education to OVC, and being treated fairly by social workers (Hearle & Ruwanpura, 2009; Nyasani et al., 2009). The quality of relationship between participants and OVC, and how social workers support OVC was discussed at length. Social workers, instead of helping participants to cope with these challenges, threatened to move orphans from their care, creating unnecessary stress for caregivers (Hearle & Ruwanpura, 2009). Emotions were high during discussions. It seems participants were unsupported in both districts. Therefore challenges are that participants struggle to meet

household needs and this highlights that their capacity to care for OVC is inadequate. Empowering and advocating only for OVC will further demoralize caregivers.

5.1.3 Support systems available to participants.

Unlike financial support provided by the government, caregivers were not supported emotionally and spiritually. This study found that there were no support groups available to support caregivers; friends or other family members were absent; caregivers focus completely on fulfilling household needs. With regard to the structures, such as the CCG, that was supposed to ease the burden of caring for OVC and provide needed support were found to be corrupt.

However, these findings are inconsistent with literature, particularly a study conducted by Nyasani et al. (2009) in Richards Bay that found that caregivers had support groups that helped them to cope with emotional burden of caring for OVC; as well as the study conducted by Kiggundu and Oldewage-Theron (2009) in Alexandra that found that caregivers had social and emotional support from friends in the form of support groups which help them deal with challenges of caring for HIV/AIDS orphans. The study continued to argue that the availability of social support increases a person's sense of self-efficacy and improves their motivation to cope with their problems. Olivier (2005 as cited in Kiggundu & Oldewage-Theron, 2009), pointed out that being integrated into a supportive and protective social structure makes a person less vulnerable during difficult times because a person will use a problem-focus coping rather than emotion-focus coping which focus on inability of a person to confront new situation. The lack of support systems largely affects or limits their self-efficacy. It is therefore, important to establish support groups for participants in order to deal with emotional and practical problems.

5.1.4 Motivation to care for OVC.

There is a wide spread perception that caregivers of OVC care for them because they want money. Some people, like the social worker in the study conducted by Nyasani et al. (2009), have created and maintained through their discourse the negative perception that caregivers care for OVC because they want money for themselves. When participants of the current study were questioned about this perception, they felt angry, hurt and annoyed. They rejected this perception with contempt, citing examples where they cared for orphans without support grants. They

believed it was their responsibility to care for their grandchildren with or without financial assistance. They related stories of how they use their old age pension to care for OVC; those who did not receive social grants related stories of how they try to find means of providing material needs for every child within their family compound. This finding concurs with the study conducted by Hearle and Ruwanpura (2009) which found that caregivers were annoyed and bitter about this negative perception. The study concluded that it is difficult to assess with certainty the motives that families have for taking in orphans. The strength of this study however, was to understand motives of participants from their perspective. They are not motivated by money but financial assistance could help them care for OVC (Freeman & Nkomo, 2006). Despite the economic realities of poverty and hardship, extended family and community members are the most likely people to be carers of OVC because they are embedded in the social space where caring for orphans is expected (Kuo & Operario, 2007).

5.1.5 Supporting extended family and community members.

Caregivers have difficulties meeting material needs of OVC because they are poor (Howard et al., 2006; Madhavan, 2004). The literature review has highlighted that caregivers have fewer resources and less capacity to deal with challenges of caring for OVC, have limited support systems, and have few, if any, assets and savings (Ritcher & Desmond, 2008). It highlighted the urgent need to substantially support OVC caregivers. It has also highlighted the effort of the government through a cash injection in the form of FCG/CSG that is paid to OVC caregivers (Hearle & Ruwanpura, 2009); and is used as a means of survival for many households. It was interesting to note that both districts preferred to be assisted with household and educational needs for OVC. The majority of participants preferred cash injection in the form of FCG, while the minority preferred voucher system to be established and implemented. Young participants preferred employment opportunities to be opened for them and OVC.

The FCG/CSG is not without problems. The literature reviewed highlighted some of these problems. The introduction of child grants is laudable and necessary because such income is a crucial determinant in assisting families to move out of poverty (Aguero et al., 2006; Hearle & Ruwanpura, 2009). The problem about the FCG/CSG is that it is child-centred (Aguero et al., 2006). This study highlighted how the FCG has precipitated relationship problems between

participants and OVC and how the macrosystem has missed the opportunity to address the issues because it is child-centred. As long as the FCG/CSG is child-centred and families are treated as intermediaries, problems highlighted in this study and in the literature will not stop. Failure to acknowledge the struggle of caregivers; and failure to implement interventions and mobilise coping strategies that will support families will result in families that are unable to care for their children.

As mentioned above, this study found that financial assistance in form of cash injection is child-centred. The study conducted by Ritcher and Desmond (2008) argued that financial support should be families-oriented rather than child-oriented because it is within family that care is provided in a natural and sustainable way, and where care is compromised when the family is under strain. The role of families is to nurture and socialize children, a role they will execute well if they are substantially financially assisted. Primary caregivers attend to their family needs rather than focusing on individuals even when that individual is an orphan. Individual needs are fulfilled within the family; therefore helping families will alleviate poverty that enslaves families. Adopting a family-oriented approach will help the government to realise the six governmental strategies to care and support families, particular strengthening their capacity (Ritcher & Desmond, 2008; Department of Welfare, 1997). This will lead to mindset shift from the focus of international organizations, governments and funders that has been up to now exclusively orphans-oriented, to families-oriented (Ritcher et al., 2009).

This study found that participants would like social workers to arrange workshops, training, counselling, and arrange meetings between orphans and themselves so that they can address a question of respect towards elderly. These findings are inconsistent with literature (Hearle & Ruwanpura, 2009; Kiggundu and Oldewage-Theron, 2009; Nyasani et al., 2009). Some studies have deduced from their findings how caregivers should be assisted (Mdletshe, 2008; Perumal, 2011). However the strength of this study was to give voice to caregivers. Participants in this study explained and expressed their feeling how they would like to be assisted, rather than the researcher suggesting how they should be assisted. Participants feel that financial assistance, workshops, training and family counselling could assist them in their duty to

care for OVC. However, social, economic and political capabilities will need to be attended to in order to support families (Department of Welfare, 1997).

5.2 Theoretical framework

The bio-ecological theory of Bronfenbrenner was used in this study. The researcher regarded this theory as useful because it attempts to view and appreciate human being in their interaction with the environment. Human beings do not exist in isolation but they interact with many systems within their environment and in turn are influence by these systems. This theory capture this interaction succinctly and point how the interaction and relationship can be studied and understood. It proposes that a more encouraging and nurturing environment will have a positive effect on human beings development because it accommodates a broad spectrum of problems and needs, that human beings faces in their interaction with the environment (Swick & Williams, 2006). Human beings are assess and analysed at various levels and identify their strength and supportive nature (Swick & Williams, 2006). Whittaker, Schinke & Gilchrist (1986) stated the value of this paradigm in designing service programmes, and how various forms of environment help in designing and increasing social support that can be useful for extended family and community members and OVC.

Therefore, this theory became a valuable tool in examining the capacity needs of extended family and community members that provide care and support to OVC. It can be used with a larger sample in investigating the capacity needs of extended family and community members that care and support OVC, because firstly it is inclusive of all of the systems in which families are enmeshed and secondly it is based on the idea of empowering families through understanding their strengths and needs (Hill & Madhere, 1996; Whittaker, Schinke & Gilchrist, 1986).

5.3 Limitations

This study has its limitations. Firstly, the purposive sampling procedure was used. Participants were recruited from people serviced by CCG, and the majority of them were extended family's members. Thus, the sample was biased towards members of extended families and those serviced by CCG. The results thus cannot be generalized to the entire population of extended family and community members that care for and support OVC, but can be transferable

only to those with similar characteristics to the sample. Secondly, participant recruitment was limited as the study was drawn from only two districts in KwaZulu-Natal, i.e. uMgungundlovu and uThukela districts. The researcher hypothesised that these districts contain a large number of OVC because of higher HIV/AIDS prevalence rates in the two districts. The findings thus cannot be generalized to other provinces of South Africa because each province is unique and the sample size was not large enough. The final limitation is the concern in the loss of data during translation and interpretation although focus group interviews were audio recorded (Terre Blanche et al., 2006). Careful consideration was taken to reduce the loss of data during translation, but loss of data may nevertheless occur during the translation of transcripts from the original language of interview isiZulu to English. To address the concern of loss of data during translation, one focus group interview was translated forward and backward. Despite these limitations, this study provided important information about capacity needs of OVC caregivers and gives opinions and views of OVC caregivers on how they want to be assisted.

5.4 Conclusion

This study showed that participants in uMgungundlovu and uThukela districts face challenges with limited resources. The study argued that, despite the problems they experience, their capacity to care for OVC need to be strengthened and supported. The next chapter will focus on conclusions, and recommendations.

Chapter 6

Conclusion

6.1 Introduction

The purpose of this chapter is to present conclusions drawn from this study, to highlight the significance of this study, make recommendations, and highlight implications for future research.

6.2 Conclusions Drawn

HIV/AIDS has disrupted family life and the extended family and some community members are increasingly caring for orphans. The intention for this study was to highlight their capacity needs. Results of this study firstly highlighted that caring for OVC within the extended family is embedded in the traditional childcare arrangement, supported by culture and a sense of obligation, while community members care for OVC out of love and fervour. It was found that money, as suggested by some people, is not a reason to assume the responsibility to care for OVC, but it could ease the burden of caring for OVC. Therefore the responsibility to care for orphans is embedded in the social space where caring for orphans is expected.

Secondly the study found that challenges and obstacles (internal and external) faced by extended family and community members were insurmountable. Internal challenges emanate within themselves and make them vulnerable and suspect in carrying the responsibility to care for OVC. Counselling and spiritual revivals can ease the burden of caring for OVC and can also act as support system. External challenges come from the environment and caregivers have no control over them. For example, the government cash injection is offered to caregivers of OVC but caregivers have no influence in determining the amount contributed. The government, in assisting OVC, has adopted a child-centred approach and this study argues that the problems and struggle faced by caregivers will continue unless all stakeholders, including international donors adopt a family-centred approach and financial contribution is substantially increased. It must be remembered that care and support of children is provided within the family environment.

Thirdly the study found that the expected community support that is presumable among African people was absent. OVC caregivers cared for OVC without internal and external support. Community members or other family members that are presumed to play a supportive role were in fact making the role of caregivers unbearable and difficult. Community support has been the pillar of community life but recent events such as HIV/AIDS and economic challenges (emanating from loss of land) posed a threat and eventually destroyed community support system (Foster, 2004). The loss of community support system normally poses a threat in the proper functioning of community life. Care of OVC will be a challenge unless structures are set in place to regularly support their endeavour to care and support OVC. It is in the environment of genuinely being supported that care giving task will be manageable.

Fourthly, voices of orphans are heard in many quarters but experiences of extended family and community members that provide care to OVC are marginalised. This study gave voice to the voiceless. Participants were able to vent their anger and frustration in a controlled environment and, above all, were able to express what support they envisage for themselves. Some studies have suggested what OVC caregivers want, and the strength of this study lies in the fact that it gave those caring for OVC the voice and to express how they want to be helped (Msomi, 2009; Perumal, 2011). For participants, it was the first time that someone took time to enquire from them what they want and how they live with OVC. Interviews did produce some degree of psychological discomfort which was addressed immediately during the interview.

Lastly, it is important that caring and supporting OVC be understood in terms of social, political, cultural, economic and educational factors that are part of extended family and community members. Families interact within various ecological levels and this can be seen only when different lenses are used to observe families. Understanding families must be sensitive enough to involve cultural forces that may be hidden beneath surface of daily life activities. The bio-ecological model provides a useful framework for addressing and understanding capacity needs of OVC caregivers because it views caregivers from a holistic perspective.

The overall conclusion is that the capacity needs of extended family and community members that care for and support OVC was remarkably weak and internal resources and

external support were limited. In order to provide the best care to OVC, the capacity needs of extended family and community members will need to be supported and strengthened. It is hoped that stakeholders involved with OVC caregivers will firstly take cognisance of this study and listen to struggle and cries of OVC caregivers. It is further hoped that the Department of Social Development (DSD) and all stakeholders who are involved with caregivers will be challenged by this study to ensure that caregivers are provided with the necessary support to enhance their capacity to care for OVC.

6.3 Significance of the Study

The results of this study highlighted challenges, psychosocial and socioeconomically, faced by extended family and community members that provide care to OVC, although their capacity is weak, they continue to care for OVC with limited resources. The study raised important issues from the perspective of OVC caregivers particularly about how they want to be supported, and gave voice to the voiceless. The information raised in this study provides service providers, stakeholders, government with the information that could inform their interventions when assisting OVC caregivers.

The bio-ecological model is apt for the study because extended family and community members do not exist in isolation but within a number of other sub-systems within the environment (Swick & Williams, 2006). The theoretical framework shows the relationship between different systems and how they influence each other. It also shows how families are impacted on if certain conditions or factors are present or absent. However, the bio-ecological model is limited in the sense that it does not show what causes the absence or presence of these conditions or factors and how these factors can be better managed in order to enhance the capacity of extended family and community members that care for and support OVC (Swick & Williams, 2006).

6.4 Recommendations

6.4.1 Recommendations at the practical level.

6.4.1.1 Counselling.

Counselling should be provided for both caregivers and OVC. For example, the caregivers of OVC face numerous challenges such as violence, meeting material needs, and lack of financial support, while OVC face challenges such as grieving and bereavement, and emotional adjustment (Mdletshe, 2008; Perumal, 2011). These issues need to be addressed in counselling. Therefore, social workers and those who are professionally trained to give counselling should offer this service to OVC caregivers and OVC. This will help in creating loving, caring and supportive families where caregivers and OVC develop a bond that will help them to deal with any negative stress in their lives.

6.4.1.2 Support groups.

Support groups should be formed in all municipal wards. It was disquieting to find that no support groups exist in the two districts where the research was conducted, although literature (Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2007) has shown that support groups played a supportive role to caregivers. Caregivers try to cope alone without the psychological help from other OVC caregivers.

6.4.1.3 Workshops.

Workshops that will include both caregivers and OVC should be organised at least twice a year in each ward by social workers. The aim of these workshops would be to strengthen relations in the mesosystem. The strengthening of relations between the caregivers of OVC and OVC will be achieved by educating both OVC and caregivers about the experience of each other. Caregivers should be educated on the experiences of OVC such as experiences at school, grieving, and challenges unique to OVC, while OVC should be educated about experiences of caregivers such as their daily struggle to provide material needs, lack of financial resources, unemployment, and their experience with social workers (Swick & Williams, 2006).

6.4.1.4 Office for caregivers.

An office that will deal specifically with the needs of caregivers should be established in each Ward. For example, problems regarding the registration of OVC, documents needed, and school-related problems could be addressed in this office (Hearle & Ruwanpura, 2009; Kiggundu & Oldewage-Theron, 2009; Mdletshe 2008; Perumal, 2011). This office could also play as a liaison role between caregivers and other stakeholders, and consolidate efforts to assist caregivers. This office could also manage a database which could be periodically updated of OVC caregivers and OVC. The establishment of this office by DSD could significantly decrease the caseload of social workers (Perumal, 2011).

6.4.1.5 Imbizo.

DSD officials, NGOs, councillors and CCG should form a stakeholders' meeting where they can collaborate in bringing necessary services to caregivers. At the moment, it seems these structures assist OVC only (Govender et al., 2012). Stakeholders' meetings should be held periodically to address problems faced by caregivers and OVC, and charted a way forward to help them. Imbizo that included all stakeholders could be called once after 2 years, in order to determine policy for government future engagement with caregivers and advocate on behalf of caregivers.

6.4.1.6 Mentorship program.

In each ward, mentorship programs that encourage involvement of men should be established. It seems the work of caring and supporting OVC is a women's duty and the non-involvement of men is disquieting (Richer & Desmond, 2008; Ritcher et al., 2008, 2009). For example only two males attended the discussions for this study, although the discussions took place on a Saturday. Males should be given a workshop on how they can mentor young people in their communities.

6.4.1.7 The FCG/CSG.

OVC caregivers are experiencing financial difficulties and it is recommended firstly that the CSG/FCG should be substantially increased (Freeman & Nkomo, 2006). The money that they receive is insufficient to meet their household needs. Without adequate cash injection,

extended family and community members that provide care to OVC will remain poor and struggling to meet its daily needs. Secondly the FCG/CSG should follow not a child and should not terminate when a child finishes primary schooling, as suggested by Lund Committee (Aguero et al., 2006; Meintjes et al., 2003). It is recommended that such a system should change and FCG/CSG should follow an orphan until that child finishes school irrespective of their age. Thirdly bursaries, specifically for orphans, either in university or Further Education and Training should be established so as to help OVC and their caregivers (Hearle & Ruwanpura, 2009; Shaibu, 2013). The government should be lobby firstly to direct financial assistance to families rather than children, and secondly to substantially increase the financial support to families (Ritcher et al., 2008).

6.4.1.8 Family day.

There is an urgent need to boost up healthy communication between caregivers and OVC, especially concerning the question of respect. Caregivers complained that OVC do not listen or respect them (Hearle & Ruwanpura, 2009; Nyasani et al., 2009). For example, having a family day where OVC caregivers and OVC are involved can boost communication, and the history of the family and clan should also be shared with OVC. The sharing of the history of the family and clan would bring with it a sense of pride, ownership of the family, and family's stories or clan's stories by their very nature command respect to the listeners (Swick & Williams, 2006). Telling family stories and promoting family heroes is side-lined by technology and need to be revived so as to build bond and respect between OVC and their caregivers.

6.4.2 Recommendations at policy level.

6.4.2.1 Family-centred approach.

It is recommended that government should adopt a family-centred approach to assisting OVC (Ritcher et al., 2008). To date, the focus of the government and international community has been placed almost exclusively on OVC, with many programmes attempting to provide services and support directly to children (Ritcher & Desmond, 2008; Ritcher et al., 2008). Seldom have they seen their families, despite their great need for assistance. It is within family that care for children are provided. Families are the most important network for orphans and it is families that carry the heaviest load in treating, caring for, supporting and protecting children

(Ritcher & Desmond, 2008). Therefore assistance geared towards orphans should be directed to families rather than to orphans, thus adopting a family-centred approach.

6.4.2.2 Partnering with families and communities to care for OVC.

It is recommended that stakeholders should partner and explore with extended families and community members ways that might help them to care for OVC. OVC caregivers must be seen as major players in caring for OVC rather than being seen as charity cases. This means that stakeholders should adopt an assets-based approach (Grobler, Schenck & Du Toit, 2003) where the strength of families to care for OVC is explored rather than adopting a deficit model – looking at what is not working in families (Swick & Williams, 2006). Families that care for OVC have shown courage to find strategies to cope with the burden of caring for OVC and this should be explored further in detail. This means that stakeholders should listen with a third ear in order to gain perspective on their strength (Grobler, Schenck & Du Toit, 2003).

6.4.2.3 Interdepartmental collaboration.

There should be a greater interdepartmental collaboration between DSD, Home Affairs and the children's court in order to easily facilitate application of the FCG. This will lead to consistency in documents required for application (Perumal, 2011).

6.4.2.4 Workshops stakeholders helping OVC caregivers.

All Social workers (including those employed by NGOs) should be given workshops (Perumal, 2011). For example, a workshop could focus on the Children's Act, No. 38, of 2005, the recent court decision regarding the FCG, White Paper for Social Welfare (Department of Social Welfare, 1997), White Paper on Families 2012 (RSA, 2012), reports and documents from the ministry of social development, and speeches of national minister of DSD and provincial ministers, so that the effort of assisting OVC caregivers will be well coordinated. This will help them to keep abreast with new development and direction assume by their department.

6.4.2.5 Awareness campaigns.

It seems caregivers lack training on how to care for OVC. They know their responsibility concerning the care of their children but they do not know how to care for OVC. They tend to

apply the same methods they applied to their children (Nyasani et al., 2009). The stress of caring for OVC is made worse by the fact that government expect quality care from OVC caregivers (Department of Welfare, 1997; RSA, 2005). Neighbours negatively influence OVC and impact on the quality of care offered. Instead of helping OVC caregivers to cope with responsibility of caring for OVC, they in turn make things worse by telling OVC what to expect and what to demand. Awareness campaigns using media will help to curb the problems encountered by caregivers and will create a sense of unity within community members where a child will belong to a community.

6.4.2.6 Monitoring system.

It is further recommended that government should strengthen its monitoring system. Caregivers in this study complained that social workers and CCG are not properly assisting them. They complained that social workers send them home for no reason, leave place of employment early, are seen doing their shopping, and are not monitoring placement of children. Unless strong mechanism to monitor social workers and CCG are put into place such allegation will continue.

6.4.2.7 Non-Governmental Organisation.

It is further recommended that government should make a conscious decision to work hand in hand with NGOs in assisting caregivers. Caregivers in this study reported that NGOs in their area focus exclusively on children, ignoring their needs. Working together and focus not only on children but also on families that care for orphans will help families move out of poverty and focus on loving and caring for OVC.

6.5 Implication for Further Research

Future studies on extended family and community members that care for OVC should focus not only on understanding challenges or experience of extended family and community members, but they should also explore strengths of extended family and community members using the assets-based approach in order to help them tap on their strength to continue care for OVC. Future studies also should investigate the capacity of extended family and community

members separately because it seems challenges faced by extended family are not those faced by community members.

Moreover, the present study was limited to uMgungundlovu and uThukela districts in KwaZulu-Natal and therefore, results cannot be generalized to other areas in South Africa. This is because each district and province is unique and has unique problems; nevertheless, this study offers a new perspective on what it means to be an OVC caregiver. In order to ensure that findings of this present study are relevant to the population of extended family and community members that care for and support OVC, a larger study using both quantitative and qualitative methods to the majority, if not all provinces in South Africa is recommended. Hence, it will also be possible and pertinent to generalize findings to the above mentioned population.

Perhaps these findings, limited as they are, could be useful in designing and informing policy that will guide all stakeholders involve with extended family and community members that care for and support OVC. The bio-ecological theory showed that caring of OVC by extended family and community members is more complex than literature and findings of this study suggest, and it further points to future research about the caring and supporting of OVC by extended family and community members.

6.6 Conclusion

This chapter presented the conclusion drawn from the results of this study, recommendations and significance of the study. Recommendations are presented so that those who engage with OVC caregivers may direct their interventions to what they pointed out in this study. OVC caregivers expressed in this study how they would like to be assisted and it is in the interest of all stakeholders to listen and implement their suggestions.

This study was just a tip of an iceberg and in-depth study will need to be commissioned. Although this study scratched the surface on the capacity needs of OVC caregivers, it revealed important information that can already be used to assist OVC caregivers. This study highlighted emotional and psychological stressors extended family and community members are forced to endure under difficult circumstances of caring and supporting OVC. These emotional stressors

will remain unless something dramatically is done to help them face and fight these stressors in their lives. The child centred approach adopted by our government, from the recommendation of Lund Committee, seems to fail families and does not alleviate poverty as it was envisaged by the government; families' sees child centre approach as undesirable. Family centred approach in assisting families should be adopted and employment opportunities for OVC caregivers and OVC be created. Such approach will liberate families from perpetually depending on government for handouts. Only when a family centred approach is adopted and families that care for OVC are fully support (physically, emotional and spiritual) then OVC caregivers will provide the optimal care to OVC and at the same time moving to the next level of Maslow's hierarchical needs.

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Appendix A

School of Applied Human Science-Discipline of Psychology University of KwaZulu-Natal

...../...../ 2013

Dear Ward Councillor or Chief/Induna

I am Vusumuzi Penyane, a Master's student in Counselling Psychology at the University of KwaZulu-Natal. As part of my studies I have to undertake a research project and for this reason I have to study the capacity needs of extended family and community members that care for and support orphans and vulnerable children (OVC) in your area.

The reason for undertaking this research project is because so little is known about the capacity needs of extended family and community members who care for and support OVC in uMgungundlovu and uThukela districts.

I will therefore request your permission to contact the people in your area that have personal experience of caring for and supporting the OVC. I would like to meet at least eight to ten (8 to 10) people who care for and support OVC. The important thing about the meeting is that I would like to find out from them what their needs are and how we can strengthen their capacity needs to carry out their task.

I would also like to ensure you that there will be no political discussion.

If you would like further information, please do not hesitate to contact me at 031-736-1296 or 031-772-0719 or 076-760-6080 or on my e-mail at 213569767@stu.ukzn.ac.za. My supervisor will also be available to assist you with any questions concerning the study. She can be contacted at 033-260-5364.

Yours sincerely

.....
Vusumuzi Penyane Date

.....
Supervisor Date

Appendix B

Research interviews questions

1. What made you to decide to care for and support OVC?
2. How did you make the decision of caring for and support OVC?
3. What do you need in order to execute your duty honourably?
4. What are the challenges/obstacles/problems you face in your responsibility?
5. What do you do to cope as a person responsible to care for and support OVC?
6. What support structures do you think will help you in carrying out your duties?
7. How would you like to be helped in your role and by whom?

Appendix C

Consent Form

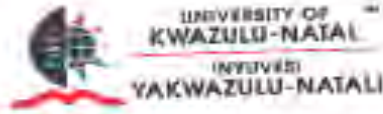
I,....., agree out of my free will to participate in this research topic, which focuses on the capacity needs of extended family and community member in the care and support of orphans and vulnerable children (OVC).

I understand that the information that I will share will be used for research purposes only and that nowhere will my identity be made known in any research report/publication. I am also aware of the fact that I can withdraw at any time during the study without incurring any penalty. I also understand that the audio recording will be destroyed after the study.

.....
Signature of research participant

.....
Date

Appendix D



18 July 2013

Mr Mmamazi M Pemanya 711369767
School of Applied Human Sciences
Pietermaritzburg Campus

Protocol reference number: H05/0482/013M
Project title: The Capacity Needs of Extended Family and Community Members in the Care and Support of Orphans and Vulnerable children in KwaZulu-Natal

Dear Mr Pemanya

Expedited approval

This letter serves to notify you that your application in connection with the above has now been granted full approval.

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

Best wishes for the successful completion of your research protocol.

Yours faithfully

Professor U Rob (Chair) and Dr S Singh (Deputy Chair)

/s/

cc: Supervisor: Ms Mindle Mamba
cc: Academic Leader Research: Professor D McCracken
cc: School Administrator: Mr Sabelo Dama

Humanities & Social Sciences Research Ethics Committee
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Website: www.ukn.ac.za

Hosting Sites are: Pietermaritzburg Pietermaritzburg Pietermaritzburg Pietermaritzburg Pietermaritzburg Pietermaritzburg



Appendix E

**School of Applied Human Science-Discipline of Psychology
University of KwaZulu-Natal**

...../...../ 2013

Dear research participant

The Capacity Needs of Extended Family and Community Members in the Care and Support of Orphans and Vulnerable Children (OVC) in uMgungundlovu and uThukela Districts

I am Vusumuzi Phenyane, a Master's student in Counselling Psychology at the University of KwaZulu-Natal. As part of my studies I have to undertake a research project and for this reason I have to conduct a study exploring the capacity needs of extended family and community members that care for and support OVC.

The reason for undertaking this research project is because little is known about the capacity needs of extended family and community members who care for OVC in uMgungundlovu and uThukela districts. Since you have personal experience about this subject, I regard you as an expert who can provide me with valuable information about this topic.

In this letter, I would also like to explain to you what your participation in this project will involve (if you agree to participate). Should you agree to participate in this research project, I would like to have a focus group interview at a place that would best suit most of you. The focus group interview would not be longer than 60 minutes.

Given that I would like to give you my full attention during the interview(s), and in view of the fact that I might forget some of the valuable information that you share, I would like with your permission to audio record the interview. After the interview, this audio recording will be written out word-for-word. When writing out the interview, all information that might identify you personally will be removed so that no one will be able to link you to any of the information that you have shared during the interview. The audio recording will be stored in a secure place by myself and my supervisor and it will be destroyed after 5 years. Some of the information that you have share will be documented in a research report and nowhere will your name or any personal information be shared; this will make it impossible for anyone to identify you.

THE CAPACITY NEEDS OF OVC CAREGIVERS

Please note that participation in the research is completely voluntary (you are free to participate or not to participate). You are not forced in any way to take part in this research project. Your decision to participate, or not to participate, will not affect you in any way now or in the future. If you agree to take part, you still have the right to change your mind at any time during the study and to withdraw from the study.

If I see that the information that you have shared during the focus group left you feeling emotionally upset, or anxious, I will do debriefing and refer you to a professional counsellor if you wish so.

You have the right to ask questions concerning the study at any time. Should you have any questions or concern about the study, please contact the following numbers 031-736-1296 or 031-772-0719 or 076-760-6080 or on my e-mail at 213569767@stu.ukzn.ac.za. My supervisor will also be available to assist you with any questions concerning the study. She can be contacted at 033-260-5364.

If you do agree to participate in this study, I would like you to sign the consent form that follows.

Yours sincerely

.....
Mr. Vusumuzi Penyane
Student researcher
Email address: 213569767@stu.ukzn.ac.za

.....
Date

.....
Ms Phindile Mayaba
Research Project Supervisor
Email address: mayabap@ukzn.ac.za

.....
Date