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**THE EVALUATION OF THE AIDS CARE PILOT PROJECT AT DURBAN'S CHILDRENS
SOCIETY AS A MODEL OF CARE FOR HIV INFECTED ORPHANS IN DURBAN.**

BY

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ABSTRACT

The HIV/AIDS orphan crisis is one of the humanitarian and developmental challenges facing the global community. Providing a home, medical care, education, psychosocial support and basic needs for these children is part of the challenge that faces our generation. The purpose of this study was to explore whether an AIDS CARE pilot project implemented at DCS was able to successfully place ten HIV/AIDS infected orphans in fostercare.

The ecological perspective provided the theoretical framework within which the study was conducted. This perspective guided the selection of the study samples and the analysis of data. Sample one comprised ten foster parents who resided in various townships and suburbs in Durban. Sample two comprised of semi professional and professional staff that were involved in the daily care of the HIV infected orphans and well as ensuring their placement in fostercare.

The study found that recruitment, training and support were vital aspects in preparing foster parents to care for the HIV/AIDS infected child. The study also found that while residential child care institutions will continue to play a role in the care of children affected by HIV/AIDS, the magnitude and social impact of the disease renders it necessary that alternate models of care (this study proposes one model), within a community development paradigm be developed.

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This dissertation unless indicated to the contrary in the text, represents the original work of the candidate.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

The devastating impact of the AIDS crisis on children in the developing world has yet to be fully understood. The number of orphans particularly in Africa constitutes nothing less than an emergency, requiring an emergency response. As already impoverished societies struggle with this massive onslaught their hard won gains in social development, including improvements in child health, nutrition and education will be negated. This study aimed at evaluating the AIDSCARE PILOT PROJECT at Durban Children's Society as a model of care for HIV infected orphans in Durban.

STATEMENT OF THE PROBLEM

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that, at the end of the twentieth century, nearly 19 million people died from AIDS around the world, leaving over 13 million orphans. Africa has been struck the hardest. About 70% of the world's 34 million HIV positive people live in the South of the Sahara desert and about 95% of the world's AIDS orphans are African. In the Ugandan context, orphans are children of less than eighteen years of age who have lost one or (commonly) both parents, initially due to civil strife but increasingly because of the burgeoning Acquired Immune Deficiency Syndrome (AIDS) that now affects the entire country. The 1.7 million estimate for the number of children orphaned by AIDS is expected to rise to 3.5 million by 2010, according to the United Nations Children's Fund (UNICEF). In seven Southern African countries, an extraordinary one in five adults (defined as those aged 15 to 49) is thought to be infected (Guest, 2001). They're all in Southern Africa. In 1998, South Africa had an adult HIV prevalence of about 13%. By 2000, 20% were infected. That's over four million infected people, the largest number in any country. Unless sexual behaviour changes, between 6 – 10 million South Africans, from a population of about 42 million, may die of AIDS in the next 10 – 15 years. The figures are staggering, perhaps 19 million dead already and 12 million grieving children around the world. With 34 million currently infected and likely to die during the next decade, many more children face being orphaned.

The United States Agency for International Development (USAID) estimated that 44 million children globally would have lost one or both parents by 2010, mostly to AIDS (Guest, 2001:1). ✓

AIDS (Acquired Immune Deficiency Syndrome) was first recognized as a syndrome of illness in 1981 (Berer and Sunanda ,1993:6). It is caused by the Human Immunodeficiency Virus (HIV), which is one of a group of viruses known as “retroviruses”. Two major strains of HIV have been identified to date, though within these there are many different variations. HIV-1 is most prevalent in Western countries, Asia, Latin America and most of Africa. HIV-2 is found mainly in West Africa, although it has been reported in Mozambique and is thought to be present in Kwa-Zulu Natal. It is more difficult to detect than HIV 1 and may take longer to affect individuals post infection (Whiteside , 1995:4).

In order to develop, HIV has to enter the bloodstream, the main routes of transmission from one individual to another being through sexual contact, from contact with infected blood or from an infected mother to her unborn or newly born child (Whiteside ,1995:3) describes the progress of the disease. Immediately after infection individuals are highly infectious, although at this stage they do not show any symptoms and will not have produced sufficient anti-bodies for the virus to be detected through testing. This follows a “latent period” in which the individual still does not show symptoms but the virus can be detected by testing. During the next stage individuals begin to develop “opportunistic” infections and AIDS related illnesses, but HIV is a slow-acting virus and individuals can remain well or experience only minor symptoms for years. Initially bouts of illness may be of short duration and not particularly severe, but they become ever more debilitating as the disease develops.

AIDS is defined by Berer and Sunanda (1993) as a list of minor illnesses, which alone or in combination are most likely to indicate that a person has AIDS.

Manifestation of AIDS is similar throughout the world, but there is age, gender and regional differences in the presentation of the disease (Fleming, 1993). The length of time from HIV infection to the development of AIDS varies greatly, and is

dependent on an individual's general state of health, socio-economic condition, age and access to health care (Berer and Sunanda, 1993). The average time for orphans is estimated to be at 7-8 years Whiteside (1995), but this is generally higher in developed countries (Berer and Sunanda, 1993), and lower in the less developed countries. In South Africa the length of time from infection to the onset of AIDS is said to range between 3 and 8 years (McKerrow, 1995).

The length of time from the point of HIV-seropositivity to death is similarly varied, ranging from a few weeks to a possible 30 years, with a mean of 7-8 years (Whiteside, 1995:5). Although there has been some optimism about new drug treatments for AIDS patients, these are far too expensive to become widely available in less developed countries (Wood & Masson, 1997:6). As yet there is no cure or vaccine for AIDS, which is thought to be almost always fatal.

AIDS was first reported in South Africa in 1982. It emerged initially in the white homosexual population, but by 1985 heterosexually transmitted cases of HIV infection had been found in migrant labourers working in the mines (Patel, 1995:1). The epidemic has spread most rapidly among African heterosexuals. Predictions by the World Bank suggest that by 2005 eight million South Africans will be infected and that 300 to 500 people will die from AIDS-related diseases every day.

A total of 4.7 million South Africans (i.e approximately one in nine or twelve percent of the population) were estimated to be infected with HIV at the end of 2000, based on an official survey of women attending public antenatal clinics. Some 2.5 million women and 2.2 million men aged between 15 and 49 years and 106000 babies, were estimated to be HIV positive. According to Mark Heywood (2001) the lawyer for the Treatment Action Campaign (a non-governmental lobby group), 75000 babies or 30 percent of the babies born to HIV positive mothers were born HIV positive every year.

The estimated number of orphans in South Africa by 2010 will be around 2 million and of this number, 500 000 will be found in Kwa-Zulu Natal. This suggests that up to 1 in 5 children in school, or of school age, could be orphans. The impact of this suggestion is beyond the experience of anyone in the educational, social and welfare

field and certainly beyond the capacity of the limited counselling and support services available. The orphans will be another lost generation, growing up without family, without care, without love, compared to other children, they will be more likely to be malnourished, unhealthy and ill; more likely to drop out of school, more likely to join gangs and turn to illegal activity to survive (Launch of Aids Orphans Trust – ICC – 2/3/02 phamplet). ✓

CONTEXT OF THE STUDY

The Durban Children's Society was constituted in October 1999 as a result of three Child Welfare agencies in the Durban area merging, namely Child Family and Community care Centre founded in 1927; Durban Child and Family Welfare Society founded in 1918; Umlazi and District Child Welfare Society founded in 1936.

The area of operation of the Society is the Durban Metropole and North and South areas including Umlazi but excluding Chatsworth and Phoenix. The Society employs 73 Social Workers and four social auxiliary workers. The Society's core business is child protection, operating mainly in the poor and previously disadvantaged communities including informal settlements within Durban. Included in the work of the Society is a project which devotes specific attention to AIDS infected and affected children. The Society facilitates the development of informal educare centers. In addition the Society operates ten formal educare centers.

While the aim of the Society is to preserve the family unit, there are times when it is necessary to place children within children's homes. An increasing number of abandoned children are being placed in the children's home when it is not possible to find alternate family or community care.

VALUE OF STUDY

The goal of developmental social welfare is a humane, peaceful, just and caring society which will uphold welfare rights, facilitate the meeting of basic human needs, release people's creative energies, help them achieve their aspirations, build human

capacity and self reliance and participate fully in all spheres of social, economic and political life (White Paper for Social Welfare, 1996, Preamble).

The value of this study lies in its potential to uphold the rights of the child as espoused to in the United Nations Convention on the Rights of Child (1989) as well as the right to have quality of life. The value of the study is also enshrined in the Constitutional Mission Statement of DCS, which states that as a non discriminatory equal opportunity organization, the Society's objectives are to protect the rights and promote the quality of life of children, families and communities within its area of operation and to work for the course of social justice. The study acknowledges the need to change mindsets about people involved with children infected and affected by AIDS orphans with regards to fostering them. It aims to develop a programme to recruit and train prospective foster parents to care for the HIV infected child. The study acknowledges the need to develop a "best practice model" in providing services to orphans and to disseminate information if successful, encouraging communities to participate in the programme so that fostering HIV infected orphans becomes a norm.

Social workers and childcare workers are at the interface with the community, therefore they are in a position to influence the development and value of policy making.

RESEARCH APPROACH

A detailed description of the Research Methodology is outlined in Chapter Three. A programme evaluation research design was used. The researcher who is the facilitator of the AIDS Care pilot project chose the participants who attended the monthly Masakhane Support Group meetings, which the researcher facilitated. The researcher/facilitator's intention was to evaluate whether the pilot project was successful. The research approach used coheres with the ecological theoretical framework. The ecological theory was used throughout the study.

RESEARCH AIM

The aim of this research study was to evaluate the AIDSCARE Pilot Project at Durban Children's Society as a model of care for HIV infected orphans in Durban.

OBJECTIVES OF THE STUDY

The study was guided by the following objectives:

- 1) To establish how effective the pilot project has been in recruiting, training and orientating foster parents to care for HIV infected orphans.
- 2) To evaluate the foster parent's experience of fostering HIV infected orphans.
- 3) To evaluate the service providers perceptions of the pilot project.
- 4) To establish whether the Masakhane Support Group has been successful in meeting the needs of foster parents.
- 5) To evaluate the HIV infected children's progress in fostercare.

THEORETICAL FRAMEWORK

The ecological perspective was viewed as an appropriate framework within which to contextualize this study. 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). McKendrick (1990) viewed the person in transaction with the environment stance as being the most useful and relevant approach for the South African social worker. One of the distinguishing characteristics of social work is its focus on the "wholeness and the totality of the person – in situation, gestalt", (Thackeray, Farley & Skidmore, 1994). The holistic, dynamic view of the reciprocal exchanges between people and environment moves away from simplistic linear cause – effect explanations (McKendrick, 1990). In fact, Brower (1988) maintained that the ecological model was one that grew directly out of the social work profession's dual commitment to the person and to the environment. The environment is 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 ones demographic characteristics" (Brower,1988:424). The author stressed that the

concepts “person” and “environment” were inseparable and that behaviours must be viewed within the person-environment interaction.

Similarly Whittaker et al (1986:482) viewed the environment as a set of “nested concentric structures”, each influencing the other and ultimately the developing child and these structures may be viewed as contexts or systems that never function in isolation.

The ecological perspective accommodates a broad spectrum of problems and needs, it provides a suitable framework for understanding – the concepts illness and death and re-approval process between people and the environment.

Whittaker et al (1986) outlined the value of this paradigm in designing service programmes for children, youth and families, namely:

- building more supportive, nutritional environments for people through various forms of environmental helping that are designed to increase social support.
- Improving competence in dealing with proximate and distal environments through the teaching of specific life skills such as social skills for adolescents, conflict resolution skills and family living skills.

This study was based on the assumption that foster care is a preferable alternative to traditional residential care models for the HIV infected child. Placement in a family can enhance the HIV infected child’s well being and extend the lifespan of the infected child. USAID (2000:11)

“Adoption and fostercare mechanisms will be in need of special placement. This will involve strengthening and expanding government and non governmental fostercare and adoption programmes, supporting measures which ensure the rapid placement of abandoned infants ... Institutional placement is at best, a last resort, to be used only on an interim basis until a more acceptable

placement can be arranged. Institutional care is not an acceptable solution to the growing problem of AIDS orphans, because it generally fails to meet children's developmental needs, including opportunities for attachment and normal socialization (and cultural norms). The younger the child the more likely that placement in an institution will impair his/her psychological development. It is too expensive to provide on large scale and it tends to create more demand for children's placement by poor families who are struggling to care for orphans.

The UNICEF report (2000:18) states that programmes should be "promoting supportive and economically self sufficient community environments, promoting community based responses including identifying vulnerable children, finding innovative ways to support and strengthening family and community coping mechanisms, supporting the development of effective community based approaches to assist children and families affected by HIV/AIDS.

The ecological perspective is closely linked to the primary prevention perspective as both these approaches focus on people and their interaction with the environment. The focus of the ecological perspective and primary prevention are on opportunities for positive social participation and skills to promote building successful relationships (Fraser ,1996).

DEFINITION OF KEY CONCEPTS

Foster parent/s - a single/couple who assume custodial responsibility for a non-related child through a court order.

AIDS – Acquired Immuno Deficiency Syndrome,

Orphan/s- child/ren who have lost both a natural mother and father and do not have a guardian

Vulnerable children – children who are at risk of abuse, neglect and abandonment.

Foster care- placement of a child in terms of Section 15(1)(b) of the Child Care Act with a related/non related family. The family gets temporary custody over the child. The placement is supervised by a social worker.

Kinship care- caring for a child who is biologically related or a child where a relationship already exists

Adoption- refers to a permanent placement which gives guardianship to the adoptive parents which affords the child the same status has the biological child.

PRESENTATION OF THE STUDY

Chapter one provided an introduction to the research study. The statement of the problem, the objectives of the study, its theoretical framework as well as definition of key concepts were outlined. The Literature Review is presented in Chapter Two. In Chapter Three the research methodology, data collection and sampling guiding the study is highlighted. Chapter Four focuses on the analysis, interpretation and discussion of results. In Chapter Five, the conclusions and recommendations of the study are presented and some proposals are suggested.

CHAPTER TWO

LITERATURE REVIEW

This chapter deals with the review of literature concerning various aspects of AIDS and its social implications for infected orphans. An outline of paediatric AIDS, mother to child transmission prevention, the global response to orphans, the South African governments response to the pandemic outlines the extent of the problem. The Durban Children's Society response and the models of care are then discussed. The focus of this chapter will be on foster care of HIV/AIDS orphans.

Nature and extent of HIV/AIDS in South Africa

Global statistics regarding the nature and extent of HIV/AIDS has already been outlined in Chapter One. The Child Health Policy Institute in Cape Town estimates that by the year 2005, South Africa will have over one million AIDS orphans, many of whom themselves will be HIV positive. Poor, under-resourced communities already carrying the burden of providing for the sick, the elderly and the orphaned will be unable to cope with caring for the escalating number of victims of the AIDS epidemic. South Africa has only recently emerged from the tragedy of apartheid; the country is currently in the process of major socio-economic transformation that touches every aspect of life. Social Welfare needs have to compete with demands for more housing, better education, provision of water and electricity, improvement of roads in disadvantaged areas and crime prevention. Moreover, as South Africa struggles to shake off the legacy of apartheid and to create a more equitable and just society, it is faced with new problems created by a rapidly developing HIV/AIDS pandemic. The pandemic has raised immense social and economic problems in its wake, not the least of which is the impact of HIV/AIDS on children and their families.

Mother to Child Transmission Prevention

Most cases of pediatric AIDS is due to vertical transmission. Paediatric AIDS occurs in populations with limited access to healthcare and HIV related mortality would be a more serious problem where child mortality from other causes is low by developing

countries standards. Since women are the traditional providers of childcare, the high ratio of women infected has devastating consequences for children. Veeran (2000) stated that women's position in society is dictated by the various roles they play. In most if not all situations woman have the dual responsibility of maintaining a household and working, placing additional strain on the woman to take greater responsibility for her and her family's well being.

Although the availability of anti-retroviral drugs to reduce mother to child transmission has been promoted in KwaZulu Natal, children may become infected by their infected mother. The long-term impact will be the loss of mothers and fathers of young children and the subsequent increase in the number of orphans. On average babies who are infected will develop AIDS by the time they reach between 9 and 18 months. Their chances of survival thereafter vary between 3 months to 2 years. Although a growing number of children as was evident in the current study are reported to be surviving beyond 5 years, these remain the exception. In Kwa-Zulu Natal most do not live to see their second birthday (McKerrow, 1995).

More than 150 children are born with HIV every day in South Africa. They live short and miserable lives, encountering respiratory infections, malnourishment, diarrhoea and fungal infection. Repeated regular visits to health facilities helps a little, but after a short life with much pain, these children die. Scientific research conducted by the Nelson Mandela School of Medicine (2001) shows that HIV transmission to half these children can be prevented if the government implements a mother-to-child transmission prevention (MTCTP) programme. The research further shows that MTCTP through the use of Nevirapine (a drug that has been registered for this purpose) is safe, effective, cheap and simple to administer. Despite Boeringer-Ingelheim's offer to the government of free Nevirapine for five years, it has refused to implement such a programme. TAC decided to launch the court case to pressurize government (which has been ignoring science, economics, morality, good planning, good governance and the law on this issue for more than five years) to make anti-retroviral drugs freely available to all sectors of the communities; this action occurred only after three years of meetings, petitions and protests went unheeded by the government. In September 2001, a court action was set in motion. Treatment Action Campaign's case was based on the premise that government was not implementing

a national programme, government was failing to recognize women's right to dignity, reproductive choice and health care and children's right to life. On 26 November the first hearing took place in the Pretoria High Court. On 14 December, the High Court ruled in TAC's favour, ordering the government to:

1. Develop a roll-out plan for a national MTCTP.
2. Make Nevirapine available to pregnant women with HIV who give birth in the public sector, to babies in public health facilities to which (government's) present programme for the prevention of MTCT of HIV has not been extended.

Government appealed this ruling and took the matter to the Constitutional Court. The Constitutional Court heard both sides again on 2 May 2002 and is expected to make a final judgement either reinforcing the High Court order or leaving it up to the government to decide when, how, or whether to implement a national programme to prevent MTCT.

Non Governmental Response to the Problems of Orphans

The most critical challenge currently facing non governmental organizations seeking to assist AIDS-affected children is that of developing responses to problems on the same enormous scale that they are occurring. Millions of children have already been orphaned by HIV/AIDS; tens of millions more will lose one or both parents to the pandemic in the first decade of the 21st century. The World Bank estimates that under "normal" circumstances 5 percent of children in Africa are parentless and un-accommodated within the extended family structure. This figure changes markedly when one introduces AIDS and its accompanying social consequences to the picture. Tens of millions more will suffer indirectly. While it is reasonable to believe that the international community will make substantial resources available to assist these children than are currently allocated, resource levels will still be far lower than required. Each governmental/non governmental organization involved in programming must carefully consider how to use its limited resources to ensure quality care is provided to the highest number of AIDS affected children/adolescents possible. Programmes should be designed and developed to benefit as many children as

they can (scaling out) and effective approaches should be adopted and adapted by organizations in other areas (scaling out).

The problem of orphans is old as society itself, the only difference now is that the problem as now become more pronounced due to the AIDS pandemic. Thus there have always been care arrangements both formal and non formal. The responses to the problems of orphans include the use of the extended family system, foster care, adoption, institutional care and community based care as explained on pg.22.

South African child welfare agencies are faced with a huge task, not only must they find strategies to tackle poverty and redress inequalities created by apartheid, but in addition they must develop effective models of care to support children and families affected by the rapidly spreading HIV/AIDS pandemic. HIV/AIDS is a global epidemic that is resulting in a vast number of children with dead or dying parents (Levine, 1992). When their parents die, these children need financial assistance, shelter, food and medical care. These psychosocial needs of the children would have once been available through the extended family (aunts, uncles, grandparents and cousins) support system. The increase in the number of orphans has increased the responsibility of the extended family system, which in the past used to accept the responsibilities of orphans. Since society has always had an orphan problem existing social structures provide care to orphans in traditional ways. The extended family (uncle's, aunt's, elder brothers and sisters and grandparents) is a source of physical, moral support. Increasing impoverishment and numbers of orphans tend to breakdown some of these traditional structures. Furthermore socio-economic factors are undermining the effectiveness of the extended family system. These include the harsh economic environment, which makes it difficult for individuals to extend assistance to their needy relatives. Also, there has been a gradual weakening of kinship ties as a result of urbanization and industrialization. Those who take on the responsibility often do so with little or no support from the government. As a result the material needs of the orphans are often not met. The problem is often compounded by the fact that when parents die, they rarely leave any inheritance to their children, as they use all their resources to seek treatment for AIDS related

illnesses (Kaseke & Matshalaga, 1998). This impacts negatively on the welfare of orphaned children.

In developing countries orphaned children have traditionally been cared for by family members. Although the traditional arrangements for the care of orphaned children still exist, the magnitude of the problems of AIDS orphans has rendered the extended family system unable to cope. A significant feature of the AIDS pandemic has been the emergence of child-headed households and households headed by elderly persons. The existence of child-headed households in particular is a reflection of the growing incapacity of the extended family to provide care and protection to the orphaned children. Under such circumstances the eldest child assumes the responsibility for looking after the younger siblings, sometimes with the assistance of relatives or other members of the community. Unfortunately these children rarely have the resources and often find it difficult to access social safety nets because of their minor status. As a result they struggle to meet their basic needs (Kaseke & Gumbo, 2001).

In areas where an increase in the prevalence of AIDS has been noted, there are increasing stresses to the capacity of extended families and communities to provide care. Hence the option of a residential facility which is not an appropriate option is chosen. These residential facilities generally do not adequately meet key developmental needs such as consistency of care, especially for younger children. In addition, when children grow up without family and community connections, they are cut off from support networks they will need as adults, as well as the opportunities to learn the skills and culture that children learn in families in their communities. Their social integration in adulthood is a more difficult task as they are accustomed to been socialized in a group. They are usually ill-prepared for life after they leave the institution and this is exacerbated by the fact that they do not have marketable job skills when they leave the institution. The Inter-Ministerial Committee (IMC) on Young People at Risk (1996:26) stated that in terms of the continuum of care services to emotionally and/or behaviourally troubled children and youth (and their families), it is recognized that (a) there are presently more than 30 000 children in the child and youth care system and it will take years to develop and implement the full framework and transformation of the system, (b) HIV/AIDS is a factor which

- Assist children, families, communities and provinces to identify the most vulnerable, to help prioritize resources and to preserve family life;
 - Strengthen families, children and communities in using their own strengths to help themselves through prevention, counselling and support to those who have been traumatized;
 - Support families, communities and other stakeholders to identify and implement strategies that promote the children's well being, for example medical care, substitute care, nutritional needs, educational needs and protection from abuse and exploitation;
 - Identify external supports for communities and enable communities to build support networks.
- b) The implementation and further development of effective and affordable community based care and support models and targeted preventative interventions.
- c) To ensure that the Comprehensive Childcare Legislation being developed by the SA Law Commission deals effectively with the needs of orphans and this includes the protection of children's inheritance.
- d) Establishing and strengthening poverty alleviation / eradication programmes in affected areas.
- e) Training programmes for professional community workers, child and youth care workers, community leaders, families, NGOs and CBOs.
- f) To foster intersectoral collaboration at all levels and establish integrated institutional arrangements at provincial, regional and local levels for implementation and monitoring of the strategy.
- g) To determine the financial implications of implementing the strategy.

Services to children infected and affected by HIV/AIDS would need to be contextualised within the framework and the process of the transformed child and

youth care system, which has been established as a process and procedure. The framework is underpinned by a developmental approach which focuses on strengths rather than pathology, understanding and responding appropriately to developmental tasks and needs, maximizing the potential of each individual, family and community to deal appropriately with challenges confronting them.

Durban Children's Society's Response to the AIDS Pandemic

Durban Child and Family Welfare Society, Child Family and Community Care Centre of Durban and Umlazi and District Child and Family Welfare Society merged in October 1999 to become Durban Children's Society and hereafter referred to as DCS. The Society became concerned about the increasing number of children in distress because of the death of their parents and primary caregiver due to HIV/AIDS. With the support and assistance of the AIDS Foundation of South Africa, an AIDS Co-ordinator (COR) was appointed. It seemed clear that the traditional strategies of alternative care for vulnerable children such as foster care; adoption and residential children's homes would not meet this increasing need. Foster care is the placement of child through a court order in the temporary custody of a relative or a non related family where no written parental consent is required; adoption is the placement of a child through a court order into the permanent custody and guardianship of a new family with consent from the biological family; a children's home is the placement of a child through a court order into an institution which can be characterized by dormitory accommodation or a cottage system where children are socialized in a group setting (The Child Care Act 74/1983)

An evaluation of statistics of DCS compiled for the period October 1999 to April 2002 of registered HIV/AIDS related cases from all geographical areas that is areas in the north of Durban to Umhlanga, south of Durban to Umlazi and west of Durban to Reservoir Hills serviced by DCS indicated that over the 37 months, 98 parents were deceased leaving a total of 370 orphans who were referred to the society for services. These children were referred to DCS as a result of their parents dying from an AIDS related illness. (Neilson – Aids Co-ordinator, DCS April 2002). At the end of November 2001, DCS was monitoring the care of 2142 orphans in Kinship care and a further 321 in non-related foster care. Between 70 and a 100 new orphans are now

being registered each month. This has increased from between 30 to 50 orphans since December 2001.

The decision was made that the Society's services would have to be re-examined and modified and / or new care models developed, changes had to be made based on the following principles:-

- all children have a right to family care and siblings should remain together where possible;
- the family (nuclear and extended) is the primary care system and must be supported and empowered;
- children who cannot live with their own family should preferably remain in their own community or in a similar environment and culture;
- all children have a right to protection from abuse and exploitation.

These principles were and are compatible with the philosophical stance adopted in the South African White Paper on Social Welfare professional social work values and also DCS Mission and Aims. The above principles are also enshrined in the United Nations Convention on the Rights of the Child (UNCRC) 1989 . The UNCRC states that " children are born with fundamental freedoms and inherent rights of all human beings. This is the basic premise of the Convention on the Rights of the Child, an international human rights treaty that is transforming the lives of the children and their families around the globe. People in every country, in every culture and every religion are working to ensure that each of the two billion children in the world enjoy the rights to survival, health and education; to a caring family environment, play and culture; to protection from exploitation and abuse of all kinds; and to have his and her voice and opinions taken into account on significant issues.

According to DCS statistics for the period March to May 2000, 275 orphans needed alternative family care ie. Substitute care. The provision of substitute care is one of the most widespread remedial approaches, which is practiced in both developed and developing countries. In South Africa voluntary organisations including child welfare societies, have been instrumental in developing and administering a range of substitute care options for children in need of fostercare. DCS is committed to

developing strategies and implementing services which effectively mobilize, capacitate and involve children, families and communities in combating the impact of HIV/AIDS with particular emphasis on facilitating the care of children infected and affected by the pandemic. DCS has prioritized a range of services, which will ensure that orphans, children infected with HIV and other vulnerable children have access to adequate family or family type care. DCS with the support of the AIDS Foundation of South Africa launched its Co-ordinated Orphan Response (COR) aimed at developing a range of home or community- based care for children infected and affected by AIDS and other vulnerable children.

The general objectives of COR which forms the conceptual model of the programme are:

- a) To establish the number of orphans and vulnerable children (OVC) within our area of operation and identify their needs and the needs of their caregivers.
- b) To promote the early identification and rapid referral of vulnerable children.
- c) To ensure the adequate care of OVC's already integrated into a family system.
- d) To identify, promote and facilitate alternative family care for OVC's in need.
- e) To develop and facilitate new community-based care and support systems for OVC's in need.
- f) To design, develop and evaluate a "continuum of community care" for OVC's and evaluate the effectiveness of the range of options incorporated therein.

One of the strategies for achieving objective 4. was to implement the proposed "AIDS Care" Project. This pilot project had been funded for three years, should the project be successful the funding will be continued.

The AIDS Care pilot project promotes, encourages, facilitates and supports the placement of HIV infected babies into foster family care as an alternative to institutional care. The project has recruited, orientated and assessed 10 special foster parents/families who are willing to offer a suitable and loving home to a HIV positive baby or young child who may have been orphaned or abandoned, who would benefit from being cared for within a family rather than in a children's home.

The Project AIDS Care Leader (PAL) who is the researcher processes the essential statutory procedures and monitoring the utilization of the child's "Aids-Care" allowance and state provided foster child grant. More importantly, the project leader offers preparatory and ongoing individualised practical and emotional support, as well as facilitating support groups to foster parent. The project leader has initiated a Support Group for these foster parents. The Support Group is known as the Masakhane Support Group (MSG). It was formed in June 2001 with 6 foster parents. It presently comprises of 12 foster parents. The MSG meets once a month and the meeting is facilitated by the project leader. The Project includes the provision of grief and bereavement counseling for the foster parent. Nurses will provide special training and advice to help the caregivers to defer the onset of opportunistic infections, cope with the inevitable bouts of ill health and if possible, continue giving "their" child personal love and emotional care during the terminal phase. Such assistance includes the use of vitamins and/or nutritional supplements, special care necessities, palliative care and/or respite care. A paediatrician is available to give essential advice. The initial Workplan (attached as Appendix A) provides an outline of the project.

Models of care

In South Africa voluntary organizations including child welfare societies, have been instrumental in developing and administering a range of substitute care options for children in need of foster care. In some countries like Britain and America foster care is seen strictly as a temporary arrangement, whereas in other countries like South Africa the norm is for long-term and quasi-adoption placements. Given these diversities Colton and Williams (1997:48) suggest the following inclusive, if rather cumbersome, definition of foster care.

a) Foster care

Foster care is care provided in the carers' home, on a temporary or permanent basis, through the mediation of a recognized authority, by specific

carers, who may be related or not, to a child who may or may not be officially resident with the foster carer.

Pakati (1992) states that many children in South Africa live apart from their parents either temporarily or permanently, it is not uncommon that children are brought up by an aunt or uncle. Such family care is not re-imbursed and the parents can and do claim their children back whenever they feel like. Kinship care is common, especially in the African population. These arrangements are generally informal, being agreed between individuals without recourse to formal rules and regulations. By contrast, formal foster care is defined by law and its practice is informed by regulations and procedures. Like adoption, the practice of formal fostering was introduced into South Africa and has been based on literature and practice drawn from Western countries.

- b) Foster care by a group or community rather than an individual.

Here social, religious, sport or other cultural groups accept responsibility for the well being of the children, catering for basic needs. Individuals within the group may accept responsibility for specific needs of the children and the group as a whole undertakes with or without outside assistance, to raise the children (McKerrow, 1995).

- c) Family structured models within "registered homes".

This entails the creation of community households accommodating one or more families of orphans within an extended family setting. These households are under the supervision and management of paid, community appointed individuals and committees who provide for either specific needs of the children or for their total care (McKerrow, 1995).

- d) Traditional institutional care

Children are cared for in a group in an institution. They reside in dormitory style accommodation or cottage systems. Their primary caregiver is a shared

child care worker. Economically, institutional care is not feasible for large numbers of children. A cost benefit analysis done by the Aids Co-ordinator at DCS in February 2000 estimated that the cost of retaining a child in a children's home totalled R1572,00 per month per child. In comparison a child placed in fostercare costs the state R410,00 per month per child. The resources needed to support institutional care for a single child can assist scores even hundreds of children if used effectively to support a community based initiative. In communities under economic stress, increasing the number of places available in institutions has often led to more children being pushed from family care to fill those places, where material standards are seen as being higher than what families can provide. This increases the scale of the problem and consumes resources that could do more if directed towards strengthening families and community capacity to care for vulnerable children. Institutional care can be helpful in some cases where there is no other option, as an interim solution whilst a fostering situation is arranged. Children in this situation should be reintegrated into the community as soon as a reliable caregiver is identified.

According to the IMC document children needing residential care in the future are likely to be (1) those children who are orphaned / abandoned and who cannot be absorbed into communities, (2) those who have serious emotional and/or behavioural problems and cannot be best served within their families or in foster care, (3) those who are seriously disabled and who cannot be best served in their families and foster care.

The continuum of care refers to a range of alternative care interventions which offer differentiated programmes and which are compatible with the varying degrees of the young person's need for protection. The continuum logically ranges from adoption and foster care, which is least restrictive at one end through to various forms of secure care with youth correctional facilities at the other end being the most restrictive.

Recruitment of Foster Parents

The recruitment and training foster parents is linked to objective 1 of the study. There is a continuing need for foster homes particularly for older and special needs children. A range of recruitment means are utilized including direct presentations by social workers or foster parents to select individuals or groups; newspaper advertisements and "word of mouth" among foster parents. Stone (1974) and Huntzeger (1974) concluded that recruitment methods are not successful, with the exception of referral by other foster parents. Although some studies report acceptable payment as a factor in attracting appropriate foster parent applications, Grow (1970) and Smith (1970) found that many agencies believe that there is no relationship between the foster care grant (boarding rate) and recruitment. Although various means are utilized agreement on effective methods is lacking. Other recommendations for recruiting include increasing the number of agency staff, utilizing foster parents and foster parent organizations and offering fees for service or reasonable payment.

Motivation of foster parents

Josselyn (1952:20,21) outlines the most common motivations expressed by potential foster parents as:

- a) The family has learned through the newspaper and radio publications that there is a need for foster homes, they have an extra room and feel that they should take a child.
- b) Often coupled with the above is the statement that they like children and would enjoy having an additional child in the home.
- c) The couple has one child and feel that their child shows signs of being spoiled and deprived of the experiences that a larger family seems to have. They therefore wish to enrich their child's own life by taking in the additional child.
- d) The parents wished to have more than one child for medical or economic reasons it is not possible, they wish to augment their family by fostering a child whose stay is not permanent.
- e) They have attempted to adopt, but the agency does not have a suitable child for them, they see a foster child as a substitute for an adopted child.

- f) They have lost a child and have decided to fill the void by fostering a child.
- g) One or the other of the couple was brought up in an orphanage or in an unhappy childhood environment and wishes to give another child with a similar background a satisfactory life experience in their home.
- h) The couple's own children have reached an independent age where they are no longer emotionally dependent. Since the couple is too old to start their own family, they wish to substitute a foster child to meet their emotional needs.
- i) The wife feels that she needs to substitute the family income but does not wish to work outside the home, she decides to augment the family income by fostering.
- j) A sense of religious duty also motivates foster parents to foster a child.

Training of foster parents

George (1970) found in a study that he conducted that child care workers who viewed foster parents as professional colleagues were in agreement with the question that foster parents should attend short training courses in foster care principles and methods. Similarly, foster parents being consistent with their view that the fostering role is very similar to the parenting role, rejected the idea of training courses. One foster parent commented that such courses were necessary only for a few foster parents who cared for 'children in need of special care and treatment'. For the majority of foster children they were not necessary because 'normal children need love, understanding and being part of a family. Such things cannot be 'taught'.

An overview of research found that a majority of programmes emphasize the special roles and relationships in foster care, a few focus on Mother/child interactions or child management techniques. Educational programmes involve a series of weekly meetings emphasizing child development, foster care roles and problem solving. A few programmes give certificates of completion or university credits, none specify any change in foster care payments as a result of program completion.

It is standard procedure in all South African child welfare agencies South African Council for Child Welfare (1987) that prospective alternate parents participate in a screening and training process. This practice benefits all parties involved:

- a) It provides sufficient and accurate information to Court.
- b) Pertinent knowledge of the applicants, their families and resources, facilitates the matching process, which ensures the child's needs are met.
- c) During the screening process, the applicants' motivation, wishes and misperceptions are addressed. This gives the social worker a chance to provide the supportive and counselling services for all prospective carers involved.

Personality traits and characteristics of foster parents

The personality traits and characteristics of foster parents is linked to objective 2 and 3.

Josselyn (1952) states that the emotional maturity of foster parents is very important with regard to the needs of a special child. The prospective carers should insight into children's feelings and child development.

A study done about caregivers of HIV positive children in Johannesburg, Soweto and Alexandra Township in South Africa found that only females responded to their study as woman were commonly recruited as foster parents (Levine, Michaels, Back, 1996).

This Chapter reviewed literature on aspects of AIDS, its social implications for orphans, paediatric AIDS, the global response to the AIDS pandemic, the South African Government's response and Durban Children's Society's response, lastly the models of care for infected children were outlined.

The next Chapter will outline the Methodology and will focus on the research design, sampling and data collection.

CHAPTER THREE

METHODOLOGY

Research Design

The value of a study is determined by the extent to which it is compatible with the research approach and the guiding theoretical framework (Patton, 1987(b)). Programme evaluation was the primary research method used in this study.

Babbie (1992) states that evaluation research sometimes called programme evaluation, refers to a research purpose rather than a specific research method. Its special purpose is to evaluate the impact of social interventions such as new teaching methods or as in this study, an intervention method. Evaluation research is a matter of finding out whether something is there or not there, whether something happened or did not happen.

Paton (1986:14) defined programme evaluation as "the systemic collection of information about the activities, characteristics and outcomes of programmes for use by specific people to reduce uncertainties, improve effectiveness and make decisions with regard to what those programmes are doing and affecting".

Patton (1986) highlighted differences between programme evaluation and evaluation research. He maintained that while programme evaluation used research methods to gather information, evaluation differed fundamentally from basic research in the purpose of data collection. Basic scientific research is undertaken to discover new knowledge, test theories, establish truth and generalize across time and space. Programme evaluation is undertaken to inform decisions, clarify options, reduce uncertainties and provide information about programmes and policies within contextual boundaries of time, place, values and politics (Patton, 1986). In support of Paton (1986), Lincoln and Guba cited in Palumbo (1987) asserted that systematic differences in the purpose of the activities, signal differences in outcomes. Guba & Lincoln (1989:8) state that evaluation outcomes are not descriptions of the "way things really are or really work" or of some true "state of affairs, but represent

meaningful constructions that individual actors or groups of actors form to make sense” of the situations in which they find themselves. The findings are not facts in some ultimate sense but are, instead literally *created* through an interactive process that includes the evaluator. What emerges from this process is one or more constructions that are the realities of the case. In this study the participants interacted with the researcher in the monthly MSG meetings, therefore the researcher was able to “make sense” of their situation.

DCS decided that their services needed to be re-examined and modified and new care models developed in response to the growing AIDS pandemic. DCS is committed to developing strategies and implementing services, which effectively mobilize, capacitate and involve children, families and communities in combating the impact of HIV/AIDS with particular emphasis on facilitating the care of children infected and affected by the pandemic. DCS has prioritized a range of services, which will ensure that orphans, children infected with HIV and other vulnerable children have access to adequate family or family type care. Therefore the AIDS Care programme was developed as a pilot programme, hence programme evaluation will be the applicable approach for this study because DCS has implemented a new programme and it is important to have feedback and evaluate services. Furthermore participants were allowed to give inputs beyond the scope of the guiding questions.

Sampling

The type of sampling method used was non-probability purposive sampling. Marlow (1993) states that purposive sampling purposively includes in the sample those elements of interest to the researcher. Marlow (1993) elaborates on the fact that a purposive sample differs from an availability sample in that a purposive sample contains elements that possess the characteristics you are interested in studying. An availability sample chooses the sample because of its ease of selection. The researcher chose the non-probability purposive sampling technique, as it was imperative to include only those participants who were selected and trained as foster parents.

Sample

A total of nineteen participants participated in the research study comprising the foster parents and service providers. Sample one comprised ten foster parents who participated in the AIDS Care project; they resided in the following suburbs/townships in Durban; Cato Crest, Bonella, Bluff, Hillary, Durban Central, Kwa Mashu and Wentworth. Some of these residential areas were occupied predominantly by white residents during the apartheid era in South Africa. Areas like Kwa Mashu continues to be occupied by African families and Wentworth is occupied by Coloured families. Five foster parents were married and five foster parents were single, only the foster mothers from the married couples were interviewed because they were the primary caregivers of the children.

Sample two comprised 9 service providers. There was one orphan response coordinator who is the senior manager at D.C.S (she designed and formulated the pilot project) , one manager, two residential social workers, one nursing sister from the William Clark/Othandweni Children's Home that comprised the professional sample. There were four Child Care Workers from the said children's home who were part of the 9 service providers.

The researcher (PAL) of this study had to implement the pilot project as well as research it.

Data Collection

The data was collected by means of structured interviews using an interview schedule. The interview schedule was designed by using the researcher's experience as a social worker in this field and guided by literature reviewed. Different interview schedules were used for each sample. The data was collected by PAL who also the researcher. The strengths were that the researcher was able to clarify uncertainties and observe interactions amongst foster parents. Inconsistencies that were observed yielded useful data.

Sample One

Annexure B: Interview Schedule for foster parents

This interview schedule was administered to the foster mothers on an individual basis and when necessary the social auxiliary worker was used to interpret the questions to them if they were Zulu speaking. The purpose of this questionnaire was to gain an understanding of foster parents motivation to foster, understanding of AIDS issues, training to be a foster parent and support opportunities available.

Sample 2

Annexure C: Interview Schedule for service providers

This schedule was administered to the Orphan Response Co-ordinator, Residential Manager, two Social Workers and the nursing sister from the children's home. In addition the schedule was administered to the two senior childcare workers (these child care workers supervised the two child care workers who were directly involved in the daily care of the infected children). The purpose of this schedule was to elicit their understanding of the AIDSCARE project and how they participated in this project.

Annexure D: Interview Schedule for service providers (child care workers)

This schedule was administered to the two childcare workers who supervised the children's growth and development on a daily basis in the children's home prior to their placement in fostercare. The data obtained from here will indicate what the children's physical, mental and developmental status whilst in the institution. The diagrammatic developmental assessment was compiled by the ex Principal Head of Pediatrics, Dr. Winship, Addington Hospital, 1980.

The researcher facilitated and conducted the interviews. Interviews with the staff from the children's home were held at the children's home, interviews with the COR and foster parents was held at DCS offices. Participants were allowed to make inputs beyond the scope of the guiding questions.

The study used both closed and open-ended questions. In devising close-ended questions, the researcher used her own knowledge of what the responses might be as a frame of reference for categorization. According to Bailey (1982) the disadvantage of close-ended questions was that a respondent could feel frustrated if her answer was not contained within any of the categories provided. In order to avoid such difficulties the researcher provided an "other" category. Data was analysed by drawing out relevant themes and categorizing them into sub themes.

ETHICAL CONSIDERATIONS

The use of human beings as respondents or otherwise in any research invokes the issue of ethics. Social work ethics serve to regulate the relationship between the client and the worker in the helping relationship and in research. According to Grinnell (1993) ethical considerations have to be made concerning the effects of the research process on the research participants, the social work profession and the larger society. The following ethical issues were taken into consideration throughout this study:

- a) Confidentiality and anonymity: all participants in the study were assured of confidentiality. Data derived from the joint interaction was used strictly for the purpose of the study. Foster parents, childcare workers and service providers were not asked to disclose their names in an attempt to protect their identities. They were informed about their anonymity prior to their participation.
- b) Informed consent: All the research participants were informed about the purpose of this study at the outset as well as notified of their right to decline participation if they did not wish to participate. According to Grinnell (1993) research participants must be competent to give consent and this requires that they must be provided with sufficient information to enable them to make an informed consent. All research participants were consulted and those that did not wish to participate in the study were free to decline. Interestingly enough, no foster parents declined.

- c) Dissemination of research finding: the results of this study will be made available to all research participants, the AIDS Foundation of South Africa who are administering the funding of this project, other relevant authorities who are likely to benefit from the findings of this study. Research data will also be made available by lodging copies at the University libraries and publications in scientific journals and newspapers.

LIMITATIONS OF THE STUDY

The researcher must be aware of the strengths and limitations of the method chosen in producing valid and reliable data and how this will affect the study and the generalizations that can and cannot be made from the findings. A discussion of the possible limitations in the design and methodology of this study follows.

Reliability and Validity

In choosing an evaluation methodology it was important to monitor the reliability and validity of evaluation instruments and designs. Reliability refers to the standardized nature of the measurement instrument (such as a test or questionnaire) which assumes that it will produce consistent information across different applications. If the questionnaire items are worded vaguely responses will be arbitrary and erratic, producing an instrument that is not reliable. On the other hand, validity refers to whether or not you are really measuring what you want to measure. It is possible that respondents will answer a given question consistently in a way that is different from what the evaluation intended and consequently the results will not be valid.

In this study the validity of the interview schedule was enhanced by the fact that the researcher conducted a literature review which guided the research, the interview schedule was also carefully studied by the COR to eliminate any subjectivity. The content validity was enhanced by pre-testing the instrument with the COR and a foster parent. The interview schedule was subsequently refined.

Reliability was enhanced by seeking the multiple perceptions of the sample groups to clarify meaning and repeatability of observation and interpretations.

Sample Size

The small sample size limits its representatives of the population from which it is drawn (Marlow, 1993). This factor further limits the generalisability of the study. It must be noted that the sample was selected in order to obtain in-depth information. It has however been argued that qualitative research is more concerned with generating information rich data, and that the smaller the sample the more the likelihood that quality rather than quantity data will be generated. This study will therefore benefit from the small sample, which will enable that data be analysed in context.

Language Barrier

In this research the major shortcoming was language, as the researcher did not speak isiZulu. Some problems were encountered during the data collection as some research participants like the foster parents had limited English communication skills, making it difficult to probe without losing the context within which the question was asked. This was overcome by using the social auxiliary worker who normally assists in facilitating the support group meetings to translate the information, in order to minimize loss of contextual responses.

Researcher Bias

In view of the fact that the researcher was also the facilitator of the project it is impossible to totally eliminate researcher bias. Throughout the study, the researcher took cognizance of this and paid attention to ways in which she influenced the study, both in the data collection and data reporting. The researcher checked out the data collected with the COR who perused the data. The COR was present as an observer during the data collection process. The researcher used the social auxiliary worker to assist in the data collection, the auxiliary worker was unable to prompt responses because she lacked knowledge of the pilot project. The researcher also confirmed the data collected with the auxiliary worker to eliminate misinterpretation. In addition,

the researcher assured foster parents of confidentiality and that they needed to be honest with their responses.

Participant Bias

This refers to situations where participants attempt to preempt the researchers' expectations and respond in a manner that they assume meets the expectations of the researcher. In this study, this was offset by further probing and cross-checking with the social auxiliary worker who is not familiar with the work plan of the pilot project.

This Chapter has reviewed the research design, sampling, data collection, ethical considerations, and limitations of the study. The next chapter will interpret the findings and analyse the data collected.

CHAPTER 4

FINDINGS AND DISCUSSION

In this chapter the results of the study are discussed. The results are presented, analyzed and interpreted using literature reviewed in Chapter 2 of this study.

The study comprised two sample groups namely 10 foster parents and 9 service providers - 6 of whom were professional and three of whom were semi professional staff. Deductions were made on the basis of the results obtained. Themes were identified from the responses and categorized. In the discussion that follows these samples will be referred to as the foster parents' sample and service providers' sample.

Presentation of the findings in this Chapter will be illustrated by tables/figures where necessary.

FOSTER PARENTS: WHO THEY ARE AND THEIR EXPERIENCES

The following table illustrates the profile of foster parents.

TABLE 1: PROFILE OF FOSTER PARENTS

Foster Parent	Age Group	Race & Language	Marital Status	Monthly Household Income	Occupation	Level of Education
Mrs A	33 yrs	African Zulu	Single	R1001- R2000	Self employed vendor	Std 5
Mrs B	34 yrs	White English	Married	R5000- R8000	Housewife – income is husbands	Std 9
Mrs C	35 yrs	African Zulu	divorced	R1001- R2000	Fruit and vegetable hawker	Diploma in Fashion Designing
Mrs D	36 yrs	Coloured English	Widow	R1001- R2000	Unemployed	Std 10
Mrs E	36 yrs	African Zulu	Married	R2001- R5000	Casually employed as a waitress	Std 8
Mrs F	40 yrs	African Zulu	Married	Over R8000	Debtors consultant	Std 8 – diploma in security management and a Paramedic
Mrs G	49 yrs	African Zulu	Single	R1001- R2000	Child Care Worker	Std 9 – BQC Child Care Qualification
Mrs H	50 yrs	African Zulu	Married	R2001- R5000	Unemployed	Std 7
Mrs I	51 yrs	African Zulu	Widow	R1001- R2000	Self employed Dressmaker	Illiterate
Mrs J	62yrs	White English	Married	R5000- R8000	Pensioner	Std 8

Age of participants

The average age of the foster parents was 41 years. It was also noted that one foster parent was 62 years old, "the age of foster parents should be considered only as it affects their physical energy, flexibility and ability to care for a specific child" (Child Welfare League of America, 1975:55). Slightly older applicants (in the age range of 33 to 62 years) responded to the recruitment drive. This coheres with international experience, for example in Scotland, suitable foster carers to children with HIV are considered to be mature people who have already had children of their own and have had good rewarding child care experience (O'Hara, 1993:60). The tendency for older foster parents to care for children is also not uncommon in South Africa. The age of 62 is when most people are preparing for retirement and do not have the energy nor the inclination to become involved in child rearing, however the AIDS pandemic is rapidly changing this role.

Employment

Five participants were informally employed that is they derived an income from hawking fruit and vegetables therefore their income was not stable.

Two participants were employed formally that is one was a debtors consultant whilst the other one was a child care worker at a state place of safety.

One participant was an old age pensioner.

Two participants were unemployed and were financially dependent on other members of their families.

Five of the foster parents received an income between R1001 – R2000. The income of these foster parents were derived from paid up work such as selling fruit, vegetables, soft drinks to augment the household income. This form of self employment is not uncommon in South Africa among the lower socio-economic groups. The income of the two foster parents who were unemployed refers to the household income contributed to by other employed family members in the home. The income of the foster parent who is a pensioner includes her pension and other family members household contributions. "Management of income should be considered more important than the amount of income. If financial problems develop

in the course of the family's care of a foster child and the child's best interests will be served by remaining in the home, temporary assistance should be given to the family until they can make stable financial arrangements" (Child Welfare League of America, 1975:56). In other words the ability of these families to provide material security and stability and the way in which they budgeted their income in meeting the infected child's needs is of utmost importance rather than the amount of income they earned. The decision to foster an infected child was a family decision therefore the care of the infected child was not compromised because family members assisted in ensuring that the needs of the child were met.

In addition these foster parents were in receipt of a monthly foster child grant amounting to R410 per month per child. In addition four foster parents also received an AIDS Care allowance of R200, which was provided to foster parents in this project whose income was assessed as being very low.

Recruitment of foster parents

The following table illustrates the type of recruitment drive.

Table 2: Type of Recruitment Drive

TYPE OF RECRUITMENT DRIVE	NO. OF FOSTER PARENTS
By Project Aids Care Leader (Pal)	5
Talks at Church	1
Talks over the Radio	1
Masakhane Support Group	2
Crisis Care	1
Total	10

The Project AIDSCARE Leader (PAL) had been entrusted with the responsibility of recruiting foster parents for the AIDSCARE programme. Twelve recruitment drives were conducted. Some of the methods used to recruit foster parents were addressing church congregations and women's groups from the Methodist Church, Anglican Church, Catholic Church and the Diakonia Council of Churches; writing articles in the local newspapers eg. Berea Mail, Northglen News, Southlands Sun

and church newsletters and issuing bulletins appealing to the people to avail themselves. The purpose of targeting the churches was to evoke a sense of “social conscience” and a spirit of UBUNTU. The results yielded from such recruitment methods were that people offered donations of clothes and money instead of making a commitment to an infected child. Members of the Masakhane Group were also instrumental in ensuring that they encouraged other community members to become involved. Interested foster parents came forward from the Bluff, Cato Crest, Hillary Inanda, Wentworth, Bonella and Kwa Mashu areas.

The findings of the recruitment methods, motivation and role of the foster parents concur with the recruitment campaigns, motivation and foster parent roles reviewed in Chapter 2, Literature Review.

As discussed in Chapter 2, the most successful method of recruiting foster parents appears to be by “word of mouth”.

Motivation

Five participants stated that religion motivated them to become involved in fostering HIV infected children. They made comments like *“it was a calling from God, my priest has been encouraging the congregation to assist with these vulnerable children”*.

While religious commitment is seen as a strength, broad mindedness, tolerance and acceptance of diversity are especially important. Brouard (2000) stated that in “Africa there’s a strong sense of community and rich tradition of doing good work- reaching out to your neighbour and sick friend”. Simple compassion for others who are suffering is a common motivation for wanting to assist. Very many people are motivated, too, by personal experience of AIDS in family or friends. They may have painful memories of helplessness they felt without knowledge or skills when AIDS came into their lives and what they learn as foster parents is hugely empowering and a source of pride.

A study of foster carers in Malawi similarly found that people came forward to foster a child who was HIV positive because “God would of expected them to, God’s children should be cared for” (Bandawe & Louw, 1997:545). In the South African context the foster parents were motivated by the spirit of UBUNTU. This concurs with

the findings of the present study where all the participants were motivated by their religion.

The other five participants were motivated for altruistic reasons.

In addition to the above motivation people who want to foster may simply want to join the effort to control the disease that is spiralling out of control (UNAIDS case study, 2000:15). This is supported by all the foster parents who stated that

“the infected child is like any other child with similar needs,
bonded with child without knowledge of HIV status,
have empathy for vulnerable children,
give sick child love, not many people want to do this”.

Four participants felt that “unconditional love irrespective of creed, colour, religion,” was one of the qualities of a foster parent. Two participants felt perseverance, tolerance, a good home, compassion for children, sound mind, patience, ability to provide a better quality of life than a children’s home were some of the qualities of a foster parent.” The remaining four participants felt that a combination of these qualities were essential in foster parents.

Role of foster parent

Two foster parents had experience in fostering. Both had fostered one child each on a short term basis, one foster child was a male aged eight months and the other one was a female aged one year and three months. These children were healthy uninfected children who were eventually returned to the custody of their own parents. These two participants’ motivation for foster care is aimed at improving the quality of life of others. In the South African context this action is linked with the principle of UBUNTU. UBUNTU has been adopted as a principle in the White Paper for Social Welfare (1996:18) as a “principle of caring for each other’s well being. It acknowledges the rights and responsibilities of every citizen in promoting individual and societal well being.

These two foster parents understood their role as:

- promoting emotional relationships of the child with other members of the family,
socialization of the child,
- providing role models for a home and family life, like all children, AIDS orphans need
- to acquire cultural values and behavioural norms necessary for their integration into society.
- sharing the responsibility of housekeeping chores.

Eight foster parents had no experience in foster care however they were able to state that they perceived the qualities of foster parents to be compassion, perseverance and unconditional love for children. The qualities that these foster parents perceived is supported by the Standards For Foster Family Service, (Child Welfare League of America, 1985), in addition it coheres with what foster parents outlined as their motivation to foster as well as with what the recruitment drive promoted.

Training

In response to the need for training, the responses varied. Eight of the foster parents said that training had not been compulsory while for two it had been compulsory. This was interesting to note because training is compulsory before you are accepted as a suitable foster parent. It may have been that foster parents saw orientation and training as one and the same. In addition foster parents were also asked to whom should training be directed, four foster parents stated that training should be directed to foster parents with infected children whilst six foster parents stated that training should be directed to foster parents in general.

All participants concurred that the training entailed knowledge about such aspects as:

- physical care,
- HIV management and treatment,
- to recognize health problems;
- administering first aid;

- special diet;
- hygiene and caring adequately for the infected child to extend their lifespan;
- orientation into aspects of foster care such as roles and expectations of foster parents,
- legal aspects of foster care;
- expectations of foster children.

Foster parents felt that HIV management and treatment, administering first aid and a special diet as most useful aspects of training.

The above findings cohere with the literature reviewed in Chapter 2. Aspects of the training programme are congruent with the Child Welfare League of America's Standard for Foster Family Service (1975) who state that ongoing training opportunities for all foster parents providing specialized care and library resources about child care and child development should be made available

Authors Skinner (1991:139) and O'Hara (1993:60) suggest that special training is vital for prospective foster carers of HIV infected children. Foster parents require this specialized training for them to care adequately for the infected child thus expanding their lifespan. This training will assist them in early identification of the child's symptoms so that they can proactively treat them. Theorists such as Brendtro (1976); Preen (1992) and Brown (1991) contend that foster parents require relevant and updated information (children's needs change all the time so to will the responses to them) in Child Care in order to perform their tasks effectively and in order to have a positive impact on children. What these authors have proposed supports the findings of this study,

Support for foster parents

Eight participants used the Project AIDSCARE Leader at Masakhane Support Group Meetings as their opportunity to ventilate and obtain emotional support. These participants also chose to seek help and support from neighbours, the general medical practitioner, the church, their mothers, friends and occasionally the hospital. These responses are supported by the National Strategic Framework for children affected and infected by HIV/AIDS of the Department of Welfare (2000:5-7) whose

objectives as outlined in the literature review are “to identify external supports for communities to enable communities to build support networks”.

Two participants did not use any support opportunities. Although they highlighted that support opportunities like their neighbours, general practitioner, family and friends were available when needed. This finding is supported by authors like Donati & Dumaret (2001) who state that families affected by HIV rarely have access or recourse to a social support system, or seek help, they generally manage on their own. This is partly due to the fear of social stigmatization that HIV infection represents, which in turn deprives families of potential individual and group support systems. These authors further state that families rarely turn to voluntary associations, as their needs tend to require an immediate response with solving a concrete problem arising of a child’s illness.

Masakhane Support Group

In the description of the AIDS care pilot project outlined in Chapter 2, provision was made for a support group should such a need arise. The support group was constituted in May 2001. They named themselves the Masakhane Support Group (MSG).

The following table illustrates attendance of foster parents, frequency of MSG meetings and issues addressed at the meetings.

Table 3: Attendance/Frequency of meetings, issues addressed

No. attending MSG	Frequency of Meetings	Issues addressed
9	Once a month	<ul style="list-style-type: none"> - Health Issues eg. the physical well being of the child, useful medication to treat sores and rashes - Fundraising events eg. raffles, fund raising fete - Skills development eg. bead making - Educational training eg. HIV infection, treatment of symptoms - Distribution of donations - Bereavement counseling

One foster parent did not attend any of the meetings because she was employed full time. Nine foster parents attended once a month for a period of seventeen months.

All nine participants were actively involved in the MSG. The MSG celebrated its one year of existence in July 2002. The MSG is the most active component of the AIDSCARE Programme. The meetings are held on a monthly basis at the Durban Children's Society offices, the duration of the meetings are approximately two hours. The topics identified for the monthly meetings arose from the needs of foster parents as well as from the conceptualisation of the programme. The consistent attendance of the foster parents at the meetings were an indication that the Support Group met their needs for socialization, training and skills development. Therefore this study supports the notion that foster parents are able to achieve their needs as already outlined above. This is further evidenced by the fact that two foster parents attend the Support Group Meetings although their foster children have sero-converted ie they are no longer HIV positive. These foster parents seemed to achieve a sense of social interaction and general fulfillment by attending.

Impact of caring for an infected child on family life

Six participants reported that there were no major changes to their family life since fostering the HIV/AIDS infected child. These participants had strong support networks and adequate resources to rely on therefore they did not feel the impact on their family life. The accessibility of support was significant for these participants to cope with caring for the infected child.

Two participants felt that the family's financial responsibility had increased especially during the periods that the child was ill consequently increasing the family's stress levels. This participant did not have the benefit and support of extended family members nor the assistance of older children, her children were in primary school. Mukoyogo and Williams (1991) suggested that the first and most basic need is for food. AIDS diminishes the family's capacity to grow food or earn money to buy it as a result the children consume less food and also eat less nutritious food. Shelter is also an acute problem. AIDS orphans are more prone to malnutrition and infections and less likely to receive health care than other children.

The trauma of their parents protracted illness followed by death leaves AIDS orphans with a profound sense of loss, abandonment and guilt. They, therefore, have a greater need for love, affection and a sense of security. Without special emotional and psychological support they are more likely to become depressive, suffer learning difficulties at school, engage in anti social behaviour and experiment with unprotected sex. However, this study has shown that the emotional support from the Support Group and the financial support from the AIDS Care allowance has assisted the family to cope with the infected child's physical and emotional needs.

Two participants felt their family routine had changed in terms of interrupted sleep to provide night feeds and in spending less time with their own spouses and children when the infected child became very ill. This finding is supported by Donati and Dumaret (2001:81) who suggests that the new parental role of fostering upsets the positions and roles of people involved "...tensions can emerge with other children in

the family, either extended or fostered; they feel that their parents take less care of them or even that they have lost their place in their families”.

**Foster parents perception of the type of assistance
required from government**

All ten participants were of the opinion that it was the government’s responsibility to provide financially for the foster child. This opinion of the participants was supported by research conducted by McKerrow & Verbeek (1995:45) that the state is held to be ultimately responsible for the care of orphans. The participant’s perception of the state’s role in terms of AIDS orphans is in conflict with the White paper for Social Welfare (1996) which promotes a major shift of approach from welfare provision. The new approach is based on the principle of ‘developmental social welfare’. This is a broad concept incorporating ideas such as ‘promoting self reliance’, ‘building human capacity’, creating ‘appropriate’ services through ‘community development. The White Paper does acknowledge vulnerable groups like women, children, youth and the disabled, what is promoted is a partnership between the state and civil society.

Seven participants felt that the foster child grant was sufficient to provide for the needs of the child whilst three participants felt that the foster child grant was insufficient and that the state should recognize AIDS as a special need thus qualifying them to apply for a special needs grant which would supplement the foster care grant.

The following table illustrates what other assistance should be provided by the government.

Table 4: Other assistance you think should be provided by the government

	Number responded
More money from government (that is an increase in the foster child grant)	4

Free medical treatment for child	5
Free schooling for child	5
Total	14

The total number of responses received were more than 9 because multiple responses were allowed.

Four participants felt that the government should increase the monthly foster child grant whilst six felt it was sufficient. This illustrated confusion amongst foster parents. These participants were unable to estimate a monetary value above the current foster child grant of R410 per month. The other five participants felt that free schooling and free medical treatment would suffice, and an increase in the foster child grant would not be necessary. Foster parents responded in this manner because they feel that government should increase the foster child grant as the child grows older and their individual needs get more demanding. Children still need free medical treatment until 18 years. After the 1994 democratic elections in South Africa the then president Nelson Mandela declared that children under six years should access medical treatment freely at state hospitals, however it has been the foster parents experience that Mr. Mandela's declaration is not a reality in the state hospitals. Similarly school is a right and foster parents can be exempted from paying school fees, but this seldom happens.

The participants view of additional assistance is not unrealistic in terms of the medical costs incurred in treating an infected child as well as the frequency in seeking medical care. The healthy child or the uninfected child does require the intense palliative care that the infected child needs and medicines for their treatment are not that expensive.

PROGRESS OF CHILDREN IN FOSTER CARE

Based on records kept by child care workers (Annexure D) and report back at MSG, the following were the observations of child care workers and foster parents:

Three of the participants noted that four of the infected children were unable to use the words "baba" and "dada" by one year. Two of the infected children did not have

sphincter control because of constant diarrhoea. The Masakhane Support Group meeting's agenda included the item "meeting the development of these children", the foster parents of the four children concerned reported that since placement in their foster care these developmental delays were overcome.

One participant stated that three of the infected children were unable to hold toys in their hands or pick up small objects between their thumbs and their index finger. The children lacked this fine motor skill which was appropriate for their age. This observation was also checked with the foster parent who informed that since the child's placement, this fine motor skill delay was overcome with stimulation and individual care.

The quality of child care settings are likely to affect virtually every aspect of development that researchers know how to measure including language development, social interaction, problem solving capacity or attention span.

Theorists like Basckin (1985) and Kool (1995) suggested that physical care is not sufficient to ensure satisfying emotional, social and intellectual growth. In Maslow's "hierarchy of needs" physical security, food, clothes and shelter, take precedence (Maslow, 1962:139). Brill, Thomas and Brearly as cited by Watson (1997) contend that the question of needs can be approached from many angles, but the emotional needs take priority as directive forces in the child's growth to maturity. The child needs to have a close relationship with at least one significant adult.

From the findings in this section it can be concluded that the infected child thrived in the foster parents care due to the individual nature of the care as well as the reciprocal bond that the infected child shared with this significant, stable care giver in comparison to their relationship with childcare workers.

SERVICE PROVIDERS

Professional and semi professional staff sample

A total of nine professional and semi-professional staff participated in the study. They ranged from assistant childcare workers, manager of residential services to the co-ordinator of the AIDS programme.

The following table illustrates the position of professional and semi professional staff as well as their involvement with HIV/AIDS infected children.

Table 5: Position and involvement with HIV/AIDS infected children

POSITION AT DCS	INVOLVEMENT WITH HIV/AIDS INFECTED CHILDREN	PERIOD OF INVOLVEMENT
AIDS Programme Co-ordinator / Researcher (Senior Manager at DCS)	To design and develop programs and projects for the care and protection of infected children. To receive funding for the implementation of such programmes / projects.	From inception of programme until implementation.
Senior Professional Nurse	Establishing the Special Care Unit at the children's home for HIV/AIDS infected children.	From inception of programme until implementation
Senior Child Care Worker	Work in the Special Care Unit and supervise assistant child care workers.	From inception till placement in foster care.
2 Assistant Child Care Workers including the Volunteer	Work in Special Care Unit with infected children, stimulating, bathing, feeding, cleaning the children and sponsoring recreational activities and opportunities for them.	From inception till placement in foster care.
1 Senior Social Worker	Both are involved in facilitating the	From inception till

and 1 Social Worker	infected child's placement from the Special Care Unit to foster care. Liaising with the nursing sister in respect of the children's medical needs.	placement in foster care.
1 Manager of Children's Home	Management of the children's home and supervision of the different categories of staff. Involved in the establishment of the Special Care Unit.	From inception of programme until implementation

The above categories of staff have been directly/indirectly linked to the AIDSCARE programme and as outlined in the literature review Durban Children's Society had to re-examine and modify its care models in response to the HIV/AIDS pandemic. Hence, the Work Plan in the literature review (attached as Annexure A) outlines the intersectoral collaboration of the various members of staff at Durban Children's Society in the AIDSCARE programme. Although, each participant had a specific role, responsibility, the primary goal was focused on the well-being, welfare and placement of the ten infected children. This is coheres with the eco-system theory which focuses on the study of individuals/groups in relation to their environments. This theory marks a shift in an emphasis from the characteristics of individuals, to an interaction and interrelatedness of the individual with a multiplicity of systems Compton and Galoway, (1979:73). In essence, the study highlighted the intersectoral collaboration necessary for the achievement of the objectives of the AIDSCARE project. As espoused by the ecosystems theory, the various systems necessary for promoting the holistic care of the children, were required to work in synergy with each other.

The following table illustrates the understanding of the AIDS Care Project by professional and semi-professional staff.

Table 6: Understanding of the AIDSCARE Project

PROFESSIONAL SEMI PROFESSIONAL	UNDERSTANDING OF AIDSCARE PROJECT
Co-ordinator Orphan Response/ Researcher	She understood the project to be a pilot project providing foster care for ten infected children. She designed and formulated the project.
Senior Professional Nurse	She was concerned about the care of the young infected child been placed in a Children's Home rather than in foster care .She understood the pilot project as changing this status quo.
Senior Child Care worker and 3 Child Care Workers	Foster care allowed a child to be cared for within a family providing them with special food so that they could live longer.
Managers, Senior Social Worker, Social worker, volunteer	AIDSCARE Project needed to recruit screen and train foster parents who will care for the infected child irrespective to their health status. To provide a support group for foster parents undertaking this role.

The participants understanding of the AIDSCARE project is congruent with the overall description of the project as outlined in the literature review that Durban Children's Society was committed to developing strategies and implementing services which effectively mobilized, capacitated and involved children, families and communities in combating the impact of HIV/AIDS with particular emphasis on facilitating the care of the children infected and affected by the pandemic. The

childcare workers perception of the AIDSCARE programme was limited to the physical needs of the child. They viewed it from the perspective of providing for the physical needs of the child, which will strengthen and contribute to a longer healthier life.

Role of professionals and semi-professionals in respect of recruitment, orientation and selection

Professional/semi-professional staff were involved in the recruitment aspect of the AIDSCARE project. Five participants were directly involved in recruitment campaign for foster parents through their church (however no prospective parents responded); “word of mouth” and by compiling a pamphlet for recruitment; encouraging visitors / volunteers to the Special Care Unit to foster these children as they believed that infected children should be brought up in their own communities.

Two participants were involved in the discussion on the philosophy underlying the project. The two participants were the AIDS Programme Co-ordinator and Senior Professional Nurse.

The roles of the professional/semi professional staff emanates from the conceptualization of the Co-ordinated Orphan Response which is aimed at developing a range of home or community based care for children infected and affected by HIV/AIDS.

Criteria for recruitment / selection and orientation

In response to the question on identifying criteria, seven participants expressed the following:

- genuine love as a motivation versus financial reasons as a motivation
- a loving family life (either short term or long term);
- foster parents non-judgemental attitude and;

- the family's ability to cope emotionally with the infected child as necessary aspects in the recruitment and selection.

This is a perception that professional/semi-professionals have of foster parents. This perception was supported by the foster parent sample group who outlined this as qualities of a foster parent

Two participants felt that love for a child irrespective of their health status, basic knowledge of the effects of AIDS and how to minimize these effects were important aspects in the orientation of foster parents. These views have been supported by their foster parents who were interviewed that unconditional love was the ultimate motivation.

Needs of child matched to strengths/resources of foster parents

All nine participants identified the following as being the needs of the infected child, unconditional love and care; a happy life and a peaceful death. Interestingly enough, none of the foster parents commented on the death of the foster child. Their concern appeared to focus on the cost of funerals. These participants felt that these were matched as compatible with foster parents by a Placement panel. This panel comprised of the researcher, one of the participants from the children's home and the Homefinding Team. The panel considers the attributes and character of the foster parents such as age, income, level of education, motivation to become a foster parent, experience in child care and character references. The foster parents were taken through the three stages of preparation, the first stage being the Intake phase, the second stage being the Orientation and Screening phase and the third stage being the Selection phase (this is the role of the Placement panel). The Placement panel views the needs of the child as outlined in the child's profile against the profile of the foster parents in terms of the age, sex and length of institutionalization.

Foster homes should be selected for a particular child on the basis of suitability of the foster family and the child for each other, taking into consideration:

-the extent to which interests, strengths, abilities and needs of the foster family enable them to understand, accept and provide for the individual needs of a specific child, in relation to his age, developmental level, interests, religion, intelligence, educational status, social adjustment, cultural and racial background, common language, parental background

-the extent to which the personal characteristics of the child and the foster family will be appealing to one another and enable them to be comfortable with each other (Child Welfare League of America, 1975:41-42) .

This study has found that due to the AIDS pandemic children are matched in terms of meeting their need for individual, love, care and protection rather than in meeting the needs of foster parents. The Child Welfare League of America (1975:10-11) states that foster family care may be used for the child who is unable to fit into a regular pattern of family living but may be able to benefit by experiences of family life adapted to his needs, who can be permitted some freedom in the family and community, who has the capacity to function in regular schools or in special schools. Such children include:

- the disturbed child;
- the child requiring specialized medical and physical care, for whom a suitable foster home can be found to meet his or her special needs;
- the emotionally disturbed or physically disabled child who is ready for discharge from residential treatment and can live in a family and community.

Assessment / perception of professional / semi-professional staff in respect of the training programme

Four participants felt that the training programme assisted foster parents in understanding the dynamics involved in caring for a sick child and to manage the situation appropriately.

Two participants felt that foster parents got a realistic picture of parenting and that parenting a foster child is different from parenting your own child. With your own child there is a biological link or kin tie and the relationship between the foster parent and their own child is not “imposed” upon them, because they have reared their own child from infancy and moulded their character and personality. Furthermore the biological child is in its natural setting whereas the foster child has to adjust to a new family environment to obtain a degree of security and a sense of belonging. Most foster children may have a socially constructed identity which may conflict with the values of the foster family. Their identity has been developed in terms of their life experiences with their own biological parents, these experiences may have been negative or deviant therefore it would conflict with foster parent’s values.

One participant felt that involving a foster parent to share their experience provided a learning opportunity. Since the foster parent provided the pros and cons to fostering, the participant felt that she got a holistic picture of foster care.

Two participants felt that the training programme prepared them for the task of fostering so that they could make informed decisions. The training programme conducted with the foster parents was based on cognitive – behavioural and social learning theory. Social learning theory takes the viewpoint that most behaviour are learnt and that they can therefore be unlearned, and new alternative behaviours mastered in their stead (Bandura, 1977). Attachment theorists believe that a secure base for relationships requires consistency, calm, sensitive responses and the absences of hostility (Sutton, 1999). These are all skills or qualities promoted in the training programme. The finding of this study supports the fact that the training programme satisfied the training needs of the foster parents.

Recourse for foster parents

The professional/semi-professionals understanding of the recourse that foster parents had if there were any problems were as follows:

- two participants felt that the Project AIDSCARE leader (PAL) was available to the foster parents within her role in the MSG;
- two participants felt that the supervising social worker fulfilled this role when she was visiting the family and supervising the child's placement;
- One participant felt that if the above failed the Senior Manager or Director could intervene, should the foster parents approach them directly for assistance by conducting a case review meeting;
- Four participants felt that the Masakhane Support Group provided the recourse, besides the foster parent would be having regular contact with PAL.

Although these were the perceptions of the professionals and semi-professionals in reality the foster parents approached the Project AIDSCARE Leader. This could be attributed to the fact that a good working relationship exists between PAL and the foster parents, PAL is more accessible to them and there is a better understanding of their needs by PAL than their supervising social worker.

Reporting on progress of AIDSCARE Project

Reporting on the progress of the project varied according to the different categories of staff involved varied. It must be noted that the Project AIDS Care Leader (who is the researcher) and the AIDS Co-ordinator has primary responsibilities for compiling progress reports for the funders. Other categories of staff have a secondary role in reporting on the progress of the project.

The following table illustrates the staff involved in reporting on the progress of the project.

TABLE 7: Reporting on progress of project

CATEGORY OF STAFF	FREQUENCY OF PROGRESS REPORTS	TO WHOM
Aids co-ordinator	Two monthly Six monthly	To Board of Governors The AIDS Foundation of South Africa
Manager, Senior social worker social worker, Senior child care worker, Child care workers and Nursing Sister from the Children's Home	Six monthly Intermittently	AIDS Co-ordinator Project AIDSCARE Leader

Summary and narrative evaluation reports (for an example see attached as Annexure E is an explanation of such a report) are completed for submission to the AIDS Foundation of South Africa who administer the funding from the Norwegian Church Aid to Durban Children's Society. As outlined in Chapter 3, the Methodology it is important to evaluate new services and programmes. Programme evaluation is undertaken to inform decisions, clarify options and provide information about programmes within contextual boundaries.

Evaluation Criteria

Six participants identified the number of AIDS infected children being transferred from the Special Care Unit to foster care as one of the criteria.

One participant felt that long term success rate (the children are well cared for in the foster home if possible until terminal/death) was another criteria.

Two participants felt that the number of children in foster care where the foster parents have adequate support systems was another criteria. This means that the foster parents have adequate family support and physical assistance to care and meet the needs of the infected child and will continue to care for the child despite

adverse circumstances until the death of the child. In addition to this they felt that the number of parents attending the MSG was a way of assessing the success of the project. This finding is supported by the foster parents sample group who stated that the supportive environment within which they fostered helped them cope with the infected child's inevitable bouts of ill health.

The finding in this study strengthens the fact that the objectives that were outlined in Chapter one have been achieved. The AIDSCARE Project set out to achieve certain objectives which were identified in this research.

This chapter has viewed the involvement of all stakeholders in implementing the AIDSCARE pilot programme which is a community based initiative encompassing the following principles:

- d) all children have a right to family care and siblings should remain together;
- e) the family (nuclear and extended) is the primary care system and must be supported and empowered;
- f) children who cannot live with their own family should preferably remain in their own community or in a similar environment and culture;
- g) children, families and communities must take an active role in decision making and service delivery;
- h) all children have a right to be protected from exploitation and abuse.

These principles are compatible with the White Paper on Social Welfare (1996) as well as with various Bills and Charters on the Rights of Children.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter will re-introduce the study's main aim, research design, theoretical framework, the value of the study and objectives. A broad overview of the main findings will be presented and linked to the study's theoretical framework. Finally the recommendations from the researcher will be discussed.

AIM

The main aim of the study was to evaluate the AIDS Care Pilot Project at Durban Children's Society as a model of care for HIV infected orphans in Durban. During the implementation of the project ten foster families and ten children were successfully placed.

RESEARCH DESIGN

Programme evaluation was the primary research method used in this study. The relevance of this design is evident in the usefulness of information that was obtained from the research. This information will be shared with relevant stakeholders in an attempt to improve services which is in fact one of the main aims of evaluation research.

THEORETICAL FRAMEWORK

The study was guided by the ecological perspective which was viewed as an appropriate framework within which to contextualise this study. This approach emphasizes the multiple contextual influences on human behaviour and the concept of reciprocating between the individual and the environment Hill et al (1996). Similarly Brower (1988) stressed that the concepts "person" and "environment" were inseparable and that behaviours must be viewed within the person's environment interaction. Particularly important in this study was to recognize the inter-relationship

between the various parties who care for children affected by HIV/AIDS in terms of preparation and support for foster parents.

VALUE OF THE STUDY

As noted in Chapter one, the value of this study for the field of social work included

- a) a confirmation of the ethos of social work through the use of research methods which value consultation, democracy, social justice and equity;
- b) upholding and promoting the rights of the child as espoused to in the United Nations Convention on the Rights of the Child (1989) as well as the right to have quality of life.
- c) The need to develop a “best practice model” in providing services to HIV/AIDS infected/affected orphans and encouraging communities to participate in the programme.
- d) Social workers and child care workers are at the interface with the community and they can influence the development of policy.

OBJECTIVES AND FINDINGS

The main findings in relation to each objective were:

Objective One

To establish how effective the pilot project has been in recruiting, training and orientating foster parents to care for HIV infected and affected children.

Finding

This study was able to show that 10 foster parents were successfully recruited and orientated. However eight of the foster parents felt that training was not compulsory. This was interesting to note in that training is an important aspect of preparing foster parents for their role. Recruitment by “word of mouth” appeared to be the most successful method of recruitment.

Objective Two

To evaluate the foster parents experience of fostering HIV infected children.

Finding

The study found that foster parents' motivation was their sense of religious duty and their compassion for people who are suffering . Foster parents who had experience in fostering healthy uninfected children understood their role as socialization of the child, providing role models for home and family life. The study found further that participants used the Project AIDSCARE Leader at the MSG as their opportunity to ventilate and obtain emotional support. Literature reviewed however suggested that families affected by HIV rarely have access nor recourse to a social support system, or seek help, they generally manage on their own. This is partly due to stigmatization hat HIV infection represents.

Objective Three

To evaluate the service providers perception of the project.

Finding

The study found that service providers felt that foster parents got a realistic picture of parenting and that parenting a foster child is different from parenting ones own child. Involving foster parents to share their experience provided a learning opportunity. Service providers also perceived the training programme as preparation for the fostering role, so that foster parents can make an informed decision. Service providers were able to identify the recourse that the foster parents had if they encountered problems.

Objective Four

To establish whether the MSG had been successful in meeting the needs of foster parents.

Finding

The study found that the support group which was an optional provision in the description of the pilot project, became a very successful support opportunity and important component to the pilot project, when it was implemented. The foster parents found that the supportive environment within which they fostered helped them to cope with the child's inevitable bouts of ill health.

Objective Five

To evaluate the HIV infected child's progress in foster care.

Finding

The study found that foster parents reported that since the infected child's placement in their care, the child was able to overcome developmental delays with their individual nurturing and stimulation.

The study also found that although the AIDS Pilot Project was successful in placing the ten infected children in care, two of the children sero-converted ie. they tested Eliza negative by 18 months, although they were Eliza positive at the time of their placements. This could be attributed to the fact that when the Eliza tests were done they tested the mothers anti-bodies and not the child's (which had not developed yet).

RESEARCHERS RECOMMENDATIONS

In relation to the study's findings some additional suggestions are made by the researcher. These suggestions are discussed in three categories: research, policy and practice.

POLICY

Community based care programmes remain the only pragmatic and appropriate response to the problem of orphan care, particularly in circumstances where the extended family system is unable to assist. However the community based orphan

care programme needs to be replicated at a national level if it is to make a national impact on the AIDS pandemic. For this to happen factors like more funding , availability of anti-retroviral drugs, strengthening community capacities (support networks), home based educare programmes and more social work personnel to be employed need to be considered for these programmes to be successful in their impact.

It is further recommended that the provision of anti-retroviral drugs by the government be made available to all pregnant women and children infected with HIV. This will reduce transmission and consequently would result in fewer children needing alternative placement.

RESEARCH

In terms of future research it is recommended that a follow up longitudinal study be conducted to assess the length of survival of these infected children since their placement in foster care.

PRACTICE

The consequences of not caring for the affected children will be felt throughout Society for many generations to come. To avert this social disaster an imaginative response will have to come from both the public and private sector partnership. One suggestion for practice is to train surrogate parents selected by community and church groups in conjunction with the local authority. Orphans will be housed with their surrogate parents who will be paid a small salary for supervision and be provided with sufficient funds to cover food, clothing and incidental expenses.

It is further recommended that financial incentives like that of the AIDS Care allowance from this pilot project be available in recruiting foster parents to foster HIV infected and affected children.

The answer to the AIDS orphan care problem lies in addressing the AIDS crisis itself. In the absence of a cure, the emphasis needs to fall on promoting behavioural

changes, particularly among school children, with a view towards creating an AIDS free generation in the long term. The education system is where prevention must begin. It is a matter of the highest priority to have an educational plan in place which specifically copes with the consequences of the epidemic.

CONCLUSION

“On the issue of HIV/AIDS, the majority of South Africans can be divided into 2 broad categories: those who bury their heads in the sand and deny that the epidemic exists, and those who believe that it exists but they cannot do anything about it” (Whiteside and Sunter, 2001) .

This research has shown that there are people out there that fall into the second category, who believe that they can make a difference to the pandemic and that social workers can play an important role in supporting them.

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ANNEXURE A: WORK PLAN for the "AIDS-CARE" PROJECT: Year 1 (1st 6 mths)

ACTIVITIES	RESOURCES	ANTICIPATED OUTPUTS/OUTCOMES	REVISED TIME SCALE
Identify staff and community partners	Specialist and community social workers	Effective working group established	Feb 2001
Establish parameters and clarify roles Plan and prepare the recruitment campaign and the orientation/training programme	Community groups/organisations Orphan Project Co-ordinator Social Workers (Placement Team) Nursing Sister Representatives of relevant groups/organisations	Provisional plan reviewed Recruitment campaign planned Specialised Orientation/Training Programme completed	Feb/Mar 2001
Recruit "special" foster parents	Orphan Project Co-ordinator Social workers (specialist and community-based) Church and other appropriate organisations Media	Orientation Programme done individually.	April 2001
Present the orientation/training programme	Social Workers (Placement Team) Nursing Sister Prospective foster parents	Suitable foster-parents trained, assessed and accepted	July 2001 and ongoing as necessary
Place child-in-need with the appropriate foster-family - introductions - matching - legal processes	Social workers (Placement Team) Social Auxiliary & Child Care workers Nursing Sister Court Personnel	AIDS infected children placed in appropriate family care	Ongoing from May 2001
Provide the required health and emotional support	Social Workers (specialist and/or community-based) Nursing Sister Social Auxiliary workers Foster-parents Paediatrician (if necessary)	Foster families assisted in order to give their child loving care	Ongoing until after death of the child
Provide the necessary legal and financial support and monitoring	Social Workers DCS Financial Dept.	Statutory processes are followed. State Grant is secured. AIDS-Care allowance is used for the benefit of the child.	Ongoing
Evaluate the effectiveness of the "AIDS-Care" project	Social Workers Nursing Sister / Foster Parents Orphan Project Co-ordinator Community groups/organizations	Formal Reports completed Informal feedback given 1st Year evaluated and adapted if necessary. Re-planning for continuation of project	6 monthly Nov/Dec 2001

ANNEXURE B

INTERVIEW SCHEDULE 1: FOSTER PARENTS

IDENTIFYING DETAILS

1) What is/are your age/s? _____

2) What is/are your marital status? (tick applicable answer)

MARRIED	
LIVING TOGETHER	
SINGLE	
WIDOW	
OTHER	

3) How many adults (persons over the age of 18 years) live with you?

4) How many people living in your house are employed? _____

5) What is the combined monthly income of all the people in your house (including salaries, casual wages, grants, pensions, etc.)? (tick applicable block)

R0 – R500	R501 – R1000	R1001 – R2000	R2001 – R5000	R5001 – 8000	Over R8000
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6) What is your home language? (tick applicable block)

English	Afrikaans	IsiXhosa	IsiZulu	Other
---------	-----------	----------	---------	-------

If 'Other', please state. _____

7) What is your highest level of education?

School standard _____ After school qualification

8) Are you employed?

Yes	No
-----	----

If yes, what is your current occupation? _____

9) ROLE AS A FOSTER PARENT

i) Have you fostered children before?

Yes	No
-----	----

If yes, how many? _____
What age/s? _____
What sex? _____

ii) Are they still in your care?

Yes	No
-----	----

iii) If no, do you still have contact with them?

Yes	No
-----	----

10) RECRUITMENT

How did you learn about the Aids Care Pilot Programme? _____

10) MOTIVATION

1 Why did you decide to foster an HIV/AIDS infected child

2 What motivated you to apply to be a foster parent?

3 Do you have any experience in caring for an HIV/AIDS infected person / child?

4 What do you see as important qualities of a foster parent?

11) TRAINING

1 Was it compulsory to undergo training to be a foster parent?

What did the training entail?

2 What aspects of training did you find useful?

3 Would you recommend this training for: (tick applicable)

a) foster parents in general	<input type="checkbox"/>
b) foster parents who care for HIV/AIDS infected children	<input type="checkbox"/>

12) SUPPORT

1 What support opportunities do you have?

2 Are you a member of the Masakhane Support Group?

3 How often do you attend the Support Group Meeting?

4 What are some of the issues addressed in the Support Group Meeting ?

13) Are you receiving assistance in caring for the HIV/AIDS infected orphan?

Yes	No
-----	----

If yes, what is the nature of this assistance?

14) How has caring for an HIV/AIDS child impacted on your family life?

15) If you are already caring for an infected child and receive a foster care grant from government, what is your opinion about this financial support ?

16. What other assistance do you think should be provided by the government?

More money from the government _____
Free medical treatment for the child _____
Free schooling for the child _____

ANNEXURE C

INTERVIEW SCHEDULE 2: PROFESSIONAL AND SEMI-PROFESSIONAL WORKERS

1. What is your position at Durban Children's Society?

2. How are you involved with HIV/AIDS infected children?

3. What is your understanding of the AIDS Care project?

4. How did you become involved in the project?

What was your role with regard to recruitment, orientation and selection of the prospective foster parents?

5. What do you regard as necessary aspects in the above?

6. How does the training programme cater for the foster parents' needs?

7. How are the needs of the children matched with the strengths / resources of the foster parents?

8. What recourse should the foster parents have if needs are not met?

9. When, what and how do you report on the progress of the project?

10. What evaluation criteria has been identified to assess the project?

11. How will the project be assessed?

12. What is the time span of the project?

INTERVIEW SCHEDULE 3 – DEVELOPMENTAL ASSESSMENT :SEMI-

PROFESSIONAL STAFF

The diagrammatic developmental assessment was compiled by the Principal Head of Pediatrics , Dr. Winship Addington Hospital 1980 .

1) What is your position? _____

2) Have you cared for HIV/AIDS infected babies / toddlers? (tick applicable box)

YES	NO
-----	----

3) Whilst this child was in your care, was he / she doing the following:

Smiling (normal \pm 6 weeks)

YES	NO
-----	----

Posture in prone position (describe). _____

Rolled over prone to supine (normal \pm 5 months)

YES	NO
-----	----

Grasped preferred objects (normal \pm 4 months)

YES	NO
-----	----

Sitting (normal 5 – 8 months)

YES	NO
-----	----

Standing

YES	NO
-----	----

Speech 'baba' 'dada' (normal 12 months)

YES	NO
-----	----

Simple 2 – 3 word phrases (normal by 2 years)

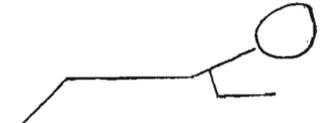
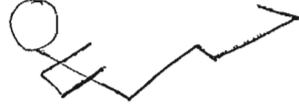
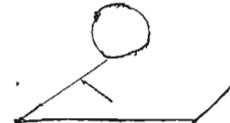
YES	NO
-----	----

Spinchter control

YES	NO
-----	----

**DEVELOPMENTAL EXAMINATION
(ALLOWANCE MUST BE MADE FOR PREMATURITY/ILLNESS)**

Please complete relevant column for child's age

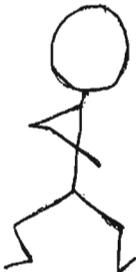
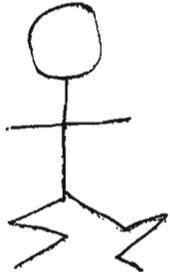
	6 WEEKS	3 MONTHS	6 MONTHS	9 MONTHS	1 YEAR
PRONE					
PULL TO SIT					
SITTING/WALK					
MORO-REFLEX	PRESENT	DISAPPEARING	ABSENT	-	-
FINE MOTOR	---	Pulls at clothes. Holds rattle put in hand Hands mostly open	Reaches and grasps toy from one hand to other. Holds bottle	Holds toy in each hand. Bangs toy on table. Picks up small object between thumbs and index fingers.	Pincer grasp. Releases object on request. Throws object on floor.
FACIAL & LANGUAGE	---	Coos and chuckles "Talks back"	Variety of sounds and cadences. Looks for dropped cube	Shouts for attention. Babies.	Says mama/dada with meaning Understands simple commands

FINAL ASSESSMENT

SATISFACTORY

DOUBTFUL – REQUIRES FURTHER ASSESSMENT (REFERRAL)

UNSATISFACTORY –REASONS

	15 MONTHS	18 MONTHS	24 MONTHS	36 MONTHS
Gross Motor		<ul style="list-style-type: none"> - Pulls toy - Throws a ball without falling - Climbs into a chair 	<ul style="list-style-type: none"> - Goes up and down stairs 2 feet per step - Kicks a ball 	<ul style="list-style-type: none"> - Goes upstairs 1 foot per step - Goes downstairs 2 per step - Rides tricycle
				
Fine Motor	<ul style="list-style-type: none"> - Attempts feeding self with a spoon, spills most of the food 	<ul style="list-style-type: none"> - 2-3 cube tower - Feeds self with spoon more successfully 	<ul style="list-style-type: none"> - 6 cube tower - Horizontal train of 3 blocks - Can initiate a horizontal and vertical line 	<ul style="list-style-type: none"> - 9 cube tower - Copies a circle
Social And Language	<ul style="list-style-type: none"> - One word sentences 	<ul style="list-style-type: none"> - Two word utterances commence - Looks at pictures in a book- turns pages several at a time 	<ul style="list-style-type: none"> - Uses domestic mimicry - Says short phrases e.g. 'mine', 'me', 'you', and 'I' - Refers to self by name - Follows simple instructions - Clean and dry by day 	<ul style="list-style-type: none"> - Talks incessantly - Knows name and sex - Speaks sentences

er for Assessment-

-

Failure to walk
Mouthing
Drooling

-

Tremor or incoordination
Absent speech
Indistinct speech

-

Ataxia
Gait disturbance

5) Immune Boosters

An organisation that sponsored an immune booster for the Special Care Unit at William Clark Gardens Children's Home, agreed to also supply foster parents with the supplement for their children.

DIFFICULTIES / CHALLENGES

- 1) Children have been placed inappropriately (i.e. have converted from HIV positive to HIV negative as they have developed).
- 2) Difficulty has been experienced in obtaining PCR tests in terms of cost and human capacity (this has resulted in the above).
- 3) The co-ordinator was only able to devote part of her time to this pilot programme, as the programme had to be integrated into the Homefinding services. It was originally planned that the co-ordinator would supervise all the AIDS-Care placements until the death of the children – this may not now happen.
- 4) The utilisation of the experience of the nursing sister as per work plan has not been too successful. Foster parents have therefore had to be diverted to their local clinics for health-related issues or health personnel from other departments / organisations were used.
- 5) Counselling and supportive services to staff at Special Care Unit, William Clark Gardens was not undertaken due to lack of human resources.

RESEARCH

The Pilot Programme will be integrated into formal research for a Masters Degree in Social Work. A copy of the completed research can be made available to the funders.

PLANNING FOR THE NEXT YEAR [2002]

- 1) A volunteer to be trained to undertake grief counselling with staff at the Special Care Unit [William Clark Gardens Children's Home].
- 2) Arrangements will have to be made to undertake PCR tests on HIV+ children in order to ascertain AIDS status and ensure appropriate placement.
- 3) Increase outreach to churches and organisations with congruent objectives, to recruit potential foster parents. A special Recruitment Campaign is planned for May 2002 in addition to ongoing recruitment through the Masakhane Support Group.
- 4) Funds to be sought to purchase educational toys for HIV children so those foster parents can conduct home-based Educare as part of their early childhood development.
- 5) Obtain the immune booster regularly from the residential Special Care Unit and distribute to the foster-parents via the Masekhane Support Group.
- 6) Recruit a retired nurse to attend meetings on a volunteer basis to provide nursing / medical advice, direction and guidance.

J. Pillay February 2002

Project "AIDS-Care" Leader (PAL

EVALUATION OF REVISED ACTIVITY PLAN
"AIDS-CARE" PROJECT

ACTIVITIES	RESOURCES	ANTICIPATED OUTPUTS/OUTCOMES	REVISED TIME SCALE	ACTUAL OUTPUTS AND OUTCOMES
<p>Identify staff and community partners</p> <p>Establish parameters and clarify roles</p>	<p>Residential social workers PAL</p> <p>Community groups/Volunteers</p>	<p>Effective working group established</p> <p>Provisional plan reviewed</p>	<p>Started January 2001</p> <p>Terminated August 2001</p> <p>Started February 2002</p>	<p>Specialist social worker was seconded to implement the programme.</p> <p>Working group was established involving: Nursing Sister: Special Care Unit Children's home social worker; Volunteer representative; Crisis parent; Foster parent.</p>
<p>Plan and prepare the recruitment campaign and the orientation/training programme</p>	<p>Orphan Project Co-ordinator Social Workers (Placement Team) Nursing Sister Representatives of relevant groups/organisations</p>	<p>Recruitment campaign planned</p> <p>Specialised Orientation/Training Programme completed</p> <p>To form Support Group</p>	<p>Ongoing</p> <p>April 2001</p> <p>May 2001</p>	<p>Masakhane Support Group formed. 8 x monthly meetings have been held Recruitment strategies have been planned and implementation started via:</p>

ACTIVITIES	RESOURCES	ANTICIPATED OUTPUTS/OUTCOMES	REVISED TIME SCALE	ACTUAL OUTPUTS AND OUTCOMES
				6 local newspapers 3 local radio stations Diakonia Council of Churches Women's groups PLWA groups Gay / Lesbian groups and Media Awareness leaflets printed for publication and circulation Training topics identified
Recruit "special" foster parents	Social workers (specialist and community-based) Church and other appropriate organisations Media	Orientation Programme done individually.	April 2001 Ongoing May to November 2001	20 / 25 potential foster parents came forward; Individual Orientation offered regarding special needs of Aids infected children and special services offered by Durban Children's Society 8 families have offered to take children and have been assessed and accepted as foster parents
Place child-in-need with the appropriate foster-family ➤ introductions ➤ matching ➤ legal processes	Social workers (Homefinding Team) Social Auxiliary workers Nursing Sister Court Personnel	AIDS infected children placed in appropriate family care	Ongoing from May 2001	8 babies / children have been linked with prospective foster families.
Provide the required health and emotional support	Social Workers (specialist) Nursing Sister	Foster families assisted in order to give their child loving care	Ongoing until after death of the child	<ul style="list-style-type: none"> Recruited individual social work services and support and health care guidance

ACTIVITIES	RESOURCES	ANTICIPATED OUTPUTS/OUTCOMES	REVISED TIME SCALE	ACTUAL OUTPUTS AND OUTCOMES
	Foster-parents Paediatrician			<p>have been provided.</p> <ul style="list-style-type: none"> • Group of private practitioners / state paediatricians have offered pro-bono assistance • Support group has been formed and met 8 times • 10 people attend (including one relative caring for an Aids infected grandchild that was not specially recruited)
Provide the necessary legal and financial support and monitoring	Social Workers DCS Financial Dept.	Statutory processes are followed. State Grant is secured. AIDS-Care allowance is used for the benefit of the child.	Ongoing	Statutory process to access state grant has been started – some of the foster parents are in receipt of grant. 7 children have needed and been given additional financial assistance (Aids Care allowance).
Evaluate the effectiveness of the "AIDS-Care" project in view of staff restructuring	Social Worker (specialist) Orphan Project Co-ordinator Foster parents Comm/grps/orgs		6 monthly Feb 2002	See attached qualitative evaluation