

**University of Ottawa: School of International Development and Global Studies**

**Caregiver Perspectives on Psychosocial Support Programming for  
Orphans and Vulnerable Children in South Africa:**

**A Non-Governmental Organization Case Study**

**Cherie Martin**

**Thesis Supervisor: Dr. Lauchlan Munro**

© Cherie Martin, Ottawa, Canada, 2015

## Table of Contents

<b>1.0 CHAPTER 1: INTRODUCTION.....</b>	<b>1</b>
<b>1.1 Overview .....</b>	<b>1</b>
<b>1.2 Terminology .....</b>	<b>3</b>
<b>1.3 South African Context.....</b>	<b>5</b>
<b>1.4 Political and Economic History .....</b>	<b>6</b>
<b>1.5 HIV/AIDS in South Africa .....</b>	<b>9</b>
<b>1.6 Orphaned and Vulnerable Children (OVC) .....</b>	<b>11</b>
<b>1.7 Crime, Violence and Child Abuse .....</b>	<b>12</b>
<b>1.8 Fetal Alcohol Syndrome .....</b>	<b>13</b>
<b>1.9 Tuberculosis (TB) .....</b>	<b>14</b>
<b>2.0 CHAPTER 2: LITERATURE REVIEW.....</b>	<b>16</b>
<b>2.1 Outcomes for Psychosocial Development and Mental Health for OVCs .....</b>	<b>16</b>
<b>2.2 Psychosocial Programs and Interventions for OVCs .....</b>	<b>19</b>
<b>2.3 South African Policy Frameworks for HIV/AIDS OVCs .....</b>	<b>20</b>
<b>2.4 Challenges and Considerations for Policy .....</b>	<b>23</b>
2.4.1 Foster care policy.....	24
2.4.2 Foster care vs. institutionalized group homes.....	25
2.4.3 Caregiver burnout .....	26
2.4.3 Gender.....	27
2.4.4 Political challenges .....	28
2.4.5 Human-Rights based policy.....	30
<b>2.5 Gaps in the Literature and Contributions.....</b>	<b>30</b>
<b>3.0 CHAPTER 3: THEORY &amp; METHODS.....</b>	<b>33</b>
<b>3.1 Theory .....</b>	<b>33</b>
3.1.1 Child development theory.....	33
3.1.2 Theoretical framework.....	36
<b>3.2 Methodology .....</b>	<b>38</b>
3.2.1 Research design: a qualitative case study .....	38
3.2.2 Organization recruitment .....	39
3.2.3 Research ethics protocol .....	40
3.2.4 Changes in research design and complications.....	40
3.2.5 Participant observation (the crèche) .....	42
3.2.6 Participant recruitment.....	43
3.2.7 Individual interviews .....	44
3.2.8 Debriefing procedures .....	44
3.2.9 Data Capturing, analysis and reporting.....	45
<b>3.3 Background Information .....</b>	<b>46</b>
3.3.1 HomefromHome strategy .....	46
3.3.2 Structure of the foster homes .....	48
3.3.3 Nature of vulnerability and orphanhood .....	48
3.3.4 Regions .....	50
<b>3.4 Limitations.....</b>	<b>52</b>

<b>4.0 CHAPTER 4: FINDINGS .....</b>	<b>57</b>
<b>4.1 Research Questions.....</b>	<b>57</b>
<b>4.2 Foster Mothers .....</b>	<b>57</b>
4.2.1 Challenges in providing psychosocial support .....	57
4.2.2 Best forms and sources of psychosocial support .....	59
4.2.3 Awareness for policy makers.....	62
4.2.4 The role of psychosocial support.....	63
4.2.5 Caregiver suggestions .....	69
4.2.6 Role of the church & local community.....	71
4.2.7 Challenges related to children’s biological families.....	72
4.2.8 The future of the children .....	75
4.2.9 Gendered Issues .....	78
<b>4.3 HomeFromHome Personnel (Social workers and administrator) .....</b>	<b>79</b>
4.3.1 Challenges in providing psychosocial support .....	79
4.3.2 Best forms and sources of psychosocial support .....	82
4.3.3 Awareness for policy makers.....	84
4.3.4 The effects of trauma and children’s emotional and behavioural problems.....	86
4.3.5 The role of formal psychosocial support .....	89
4.3.6 Challenges related to children’s biological families.....	90
4.3.7 The importance of community integration .....	92
4.3.8 Failing systems .....	93
<b>5.0 CHAPTER 5: DISCUSSION .....</b>	<b>96</b>
<b>5.1 Challenges in Delivering Psychosocial Support .....</b>	<b>96</b>
<b>5.2 Best forms and Sources of Psychosocial Support .....</b>	<b>98</b>
<b>5.3 Suggestions and Concerns for Policy Makers .....</b>	<b>101</b>
<b>5.4 Identified Themes .....</b>	<b>103</b>
5.4.1 The role of psychosocial support.....	104
5.4.2 Child development theory.....	106
5.4.3 Different forms of alternative child care & determinants of vulnerability .....	107
5.4.4 Role of the community and the church.....	108
5.4.5 Gap between policy and implementation.....	110
5.4.6 Gender issues .....	111
5.4.7 The aging-out process.....	113
5.4.8 Biological families.....	114
<b>6.0 CHAPTER 6: CONCLUSION.....</b>	<b>115</b>
<b>APPENDIX 1 - Different Forms of Alternative Child Care .....</b>	<b>118</b>
<b>APPENDIX 2 - Interview Questions for Foster Mothers.....</b>	<b>121</b>
<b>APPENDIX 3 - Interview Questions for Social Workers.....</b>	<b>125</b>
<b>APPENDIX 4 - Interview Questions for the Administrator .....</b>	<b>129</b>
<b>APPENDIX 5 - Map of the HomeFromHome Communities .....</b>	<b>132</b>
<b>APPENDIX 6 - Initial Findings Report .....</b>	<b>133</b>
<b>References .....</b>	<b>137</b>

## **ABSTRACT**

In 2011 there were an estimated 3.9 million orphaned children in South Africa, many of them orphaned by HIV/AIDS. These children are at high risk for developing psychosocial and mental health problems. The National Strategy for the care of orphans and other vulnerable children (OVCs) recognizes the importance of psychosocial support but there are few specific guidelines on best practice and little research on the effectiveness of psychosocial support programs. There is even less research capturing the perspectives of front-line staff and caregivers. This master's thesis project conducted a case study of an NGO that provides foster care for OVCs in the Western Cape of South Africa.

Semi-structured interviews were carried out with 14 foster mothers, four social workers and one administrator of the HomeFromHome organization. Interviews explored the experiences, opinions and concerns of participants regarding psychosocial support and the respondents' views on the (1) main challenges they face in providing psychosocial support (2) what they see as the most effective forms of support and (3) their recommendations for policy changes.

Responses highlighted the psychosocial challenges faced by OVCs, those caring for children, and program staff. The research findings support the existing literature, which promotes psychosocial support as essential for orphaned, and vulnerable children. This case study found that HomeFromHome social workers, foster mothers and administration want increased levels of psychosocial support for both children and caregivers. Respondents identified foster mothers and a primary loving caregiver as the most significant form and source of psychosocial support for the children.

An analysis of the participant responses identified several areas that warrant further investigation for future policy and program development. These include: the different forms of alternative childcare, the role of the community and the church, the gap between policy and implementation, gendered issues, the aging out process, and issues concerning biological families.

## **1.0 CHAPTER 1: INTRODUCTION**

### *1.1 Overview*

Maltreatment and trauma experienced at a young age have been linked to a range of future mental health problems and psychological disorders including anxiety, depression, and post-traumatic stress disorder (PTSD) (Hermenau et al., 2011; T. Lee, Foster, Makufa, & Hinton, 2002). Psychological disorders and mental illness have both direct and indirect negative consequences for individuals, family members, employers and even society as a whole. Numerous studies have shown that psychological disorders can diminish educational attainment, individual productivity and skills development, thereby reducing human capital (Alonso et al., 2011; Hermenau et al., 2011; World Economic Forum, 2011). This loss of human capital and need for increased social services further strains government resources and can impede national development efforts (UNAIDS, 2010b). In South Africa the current and future implications of widespread child vulnerability and increased risk for mental illness are extreme. In 2011 there were an estimated 3.9 million orphaned children in South Africa, as well as an unknown number of children made vulnerable by other detrimental circumstances such as childhood trauma, abuse, poverty and disease. These conditions indicate that millions of South African children are at a high risk for developing psychosocial and mental health problems. For South Africa, the scale of the problem makes this a potential compounding tragedy for children, families, communities, and national development (Frith, 2014) .

Numerous non-governmental organizations, development agencies and government departments have recognized the need to support and protect the millions of orphaned and vulnerable children (OVCs) in South Africa. Many policies and frameworks have also been developed that acknowledge the need to provide support to promote healthy psychosocial development of OVCs. However, an analysis of these policies, which was conducted for this study, indicates that there are few specific guidelines for practice and implementation. Furthermore, while there is considerable literature documenting the psychosocial problems and needs of OVCs, there has been little research to date that examines specific interventions that promote their psychosocial health, and few that identify the specific characteristics of effective

OVC care programs. Specifically, the existing literature lacks experiences and opinions from front-line workers who provide care to OVCs (Cluver and Gardner, 2007). There is a clear need for a better understanding of the role of psychosocial support for OVCs and identifying the best methods to alleviate future psychosocial problems. The current study aims to contribute to this knowledge base for policy makers and program providers through the perspectives of caregivers and front-line staff working directly with OVCs.

This research focused on the following central research question: What can the experiences, opinions and concerns of OVC caregivers and program staff tell us about psychosocial support and the role of psychosocial support programs for OVCs in South Africa? More specifically, the research sought to identify: 1) the problems OVC caregivers and program staff encounter in delivering psychosocial support; 2) what the caregivers and program staff believe are the characteristics of the best forms and sources of psychosocial support and 3) what program staff and caregivers want policy makers to be aware of or be incorporated into future policy developments regarding orphaned and vulnerable children.

This qualitative case study used open-ended interviews and participant observation of a South African NGO, called HomeFromHome. The HomeFromHome (HFH) organization partners with various community organizations to develop and support foster homes within several communities across the Cape Town region of the Western Cape of South Africa. The organization provides care for OVCs by placing children in supported foster homes, with a foster mother, an assigned social worker and general caregiving support. For this study, 14 social workers, four social workers, and one administrator from HFH were interviewed to obtain their perspectives on the role of psychosocial support for orphaned and vulnerable children.

The responses from foster mothers, social workers and program staff provided insight into their frontline experiences and their perspectives on how to best support vulnerable children and the challenges they face in doing this. The experiences of, and issues raised by, these frontline staff are consistent with the existing research that emphasizes the critical importance of meeting the psychosocial needs of vulnerable children in addition to their basic physical needs such as food and shelter. Taking into account the current economic, political and social context of South Africa, and the current policies and frameworks, a number of common themes were identified from the participant responses. These themes are then discussed as areas that warrant

further investigation in order to identify ways of improving the psychosocial support for OVCs in South Africa.

This thesis is structured into six chapters. Chapter one has first laid out a brief introduction to the research project with an overview of the study design and purpose, and will next provide an overview of the South African context with relevant background information. This contextual information includes: the key terminology, the history of South Africa; the HIV/AIDS epidemic; orphaned and vulnerable children; crime, violence and child abuse; fetal alcohol syndrome; and tuberculosis. Chapter two then provides a literature review of the relevant research related to psychosocial support for OVCs including the outcomes for psychosocial development and mental health of OVCs, the existing psychosocial programs and interventions, the South African policy frameworks for OVCs, the challenges and considerations for policy development, and the identified gaps in the literature. Chapter three describes the theory and methods of the research project, including the theoretical framework, and the study design. The methodology section also presents the detailed background information on the HomeFromHome organization, how this organization was selected, the changes in research design, the participant observation, and a detailed overview of the procedures taken for recruiting participants, conducting interviews, debriefing and data analysis. Chapter Four discusses the research findings by presenting direct quotes from participant's responses as well as a brief identification of common themes. Chapter five then provides a discussion of these findings in relation to the central research questions, followed by a discussion of the identified themes, specifically focusing on the areas that warrant further investigation based on the research findings. Finally Chapter 6 provides a summary and conclusion of the study.

## *1.2 Terminology*

Two key terms used throughout this thesis research project are 'OVC' and 'psychosocial'. While the term OVC is frequently used to refer to orphans and vulnerable children who are affected by HIV/AIDS, the term OVC was coined by researchers and development practitioners to represent all children at elevated risk, whether due to HIV or other causes (Cheney, 2012; Schenk, Michaelis, Nelson Sapiano, Brown, & Weiss, 2010). Previous

terminology such as “AIDS orphans” implied that a child was either HIV-positive or that both parents had died from AIDS. The term OVC aims to broaden this definition to represent children orphaned or made vulnerable by various circumstances, including but not limited to HIV/AIDS. Many children in foster care and orphanages are not HIV-positive, have living parent(s), and are not directly impacted by the AIDS epidemic. This study found that many children are orphaned or made vulnerable by various other circumstances, including the detrimental impacts of physical and sexual child abuse, Fetal Alcohol Syndrome (FAS) and other potentially fatal diseases such as tuberculosis. In South Africa, there is a large population of children who have been exposed to terminal illness, early life trauma, family loss, maltreatment and abuse (Moses & Meintjes, 2010).

For the term psychosocial, this research adopts the definitions of psychosocial needs, psychosocial well-being, and psychosocial programming, care and support used by Richter, Foster & Sherr (2006), who provide a clear and consistent set of terminology that is applicable to and relevant for the current study. While there are variations in definitions of psychosocial well-being within the field of psychology, there is a general underlying consensus that healthy human development requires physical, mental, and social well-being, and not merely the absence of disease and infirmity (World Health Organization (WHO), 1978; WHO, 2006). Richter, Foster & Sherr (2006) define psychosocial needs as the universal needs for healthy development of children in order to be happy, creative, socially functioning individuals who have positive aspirations for the future. Psychosocial well-being refers to positive age- and stage-appropriate outcomes in children’s physical, social and psychological development and is determined by a combination of children’s capacities and their social and material environment (Richter, Foster, & Sherr, 2006). Psychosocial interventions and psychosocial programming are specific and formalised activities, programs, and services which include counselling, debriefing and cognitive behaviour therapy (Richter et al., 2006). Psychosocial support programs are efforts by individuals and groups outside of the child’s usual social networks. Informal psychosocial care and support is provided through interpersonal interactions that occur in caring relationships in everyday life, at home, school and in the community (Richter et al., 2006).

### *1.3 South African Context*

To attempt to understand the complexity of the issue of OVCs and psychosocial health in South Africa it is first necessary to understand the causes, the context, and the scale of the problem. Many of the interconnected factors of OVCs are directly related or resultant of South Africa's history of oppression, racism, and political conflict (Noyoo, 2006). The infamous legacy of apartheid still weighs heavily on South Africa and millions of South Africans still face residual impacts of the ingrained racial segregation including high levels of poverty, inequality, racism, crime, unemployment and violence (Crais, 2011; Faul, 2013; Mogale, Burns, & Richter, 2012). There is also widespread disease, including the on-going HIV/AIDS epidemic, and a relatively high under-five mortality rate of 45 deaths per 1,000 live births in 2012 (World Bank Databank, 2014). Millions of people still lack basic housing and have poor access to public services (Adato, Carter, & May, 2006). There is inconsistent quality and access to education and health care across the country, and a land and a serious housing crisis with millions of people living in informal settlements (townships), without proper sanitation, electrical or water services. In 2012, 26% of the population did not have access to sanitation facilities and 13% did not have access to clean drinking water (World Bank, 2014). While many issues have improved over the past two decades, including the rates of poverty, primary education, and access to health care, the implications of generations of oppression continue to devastate the nation with highly complex consequences and no simple solutions.

In 2014 South Africa still has one of the most unequal income distribution patterns in the world (World Bank, 2014). While a notable black<sup>1</sup> elite rapidly emerged after the end of apartheid, whites still maintain a very high level of income compared to the vast majority of South Africans (Crais & McClendon, 2013). Approximately 60% of the population earns less than R42,000 per year (approximately US\$7,000), whereas 2.2% of the population has an income exceeding R360,000 per year (approximately US\$50,000) (Sharma, 2012). The coloured and black majority still face high rates of unemployment (25%), severe housing shortages, and on-going land disputes (World Bank, 2014). Non-whites still have much lower access to

---

<sup>1</sup> The terms 'black' and 'mixed-race' will be used interchangeably throughout this paper to refer to all non-white South Africans, recognizing that not all non-white South Africans are black.

adequate education and medical care (Crais & McClendon, 2013). There are also very high levels of sexual violence, with more than 500,000 women raped yearly (Crais & McClendon, 2013). Racial and ethnic relations remain tense, and politics remain volatile with continued issues of corruption, police brutality and exploitation.

#### *1.4 Political and Economic History*

Racial discrimination and segregation between minority whites and majority non-white South Africans has existed since the colonial rule of the Dutch and British in the 16<sup>th</sup> and 17<sup>th</sup> centuries. In 1910, the first independent government approved a constitution that permitted an all-white government to abolish all 'non-white' political representation (Thompson, 2000). Between 1910 and 1948, successive South African administrations consolidated white power and control over the black majority population (Thompson, 2000). In 1948, South Africa's National Party came into power and officially introduced Apartheid, a system of racial segregation that maintained, legalized, systematized, and consolidated white supremacy. Apartheid segregated life along racial lines and systematically discriminated against black, Asian and coloured South Africans in all aspects of life, giving them inferior status in legal and political rights, land ownership and housing, employment, transportation, health care, marriage, education, public services, and access to public venues.

It was not until 1994, after an extensive anti-apartheid struggle, that the first multi-racial democratic election was held, enabling a democratic government to come into power (Thompson, 2000). While there had been substantial opposition to the white supremacy by black South Africans throughout the period of colonialism and white domination, the most significant organized civil forum for the freedom struggle in South Africa was the African National Congress (ANC). The overthrow of Apartheid was brought about by the ANC with broad coalitions of various civil society organizations both domestically and internationally. The global anti-apartheid network connected thousands of groups across more than 100 countries. Violent uprisings, an uncontrollable work-force, a national financial crisis and international economic sanctions and boycotts put increasing pressure on the apartheid government to end racial segregation. From the mid-1980s onwards, the apartheid regime was forced to recognize

that South Africa was becoming ungovernable, and the government opened negotiations with the ANC. Apartheid officially ended in 1994 with the election of Nelson Mandela, leader of the ANC, as president and with an ANC-dominated Parliament (Republic of South Africa, 1996).

When the ANC won the first post-apartheid democratic elections in South Africa, the party came into power with a socialist agenda with priorities to reduce poverty and inequality. Prior to the 1994 election, the ANC had issued a policy document entitled The Reconstruction and Development Program (RDP) which explicitly laid out its poverty reduction strategy and social reconstruction plan (Marais, 2011; Republic of South Africa, 1994). The RDP focused on providing for the basic human needs of all South African citizens, democratizing the state and society, and developing human resources and nation-building (African National Congress, 1994; in Noyoo, 2006). The new South African Constitution, approved in 1996, enshrined these principles as rights and recognized the significance and rights of civil society, social movements, and many other organizations in all aspects of government (Jagwanth, 2003; Republic of South Africa, 1996).

Although the RDP was viewed as the foundation of the new government development policy, it did not deliver the anticipated and desired outcomes. Specifically, the RDP had serious negative economic impacts (South African History Online, 2013). The government faced challenges implementing the RDP due to fiscal constraints resultant from the poor fiscal legacy inherited after fifty years of Apartheid (SAHO, 2013). The new government was also criticized for its inability to prioritise the RDP and to integrate it as the guiding principle of its socio-economic policies. Other problems with the RDP were that it did not implement or increase new taxes, it focused narrowly on fiscal prudence and the reallocation of existing revenues and the new framework had poor policy co-ordination and implementation methods (SAHO, 2013).

To tackle the economic constraints, the Government introduced a macroeconomic policy framework called the Growth, Employment and Redistribution (GEAR) strategy in 1996 to stimulate faster economic growth. The new framework aimed to secure the necessary resources to meet social investment needs. GEAR adopted neo-liberal economic measures in order to shore up their currency and maintain foreign investment (Carmondy, 2002; Seekings, 2007; Thompson, 2000). The policy incorporated most of the social objectives of the RDP but was also aimed at reducing fiscal deficits, lowering inflation, maintaining exchange rate stability,

decreasing barriers to trade and liberalizing capital flows (SAHO, 2013). The new policy described measures to open the economy to global markets, attract foreign direct investment, increase domestic savings, create industrial competitiveness, tighten fiscal policy, and moderate wage increases (Marais, 2011; Noyoo, 2006). That same year, South Africa voluntarily joined the World Trade Organization (WTO), further liberalizing and globalizing the economy (Carmondy, 2002). These new macroeconomic policies faced opposition from ANC allies in government, including the South African Communist Party, trade unions, and many civil society groups (Marais, 2011; Thompson, 2000).

The Government anticipated that GEAR policies would eventually lead to increased wealth enabling the Government to reduce poverty and inequality (Marais, 2011). In fact, there is considerable evidence that the opposite occurred; while economic growth was reported as a result of GEAR strategies, and poverty rates decreased, inequality actually increased (Marais, 2011). In 1995 approximately 40% of the population was living in poverty (using a poverty headcount ratio at \$2 per day), and by 2012 this rate had dropped to 26.2% (World Bank, 2014). In 1995 income inequality was remarkably high with a Gini coefficient<sup>2</sup> of 56.6 (World Bank, 2014); however, inequality appears to be on the increase, with a Gini coefficient of 65.0 in 2011). The 2011 Gini coefficient of 65.0 is a very high score and South Africa is in fact ranked among the most unequal countries in the world with particularly high differences between the poorest and richest quintiles (Central Intelligence Agency, 2014; UNDP, 2014). The quintile ratio for 2011 was 20.2% indicating that the top 20% of earners earn over 20 times more than the bottom 20%, a ratio much higher than the median for middle income countries (OECD, 2011; UNDP, 2014). A comparison with other emerging countries including China, Brazil, India and Argentina indicated that in South Africa the highest increases in household income since 1990 were systematically observed in the top quintile (OECD, 2011). Furthermore, between 1995 and 2012, unemployment rates rose from 17% unemployment to 25% (StatsSA, 2010; World Bank, 2014) and in 2012, South Africa's youth unemployment rates were among the highest in the world, at 52% (World Bank, 2014). Although welfare and social spending has continuously

---

<sup>2</sup>The Gini index measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality (World DataBank, 2014).

increased, there are still huge gaps in services for black South Africans (Bhorat & Cassim, 2014; Seekings, 2007).

<b>Table 1 South African Economic Development</b>							
<b>Indicator (World Bank Data Bank 2014)</b>	<b>1993</b>	<b>1995</b>	<b>2000</b>	<b>2006</b>	<b>2009</b>	<b>2011</b>	<b>2012</b>
GDP growth (annual %)	1.2	3.1	4.2	5.6	-1.5	3.6	N/A
Poverty headcount ratio at \$2 a day (PPP) (% of population)	41.1	39.9	42.9	35.2	31.2	26.2	N/A
Gini coefficient	59.3	56.6	57.8	67.4	63.1	65.0	N/A
Unemployment, total (% of total labour force) (modeled ILO estimate)	26	17	27	23	24	25	25
Unemployment, youth total (% of total labour force ages 15-24)	50	34	45	47	48	50	52

### *1.5 HIV/AIDS in South Africa*

The political and economic challenges were not the only obstacles for the new ANC government. At the same time as the shift in economic policy and severe fiscal challenges, it became clear that South Africa was facing one of the most serious HIV/AIDS pandemics in the world (UNAIDS, 2010b). The spread of HIV could not have come at a worse time in South Africa considering the political and economic context. In the 1980s and 1990s not only was everyone's attention focused on the anti-apartheid movement, the pandemic was ignored, downplayed and even denied by key political figures including Thabo Mbeki, the second post-apartheid President of South Africa (1999-2008). Mbeki, the ANC Government, and even Nelson Mandela were highly criticised for their lack of action against the AIDS pandemic in South Africa (Fassin, 2013; Frontline, 2013). Free public antiretroviral (ART) treatments were not available until 2003 when the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa was finally approved (Ruud, Srinivas, & Toverud, 2009). In 2011 South Africa was reported to have the largest ART programme in the world, with about 1.8 million people estimated to be taking antiretrovirals (Mayosi et al., 2012). However, with the delay in action and implementation of public ART programmes, compounded by the

many other social, economic, health and poverty issues, HIV/AIDS spread so rapidly in the past 30 years that South Africa still has an extremely high prevalence of HIV (UNAIDS, 2014). In fact, with an estimated 6.1 million people living with HIV or AIDS in 2012, South Africa was ranked as the country with the highest occurrence of people living with HIV/AIDS in the world (UNAIDS, 2012).

However, there has been some real progress and serious efforts to combat the epidemic. In the past decade South Africa has introduced multiple policies and intervention programs to deal with the AIDS epidemic (Statistics South Africa (StatsSA), 2010). Most recently, the South African National AIDS Council (SANAC) released its new National Strategic Plan (2012-2016) on HIV/AIDS, sexually transmitted infections (STIs) and tuberculosis (TB), which identifies the key principles, high risk groups, goals, and strategic objectives for combating HIV/AIDS in South Africa (SANAC, 2012). These efforts are having real positive impacts as antiretroviral therapy has become increasingly accessible to infected persons (SANAC, 2011), the rate of new infections per annum (incidence) is declining (StatsSA, 2010), and the annual AIDS death rate is decreasing (UNAIDS, 2014). Annual incidence decreased from 2% in the first half of the decade to 1.3% in 2011 (StatsSA, 2010) and the recorded number of new HIV infections dropped from 540,000 new infections in 2004 to 370,000 in 2012 (UNAIDS, 2014).

Although these are promising statistics, they likely underestimate the real numbers of infected persons due to the continued high stigma surrounding HIV status, which discourages people from getting tested (Operario, Pettifor, Cluver, MacPhail, & Rees, 2007). Furthermore, it is important to note that, although new infections are decreasing, improved access to antiretroviral therapy is increasing life expectancy and decreasing death rates, and so the prevalence rate is increasing. The prevalence rate or the percentage of people aged 15-49 who are infected with HIV increased between 2002-2012 from 16% to 18% (World Bank, 2012). For this reason, in addition to the focus on prevention and treatment of HIV/AIDS, there is growing attention on the large population infected and affected by HIV/AIDS (StatsSA, 2010), and in particular, the growing number of children infected, orphaned, and/or made vulnerable by HIV/AIDS (UNICEF, 2010b).

### *1.6 Orphaned and Vulnerable Children (OVC)*

As the highest HIV/AIDS mortality rates in all Sub-Saharan Africa are in young adults, millions of children have been orphaned by the death of their HIV-positive parents (StatsSA, 2008a). According to the 2011 General Household Survey, there are approximately 3.85 million orphans (children without a living biological mother, father or both parents) in South Africa, which is 21% of all children under the age of 17 (Children's Institute, 2014). Another study reported similar findings in 2012, and found that 19% of young children aged 0-4 in South Africa do not live with either one of their biological parents and only 36% of young children live with both biological parents (StatsSA, 2012). For the remaining 45% of children, it was reported that 43% live with only their biological mother and 2% live with their biological father only (StatsSA, 2012). The South African National Household Survey revealed that 27% of youth between 15 and 24 years report that one or more of their parents has died (higher than the reported 19% for children under 18)(Children's Institute, 2014; Operario et al., 2007). Even more worrisome is the fact that these statistics are not improving; the total number of orphans in South Africa increased by 845, 000, (28%) between the years 2002 and 2010 (Children's Institute, 2014). Even after accounting for population growth, the number of orphans increased 21% faster than the population (Children's Institute, 2014).

In addition to direct infection and parental loss, children are affected by HIV/AIDS in many other detrimental ways. For example, OVCs can be children who have ill parents, or who live in a household that cares for someone with HIV/AIDS, or who are discriminated against due to their parents being HIV-positive (Andrews, Skinner, & Zuma, 2006). The millions of children affected and made vulnerable by AIDS are identified as one of the most complex outcomes of the disease (StatsSA, 2010). Furthermore, there are millions of children made vulnerable by other common factors, such as childhood trauma, mental and physical disabilities, and other terminal illnesses. The following three sub-sections discuss the impacts of crime, violence, child abuse, FAS, and tuberculosis, since they were determinants of vulnerability for some of the children supported by the organization of this study.

### *1.7 Crime, Violence and Child Abuse*

Across South Africa, and especially within the urban townships, many communities suffer from very high rates of crime, violence, drug and alcohol abuse, as well as high rates of serious physical and sexual abuse (Africa Check, 2013; Thomson, 2004). In 2013 alone there were 16,211 murders, 16,344 attempted murders, and 358,374 physical assaults reported to the South African Police Service (SAPS) (Crime Stats SA, 2013). The murder rate in 2013 was 31.3/100,000, which is about four and a half times higher than the global average of 6.9 murders per 100,000 (Africa Check, 2013). In South Africa, over 66,000 cases were reported to police in 2013 (Africa Check, 2013; Crime Stats SA, 2013). This still is a highly under-representative statistic since rape and other sexual assaults frequently go unreported in South Africa (Rape Crisis, 2012), as elsewhere. If all rapes were reported, the count could be as high as 500,000 per year (Rape Crisis, 2012).

In South Africa, as elsewhere, child abuse is a very serious problem. The existence of the many other serious social problems such as violence and drug abuse mentioned above, suggest that child abuse and neglect may be very high in South Africa. Child abuse can be defined as any form of physical and mental abuse including sexual abuse, exploitative work, trafficking or negligent treatment of a child (Janssen, Van Dijk, Al Malki, & Van As, 2013; Richter, 2008). It is difficult to identify the exact scale of the problem because of the different interpretations of what constitutes child abuse and frequent underreporting of abuse and neglect (Richter, 2008). Furthermore, it isn't currently possible to review longitudinal trends of child abuse in South Africa since SAPS victimization surveys did not record crimes against children until recent years (Altbeker, 2005). However, some research studies reviewing the available recent data, have reported increased rates of physical abuse against children in South Africa, suggesting a need for increased preventative measures to protect children from abuse (South African Police Service (SAPS), 2013).

A recent literature review conducted a data analysis on a children's hospital cases and found that child sexual assault and rape increased between 2008-2010 (Janssen et al., 2013). It also illustrated that boys were at much higher risk of physical abuse (70.5% vs. 29.5%) and that physical abuse was much more commonly reported than any other form of abuse (Janssen et al.,

2013). However, considering this research was based on hospital admissions, it makes sense there would be a higher rate of physical incidents reported. This reporting bias underscores the importance of creating broader forms of reporting of violence and abuse against children which incorporate, criminal convictions by SAPS, hospital admissions, as well including reports from social services and other less formal measures.

There is a recognized need to address social and cultural attitudes towards child abuse. While there is legislation in place to protect the rights of the child, including adoption of the Convention on the Rights of the Child and the implementation of the South African Children's Act, attitudes towards child discipline and treatment still have ties to the previously institutionalized physical punishment of children that was practised in the justice system and in schools as the primary method of discipline (Richter, 2008). Patriarchal cultures, sexism, violence, drug abuse, and religious beliefs have all been suggested as having different negative impacts on the treatment of children and the number of children orphaned and made vulnerable in South Africa (Janssen et al., 2013). While these interconnected variables are important aspects to consider for support the needs of OVCs and ending the generational cycles, these issues are complex and a full analysis of their intersectionality is beyond the scope of this specific study.

### *1.8 Fetal Alcohol Syndrome*

Another key variable contributing to the problem of OVCS in South Africa is Fetal Alcohol Syndrome (FAS). FAS and Fetal Alcohol Spectrum Disorders (FASD) result from exposure to large amounts of alcohol by an unborn fetus, with FAS being the most severe condition (FASD Prevention Symposium, 2008). FAS has been directly linked to a variety of negative health outcomes, including deficiencies in both mental and physical development (Eaton et al., 2012). It primarily causes brain damage in early development, resulting in learning difficulties and lower intelligence, behavioural disorders, language development problems, delayed motor skills, impaired memory and attention deficits, and poor social judgement (FASD Prevention Symposium, 2008; Zolotova, 2011). The physical characteristics of children born with FAS present a distinctive appearance and frequently include a short stature, a small head,

and smaller brain size (Zolotova, 2011). Since there is no cure for FAS, treatment focuses on services to manage the lifelong disabilities (Zolotova, 2011).

Since there is currently no official system collecting the number of diagnosed cases of FAS in South Africa, the exact prevalence in the national population is unknown (FASD Prevention Symposium, 2008). In high risk areas, particularly in impoverished townships in the Western Cape, prevalence rates have been reported as high as 12% and South Africa has been rated as having the highest estimated prevalence of FAS in the World (Eaton et al., 2012; May et al., 2013; Zolotova, 2011). The contributing factors to such high prevalence rates are associated with South Africa's history of apartheid, high poverty and inequality. In the Western Cape, the centuries of large scale wine production and payment of workers in wine has influenced drinking patterns, addictions, and contributed significantly to the problem of FAS (Al et al., 2005). This "Dop" system of paying vineyard staff in wine subsidies was outlawed post-apartheid South Africa; however this form of payment is still common and centuries of exploitation has created cyclic alcohol dependencies among coloured and black communities (Al et al., 2005).

The majority of South African women who are at risk of alcohol-exposed pregnancies are women living in poverty. A recent South African study found that women living in impoverished townships in the Western Cape report that high levels of alcohol consumption during pregnancy has become a normalized practice (Eaton et al., 2012). The study also found that daily, or almost daily binge drinking was statistically more significant among pregnant women than non-pregnant women (8.4% vs. 4.2%;  $\chi^2=6.24$ ,  $p<0.01$ ,) (Eaton et al., 2012). While there is not necessarily a clear direct causal relationship of alcohol abuse, FAS, and orphans, there is a clear risk of having casual attitudes towards prenatal alcohol consumption, high incidence of alcohol abuse and a large proportion of children born with FAS in poor communities.

### *1.9 Tuberculosis (TB)*

Another disease that is associated with OVCs is Tuberculosis (TB). TB has a very high prevalence and is the leading cause of death in South Africa (Avert, 2012; StatsSA, 2008b)(WHO, 2013a). A central concern in South Africa is the co-prevalence of TB and HIV and the compounding effects of the two diseases. South Africa has one of the world's highest co-

infection rates of TB and HIV, with almost 75% of people with TB also testing HIV-positive (WHO, 2013b). However, the statistics for children made vulnerable or orphaned by TB alone was not found to be disaggregated from HIV statistics in South Africa. As TB is the leading cause of death in South Africa it is likely that TB plays a significant role in the number of OVCs. Furthermore, TB poses increased health implications for OVCs and child caregivers. Cluver et al. (2013) found that children providing home medical care to ill caregivers are at a significantly increased risk of contracting TB (Cluver, Orkin, Moshabela, Kuo, & Boyes, 2013). This research highlighted the need for increased tuberculosis screening and anti-tuberculosis treatment for children caring for ill adults in contexts with a high burden of HIV and tuberculosis (Cluver et al., 2013).

To address the high burden of TB, the South African National AIDS Council integrates TB into the National Strategic Action Plan and emphasised the importance of considering HIV and TB co-infection in all levels of planning and strategy (SANAC, 2012). However, there is a substantial gap when it comes to the role of TB in relation to policy and OVCs in South Africa. None of the central policy documents on orphans and vulnerable children discuss the role of TB other than the need to protect children from TB infection (Bruin Cardoso, 2010; SADC, 2009; SARP, 2005). The National Strategic Plan on HIV, STIs and TB 2012-2016 does however set an objective to mitigate the impact of HIV, STIs and TB on orphans, vulnerable children and youth (SANAC, 2012). However, here again the focus is more on the need to protect children from TB infection rather than highlight the role TB has in contributing to the number of OVCs in South Africa.

The political, economic and environmental history of South Africa illustrate that the factors at play contributing to the problem of OVCs is highly complex and multifaceted. To support the healthy development of existing OVCs and prevent more children from becoming orphaned or made vulnerable, it will require continued collaborated efforts and resources that tackle the problem from a holistic perspective, acknowledging the intersectionality of these various factors. This study attempts to contribute to the literature that is relevant and useful for future policy developments that aims to support the needs of OVCs.

## **2.0 CHAPTER 2: LITERATURE REVIEW**

In order to conduct research that will provide an informative contribution to the knowledgebase of OVCs and their psychosocial health needs, it was first critical to examine the existing research and identify the gaps in the current literature. The following chapter presents an overview of the literature on psychosocial and mental health outcomes associated with OVCs, and the implications of these outcomes. Next, the existing psychosocial programs and interventions are reviewed, followed by the South African policy frameworks for HIV/AIDS and OVCs. Then a few of the various challenges and policies that require consideration for future policy development are discussed. These include the challenges and considerations surrounding foster care policy, the different forms of childcare, caregiver burnout, gendered issues, political challenges, and human- rights based policy. Chapter two then concludes with the identified gaps in the literature.

### *2.1 Outcomes for Psychosocial Development and Mental Health for OVCs*

Orphaned and vulnerable children are at a higher risk for developing a range of psychosocial and mental health problems. Psychosocial health and well-being can be loosely defined as a state of healthy social, emotional, and psychological well-being (Richter, Foster, & Sherr, 2006). Psychosocial theory emphasizes the need for a combination of positive social and material environments in addition to children's own capacities to attain positive age- and stage-appropriate outcomes in children's physical, social and psychological development (Richter et al., 2006). In contrast, negative social and physical environments are associated with poor psychosocial development in children and increased risk of mental illness.

Whether children have been made more vulnerable due to sexual, physical or emotional abuse, or because they were orphaned by a serious illness such as HIV/AIDS or TB, research indicates that separation from biological family, systemic problems with child protective services, and traumatic or stressful experiences from their childhood put OVCs at a much higher risk for a range of developmental problems and mental illnesses (Cluver, Gardner, & Operario, 2009; Cluver, 2011; Kuo & Operario, 2009; Onuoha & Munakata, 2010).

The loss of close relatives, especially parents and guardians, due to HIV/AIDS is highly correlated with negative impacts on psychosocial well-being including mental health, and emotional functioning (Unicef, 2001). For children with parents who are HIV-positive, the psychological impact of witnessing parents cope with or perish to the disease are equally detrimental (Andrews et al., 2006). A study in Ghana reported that orphans in general and children living with HIV-infected parents consistently demonstrate poorer psychosocial adjustment than their child comparison group in the same community (Doku, 2010). OVCs require special attention with culturally and developmentally appropriate intervention efforts that focus on risk and resilience factors, both individual and contextual (Doku, 2010). Orphaned children also score worse on measures of emotional symptoms, conduct problems, hyperactivity, peer relationship problems and behavioural problems (Doku, 2010). In South Africa, a study reported that OVCs demonstrate higher levels of depression, peer problems, post-traumatic stress symptoms, and delinquency than control groups (Cluver et al., 2009).

In addition to the direct impacts of trauma and parental loss, there are many indirect negative impacts from the contextual factors that are common for various OVCs, including poverty and unstable family environments. Multiple studies (Operario et al., 2007; Schenk, 2009) have even reported that OVCs are subject to a combination of disadvantages and risk factors, over and above those caused by living in already disadvantaged communities, including higher rates of poverty (Cluver et al., 2009), stigma (Surkan et al., 2010), reduced access to health care (Andrews et al., 2006), decreased food security (Nyambedha, Wandibba, & Aagaard-Hansen, 2001), lack of adult care and emotional support (Heymann, Earle, Rajaraman, Miller, & Bogen, 2007), and decreased rates of educational access and achievement (Ainsworth, Beegle, & Koda, 2005).

Furthermore, the changes in caregiver and family composition (such as separation from siblings and the change to grandparent-headed households) as a result of death and migration have been found to be a predictor of emotional distress in children and adolescents (Richter, 2004). Children are also found to become increasingly vulnerable when primary care is provided by much older relatives, as children and young adults may themselves increasingly have to become caregivers for grandparents (Richter, 2004). This mutual dependency is a common occurrence in children orphaned by parental deaths of AIDS (Richter, 2004). Similar to findings

for children exposed to extreme conditions of poverty, OVCs are negatively impacted by the added burden of increased domestic and labour responsibilities (Unicef, 2001). Perceived discrimination and stigma toward children affected by HIV/AIDS which has been self-reported as frequent (Surkan et al., 2010) have also been associated with negative psychosocial outcomes including increased depressive symptoms (Surkan et al., 2010; Williams, Neighbors, & Jackson, 2003).

The various detrimental circumstances of poverty, community violence, co-dependence, stigma, and trauma significantly increase the risk for future problems in physical and mental health (including depression, peer problems and post-traumatic stress) regardless of HIV infection rates (Cluver et al., 2009). This is a compounding tragedy for individuals, families, and communities (Doku, 2010). With over 3.8 million orphaned children in South Africa, as well as the unknown number of children made vulnerable by other factors than HIV, this is also a national issue. Not only is this because of the resultant loss of life and human capital, but also the psychological impacts, the scale of the problem, and the interconnected and cyclical issues such as poverty, poor education and poor access to health care (Kuo & Operario, 2010; UNAIDS, 2010a; UNICEF, 2010b). With the associated risk of poor educational attainment, and low employment rates, the OVC problem impedes community and national development resulting in the loss of future human capital (Doku, 2010). On a nation-wide scale, OVCs can impact the national labour force, costs of health and social care, and restrict domestic economic growth (UNAIDS, 2010a; UNICEF, 2010b).

Munro describes the effects of ongoing conflict on a generation of children in Zimbabwe and the negative effect this had on individuals and the country (Munro, 2001, 2012). The effects of AIDS and other traumas on children can be viewed in a similar fashion with similar large-scale impacts. Given the numbers of children affected in South Africa, OVCs are a major concern for national development and will constitute a significant challenge for communities across the nation for many future generations. These realities underscore why research exploring the best avenues to support OVCs and their psychosocial development are crucial.

## *2.2 Psychosocial Programs and Interventions for OVCs*

There are a variety of government and community-based interventions that attempt to mitigate the multiple risks to OVC health, education and psychosocial wellbeing in South Africa. Different interventions aim to provide financial and educational assistance, home-based care, legal protection and psychosocial support for OVCs (Schenk, 2009). However, there are few documented programs that specifically target the improvements of psychosocial wellbeing in OVCs in South Africa. Studies in some other Sub-Saharan African countries investigate programmes and strategies which focus on individual clinical care such as psychological therapy and counselling (Clacherty & Donald, 2005; Lee, Foster, Makufa, & Hinton, 2002) and programs aimed at strengthening family and community support (Drew, Makufa, & Foster, 1998; Richter et al., 2006; Thurman, 2007). Other, less direct, interventions promote the need for government protection in order to mitigate the detrimental effects of the environmental conditions associated with psychosocial outcomes for OVCs such as poverty and unsupportive, unstable environments (Richter et al., 2006; UNAIDS, 2010b).

Each of these forms of intervention report some positive psychosocial outcomes. For example, a specific intervention program that focused on the psychosocial benefits of a community-based adult volunteer mentoring program for youth-headed households in Rwanda reported improvements in psychosocial outcomes including decreased feelings of marginalization, grief, and depressive symptoms (Thurman, 2007). Other studies have found direct counselling for children affected by HIV/AIDS to be associated with better outcomes of psychosocial well-being including decreased levels of emotional stress, increased confidence and more positive self-perceptions for future well-being and livelihoods (Clacherty & Donald, 2005).

In addition to direct psychosocial interventions, the literature suggests that physical and material interventions (for example focusing on poverty alleviation) may also be effective in improving psychosocial outcomes for OVCs, especially in environments with poor resources where psychosocial well-being is often dependent upon the physical environment (King, De Silva, Stein, & Patel, 2009). For example, a program that focuses on reducing adult roles for OVCs such as employment and child-care of younger siblings will likely be associated with decreased levels of stress, a common psychosocial outcome variable. Poverty alleviation

programs as well as interventions focused at education and skills training play significant roles in providing assistance for OVCs. However, the argument here is that programs focusing solely on poverty alleviation or education are not always a solution in-and-of themselves to the many other associated issues faced by OVCs, including their psychosocial development. The role of psychosocial support in all intervention programs is crucial for supporting healthy child development in OVCs(King, De Silva, Stein, & Patel, 2009).

From a human rights perspective, the need to attend to the high number of OVCs is a state and civil obligation for South Africans (United Nations CRC, 1989). The Convention on the Rights of the Child (CRC) addresses the responsibility of states and parents and other caregivers to respect, protect and promote children's rights (United Nations, 1989). Specifically, the CRC states that all children have the right: to survival; to develop to the fullest; to education; to the highest attainable standard of healthcare; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life; and to have a name (United Nations, 1989). The CRC highlights the importance of identifying and implementing policies, programs and interventions to protect all children and has specific provisions for the most vulnerable children. Addressing the psychosocial health needs of OVCs could have positive impacts on more than the individual psychosocial well-being of children themselves and their future quality of life. It could also improve community involvement, educational achievement, and local human capital, and has the potential to play a role in reducing national rates of poverty, unemployment, crime, child abuse, and prevalence of serious diseases such as HIV/AIDS, TB, and FAS.

### *2.3 South African Policy Frameworks for HIV/AIDS OVCs*

South Africa has a substantial set of policies targeted at HIV/AIDS and care for OVCs. The National Strategic Plan for HIV and AIDS, STIs and TB 2012-2016 (South African National AIDS Council (SANAC), 2011) incorporates policies, frameworks and goals to coincide with international and regional obligations, frames and goals including: the United Nations Universal Access and Millennium Development Goals, UNAIDS 2011-2015 Strategy, WHO Health

Strategy on HIV and AIDS 2011-2015, the Southern African Development Community (SADC), and the African Union (SANAC, 2011).

SANAC is a partnership of both government and civil society organisations (SANAC, 2011), formed to strengthen political leadership, and ensure inclusion of civil society in the response to HIV and AIDS in South Africa (SANAC, 2011). SANAC coordinates with a number of other NGOs including; the Networking HIV AIDS Community of South Africa, AIDS Consortium, and South African Business Coalition on HIV and AIDS South Africa has adopted national goals based on the targets set out in the United Nations General Assembly Special Session on HIV and AIDS Political Declaration Targets for 2015, which includes the target to ‘ensure equal access to education for children orphaned and made vulnerable by AIDS’ (SANAC, 2011).

SADC has constructed a Strategic Framework and Plan of Action (2008-2015) that is a comprehensive care and support framework for orphans and other vulnerable children and youth (OVCY)(SADC, 2009). This is meant to ensure that the rights and basic needs of all children and youth in the SADC region are fully met (SANAC, 2011). The Strategic Framework adopts a multifaceted child development approach and outlines guiding principles for comprehensive care and support for OVCs. The guidelines emphasize that interventions should focus on empowering and building capacities of children and youth to realise their full human potential. The Framework aims to provide a common holistic developmental philosophy and approach to addressing challenges faced by orphans, vulnerable children and youth, their families and care givers, within the socio- cultural, economic and political realities of the SADC region. SADC has also developed a minimum package of services report to guide approaches for the scale up of service provision, as well as to address risk mitigation amongst vulnerable groups(SADC, 2010). A situational analysis of the minimum package of services found that, although there is a lot of good practice within the SADC region, and significant progress has been made in the realm of policy improvements for orphans and vulnerable children, there are still significant gaps and a substantial disconnect between policy and practice.

One leading NGO that focuses in on psychosocial support for OVCs is the Regional Psychosocial Support Initiative (REPSSI). The SADC OVCY Framework and Business Plan, and the draft Minimum Package of Services for OVCY were developed in partnership with

REPSSI (REPSSI, 2011). REPSSI aims to lessen the psychosocial impacts of poverty, conflict, HIV and AIDS among children and youth across Eastern and Southern Africa. Partnering with governments, development agencies, international organizations and other NGOs, it provides technical leadership, knowledge development and capacity-building programs. These are designed to promote regional coordinated responses to promote the psychosocial wellbeing of OVCs and their families (REPSSI, 2011). REPSSI partners include non-profit organizations that work directly with children, as well as government departments aiming to assist OVCs.

REPSSI's approach includes the provision of tools that are meant to be easy-to-use and culturally appropriate. They promote knowledge sharing of innovative approaches, and train partners to provide social and emotional services to children and their communities. REPSSI designs activities and tools that can be used with children, youth, caregivers and communities, including manuals that are available online for free. These tools are designed to facilitate the implementation of psychosocial care, and include factsheets, reports, manuals and certificate courses. The initiative is also engaged with on-going psychosocial OVC research projects, as well as supporting program monitoring and evaluation initiatives.

The National Action Committee for Children Affected by AIDS (NACCA) is a South African co-ordinating body led by the Department of Social Development that collaborates with many government departments, development agencies, civil society groups and NGOs. The Committee's main objective is to effectively synthesize efforts directed at improving services and programs for OVCs (NACCA, 2009). The coordination of government departments and development agencies together with civil society is intended to ensure that available resources are used optimally to realize the rights of OVCs and avoid duplication of efforts. In 2009 the NACCA produced a National Action Plan for orphans and other children made vulnerable by HIV and AIDS in South Africa (NACCA, 2009). While the 2012-2016 Action Plan does not appear to be available online, the 2009 Action Plan sets out general goals and priorities.

The NACCA also works to mobilise and distribute resources for the implementation of the Policy Framework for Orphans and Other Children Made vulnerable by HIV and AIDS. This framework, the only policy framework to set out more detailed guidelines for OVCs in South Africa, was developed by the Southern African Regional Poverty Network (SARPN). SARPN is a NGO that focuses on poverty reduction processes and experiences in Southern Africa (SARPN,

2005). SARPN developed the Policy Framework in 2005 “to promote an enabling environment for more effective delivery on commitments to orphans and other children made vulnerable by HIV and AIDS at legislative, policy and programmatic levels” (SARPN, 2005). The Policy Framework was designed to ensure that all government departments function in coordination to ensure OVCs rights are protected including the Departments of Home Affairs, Social Development, Agriculture, Housing, Provincial and Local Government, Public Works, Correctional Services, Policy Services, Sport and Recreation, as well as civil society stakeholders and direct services delivery providers. The guidelines within this policy which pertain to psychosocial wellbeing include the requirements to:

- Ensure that services are accessible, community-based and differentiated along a continuum of care including psychosocial support for OVC, their primary caregivers and families
- Enhance the capacity of families and primary caregivers to provide protection, psychosocial support and counselling to OVC, including very young children and those with special needs. (SARPN, 2005, p.15).

Thus, while there are several policy frameworks and a general consensus on the importance of programs to promote psychosocial development in OVCs, there is no clearly defined set of unified guidelines, goals, and policies to achieve or implement the programs.

#### *2.4 Challenges and Considerations for Policy*

The policies and procedures for providing supportive care can be complicated with real challenges but the policies in place are necessary guidelines and resources for OVC caregivers and social workers. This study will attempt to identify participants’ opinions on the role of policies and frameworks that are set out to protect OVCs and support their own caregiving efforts. The following section will provide an overview of some of the anticipated and reported challenges and considerations related to OVC policy and implementation. These include foster care policy, different forms of alternative care, caregiver burnout, gendered considerations, political challenges and the issues surrounding human rights based policy.

### **2.4.1 Foster care policy**

The foster care system and alternative care policies in South Africa are similar to those of countries such as the US, Canada and the United Kingdom (Day, Riebschleger, Dworsky, Damashek, & Fogarty, 2012; Denault, 2012; Megahead & Cesario, 2008; Okpych, 2012). These policies are in place to ensure OVCs are protected and supported through different forms of alternative care, and to ensure appropriate supervision of caregivers and placements. However, like all foster care policy, the guidelines can result in various complications and serious implications.

The aging-out process is often the most complicated or contested aspect of foster care policies since it can be difficult to balance and monitor the need to protect vulnerable children as they move into adulthood, with the need to avoid abuse of the foster care system and government resources. Since the Children's Act does not apply to people after the age of 18, foster children are no longer eligible for the same protection as children under 18. Many issues arise after the foster child turns 18. There is the issue of surviving biological parents or relatives claiming children who turn 18 but who cannot provide safe and supportive environments for the individual, or who were previous abusers. There is also the serious issue that many foster children who turn 18 are developmentally delayed, have mental health problems, have special needs and or have serious additional health problems that prevent them from being able to live independently.

In South Africa, a child placed in a child and youth care centre (institutionalized care) through a court order is able to leave the facility after turning 18; however, they are entitled to stay in alternative care until the end of the year in which he or she turns 18 years. After turning 18, the individual can be allowed to remain in alternative care until the age of 21 years if they make an application to the provincial head of the Department of Social Development. S/he can allow the extension if the current alternative caregiver agrees and is able to care for the applicant, or if the extension is necessary to enable the applicant to complete his or her studies or training (Mahery, Jamieson, & Scott, 2011). However, even if a child is able to legally reside with a foster parent, the foster grant is no longer accessible. For the at-risk individuals such as those with a mental or physical disability, there is a care-dependency grant that caregivers can apply

for. But there are many stipulations to this grant with a lengthy application process. One of the difficult requirements is that the caregiver must be the child's biological or adoptive parent, or they need to have a court order stating that they are legally required to look after the child. Caregivers are also ineligible for the grant if the child receives care from a treatment centre (Western Cape Government, 2014). Foster grants are usually provided to the foster parent until the child turns 18 years old and is terminated when the child leaves school or earlier if the child is earning an income above the stipulated level as revealed by a means test.

#### **2.4.2 Foster care vs. institutionalized group homes**

While this research project will conduct a case study of an NGO supporting foster families, many OVCs are placed in institutionalized group care. Institutionalized group children's homes are more commonly known as orphanages, which are defined in South African policy as 'child and youth care centres' (Department of Social Development, 2010). The breakdown on the percentage of children placed in foster homes in comparison to institutionalized care has not been recorded or compared, as there is no official comprehensive list of institutional care services for children in South Africa. The South African government reported that there were over 430,357 children in foster care as of May 2014 (SASSA, 2014) and 345 registered children's homes that look after approximately 21,000 children in 2010 (UNICEF, 2010a). Even though registration is mandatory under the South African Children's Act 2005, many centres are not actually registered with the South African Government and these figures are likely unrepresentative of the actual picture of alternative child care in South Africa (Moses & Meintjes, 2010). In 2010, UNICEF announced a priority to work with the Department of Social Development to strengthen alternative care for orphans and vulnerable children in South Africa and prioritized the development of a system for regular and standardised information collection on children in registered alternative care (UNICEF, 2010c). More recent data or progress on this commitment was not available as of July 2014.

A substantial body of research argues that family unit foster care creates an environment that is more conducive to healthy psychosocial development than institutionalized group care (Garvin, Tarullo, Van Ryzin, & Gunnar, 2012; Johnson, Browne, & Hamilton-Giachritsis, 2006;

Smyke, Dumitrescu, & Zeanah, 2002). Other research emphasizes the detrimental effects of institutional group care. Orphanages and ‘child and youth care centres’ are usually unable to provide a level of individual attention since there are typically more children living in a large group setting with multiple caregivers who provide rotational supervision (Smyke et al., 2002). The multiple rotating schedules are not conducive for focused attachment relationships between a child and caregiver and disrupt healthy psychosocial development (Smyke et al., 2012). While it is beyond the scope of this study to analyze the different forms of alternative care in relation to psychosocial health for OVCs, it is an area that warrants further investigation and is explored in Appendix 1 in relation to the participant responses of this study.

### **2.4.3 Caregiver burnout**

A major challenge in OVC protection is the burden placed on caregivers and professionals who are responsible for providing the general care and psychosocial support for OVCs. A 2007 study examining the experiences of various healthcare workers, caregivers, counsellors, and teachers working in the field of HIV/AIDS, found that occupational stress and burnout developed from intense feelings of personal stress, hopelessness and despair (Van Dyk, 2007). Caregivers reported feelings of bereavement overload, over-identification with their patients, fear of occupational exposure to HIV, and found it difficult to cope with their own and patients’ stigmatisation and confidentiality issues (Van Dyk, 2007). Kuo, Operario, and Cluver (2011) found that a high percentage of caregivers in South Africa reported clinical depression, regardless of whether they cared for AIDS-orphaned, other-orphaned, or non-orphaned children. They concluded that there is a strong need for mental health interventions among communities with a high HIV prevalence, particularly for caregivers (Kuo, Operario, & Cluver, 2012). The study also reported that caregivers who support orphaned children and female caregivers are at higher risk for depression.

A study conducted by SADC shows that this need has been recognized but that very few programs offer support for caregivers (SADC, 2010). In an analysis of psychosocial support provision within the SADC region, the study found that 86% of key informants claim that their organisation provides psychosocial support. However, this psychosocial support was mostly

provided to children, with very few services for vulnerable youth and caregivers. The informants of the study did, however, recognize the need to provide these services to caregivers (SADC, 2010).

### **2.4.3 Gender**

Gender is here defined here as the social categorization of females and males. Gender research, monitoring, and evaluation appear to be lacking when it comes to the social health delivery to orphans and vulnerable children. Cluver and Gardner (2007) reviewed international studies examining the psychological health of OVCs and found only one study that examined gender (Cluver & Gardner, 2007). This 2010 study examined gender and psychosocial health outcomes in sub-Saharan African children and found that there was no significant gender difference between girls' and boys' psychosocial health status (Onuoha & Munakata, 2010). The study concluded that female-exclusive psychological health facilities may be unnecessary since females' psychological health is similar to that of males.

Although not targeting gender differences, a 2011 study investigated the associations between family, peer, and community factors and resilience in orphaned adolescents in South Africa. The study found that orphaned girls and older adolescents may be in particular need of support (Wild, Flisher, & Robertson, 2011). This finding supports previous research on parental bereavement which has found higher rates of internalizing problems in girls than in boys (Dowdney, 2000; Wild et al., 2011). A study conducted in two semi-rural South African communities examined the experiences of informal caregivers supporting people living with HIV and found that home-based care undermines women's health and wellbeing, creating an excessive burden on women and thereby exacerbates existing gender inequities (Akintola, 2006). The authors argued that home-based care in some settings leads to the transfer of the responsibility of care to women who are already burdened by poverty and deprivation. They emphasized the need to incorporate gender perspectives when planning and implementing home-based care programmes. Although that study was not examining OVCs' psychosocial health needs, it illustrates some of the existing gender considerations needed to influence policy and programmes (Akintola, 2006).

With such a limited body of gender research in psychosocial health of for OVCs there is justification for further research examining the role of gender. Gender mainstreaming proposes that gender, sex difference or even cultural perception of gender difference plays a role in the levels of risk and protection needed for an individual and should be taken into consideration when developing effective interventions (Tiessen, 2005). For example, in the townships where many of the children previously resided, and where the new foster homes exist, it would be important to know if there is a higher risk of certain negative outcomes for one gender more than the other. For example, is there a higher risk of sexual and physical violence for women and girls, than males, and do boys and girls have equal access to education, health care, and employment opportunities? Does the fact that most of the foster homes are female, single-parent households play a significant role in the psychosocial development of the children? Could this role take different forms for girls and boys? Is there a need for a consistent father figure to ensure healthy psychosocial development of the boys? Is one gender at higher risk than another for certain diseases including HIV/AIDs, tuberculosis and fetal alcohol syndrome? What measures need to be put in place to ensure both boys and girls have the gender-specific psychosocial support they needs in developing healthy mental status after their previous negative life experiences? Each of these considerations would be beneficial for research for improving the psychosocial support systems for orphaned and vulnerable children in South Africa. It appears data on gender variation and outcome are still urgently needed to inform policy and research on children and HIV (Sherr, Mueller, & Varrall, 2009).

#### **2.4.4 Political challenges**

In spite of the continuing high levels of poverty and social problems, the majority of poor black<sup>3</sup> South Africans remain loyal to the ANC Government. However, accusations of ANC corruption, elitism, and abandonment of the ANCs core principles are mounting. Increasing numbers of South Africans in disadvantaged communities feel the current systems are failing

---

<sup>3</sup>Racial terminology and classification in South Africa today still reflect the four racial classes set out by the apartheid government: 'Black' refers to dark-skinned Africans, 'coloured' pertains to mixed race persons typically of lighter brown skin, 'Indian-Asian' describes all persons of Indian and Asian appearance, and 'white' applies to all white persons, typically of British and Dutch descent. The term coloured is also often expanded to include those of the 'Indian-Asian' classification. Although this terminology is still generally accepted, the interpretation of the racism associated with these terms differs with location, culture, and individuals across South Africa.

them and there are frequent protests and demands for change (Economist, 2014; Eimhjellen, 2014). In the Western Cape, where the foster parents and social workers of this study reside, the Democratic Alliance, the main national opposition party, is the governing political party at the state level. A large majority of the black population in the Western Cape remain loyal to the ANC and blame the DA for the failures in the delivery of necessary social services (Crais & McClendon, 2013; Eimhjellen, 2014). There is frustration at broken promises that the social policies promising to uphold human rights are not having real impacts for the people in need.

Although South Africa has enacted specific legislation on anti-discrimination and human rights based platforms for OVC protection and support, and a number of government sanctioned policies and frameworks for the care of OVCs, many orphaned and vulnerable children still lack adequate security, health care, education, and general caregiving. Addressing the existing system failures will require a first step of identifying the specific barriers to the implementation of the current policies and targeting efforts directly. This is a very complicated issue in the case of South Africa where the barriers are complex, multifaceted and unclear. In the case of this research study, the primary entity responsible for ensuring the safety and protection of OVCs and their development are the government departments responsible for service delivery. While these departments are accused of corruption, incompetence and indifference (Crais & McClendon, 2013), they do face very serious fiscal and implementation challenges with so many people living in poverty and a multitude of complications and issues to address. In the current context of serious social problems and continued fiscal restraints, social programs and individuals are trapped in a battle for funding and assistance. To immediately address the widespread poverty, widening inequality, and each of the various consequent problems including the psychosocial needs of OVCs substantial funding and effective programming is needed.

For civil society movements dedicated to realising the rights of OVCs, one challenge is gaining resonance among the larger population. Successful social or political movements for change require a “frame” that is salient and resonates with a large audience in order to mobilise wide support (Snow & Benford, 1992). For example, the successful *Treatment Action Campaign* (TAC) which sought to create universal access to HIV /AIDS retroviral treatment across South Africa, had clear direct implications for millions of people (Mitlin & Mogaladi, 2009). Housing, water, sanitation, and other basic needs are still unmet for millions of people. These tangible or

direct issues have widespread resonance and attract wide support. In contrast, the individual, community, and national impacts of having millions of OVCs who are at high risk for developing serious mental health issues is not as apparent, is less understood, and has a lower immediate visible impact. This is a considerable challenge for those hoping to gain political and social traction in favour of the psychosocial needs of OVCs in South Africa.

#### **2.4.5 Human-Rights based policy**

Addressing the issue of OVCs' psychosocial health is also, in some ways, constrained by the human rights based policy and approach to social and economic development issues (Kennedy, 2005; Rajagopal, 2006; Wood, 2009). Human-rights based approaches are highly contested. While they aim to free people from harm and provide them with emancipatory tools, human rights based approaches also bring risks, costs, and unanticipated outcomes (Kennedy, 2005). Human rights platforms can "clean the hands" of the international community or the domestic state. The state can point to their adoption of human rights based policies and deflect blame for failures elsewhere. In some circumstances, human rights policies can also limit avenues of action and delegitimize other emancipatory strategies including localized, religious, or community based solutions (Kennedy, 2005).

While some people view the human rights-based approach to development or social change as a way to depoliticise the issues by ignoring questions of power, others view it more as an essential tool in political struggle to reach a larger aim of justice. On the other end of the spectrum some individuals believe that the *interpretation* of human rights based policies and strategies as universal, generalizable and overarching policy deters priority setting. The human rights based approach to development denies that any prioritization of rights is possible although it does accept that actions can be prioritized (Munro, 2009). In the context of competing claims, the rights of OVCs may easily be marginalized.

#### *2.5 Gaps in the Literature and Contributions*

While there is much research documenting the problems faced by OVCs, and the need to support their psychosocial development has been identified, there is less research to date that has

explored the specific characteristics of effective OVC care programs. In particular, there is a need for a better understanding of the role of psychosocial support programs and interventions for OVCs that can alleviate future psychosocial problems (Schenk, 2009). There is little research examining the best forms and sources of psychosocial care, and the common challenges and obstacles that hinder the delivery of needed support. What is almost entirely missing in the literature, is research on the perspectives of vulnerable children themselves, frontline staff and OVC caregivers in South Africa. While it is beyond the scope of this study to identify what makes a psychosocial support program ‘effective’, it is argued here that the experiences and opinions of those directly working to support OVCs will provide a valuable contribution to the literature on psychosocial support for OVCs in South Africa and elsewhere.

A review of the literature of psychosocial care or support for OVCs indicates a lack of research that investigates the perceptions of those directly providing care and support to OVCs (Kuo & Operario, 2010). Cluver and Gardner (2007) conducted a review of international studies examining the psychological health of OVCs, and found only 24 of such studies worldwide for AIDS-orphaned children. None of these studies presented the specific opinions of frontline staff or caregivers (Cluver & Gardner, 2007). The existing literature on OVC caregivers tends to focus more on the identification of who primarily provides care for OVCs, the capacity of extended families to care for rising numbers of OVCs, and the examination of the process of care placement (Kuo & Operario, 2010). A review of the literature on OVC caregivers revealed the need to gain more refined understandings of caregivers’ challenges and perceptions, the types of support that exist, and the forms of support that are still needed in order to inform policy and program planners on caregiver needs, guidelines, and practical methods for implementation (Kuo & Operario, 2010). Schenk (2009) emphasizes that there is a need for increased evaluation of intervention programs for the benefit of the children themselves and their futures, and for their contribution to local and national communities (Schenk, 2009).

There are several possible factors contributing to the lack of research on the characteristics of effective psychosocial support and intervention programs for OVCs. First, the research of psychosocial wellbeing in OVCs is quite recent and most studies still emphasise the need for such programs rather than evaluation and monitoring of ongoing programs (Cluver et al., 2009; E. King et al., 2009). Second, many of these programs have very limited resources; for

such programs, it is difficult to conduct the interventions while also conducting rigorous monitoring and evaluation (E. King et al., 2009). Third, psychosocial interventions for OVCs are usually offered within other broader intervention programs for HIV/AIDS, making it difficult to isolate contributing variables specific to psychosocial support (E. King et al., 2009). Finally, due to the high prevalence rates of HIV/AIDS, TB, poverty and OVCs in South Africa, primary resources concentrate on basic survival needs for infected and affected persons, prioritizing health care, ART treatment, housing, food, and education.

While recognizing the significance of these constraints, it is argued here that efforts to improve psychosocial wellbeing can encourage and support healthy and sustainable development at the individual, community and national level of development. Ignoring the psychosocial needs of OVCs will have detrimental effects that can perpetuate the interconnected cycles of orphanhood, vulnerability, violence, crime, sexual and physical abuse, early pregnancy, unemployment, poor health and education. Given the very limited and stretched resources of existing programmes in South Africa, it is important to know whether the finances spent on psychosocial support are efficient and effective. Arguably, a necessary avenue to ensure effective monitoring and evaluation processes is through consultations with key stakeholders. While this study is unable to conduct all components of a thorough evaluation process, the contribution of participant consultation is a central strength of this research. It is morally and practically pertinent that those directly involved with the provision of psychosocial support for this population are provided opportunities to voice their opinions, explain their ideas and concerns and contribute to the academic research and policy developments. Research that explores the experiences, opinions and concerns of caregivers regarding psychosocial support contributes to these research gaps and may also be beneficial for policymakers, funders and NGOs (Schenk, 2009). The current study contributes to the OVC knowledge base for policy makers and program providers through the experiences, opinions and concerns of a specific group of caregivers and social workers working directly with this population of vulnerable children.

### **3.0 CHAPTER 3: THEORY & METHODS**

This research study was conducted on the foundation of psychological child development theories of resilience and was perceived from a critical realism theoretical framework. The following chapter provides an overview of these two theoretical bases and then presents a detailed account of the methodology, background information on the HomeFromHome organization, and then the limitations of the study. The methodology section includes a review of the general research design, how the Home from Home organization was selected, the procedures for obtaining ethics clearance, the changes in research design, the participant observation conducted, how participants were recruited, what the interview process entailed, the debriefing conducted, and the procedures for data analysis and theme identification. The background section discussed the HomeFromHome strategy and organizational structure, which includes details on their goals and mandate, the foster-family structure, the nature of vulnerability and orphanhood of the children, and the geographic regions they work in. The chapter then concludes with an overview of the limitations of this study.

#### *3.1 Theory*

##### **3.1.1 Child development theory**

The theory of child psychosocial development and the concepts of psychosocial buffers and child resilience are derived from research that links childhood trauma or maltreatment at a young age to a range of psychological disorders including anxiety, depression, post-traumatic stress disorder with other negative health outcomes such as personality disorders, increased risk-taking behaviour, alcoholism, obesity and repeat victimizations (Van der Vegt, Van der Ende, Ferdinand, Verhulst, & Tiemeier, 2009). Child development theory and research has identified multiple buffers or protective factors which improve outcomes in children who are exposed to early life trauma (Gewirtz & Edleson, 2007). A buffer in the context of psychological intervention refers to resilience variables that play a role in reducing the risk of developing negative psychological health outcomes. These buffers or resilience factors may be biological,

psychological, demographic, social, socio-economic or community-environmental factors (Gewirtz & Edleson, 2007).

Biological buffers are existing characteristics or traits within the maltreated child that are associated with an increased resilience to the risk of developing psychological disorders. Biological buffers include variables such as genetics, physiology, age, sex, and physical health. Psychological buffers refer to the mental and emotional aspects contributing to resilience such as temperament and personality types, attachment styles and coping strategies (Gilbert et al., 2009). Psychological buffers also encompass therapeutic interventions that focus on strengthening healthy mental and emotional patterns of thought and behaviour, including self-regulatory behaviour and information processing strategies (Ford, 2005). In this regard, psychological interventions focus on reducing risks by adding resources to counterbalance risks or by developing resilience strategies such as improving relationships, and self-regulation of behaviours (Masten & Coastworth, 1998).

Social-environmental buffers are conditions within the child's environment that strengthen or create resilience. These buffers include social support systems such as family members, educators and peers, adoption or removal from adversities, and education. Another major social-environmental buffer that has been shown to have significant influence on the resilience against developing psychological disorders following childhood trauma is the buffering effect of high socio-economic status (Gilbert et al., 2009). High socio-economic environments permit families to provide more social protective supports that can act as buffers (e.g. supportive schools, other positive relationships, and access to higher quality services (Gilbert et al., 2009). Socio-environmental buffers were defined in this study as the conditions within the child's direct environment that strengthen or create resilience and could be considered in this context as psychosocial buffers. These include informal and formal social and psychosocial support systems including family members, peers, social workers, and foster parents (C. M. Lee & Asgary, 2009; T. Lee et al., 2002; Moran & Eckenrode, 1992; Sagy & Dotan, 2001).

Lowenthal (1999), for example, identified factors influencing positive fostering or alternate parenting including acknowledgement of the child's pain, recognition of anti-social behaviours as reflections of painful experiences, participation in treatment, and optimism of

positive outcomes (Lowenthal, 1999). Irrespective of actual levels of family support, the child's positive perception of family support may also act as a buffer (Sagy & Dotan, 2001). Sagy and Dotan (2001) suggest that children's cognitive perception of their families and perception of support influences how they cope with major stressors. Higher levels of self-esteem and self-worth in maltreated children have also been identified as protective factors against the risk of developing psychological disorders later in life and promoted the need for interventions for disadvantaged children to improve self-esteem (Moran & Eckenrode, 1992). A 2011 study investigated the associations between family, peer, and community factors and resilience in orphaned adolescents in South Africa. The study found that family regulation, respect for individuality, peer connection, and community connection were significantly associated with greater emotional resilience (Wild et al., 2011). The study concluded that intervention efforts should focus on children who are in the care of nonrelatives and/or have been exposed to multiple adversities before or after the parent's death, not just HIV/AIDS orphans. The authors suggested that practitioners and policy makers might be able to facilitate resilience in orphaned adolescents by strengthening the capacity of their extended families, friends, and competent adults outside of the family to provide them with emotional support, respect for individuality, and appropriate supervision.

Other research proposes religious beliefs may in fact act as a psychological or social-environmental buffer against psychological disorders in abused children. Kim (2008) reported that both maltreated and non-maltreated children were less likely to internalize stress and develop psychological disorders later in life when they held religious beliefs and practised religion. Compensation theory proposes that the maltreated child uses God as a replacement or barrier against the lack of parental attachment while other research suggests that the church provides a stable support system outside the family and a general sense of having secure, supportive relationships (Kim, 2008). King and Schafer (1992) suggested that by providing personal meaning, broader perspectives on conflict, and inner resources, religion acts as a protective factor against stress and the associated risk of developing psychological disorders (M. King & Schafer, 1992). Children with religious beliefs may also have more positive ideas about the world, higher self-worth and in turn do not internalize major life stressors such as child abuse or neglect, decreasing the likelihood of developing psychological disorders later in life (Pearce,

Little, & Perez, 2003). Each of the studies presented above identified the need for psychosocial supports for OVCs and caregivers at a number of different levels.

These psychological child development concepts have been most frequently applied within the context of childhood abuse and maltreatment; however, child development theory was applied to this research project as an assumption that there are likely context-specific buffers that may create or strengthen resilience to psychosocial problems for OVCs in South Africa. While the theory was not designed for an OVC or HIV/AIDS demographic, the underlying developmental theory that biological, psychological, demographic, social, socio-economic or community-environmental factors play a role in children's development is a relevant theory or framework for examining the perspectives of caregivers and their opinions on the roles that these factors may play. This is a suitable framework as it enables the exploration of caregiver perceptions on the role of psychosocial support with the underlying assumption that there are potentially significant psychosocial buffers that may be context specific for OVCs. Recognizing that culture and personal interpretation play a significant factor in the knowledge, participation and practice of the support being provided, the aim of this study was not to identify and examine the buffers that have been found in previous studies. Instead, this study sought to present the experiences, opinions and concerns of those working directly with OVCs, acknowledging the context-specific elements at play and thus contributing to our understanding psychosocial social support for OVCs

### **3.1.2 Theoretical framework**

The researcher of this study adopts a mixed theoretical perspective that there are very real and measurable empirical “facts or trends” that occur in the world but that these are also highly dependent on individual and social interpretation. For example, levels of poverty are real and quantifiable, but how the statics or “trends” of poverty are perceived and experienced is very subjective. The experience and interpretation of deprivation, vulnerability, agency, and psychological impact are also very “real” attributes of poverty. Therefore, the “reality” or knowledge of empirical facts greatly depends on human interpretation, culture, values, and

environment. This research study assumes that both the empirical trends and the subjective interpretations are equally important for understanding and affecting change.

This framework and personal perspective reflects the overall research design for this study, which was conceived within a critical realism perspective. While, definitions vary by theorists and researchers, critical realism can be considered as a theoretical framework that falls somewhere in the middle of the spectrum between positivism and subjectivism. Positivist theory holds that the exclusive source of all authoritative knowledge is derived from quantitative measurements, sensory experience, and logical and mathematical calculations (Encyclopedia Britannica, 2014). On the other end of the spectrum, subjectivism contends that our own mental activity is the only unquestionable fact of human experience and knowledge (Richardson & Bowden, 1983). Subjectivism argues that knowledge is merely subjective and relative thought, and that there is no objective truth (Oxford Dictionaries, 2014).

Critical realism posits that while there are some objective truths, knowledge is something that is created and re-created through a complex array of phenomena which includes social interactions, physical factors, rituals, and beliefs (Danermark, Ekstrom, Jakobson, & Karlsson, 2002). It is the meanings attached to these phenomena by social actors that need to be understood, not just the empirical and behavioural phenomena (Saunders, Lewis, & Thornhill, 2009). There is great value in understanding the perspectives of participants as certain beliefs and practices influence the environment and others around us. For example, while there are detectable patterns that exist universally, these patterns may play out in dissimilar ways within different contexts and must be interpreted within a framework that allows for context-specific fluctuations. To reflect this theoretical framework the research design for this study is qualitative, open-ended, and exploratory in nature. It is assumed that the perceptions of caregivers and frontline staff may interact and play a significant role in the implementation of psychosocial support programs that has not yet been recognized or examined.

The purpose of many forms of qualitative research is to gain an inductive understanding of the ideas and opinions of the research participants in order to acquire an analytical understanding of how they view their world and the world around them (Desai & Potter, 2006). In this case, the purpose is to gain an understanding of the perceptions of how caregivers view the challenges faced by OVCs, the work they do to support these children, and how they consider

these efforts could be improved. The methodology is designed to give voice to this population through face-to-face interviews and other voluntary interactions with the researcher. The discussion and conclusion sections of this study will consider the participants responses in relation to the larger scale context and the theoretical framework of child development theory and psychosocial development concepts.

### *3.2 Methodology*

#### **3.2.1 Research design: a qualitative case study**

This qualitative research project attempts to capture the experiences, opinions and concerns of a sample group of individuals working directly with children in a program for OVCs in South Africa regarding OVCs' psychosocial health and well-being and their opinions about intervention programs designed to support OVCs. The research project was not designed as an evaluation of a particular program, but as a case-study conducted to gain insight into the perceptions of OVC caregivers and program staff on how psychosocial support is, could, and should be provided to OVCs. The case-study design was adopted as it an appropriate form of inquiry that investigates a contemporary phenomenon within its real-life context (Yin, 1994). This qualitative case-study design provides participants with a platform to contribute to the international and academic discussion of effective psychosocial support and to help identify specific aspects and questions for future research on the effectiveness of programs and approaches. To gain a more thorough understanding of the complex realities and processes occurring as an external investigator, this researcher first conducted an unpaid internship of participant observation prior to conducting a series of semi-structured interviews with foster mothers, social workers and administrative staff.

As this study was a small-scale case project, it is not suggested that results are generalizable to the entire population of those working with OVCs in South Africa. However, it is argued that this project has value as it attempts to synthesize and contextualize under-represented experiences, opinions, ideas, and concerns of local individuals, which are essential in this field. The responses have then been considered and analysed in the context of the current research on psychosocial buffers and support and in the context of current policies and guidelines

for OVCs provided by the Government of South Africa and the major national and international aid organizations.

### **3.2.2 Organization recruitment**

In order to identify South African organizations that would be appropriate for conducting this research, online research was carried out to locate non-government organizations that provide care for orphaned and vulnerable children in the Cape Town region. An NGO was selected rather than private or public providers since this group was the most accessible to contact and to arrange collaboration while still located in Canada. The Western Cape of South Africa was selected as an appropriate area for this study due to the high concentration of NGOs currently working to serve Cape Town and the surrounding areas including the townships and rural communities of the Western Cape. The organizations initially selected were not necessarily identified as 'psychosocial support programs' but were selected because they incorporated or focused on psychosocial care and support for OVCs. The selection criteria required that the program focus on providing general support for OVCs, provide a form of psychosocial support either directly through counselling or through general childcare, and supported at minimum 15 children.

Several organizations were considered and two organizations were initially selected. The first was a single unit orphanage that provides residential group care to OVCs and the second was a program (HomeFromHome) supporting foster parent care for OVCs in family homes across multiple communities. Both organizations were contacted to determine if they met the selection criteria and were then provided with an introduction to the proposed research study with the objectives, purpose, and potential benefits of collaboration. Once each organization had expressed interest in participation they were provided with a formal invitation letter and a permission letter to be signed. These documents were then submitted with the ethics applications and the main contacts were informed of developments and progress until the project had obtained ethical clearance from two ethics boards.

### **3.2.3 Research ethics protocol**

Prior to any data collection, ethics clearance was obtained from the Research Ethics Board (REB) of the University of Ottawa and the Human Sciences Research Council (HSRC), the South African registered ethics committee. Although it was unclear whether a South African research ethics approval was necessary for this study, the application was made to ensure local ethical standards were met in addition to the University of Ottawa's requirements. The HSRC gave its permission in a letter of Ethics Clearance approved by the HSRC Research Ethics Committee Protocol (REC No. 14/20/02/13, approved 05/20/2013). The ethics applications required standard ethics procedures to be conducted including letters of permission, informed consent forms, and detailed applications that outlined the procedures that would be carried out to ensure the research was ethical.

### **3.2.4 Changes in research design and complications**

Due to unforeseen difficulties that emerged after program selection, it was determined that the orphanage could not be included in this research study. As the challenges which occurred surrounding this orphanage are not unique, the details of this incident will be briefly discussed here as they are relevant in the discussion of the complexities in providing support for orphaned and vulnerable children. The unforeseen circumstances that lead to the orphanage's exclusion from the study related to a poor organizational structure, a lack of consistent long-term staff, and allegations of fraud and corruption in the administration.

Prior to her trip to South Africa, the organization had provided the researcher with information regarding the organizational structure of the orphanage. Through email correspondence, the researcher had been informed that the orphanage employed 14 staff to care for orphaned or disadvantaged children whose parents have been infected or affected by HIV/AIDS. Staff members were said to be providing a range of services and projects including general childcare, educational support, cultural activities, interpersonal skills support, capacity building, skills development, reintegration, and community development. It was stated that there were multiple social workers, caregivers, administration, and community volunteers, each with their own set of qualifications and experience. Unfortunately, several of these assertions turned

out not to be true. The primary contact from the organization was no longer working for the organization once the researcher arrived on site. The reason for this departure was not disclosed to the researcher.

It was apparent upon the arrival of the researcher that the staff structure had changed or was inconsistent with previously provided records. However, the researcher volunteered with the organization for one month, assisting with after school homework with children, supporting the main administrator, and developing group sessions with the new social worker. During this one month of participant observation, it was determined that there was one director, one central administrative staff, a receptionist, four cooks, one social worker, and three international student volunteers. The daily proceedings and organization of activities, documents, and coordination with volunteers were highly unorganized. The new administrator was working to become more familiar with the procedures, staff, children, and general experiences and challenges of the organization but has since left the organization for undisclosed reasons. The responsibilities of the receptionist were unclear as she was not actively engaged in any activities with other staff or children. The one social worker had only recently started working with the organization and had not yet had any sessions with the children. There were no caregivers or staff who provided the services mentioned above and there was little to no educational support, interpersonal skills development, or activities to integrate children into their community. The full-time staff mainly consisted of four women who were responsible for meal preparation and cleaning. One staff member would stay overnight at the orphanage to ensure that bedtime and personal hygiene routines were met.

Other incorrect and contradictory information was provided to the researcher as some staff claimed that none of the children were in fact HIV-positive in contrast to the previous information that many children were HIV-positive. Several children disclosed that they were not orphans but removed from their communities due to unsafe home environments. Due to the recent changes in staff, lack of familiarity of the social worker with the organization and children, incorrect information about the children, and smaller numbers of staff than anticipated, the researcher decided, in consultation with her thesis supervisor, that the orphanage would not be appropriate for the current study which aimed to capture opinions of caregivers and front-line staff with more extensive and involved experiences with orphaned and vulnerable children.

In addition to the issues of disorganization and staff structure, the organization has been publicly accused in the media of fraud and misconduct. To maintain anonymity the organization's name and details of the accusations will not be mentioned here. However, the issues were mentioned here not only as an explanation to the changes in the research design of this project but also to highlight other challenges encountered by those attempting to assist vulnerable children in South Africa. Where there is the opportunity for private profit to be made, corruption and fraud are common serious challenges for development projects and organizations (Berkman et al., 2008). In the cases of fraudulent use of funds and donations it can have larger scale impacts.

Regardless of the validity to the accusations and organizational structure of the home, the orphanage is still housing children in need of protection, support and special attention. Although the HIV status of the children was unclear, there were children who appeared to have quite severe mental illnesses and other serious physical illnesses. The children were all struggling in school and had noticeable behavioural and emotional problems. Unfortunately, if the claims of fraud are true, or if the claims deter donors from supporting the orphanage, the children will ultimately be indirectly affected by a reduction in funds if this decreases the availability of necessary psychosocial and physical support.

### **3.2.5 Participant observation (the crèche)**

Upon the researcher's arrival in South Africa, the first stage to carrying out this research project was to meet with the primary contact, the Director at HomeFromHome (HFH), to discuss where the researcher's time as a volunteer would be most valuable to the organization. As outlined in the research proposal and ethics applications, the researcher had offered to contribute time to the organization as a form of gratitude for their partnership and participation in the research study. The Director requested assistance at the crèche in Khayelitsha, a township on the outskirts of Cape Town. A crèche is a Southern African term for preschool or daycare that cares for children between the ages of 3-6 prior to attending elementary school. The HomeFromHome crèche also acts as a local centre for HomeFromHome staff, with an office for one of the social workers, a meeting area for monthly foster-mother meetings, a library, kitchen, and computer

lab, and hosts an after school Educare centre for HFH foster children in the Khayelitsha community.

At this facility the researcher assisted the daycare teachers with general class activities, distribution of meals, the afterschool program and interactions with HomeFromHome staff including teachers, foster mothers, one social worker, several HFH foster children and administrative staff. During this two-month period the researcher was able to gain a better understanding of the organizational structure of HFH and hear some of the staffs experiences, opinions and concerns through casual interactions. These observations and conversations were not recorded as research data but contributed to a personal understanding and contextualization that decreased the unfamiliarity and ‘outsider bias’ that all external researchers must attempt to diminish.

### **3.2.6 Participant recruitment**

The selection criteria for recruiting participants themselves were that they must provide some form of support to the children within the program. All interested foster parents, social workers and administration staff were invited to participate. Both male and female caregivers over the age of 18 were eligible to participate; however, for this organization most eligible participants were female.

After an initial meeting with one of the directors of Home from Home, the researcher was invited to a parenting skills workshop where she met with the foster mothers, presented the research project, and to invited attendees to participate. After verbally presenting the goals, purpose, and potential benefits of the study, each foster mother was given an invitation letter with all the details of the study. This was then followed by a sign-up sheet, which was passed around for participants to voluntarily provide their name and phone number if they were interested in being interviewed. From a total of 29 foster mothers, 17 foster mothers signed up to participate, and 14 interviews were conducted. The twelve mothers who did not sign up were absent at the parenting workshop and the three withdrawals were due to schedule conflicts and participants’ personal time constraints. The contact information for the four social workers employed at HomeFromHome was provided directly by one of the board members of

HomeFromHome and one administrator volunteered to participate in an interview. More information on the foster mothers and the foster-family structure is discussed in section 3.3.2.

### **3.2.7 Individual interviews**

Interviews were scheduled individually at a time and location preferable to each interviewee. The majority of the interviews were conducted at the foster homes, with the interviews with the social workers occurring at the HomeFromHome office. The duration of the interviews ranged from 28 minutes to one hour and 45 minutes, with the majority finishing just under an hour. Interviews were recorded using a portable audio-recorder and hand written notes were taken in a personal notebook.

There were 20 interview questions for the foster mothers, which attempted to capture personal experiences, opinions and concerns about psychosocial support and their role as a foster mother [see appendix 2]. The four social workers were each asked 27 questions which were designed to access their experiences, personal challenges and ideas regarding their role as social workers and their opinions related to psychosocial support for vulnerable children and foster mothers [see appendix 3]. The one administrative participant is a co-founder and HFH board member. This interview consisted of 25 questions that were related to psychosocial support for vulnerable children and foster mothers and also inquired into the specific challenges for administration and management [see appendix 5].

### **3.2.8 Debriefing procedures**

After all interviews with foster mothers had been completed, each interview was reviewed and a preliminary results document was drafted. This document summarized the responses of participant at face value [see appendix 6]. At the following parenting skills workshop with foster mothers, social workers, and administration, a preliminary paraphrased and anonymous summary of responses was presented to the group. The group was thanked for their participation and attendees were offered the opportunity to raise any questions regarding the interviews or the future steps of the study and reminded that the final thesis would be shared with Home from Home.

### 3.2.9 Data Capturing, analysis and reporting

Upon completion of all 19 interviews, the collected data were reviewed. The audio-recordings were stored in a secure web-based storage folder and coded with a participant number to maintain anonymity. Responses to interviews had been summarized and recorded in a personal notebook. Each interview was then reviewed by examining the personal notes and audio recordings in detail, which were then transcribed into Microsoft Word documents. An Excel spreadsheet was then developed which had a column for each interview question and a row for each coded participant. While the Word documents have word-for-word transcriptions of the interviews, the Excel database consists of selected sentences that answer each question in a more concise manner. While the spreadsheet was the basis for further analysis the interview transcripts and recordings were accessed to obtain clarification, ensure accurate information was included, and confirm that significant information had not been omitted.

A content analysis was conducted of each question asked of each respondent. The responses for each group of participants (foster mothers, social workers, and administration) were analyzed in separate groups. Each individual comment was examined and groups of categories or themes emerging from the responses were identified and formed. The number of participants making a comment related to each category or theme was then calculated. This gave an initial picture of the major experiences and opinions of each participant and the number of participants making comments in each theme that emerged. For example, the responses to the question, “What programs, activities, or services, do you believe are the best support programs that help the psychosocial well-being of the children?” was examined and then each different item mentioned was listed. Each time this item was mentioned a count was recorded.

	<b>Foster Mothers</b>
<b>“What programs, activities, or services, do you believe are the best support programs that help the psychosocial well-being of the children?”</b>	<ul style="list-style-type: none"> <li>• Sessions with social workers or psychologist (5)</li> <li>• Mentors/Volunteers (4)</li> <li>• Teachers/Education (2)</li> <li>• Youth Programs (6)</li> <li>• Talking with child one on one (2)</li> <li>• Play therapy (3)</li> <li>• Church (4)</li> <li>• Having a male role model (1)</li> </ul>

For this content analysis example, it is possible to note that church, play therapy (provided by social workers and psychologists), and youth programs are highly valued by the foster mothers. Then these items can be considered and compared in relation to the formal and informal buffers that can protect psychosocial development identified in the literature in terms of accessibility and context in South Africa. The major categories and themes that emerged from the responses of these participants were then considered in response to the central research questions. These results were then discussed in relation to the existing literature on psychosocial well-being and the effects of childhood trauma and in light of existing policies of the South African Government and of international organizations.

### *3.3 Background Information*

#### **3.3.1 HomefromHome strategy**

HomeFromHome has a transparent policy available to the public on their website. The organization has a mission to “provide and facilitate supported, supervised community-based foster care for children in need in through a network of small, family homes”(HFH, 2014). Their strategy outlines their specific approach for setting up a new foster home, and the policies that aim to ensure children received the best possible care. This approach is built on 6 central pillars; identify, empower, select, equip, support and supervise. The first step of the HFH strategy is to *identify* the need for this model of care in a particular area and to identify a suitable community or faith-based association with shared principles. To assess the community’s specific needs, HFH consults with the local government departments as well welfare organizations to avoid duplication of efforts and resources. The second stage of the process is to *empower* an associate organization to develop homes and families for which they take immediate responsibility for. This is based on the understanding that there are many existing community and faith-based organizations that want to provide children with a safe family environment within their local communities; however, many of these organizations do not have the necessary skills and resources. The third step is then the *selection* of the area within the community to situate the home, determine the type of home, procure the housing, and select foster parents. The caregiver

positions are advertised to women and couples in the community and applicants are screened for their suitability as foster parents. Promising candidates are then interviewed, with a thorough background check. Once a suitable caregiver is determined, the children are legally placed in their care through the Children's Court. HFH has a maximum of six children per family and ensures that siblings remain together. They also attempt to maintain a mixture of ages and sexes of children to reflect a 'normal' family structure. This process is conducted in collaboration with the community-based associates. The fourth stage focuses on *equipping* the home with all necessary resources including beds, clothes, general supplies, and the relevant and specialized training for foster parents. The fifth step involves multiple forms of *support* to the caregivers. These include supports from church members, HomeFromHome social workers, independent professionals, household volunteer assistants, and monthly parenting workshops. The last level of the HFH strategy is on-going *supervision*. HFH implements regular visits; both scheduled and unscheduled to ensure that the children are well looked after and that the foster parents are being sufficiently supported.

The HFH strategy holds that psychosocial support is crucial for both the foster mothers and the children at all levels, informal (foster mothers), formal (social workers) and specialist (psychologists). The administrator expressed that this support is crucial for the mothers since their role is extremely challenging and because they have such a large impact on the children. The psychosocial support is imperative for the children since each child placed in foster care has experienced some form of abuse, illness, trauma or neglect. However, the NGO does not have enough resources to provide as much psychosocial support as they would like. The main source of funding was reported to be approximately 50% overseas donations and 50% domestic contributions. Within the 50% domestic, personal donations account for approximately 15%, roughly 8% is government funded, and the remainder is obtained from corporate donations including foundations, fundraisers, philanthropists, events, and sponsors.

### **3.3.2 Structure of the foster homes**

The preliminary interview questions revealed a substantial amount of additional information on the structure of the HFH organization. For example, most of the foster mothers were responsible for 6 children, with a few having only 4 or 5 children. This reflects the HFH strategy, which outlines a belief that children develop best in small family units, and has a policy with a maximum of 6 children per household. Although no specific interview question was administered to determine the number of foster fathers, only 3 out of the 14 foster mothers interviewed mentioned having a husband. The administrator also disclosed that the majority of the foster families were primarily female-headed households, although they do accept applications from married couples. The foster parents were primarily coloured and black females with either Afrikaans or isiXhosa being their first language. However, to varying degrees, all participants also spoke English.

Supplementary interview questions were posed to identify the duration of the foster mother's experience and what they believed to be their main responsibilities. Start dates ranged from 2005 – 2013, with the majority (11/14 mothers) starting work with HFH between 2010 and 2012. The majority of foster mothers reported that their main responsibilities were providing general care and supervision for the children and that their favourite part of the job was the children themselves. In their own terms, all foster mothers understood the goal of HFH to be the provision of a safe, support and healthy environment for the children's healthy development. As described by the administrator, the HFHs central goal is to provide a safe home and family cluster form of foster care with fully rounded adults heading the households.

### **3.3.3 Nature of vulnerability and orphanhood**

This research found that a large portion of the children within the case study program were neither HIV-positive nor orphaned. Prior to commencing this research project, the cause of orphanhood or the reason for separation from the biological family for each child was not disclosed by HomeFromHome, nor was the health status of each child. This researcher had assumed that the majority of children were orphaned due to HIV/AIDS, because this was the cause provided by the host organization's website. However, after engaging with the staff and

children in South Africa, it became clear through participant observation and from disclosed information that the children had been placed into the foster care program for a variety of different reasons. A large portion of the children did have living parents and biological family members and many children were placed in care due to circumstances other than orphanhood. While some children were HIV-positive, and may have lost a parent to AIDS, many children were not HIV-positive but suffered from other illnesses or disorders including Fetal Alcohol Syndrome (FAS), physical and mental disabilities, and tuberculosis (TB). Some children were in good physical health but were placed in foster care after suffering from serious physical, emotional, and/or sexual abuse. Since only a few specific cases were disclosed regarding a child's family history, it is not possible to analyze the demographics of the foster children with any precision. However, the participant observation phase of this project revealed common issues that arise in these communities, including parental death from HIV/AIDS and TB, alcohol and drug abuse, as well as accidental deaths, including violent crimes and shack fires.

Moses and Meintjes (2010) also found a variety of causes and determinants of child vulnerability for hundreds of children placed in institutionalized care across South Africa. Their analysis revealed that there is a preoccupation at a national and international level with HIV/AIDS orphans that diverts attention away from an accurate picture of children placed in alternative care in South Africa (Moses & Meintjes, 2010). The study concluded that this skewed concept of OVCs in South Africa has had serious implications for policy and practice. These implications include increased investments into institutionalized care, decreased charitable funding for adoption and foster systems, many missed opportunities for OVCs to be placed in non-institutional placements, and increased abandonment of children based on the assumption that they will be given better care than if they remained under parental supervision (Moses & Meintjes, 2010). The authors also identified the significant gap in the literature on the role of alternative care facilities in providing care to vulnerable children who are not specifically orphaned or affected by HIV/AIDS. This literature and background information of the HFH children is relevant for understanding the context of this study and the potential relevance of the findings outside the original conception of OVCs as being HIV/AIDS-affected.

### 3.3.4 Regions

As of September 2013, HomeFromHome supported 29 foster homes across the Western Cape. Although the organization first started with a few homes in Khayelitsha it has since expanded to partner with other organizations across the Western Cape and now supports 33 foster homes with approximately 200 children (as of March, 2014). The homes are spread across 15 different communities including Khayelitsha, Goodwood, Westlake, Mowbray, Ruyterwacht, Zonnebloem, Cloeteville, Kayamandi, Masiphumelele, Ocean View, Vrygrond, Observatory, The Craggs, George, and Villiersdorp [see appendix 5](HFH, 2014). The interviews conducted for this research covered nine of these communities, and 14 different homes within Khayelitsha, Goodwood, Westlake, Zonnebloem, Cloeteville, Kayamandi, Masiphumelele, Vrygrond, and Observatory. The remaining homes and communities were not covered because mothers from these homes did not sign up to participate or were absent at the recruitment meeting. The exact number of homes per community interviewed will be omitted here to maintain anonymity.

The fact that the HFH homes are dispersed among multiple communities enabled this research to capture opinions from a more varied sample. Each community has its own strengths and challenges with different support networks, liaisons and even varied cultures. Some of the foster homes are located in the outskirts of townships while others are within wealthier suburban areas. The following section will briefly describe the demographics of each of the communities in which participants were interviewed.

Khayelitsha is the community where HFH was first implemented. The first HFH foster home was created in Khayelitsha in 2005 and is now the site with the largest network of foster homes. There are seven foster homes and a crèche, which also functions as an office for the Khayelitsha social worker, a venue for monthly foster mother meetings, a computer lab, a library and an afterschool Educare centre for older children. HFH administration, three crèche teachers and volunteers run the centre.

Khayelitsha is an informal settlement (township) on the outskirts of Cape Town. Khayelitsha was created in the early 1980s by the apartheid regime as a solution to the rapid increase of immigrants and overcrowding of other Cape Town townships (Battersby, 2011). Today Khayelitsha is reputed as one of the largest and fastest growing townships in South

Africa. The 2011 census reported Khayelitsha's population at 391,749, with a high density at 10,000 per km<sup>2</sup> (Frith, 2014). The population is 98% Black South African with isiXhosa being the primary language for over 90% of the inhabitants.

The seven HFH foster homes in Khayelitsha are all located in Harare and Litha Park, which are newer areas of Khayelitsha (HFH, 2014). These areas have more developed infrastructure than the more common dwellings of the Khayelitsha township. They are less crowded sub-communities with sufficient plumbing and homes are made of brick or concrete rather than the wood and tin shacks. Although living conditions in these outskirts are considered to be a higher quality, the Harare and Litha Park communities are still faced with challenges of high rates of HIV, crime, violence and poverty (HFH, 2014).

Masiphumelele (Masi), formally known as Site 5, is another high-density township created in the 1990s for the overflow of people living in the Khayelitsha townships (HFH, 2014). While it is smaller than Khayelitsha, with approximately 16,000 residents, the housing density is 40,000 per km<sup>2</sup> (Frith, 2014). Similar to Khayelitsha, Masi is burdened with high unemployment, HIV, and crime; conditions are such that many children raised in the community are abused and neglected, creating a large number of OVCs (HFH, 2014).

The Vrygrond community has both developed and informal housing with some areas having a population density of 38,900 per km<sup>2</sup>. It has a majority Black population (68%) but also a large number of coloured people (30%). Similar to the other townships in the Cape Town region, Vrygrond has high rates of unemployment, HIV, crime, and overcrowding, putting children at risk.

The communities of Goodwood, Zonnebloem, Observatory and Westlake, are all suburbs of Cape Town [see appendix 5]. Goodwood is located in the Northern suburbs and while the majority of residents live in brick houses and receive full services from the City of Cape Town, the community faces significant social challenges, particularly drug-related crime and teenage pregnancy (HFH, 2014). Similarly, Zonnebloem is located close to the city centre and continues to struggle with crime. Poverty is an additional concern in Zonnebloem. Although it is serviced by the City of Cape Town in terms of water, electricity and refuse removal, the majority of its residents still fall within the two lowest census income brackets (HFH, 2014). In contrast, Observatory is a very cosmopolitan suburb of Cape Town, having a commercial and residential

focus and established medical and educational services. For each of these three regions English and Afrikaans are the two dominant languages. Westlake is a small suburb in Cape Town of about 6,500 residents with a mixed population of 50% black, 25% coloured and 20% white (Frith, 2014). The region has been gone through a transition from informal shack housing to a large number of government housing. Westlake still has issues of housing shortages, high HIV rates, and significant unemployment (Schenk, 2009).

Cloetesville and Kayamandi are two communities located in the Stellenbosch wine-lands region of the Western Cape. The Cloetesville community is located just outside Stellenbosch and has a large income disparity with wealthier, middle class, and impoverished families (HFH, 2014) as well as both formal and informal housing. Cloetesville has a primarily Afrikaans speaking coloured population with 94% of inhabitants speaking Afrikaans and 88% being coloured (Frith, 2014). A third of the population is unemployed and is faced with high rates of crime, substance abuse, HIV infection and child abuse and neglect (HFH, 2014). The nearby Kayamandi township is also in the rural region of the Western Cape, but is much more crowded and consists primarily of informal housing. It was created during Apartheid to house black farmers and vineyard workers. Today 95% of the population in Kayamandi are Black South Africans with 85% speaking isiXhosa (Frith, 2014). The community is extremely overcrowded with 15,968.35 inhabitants per km<sup>2</sup> and faces challenges of high HIV prevalence, alcohol and drug abuse and a large number of single parent homes (Frith, 2014; HFH, 2014). While each of these communities have their own specific challenges and strengths, it is clear that each community has a large population of OVCs that would benefit from external social support, parenting, and housing.

### *3.4 Limitations*

The central limitations of this research project include the language barriers between the researcher and the respondent foster mothers, the outsider bias and positionality of the primary researcher, the fact that the four social workers were relatively new staff at HomeFromHome, and this study was unable to reach all of the foster mothers and administrators

working at the HFH organization. While each of the respondents was able to communicate effectively in English with the primary researcher, English was not the first language of most respondents. The foster mothers who participated spoke English at varying levels of fluency. For the majority of interviewees either isiXhosa or Afrikaans were the first languages, with English as a second language. A few isiXhosa speaking mothers had some challenges answering questions in English; however, with the rephrasing and simplification of some questions, all participants were able to answer each interview question. The four social workers and the administrator all spoke fluent English.

Outsider bias, understood as the misinterpretation of results resulting from a different understanding of events and experiences than those under study, can pose a threat to the validity of research results, interpretations and conclusions. The issue of researcher membership in the group being studied is relevant to all approaches of qualitative methodology as the researcher plays such a direct and intimate role in both data collection and analysis (Corbin Dwyer & Buckle, 2009). Additionally, as with all development research conducted by an ‘outside’ researcher, power structures and the researcher’s positionality should be recognized.

There are many non-demographic characteristics that define the position and identity of the researcher in relation to the participants in a qualitative study, including race, ethnicity, class, gender, religion, age, education, employment and even marital status (Desai & Potter, 2006). These factors can influence the quality of a research project by influencing the participant’s responses and also by shaping the researchers interpretation and analysis of responses. Acknowledging this common challenge of development research, the positionality of the primary researcher is outlined here to create the opportunity to identify possible biases or limitations presented by the individual researcher’s worldview and ways of interpretation.

The researcher of this research project comes from Western educational background with a specialization in psychology, anthropology and international development. The researcher has a secular worldview and places great value on both empirical quantitative research and on qualitative and subjective research. For this study the researcher stresses that qualitative and subjective information can provide great insight and value into the understanding of complex social issues surrounding OVCs and their development. While quantitative research has its value for obtaining crucial statistical information for policy developments, the researcher holds that it

is also critical to include and consider the voices of the people with whom policies are developed to assist.

The researcher is a mixed race Canadian female in her mid-twenties. There were likely different power relations at play between the researcher and the foster mothers as well as the researcher and the social workers. The social workers and administrator were all female Caucasian South Africans, who had secure incomes and perceivably high economic status, as well as high educational backgrounds and professional training. The most significant power dynamic between the researcher and the HFH social workers would have been potential concern from the social workers of disclosing confidential information or making critical comments that would have negative impacts on their employment or reputation with HFH. The researcher respected the permission and time provided by HFH personnel needed to conduct the case study with the HFH NGO and did not attempt to assume an authoritative role.

The power dynamic with the foster mothers had more potential for divergence as the researcher was coming from a position of higher privilege with more access to resources, from a wealthier country, and with a specific aim to conduct the research project as required component for the completion of a master's degree. The race of the primary researcher may have had little to no influence on participant responses as many of the foster parent respondents were of a similar visual race; however it is more likely that the researcher was perceived as an outsider due to her western English accent, relatively wealthy economic status, and higher educational background. Participants were informed of the purpose of the research project and so were aware of the researcher's position as a master's student from Canada. Due to the participant observation stage of the research study several interview participants were also aware of more personal details of the researcher, which may have influenced the amount of information disclosed during the later interview process.

To mitigate these risks the researcher made attempts to be conscious of the differing positionalities, to respect participants' time and willingness to participate, to avoid making any condescending or unappreciative comments, and to ensure participants were able to decline or withdraw from the study at any point. In addition, participants' responses were frequently directly quoted in the results chapter to reduce incorrect interpretations and increase representation.

Another potential limitation to this research project is the fact that the four interviewed social workers are all relatively new staff at HomeFromHome. As introductory research questions, all respondents were asked when they started working with HFH. Three of the social workers had only been with the organization for 3-6 months, while one had been there since 2009 (approximately four years at the time of the interviews). While having fairly new staff reflect on the issues and experiences of working with OVCs may only provide a superficial level of understanding, it also allows for a fresh perspectives of the many of the challenges and experiences social workers experience when working with OVCs and NGOs. In addition the three newer social workers had previous experience working with vulnerable children at other organizations and their interview responses were similar to that of the one social worker who had been consistently working with HFH for four years.

The number of foster mothers participating in this research, and the potential selection bias is considered as another potential limitation to this study. Since not all of the HFH foster mothers were present at the recruitment meeting only 17 foster mothers were directly invited to participate. The remaining participants were provided the opportunity to participate through an email distributed to all foster mothers; however, none responded to this form of invitation. The researcher was informed that several of the foster mothers who did not attend this specific workshop were absent due to a “shack fire” (housing fire in the townships) in one of the communities. This suggests that the variety of communities interviewed may have been reduced. However, the cause of their absence does not suggest that these foster mothers were any less motivated to attend workshops in general. In addition, the three foster mothers who signed up to participate but later withdrew from the study due to scheduling conflicts might have represented a sample of participants who have extra stressors, or different challenges. These limitations were mitigated as best possible and are noted here for accurate interpretation of the research findings.

The lack of voice for children themselves may be another limitation of this study. This research examined the experiences, opinions and concerns of foster mothers and social workers working directly with OVCs and gave voice to their experiences and views. While it addresses an important gap in the current literature, it did not include the voice of those most directly affected, the OVCs themselves. Although it is unrealistic to eliminate adults from social movements, research, and policy development in fields concerning children’s issues, recent

efforts are being made to ensure children have the opportunity to have a voice and to be active participants in their own research, activism and public policy developments (Desai & Potter, 2006). Ensuring children are included in research on issues concerning orphaned and vulnerable children is challenging, but necessary. Further research with OVCs themselves is needed. One fruitful avenue for further research on the perspectives of OVCS may be the cohort of OVCs who have grown in to young adults. This group may offer important insight into their challenges growing up and the things that most helped them adding to the literature on psychosocial buffers and resilience factors.

## **4.0 CHAPTER 4: FINDINGS**

### *4.1 Research Questions*

This research project focused on the following central research question: *what can the experiences, opinions and concerns of OVC caregivers and program staff tell us about psychosocial support and the role of psychosocial support programs for OVCs in South Africa?* More specifically, it focused on identifying: (1) the problems OVC caregivers and program staff encounter in delivering psychosocial support; (2) what they believe are the characteristics of the best forms and sources of psychosocial support and (3) what program staff and caregivers want policy makers to be aware of or incorporated into future policy developments regarding the needs of orphaned and vulnerable children. Since the foster parents and the program staff (the four social workers and one administrator) had a different contextual relationship to the issues, with quite different interview responses, the responses will be discussed separately; first the responses of the foster mothers and then the responses of HFH personnel.

The first section will review the responses to the interview questions that aimed at examining the three central research questions. The major themes that arose from these responses will then be identified. This is then followed by responses and emerging themes from other interview questions. The research project places emphasis on representing the voices of the participants as accurately as possible. Some of the responses are presented more than once as they relate to more than one research question or theme. The emergent themes are then further discussed in Chapter 5.

### *4.2 Foster Mothers*

#### **4.2.1 Challenges in providing psychosocial support**

The 14 HomeFromHome foster mothers reported a series of difficulties in providing psychosocial support to the children in their care. The three most frequently reported challenges were the children's behavioural and emotional problems, the foster mothers' own psychosocial well-being, and managing the health and medical aspects of care, which included transportation,

dealing with poor medical services, and challenges of providing medical care themselves. Other problematic issues reported were the challenges of providing for the family within a very limited budget, managing the multiple tasks as a single parent, sibling disputes, and parenting difficult teens. A specific challenge identified was the adjustment phase when a new child comes into a home, or when first providing care for a child and building an initial relationship. Also, foster mothers reported significant problems in relationships with, and procedures for, dealing with the children’s biological family members. Foster mothers commonly reported a major concern about the policy and procedures in place for when a child turns 18 and is no longer eligible for foster care.

<b>What do you find the most challenging aspect of your role a foster mother?</b>
<i>“Adjusting to the different backgrounds of the children. It’s difficult because at first you don’t know the child and you don’t know what the child has been through, what they are used to. I have to adjust but at the same time show them the right way. You can’t spoil a child with love.”</i>
<i>“The adjustment phase when they first come. All of them came with different problems. For example one of my children needed love he would not let anyone put him down he clung to everyone and cried when you put him down and he did not talk until he was older...”</i>
<i>“Going to the hospital. Both transportation to the hospital and frequent changes of doctors has created problems and poor service for some children.”</i>
<i>“The medical care. Taking them to the hospital and the medicine is difficult. I think transport is a big problem, a very very big problem. Sometimes you must take the child in for an operation and you sit there hoping they will be okay, but also knowing you must be home for other children and it’s hard.”</i>
<i>“The children’s development, the changing personalities and higher demands. Some of them have some anger problems and conflicting personalities and it is very hard. Also having the biological parents visit and take them. It causes a lot of strain on the children and a lot of strain on me. Parents shouldn’t come to the home because it’s not fair to the ones who don’t have biological family. Also answering their questions about their parents is difficult because I don’t know the answers.”</i>
<i>“To be yourself and to stay in control always. There are times when it can be very very challenging. Emotionally it can be very hard at times as well. Sometimes you worry you are not doing everything you can but I try.”</i>

*“The questions of the children, sometimes they have questions you can't answer because you don't know where they came from, we don't know their family. They are difficult questions sometimes.”*

*“Sometimes they don't listen to the rules. For example, I tell them not to go play far but they go anyways. I can't keep them locked up in the house all day because they have to socialize with other children but then end up getting into fights and things. So that is a challenge.”*

*“I cry a lot when the children are sick, I worry that something will go wrong. Having children of different ages, because the older one he wants his own space but he must share his room with the younger ones. Travelling to the hospital is also difficult because I must get a taxi.”*

*“Dealing with the teenagers; they don't listen they are cheeky. They come home late and won't tell me why, it upsets me. “*

Gave two examples: Children staying with biological mother without telling her where they have gone. The mother who has drinking problem. Also the older girl got involved with a dangerous gang and started becoming very violent, and ran away once.

*“It's not easy to do everything for 6 children, cooking, washing, cleaning, and homework. It is also hard emotionally when they misbehave.”*

Husband (foster father) explained that having biological family down the road is the most difficult. Other things they reported as difficult were getting used to the new environment (community), maintaining the tight budget, the noise upstairs, and attitude from the biological family.

*“I think it's the long hours I am working, I'm alone with 6 children and this is hard sometimes. Especially when the children are sick and you have to take them to the hospital and still care for the other children, it is a lot.”*

#### **4.2.2 Best forms and sources of psychosocial support**

The foster mothers identified a range of what they considered best forms and sources of psychosocial support but most frequently placed most value on the children's sessions with social workers, psychologists, and play therapy (provided by social workers and foster mothers themselves). Other resources identified included teachers and educators, youth programs, church,

having a male role model, mentoring and volunteer programs and simply talking to their child(ren) one-on-one. It is important to note here that the research question posed to the foster parents was simplified from “best forms of psychosocial support” to “best programs, services or activities, to help the children and their emotions”, when clarification was necessary.

A separate interview question asked respondents *who* they felt provides the most significant forms of psychosocial support for the children. Out of the 14 foster mothers, 12 of them listed themselves first as the most important person. The second most frequently reported was the social worker and psychologist. Other important persons included a foster father or male role model, church members or a priest, staff from partner organizations and community programs, management staff and volunteers.

<b>What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being [emotions] of the children?</b>
<i>“The organization itself (home from home) has outings, social workers and mentors, they help.”</i>
<i>“Education, clothes and the food are very important but I think support groups, a person to talk to or courses for the children would be helpful, because the children have big problems and the courses are good.”</i>
<i>“The psychologist and social worker. The social worker she comes and she plays with them and she wants to get to know their inside story.”</i>
<i>“Mentors, a teacher who helps with homework, there is an assistant from home from home and she and her husband sometimes take the kids on the weekends. That is very helpful for the boys to have a male around.”</i>
<i>“The need the church; like other children they need to go to church.”</i>
<i>“The Psychologist, therapy, play therapy, but I would like it for all kids”</i>
<i>“After school programs; drama and art. It is good to give them more encouragement and they love it so much.”</i>
<i>“Sunday school, Hope4Africa [community student youth centre], game nights, talking one on one with them, and he social worker.”</i>
<i>“Going to Church. They need something to believe in and to feel that someone is watching over them”</i>

<i>"The psychologist"</i>
<i>"We had two volunteers who were very helpful but they stopped coming, and also playing games with them that's the time they will sometimes open up".</i>
<i>"Sunday School, talking to them at home, and answering their questions."</i>
<i>"The Educare centre."</i>
<i>"The community centre has an after school kids club for them twice a week."</i>
<b>Who (people) do you feel provide the most significant forms of psychosocial support for the children?</b>
<i>"Myself [foster mother], management they support us even if we have a problem with a child, social workers are also very helpful as well as my volunteer assistant."</i>
<i>"Myself first. Then church. But it's me, they are like my children, it's like they are mine. I tell them to talk to me so I can help, I take them to the park to play, and they come with me to church. Even the neighbour's children come to talk with me sometimes. I am happy to help them, I am so happy because they take me as their own mother."</i>
<i>"Myself"</i>
<i>"Myself"</i>
<i>"Myself, priest. But think males need male role model."</i>
<i>"Myself and also foster father. Emotionally I feel we support them because I am with them all the time. I know each one's different face when it's showing what's wrong."</i>
<i>"Psychologist and us [foster mothers], because we are here every day."</i>
<i>"The psychologist"</i>
<i>"Social workers from HFM do a lot and the church. Also myself."</i>
<i>"Psychologist, myself and social worker."</i>
<i>"The social worker, our bosses, myself, the church."</i>
<i>"They open up to the social worker. To me they still block themselves, I tell them that you must open up and talk to feel better."</i>
<i>"Us [foster mothers], the parental figures, for the boys I think it is very important that they have a father figure."</i>
<i>"Myself, the church and the social workers."</i>

### 4.2.3 Awareness for policy makers

When foster mothers were asked what they want policy makers to be aware of, or incorporated into future policy developments regarding the needs of orphaned and vulnerable children, the primary responses were the desire for awareness concerning the difficulty of the job itself as a foster parent and the need for increased psychosocial support for caregivers and OVCs alike. Other recommendations were made in response to additional interview questions, such as suggestions on how to improve foster mothers support efforts and are presented within the section on ‘ caregiver suggestions’.

<b>Based on your own experience, what would you most like policy makers to know about to support vulnerable children in South Africa?</b>
<i>“They must know how difficult it is, and to take these children seriously. They [foster children] need love and patience and it’s very difficult because they come from different backgrounds.”</i>
<i>“That we need extra support for carers; we need more support otherwise it’s too much emotionally, socially, emotionally, and physically. We had a weekend retreat with other mothers and that was so helpful. You have better children when you have better mothers.”</i>
<i>“Policy makers must know how much support the children need; it is never enough; they need so many people to help. And there are so many more children who need help.”</i>
<i>“That children have their own personalities, their own questions and their own minds, so maybe having more group sessions for the children. Especially children going to the hospital because mine they go to the hospital and they only see other adult patients, we wait for hours and I wonder what they are thinking. I think it would be good if they could talk to other children their age who are going through the same thing so that they know they are not alone.”</i>
<i>“Not to isolate them and they need to be treated the same as all other children. They are no different.”</i>
<i>“How difficult it is to raise children removed from unhealthy environments/homes when they are still living in the same physical neighbourhood.”</i>

#### 4.2.4 The role of psychosocial support

Since the primary focus of this study was to examine the perspectives of caregiver opinions on the role of psychosocial support, there were several supplementary questions posed during the interviews to understand their broader thoughts on psychosocial health and well-being. Foster mothers were asked about their opinions on the importance of informal and formal psychosocial support, their suggestions for improving support, the impacts of losing family members on the children's psychosocial well-being, their ideas about children's coping capabilities and ability to discuss their emotions, things children have reported having the most difficulty with, as well as discussing their own feelings about the difficulties of talking to children about sensitive issues such as HIV status, parental loss and trauma.

In addition to the specific sources and forms of psychosocial support, foster mothers also expressed a general consensus that both informal and formal forms of support are important for the children and their development. In response to a question gauging whether or not foster mothers believe providing psychosocial support is an important part of their job, all 14 respondents said yes. Several mothers mentioned that the support groups for children were very important and requested that these sessions be increased. One major recurring theme that came out of the foster mothers' responses was the significance they placed on the role of 'loving' support for the children. When foster mothers were asked what they believed to be the most important part of their job many of them emphasized aspects of love as the most significant role.

<b>What is the most important part of your job?</b>
<i>"Love is the most important thing; they must know love. Some of them did not learn love from their biological mothers, some of them have no parents and now they've got anger. Don't just say it; you must show it."</i>
<i>"Love, if you do not have the love, and you do this job there is nothing. The other is care. If you care then it's alright for the children."</i>
<i>"To make sure they feel loved."</i>
<i>"To support them, their education, their medication, answer their questions and console them."</i>

*“To give children a lot of love and build their trust.”*

*“Just to show my love to the children and to be there for them. I must be the mother for them but sometimes it's hard.”*

*“To love them, help them build confidence, stay healthy.”*

*“[It is my responsibility] ... to take care of the children, to love them, to help them with everything they need so that that they can grow up, to teach them, make them feel safe, and feel loved.”*

This articulation and emphasis of “love” will be discussed in section 5.2 and will consider how the foster women’s perceptions of “love” and loving care overlap with conceptions of informal forms of psychosocial support.

Foster mothers also expressed the importance they place on both formal and informal psychosocial support for themselves as caregivers. They placed significant value on the group support sessions the mothers themselves and when asked for ideas and suggestions on what else foster mothers need to support the children, six respondents reported that they would like more support groups and parenting workshops. Foster mothers also expressed appreciation for the social workers when asked about their own coping strategies and sources of support. Ten foster mothers reported that when they themselves felt overwhelmed or stressed, they most frequently turned to social workers for support and guidance. The second most common source of support was peer support from other foster mothers. Several foster mothers specifically mentioned a previous retreat that had taken place as a support group where the foster mothers were able to disclose personal challenges, strategies, commonalities, and discuss in a safe environment where they could provide emotional support to one-another. A few mothers requested more events such as this one, noting that they found it extremely helpful.

#### **Select responses to a variety of different interview questions**

*“More parenting courses, they are great we learn everything there, how to do the right things and the hard things. They are very good for us because sometimes we want to give up because we don't know how so there they try to help us.”*

*“The support groups with just the mothers is really important, having that time to support each other, share how we feel, crying together it is a miracle.”*

*“I wish that there were more opportunities for the foster mothers to meet together, without the social workers. It is important that we support each other and let each other know that we are not alone, that we all understand because when you feel bad you need someone who can say you're not alone.”*

*“ I wish that we foster mothers, could sometimes have our time without the social workers, because without them we can talk freely, because sometimes we want to talk about what's happening to our children, so that we can be one heart, we are the mothers, and we are the ones taking these children far. We struggle with what's happening outside [in the communities], because there's still more children outside without homes. I wish I could have someone on that side [foster mothers from other communities], that I could depend on, so that she can talk to me and she can say you know I've got this problem and then we can talk about that problem, and then we can support each other, remind each other that we need to look after these kids, and love these kids.*

*“The support is very important I could not do it without the support.”*

*“More support groups. We do have them once a month and I am always so excited so I would like more frequent meetings, you can't get to all the stuff [topics to discuss] once a month in that time.”*

*“We went to a farm in Constantia with all the mothers and we had a great time. There was no social worker, and we just had one lady to call us to do the clay work. When we were there we were pouring out what was happening [our experiences]. I think we were around about 10-11 people but we were sharing what's happening and we were all talking and crying together. Someone said that they want to leave this job because the children they treat are very bad. That's why I made my suggestion to have more opportunities to talk about this, for the foster mother. Because the things the child can say they hurt, they say you are not my mum, you see it's very difficult. Sometimes on the other side you see that you are there just a mother, they must know that we are here for them. My own [biological] children sometimes they are very cross because I don't have time for them anymore. I just see them when I am off work. They must know that we are still here for them. In fact my children respect me but I see on the other side [in different communities] the children don't respect them [the foster mothers], but sometimes the child doesn't respect you because they don't understand. You see maybe you are doing the wrong things and the child doesn't respect you when you do things like that. So I really want that sometimes we have connections like that. Because when you feel bad you need someone who can say you're not alone. You need someone you can tell that to, someone who understands.”*

*"...Also would like more meetings for the foster mothers, we need each other for support. It is good to know that you are not the only one that has problems in the house. Once a month is not enough."*

A third set of responses that illustrated the foster mother's opinion on psychosocial support for both foster mothers and children were when they were asked about their own emotions when discussing difficult topics with the children.

**How do you feel when you talk to the children about sensitive issues?**

*"At first it was difficult, I would cry before I talked to them but now it is okay. They help me, we help each other. For example we talked about the death of my mother and my son and we help each other."*

*"It is difficult but I try to explain things to them. For example, when they are upset that they don't have parents I tell them that even though they don't have biological parents they get many things other children don't get. They have volunteer trips to places like Table Mountain and someone to make sure they go to school every day."*

*"It is difficult; they ask when they get to stop taking the medication, they don't understand that it may be forever."*

*"It's very difficult because I always put myself in their shoes. I tell them where I'm coming from and that my life was not always easy either; it's difficult to talk to them about those things."*

*"Sometimes it is very sad and they like it when I show I am sad too because it shows them I understand and I care."*

*"It can be very, very difficult but you must try. I do talk to them softly. I tell them that I am their mom."*

*"Yes, they know if they've got anything to say or feel they can talk to me one on one, they like to do that."*

*"I let them come to me. The older ones like to speak about their family but the smaller ones are not so interested. One of them gets very upset and angry when her brother speaks of the parents."*

Another apparent observation was that the foster mothers were very aware of the psychosocial needs of the children. The majority (13 of 14 of the foster mothers reported that a

child would turn to them most commonly when seeking help or support. Several foster mothers expressed their emotional experiences discussing difficult subjects with the children, while a couple mothers mentioned they did not talk to their children about their emotions. Foster mothers most frequently reported incidents of children feeling distressed or emotional about issues related to their biological families. Other difficulties included teasing from peers at school, coping with traumas (feelings of being unloved, scared, confused, and angry), and adjusting to new foster family.

<p align="center"><b>What have the children said they have the most difficulty with?</b></p>
<p><i>“Having questions about their biological family.”</i></p>
<p><i>“Getting to know me at first, because of what they'd been through with the previous foster mother they need to build trust again.”</i></p>
<p><i>“Feeling unloved, that they were given away, they remember feeling unsafe. Some of mine had a previous mother who was not loving and they remember. They witnessed a stabbing.”</i></p>
<p><i>“The one child her biological family does not visit her and it really upsets her; she gets cross and jealous of the others.”</i></p>
<p><i>“The younger ones always ask, ‘where is my mother?’ Some of them are on the street and some of them are dying. So it’s very difficult.”</i></p>
<p><i>“Being teased at school, they are scared to report to the Principal because they are scared other child will beat them.”</i></p>
<p><i>“The most difficult thing they find is every time they get a new house mum, because children are scared of change. It wasn't so bad with me because they knew me before but they were still scared and we both had to get used to the change. So, yes, they are quite scared of changes; that is the main thing.”</i></p>
<p><i>“Being teased at school, one girl was teased when her friends found out she had been raped.”</i></p>

**How do you think the impact of losing family members has affected the children's psychosocial well-being?**

*"It is very hard for them. We must look after them properly; if they have a shoulder to cry on they can forget [their past and their HIV status]. They are children, you must show them they have a mother they need love. Some of them have lots of anger."*

*"It causes problems for the children; even the little ones have got some problems and you don't know how to feel about that. Sometimes you can feel their pain and take that pain on yourself. I think the emotional pain from before is the hardest."*

*"It is difficult for them. They want to know about their own biological family."*

*"It is difficult for some of them; they ask about their biological family. Some have them and some don't. It is hard for the ones who don't to see the others go away for visits with their family. Some have got lots of anger."*

*"Negatively, they have issues of anger, feeling unloved, and confusion."*

*"Two of mine are brothers; they just lost their mother two weeks ago. Horrible experience. It has been very hard for them emotionally. One is still young but it still hurts him badly. But because they also know they have a safe home and that they are loved it helps; it's comforting."*

*"It affects them so much, they get upset and they have a lot of questions. One of my girls her mother has died and she knows her aunt but her aunt does not visit. She thinks a lot about this and it makes her confused and lonely. The social workers have contacted the aunt but she is not interested in visiting. Another girl, she has a family that she loves so much, she went back to that family but they don't care about her, they don't take her to the doctor she doesn't go to school and so they brought her back here again. But they still visit."*

*"It affects them. I have a 12 year old who asks me about her mother but I don't know the answers because she was already here when I came here and the social workers don't know the history. She asks about her relatives and I think she doesn't know that her mother is gone. The last time she saw her mother was in hospital she was very sick and I think she didn't go to the funeral. Those things are very tough because they are confused. It is very sad."*

*"Difficult, they have questions. The oldest one wants to visit family on the weekends but we have to wait for them to come to us. The younger ones always ask where their mother is. Some of them are on the street and some of them are dying. So it's very difficult."*

*"The price is love; they lost love; they lost happiness and the relationship with their parents."*

*“It affects them so much. They know they don't have a mum or a father who can take care of them it makes them very sad. Sometimes you see them standing quietly and you know something is bothering them. I think they think about it a lot.”*

*“They more talk about the lady [foster mother] that was here before me; she was here for the three years and was abusing the children. So it was very emotional for them, and now I must gain their trust bit by bit.”*

*“It's different for all of them; some still have family around, which has its own problems; another was left alone all night and all day alone in a shack and was traumatized. One of the boys doesn't seem to understand that his dad is gone.”*

*“Where they were living before it was not nice for them; it makes me sad. It's difficult for them.”*

*“All of them came with different problems. For example one of my children needed love he would not let anyone put him down he clung to everyone and cried when you put him down and he did not talk until he was older. Even now at the age of three he does not speak clearly. Another one was scared of everything and everyone when she first came to me. She would jump at every little sound. One was traumatized because after their mother had died she had been left on her own for a long time. She is scared to leave her brothers side because she was so scared to be alone. But over time they all get better and better.”*

#### **4.2.5 Caregiver suggestions**

In addition to the request for more caregiver support group sessions, another frequent suggestion was the need for more staff, volunteers, and assistants to reduce stress, for example in situations where a foster mother needs to take one child to the hospital and has to leave other children at home, or to give mothers more leave time. One foster mother said that the monthly financial grant provided by HFH is insufficient and she ends up having to use her own money to support the foster family, and that she views her job as a foster mother more as an unpaid volunteer position. She said she felt very stressed and expressed a desire to be able to have more time off to visit her own biological family. Other requests included increased financial support, parenting skills training and grief counselling, more motivation and positive feedback, and additional group sessions and educational programs for children and teens such as HIV education and awareness programs.

**Select responses to a variety of different interview questions**

*"We [foster mothers] just need support; one of the best ways is simply to show appreciation and encouragement. When someone comes and tells you that you are doing a good job, it makes you happy and [makes you] want to do more, that support is also important."*

*"I was not prepared to deal with loss of one of the children's biological mother; I wish there had been some training or counselling on this it would be good for the mothers."*

*"More volunteers and mentors are needed. More outings for kids would be good. It's difficult to make it buy on the monthly grant; to buy food, emergency money, clothes, etc."*

*"I might not be able to stay in this position. It is so hard, I love the children and I worry about leaving them but it is so very hard. I think would be better as an assistant or if I had an assistant."*

*"Motivation to keep us going, that can help us so that we won't give up on these children, even the parenting course we are in can help a lot."*

*"More money, it is very difficult to get buy on the grant we are given. It is a large stress to make it all work."*

*"I think they must advertise the positions more, I need more assistants in the house."*

*"More volunteers, more assistants at the home and more support from HFH, financially."*

*"I'm not talking to them about HIV, maybe someone could help to explain to them about the other things I don't talk to them about?"*

*"The [biological] parents mustn't be in the community. The influence is bad for the children."*

*"More reliable people to relieve you for holidays or during stressful times. I need a person for when I just need an hour or two break. The kids are very demanding and sometimes you just need a break. I think it would be a good idea to hire a person just for leave, for breaks and holidays."*

*"I just have one [person – assistant] to help this year, but she is very very busy, because she is also the coordinator now. Most of the time she doesn't come here to this house. There isn't any helper for these two houses. Even just a couple of hours a day, for two days a week would help. Like if I got to the hospital the helper can help me when I go. Because I come back very late."*

#### 4.2.6 Role of the church & local community

The (Christian) church emerged throughout the interviews as a major source of support for the foster mothers. Several of the foster mothers listed the church and church members as one of the most significant sources of psychosocial support for both themselves and the children. Foster mothers also mentioned the church as playing an important role in community for supporting the psychosocial needs of the children. When they were asked if they felt their community was supportive of them, several of foster mothers pointed to the church as the supportive community.

Select responses to a variety of different interview questions
<i>"Myself [the foster mother] first. Then <b>church</b>."</i>
<i>"Social workers from HFM do a lot and the <b>church</b>. Also myself."</i>
<i>"The social worker, our bosses, myself, the <b>church</b>."</i>
<i>"Foster mothers, assistants, social workers, volunteers, <b>church members</b>, even peer support."</i>
<i>"Myself, and then the priest."</i>
<i>"Going to <b>church</b>. They need something to believe in and to feel that someone is watching over them."</i>
<i>"They need the church, like other children they need to go to <b>church</b>."</i>
<i>"Yes, it's [the community] a big support, even the neighbours. Even if I'm not home they help even if I have errands to run at night they will help out. They tell me I can phone them if I have any problems and they will help. Some people they do not understand they say rude things and ask why I have that house with children who have got HIV. The <b>church</b> and other people they support me, though."</i>
<i>"They [community members] don't know about the [HIV] status and I think if they knew they would not be supportive. But for now the <b>church</b> helps and the teachers and volunteers."</i>
<i>"<b>Church</b> community [is supportive] yes"</i>
<i>"...I always say please God if you guide me and my children everything will be okay. I think if they children know Jesus they will be fine."</i>

*“Yes there are many people around us, a friend from the **church**, others come for prayers, others support with clothes and even food. The Neighbours brought them Christmas clothes. There is a lot of support even for school; a few students came to help them with schoolwork.”*

*“I don't think that the community actually is aware [that we are here], it's only now after the passing of their mother that someone has come here. For now the only people around are from the **church** and they support us.”*

A third area where the church was most frequently mentioned was when foster mothers were asked about their motivations for being a foster mother and how they found out about the HomeFromHome organization. The majority of mothers said they found out about the position and the HFH organization through church members and posters put up at the church. One mother said she felt it was her calling and that the position of a foster mother was more of a ministry that God wanted her to do, and took on the role because she loves children. She also said it was the church that gave her strength and the commitment to continue supporting the children in her care even though it was extremely challenging at times.

#### **4.2.7 Challenges related to children's biological families**

Another theme that emerged from the interviews with the foster mothers was the challenges surrounding the relationships with biological family members of the foster children. Although some of the children were orphaned by HIV/AIDS, many children in HFH care were placed into foster care due to other circumstances including physical and sexual abuse. Furthermore, while a child may have lost a parent or does not have guardian who can care for them, they may still have living relatives who remain in contact, or biological parents who have visitation rights to the child. A few responses that highlight the complexities of the issues regarding biological families are presented below.

### Select responses to a variety of different interview questions

*“The work we are doing, it’s not easy. Sometimes it makes you cry. You cry for two things, you cry for the child and you cry for yourself. I have one girl who stayed with me before but went back to live with her mother. I was touched by this child because she told me she loved me. I saw her at the park after she had been to her mother’s court case. I noticed she was sitting on the other side of the park and went over and sat down with her. She hugged me and started crying. I asked her what happened and she said “my mother doesn’t even love me and she’s caught up in so much stuff.” So I took her home and she told me everything that was happening. I was so hurt. She told me she doesn’t love her mother because her mother prefers to love her husband who is a gangster, someone who robs, takes drugs, is violent and all these sorts of things. She said her mother won’t pay attention to her because of the video [details of case unclear], and that they fight a lot. She said that when they went to court her mother wouldn’t talk to her. Even if the parents are like that, treat them terribly, the children still love them and it is so hurtful to them inside. When she told me all this I was so surprised and I told her “oh, baby, don’t worry, your mom is going to be fine, he loves her. Your mom is confused by that man, but don’t worry for now. For now you have me.” And then when I was finished talking to her, I went home and started to cry really hard, and I thought “oh, this child is in a deep, deep situation now. Her parents don’t love her, don’t care about her, it’s so hard for these children, very hard. And this child was only 12-13 years old at the time when she told me what was happening to her family.”*

*“Some of them have some anger problems and conflicting personalities it is very hard. Also having the biological parents visit and take them. It causes a lot of strain on the children and a lot of strain on me. Parents shouldn’t come to the home because it’s not fair to the ones who don’t have biological family. Also answering their questions about their parents is difficult because I don’t know the answers.”*

*“The cheeky child sometimes goes onto the street and when we talk about things she says “I don’t care, you’re not my mom.” Their mother lives in the same neighbourhood and sometimes she takes her sister to go see their mother. She tells me that the mother is buying them clothes. Sometimes they go there for the whole day and we don’t know where they are. I went to the mother to ask why she is taking them without telling me and she says that she wanted to see them because she misses them. I asked her why doesn’t she come tell me, I tell her they have to come to me first, that I won’t say no but you can’t just take them from the street because I was looking for them the whole day.”*

*“The one child her biological family does not visit her and it really upsets her, she gets cross and jealous of the others.”*

*“Sometimes it is difficult because the three siblings, their biological mother is living just down the road. So it’s difficult for me because they run off all the time there. The parents mustn’t be in the same community. The influence is bad. For now everything is okay, it’s only the three siblings who just run off. But I can't even stop them because they pass by there every day on their way home from school. I don't know if they are okay, if they are there, but somebody will tell me. And then there is always an argument about that. In the future, the mother will be responsible for them. But only if she can behave herself, stop drinking and that you know. She gives them sweets and things like that, so then I have trouble with them eating dinner. I make them veggies and that, and they come from there and are full on junk food. So you know most children would go for that you know, so now we have an agreement. Mondays and Thursdays and Saturdays, they go there, but then everyday they will still just run off without my permission, because they are watching movies there. I told the social worker and she said I must go every day and fetch them. But that's not right I've got so many things to do. But you see she [the mother] also gives them money. But we can't give them that, we don't have that extra money. But by the end of next month we should be better [financially] but now we can't actually give them any extra money like that. So, yeah, we hope that everything will be different.”*

*“Their biological family, they want to know more about them, they want to meet family. Some have family, but some don’t. That is difficult for them.”*

*“It is difficult for some of them, they ask about their biological family. Some have them and some don't. It is hard for the ones who don't to see the others go away for visits with their family. Some have got lots of anger.”*

These responses illustrate the challenge of dealing with specific biological family members, children’s emotions around not having biological family, and having questions about histories or circumstances of biological family members. Another issue surrounding biological family members is the concern over what will happen to a child once they reach 18 years of age and are no longer eligible for foster care supervision. Several foster mothers expressed concern about their child(ren) once they turn 18, and there were concerns about children returning to communities of biological families that they do not believe are healthy or safe environments for them to be in.

Select responses to a variety of different interview questions
<i>"I'm worried about when it's time for them to leave the home, I've seen some of their families' houses, and I'm scared. I'm really worried for the girls, worried they will get grabbed [raped] and I'm worried to send them back there from here, it will put them way behind."</i>
<i>"My biggest worry is if their [biological] parents will be looking after them when they are finished. Will they go back to their parents and if they do will the parents be ready for them, because they all [the children] want to go back, I worry they will not be ready for them."</i>
<i>"It is really hard because you don't know how they will survive the future. Because after 18 years when they leave the house we don't know what will happen to them and who will help them."</i>
<i>"Sometimes I am very worried, I worry about when they leave this house if they will be able to survive on their own. I worry about the disease and I worry that something will go wrong that people will not understand."</i>
<i>"That people will take them for granted that no one will fight for them or protect them. I worry if they will be independent enough when they are 18."</i>
<i>"I worry about their education and what will happen after they leave here. I worry about the biological family and what will happen there."</i>

These issues surrounding biological families and re-integration concerns will be explored in the discussion section of this thesis in Chapter 5 section 5.4.8.

#### 4.2.8 The future of the children

Related to the concerns about biological families and their role in the children's futures, another theme is the future of these children. When they talked about their concerns for the children's future, foster mothers expressed a range of concerns as well as positive aspirations. Most frequently, the foster mothers reported that they were concerned about the education of the children and the consequences this would have on their futures. Many of the children in foster care with HFH are behind in school and struggle to keep good grades. Foster mothers are also worried about the children's future independence, health, relations with biological families,

community integration, personal behaviours, and have concerns that the children would not have a consistent foster parent.

<b>What do you most worry about for the children you support in the future?</b>
<i>"I'm worried that when they leave the house that if I'm not here to watch them that they will stop taking their tablets (HIV medication). I worry they do not realize their life depends on it. They know it but they don't take it seriously."</i>
<i>"Education, how they do in school."</i>
<i>"I am worried about their education and their health. If you have those they will be fine."</i>
<i>"I want them to finish school and that they learn good behaviour before they grow up."</i>
<i>"The education [is what worries me]."</i>
<i>"About their studies, they are not serious and they are not doing well."</i>
<i>"Sometimes I am very worried. I worry about when they leave this house if they will be able to survive on their own. I worry about the disease and I worry that something will go wrong that people will not understand."</i>
<i>"I worry that if I leave this job that the new mother won't be good for them, the change of mother isn't good for the child and I wish to stay with them until they are big."</i>

Although the mothers had serious concerns for the children in their care, they also had positive aspirations for them. Most frequently the mothers stated their biggest hope for the children is that they will be able to complete their education, be independent and be able to get a job and have a home. The second most frequent responses were aspirations that the children would have good morals, have positive dreams and goals for themselves, be able to have their own family, and to simply be happy and healthy. Other desires included hoping the children will be safe, contribute to society, learn a skill, know God, be confident, and have a healthy relationship with their biological family.

**What do you most hope for the children in your family/program in the future?**

*"I hope that they become somebody, that they reach their dreams and goals."*

*"That they are growing, getting an education, and are healthy and safe I am happy. I think that would be the best, I always say please God if you guide me and my children everything will be okay. I think if they children know Jesus they will be fine."*

*"I hope that they can find a family member or relative and to live in their community. "*

*"My dream for them is that they finish school, get a job, get nice homes, maybe get married have a family of their own and that one day they come to me proud. I have big dreams for them and we all like to talk about that."*

*"That they find a place to live."*

*"That they will become confident and in control, health and good citizens. I hope they share lessons they have learn with others and to give to others."*

*"To have a beautiful life, positive dreams."*

*"I hope they will be okay, I worry about the guardians; they will still need a guardian because [after they turn 18] they are not a normal child."*

*"I want them to finish school, to look after each other, to be a family, to look after themselves and the smaller ones; they mustn't tell themselves that "now I'm out of that house I must live my own life." I want them to grow up in the right way, with the right behaviour and not forget about their family."*

*"I want them to learn skills, how to work with their hands, this is important for them because they have trouble learning and focusing so skills are important."*

*"I hope that they are good people and that they learn fast and finish school so that they can do things for themselves."*

*"I hope that they have their own homes, and that they can stand on their own. I hope that they know what is right and what is wrong."*

*"I hope they finish school and get a nice job."*

*"That they are good children and strive for their goals."*

#### 4.2.9 Gendered Issues

Several of the foster mothers' concerns can be categorized as gender-related concerns. The respondents expressed concerns about girls being raped, early pregnancy, and father figures. Foster mothers expressed concern in relation to the potential mental and health outcomes of previous rapes, as well as concerns of potential rapes in the future of the girls in unsafe environments. Another gender-related fear for girls was the risk of unwanted early pregnancies and the need to ensure girls finish their schooling before engaging in sexual activities. For the boys the most frequent gender concern was the lack of a father figure and the need for a consistent male role model in the girls' lives.

Select responses to a variety of different interview questions
<i>"I'm worried about when it's time for them to leave the home; I've seen some of their family's houses, and I'm scared. I'm really worried for the girls, worried they will get grabbed [raped] and I'm worried to send them back there from here it will put them way behind."</i>
<i>"Myself, and the priest [are the most significant people providing psychosocial support]. But I think males need male role model."</i>
<i>"I worry about a lot of things, I worry the girls could get pregnant or sick, I worry that they won't finish school, there are many things that could go wrong, you can only protect them inside the house."</i>
[Children have expressed having the most difficulty with] <i>"...being teased at school; one girl was teased when her friends found out she had been raped."</i>
<i>"The children mustn't get pregnant and should focus on school."</i>
<i>"My own personal goal is that we have no early or unwanted pregnancies."</i> [note: this is a comment from a HFH personnel not a foster mother, but id placed here for consistency]
<i>"Ourselves [foster parents], the parental figures, [are the most significant people providing psychosocial support]; for the boys I think it is very important that they have a father figure."</i>

*“Mentors, a teacher who helps with homework, there is an assistant from HomeFromHome and she and her husband sometimes take the kids on the weekends. That is very helpful for the boys to have a male around. [in response to what programs are most helpful for psychosocial support of children]”*

These gendered issues and their implications for OVCs and their psychosocial development are discussed in Section 5.4.6 with some gender related conclusions.

#### *4.3 HomeFromHome Personnel (Social workers and administrator)*

The following section presents the participant responses from HomeFromHome personnel, which includes four social workers and one administrator. Since the HomeFromHome administrator does not have the same direct relationship with the children, the four social workers’ responses will be discussed in relation to the project research questions with the responses from the administrator being used more as supplementary contextual information in relation to identified themes.

##### **4.3.1 Challenges in providing psychosocial support**

The four HFH social workers expressed a series of challenges in providing psychosocial support for the children and foster mothers whom they support. Two social workers reported finding it was initially challenging to build trusting relationships with the children and foster mothers. The emotional connection with the children and empathy for the traumas and experiences they have endured were also expressed as a challenge of the role of the social workers. Communication and a language barrier was another obstacle. One social worker said that she is fluent in English and Afrikaans but is not able to speak isiXhosa, which was the primary language of most of the foster homes she supported. The social worker felt that if she could communicate with the children better she would be able to discuss deeper emotions with them.

Another issue that social workers mentioned was finding the balance between being the confidant to the mothers and children while also being in a position of supervision and carrying out obligatory consequences or reprimanding mothers and children for unsafe or inappropriate

behaviours. Dealing with biological parents, foster mothers, and managing the complicated relationships between different adults and children was also mentioned as a serious challenge. Another difficulty reported were the challenges working with the Social Development Office and statutory social workers, who are the social workers typically concerned with legal matters, often employed by the government and have roles including placing children in foster care, conducting follow up assessments and acting on specific children’s court cases. A similar reported challenge included the difficulties surrounding grants and court orders. Administrative challenges expressed by the administrator included finding the right staff (social workers, foster mothers, administration), and being able to consistently monitor all levels of staff with limited resources. One social worker was also responsible for overseeing the crèche (preschool centre) and reported finding balancing these duties with her regular counselling duties to be challenging.

<p><b>What do you find the most challenging aspect of your role a social worker?</b></p>
<p><i>“I think trying not to come across as the authority on everything, and trying to get them to talk about things and giving them the time to talk.”</i></p>
<p><i>“I think what’s really difficult is finding the balance between the supportive role and the supervisory role, because you are trying to support the mums but at the same time if they are doing something that you don’t think is okay, you have to address it.”</i></p>
<p><i>“I think that is very difficult to be the confidant on the one side and then also your role as a social worker to advocate for the children, so I fear to break that trust. That relationship that you have with the mother, if you have to address an issue that she - her behaviour -wasn't correct or she has done something wrong, to do it in such a manner that you continue in that relationship but also be strict or assertive enough for her to change her behaviour.”</i></p>
<p><i>“I think the most difficult part would be if I’m bringing up something that they’re doing or not doing that they should be, so correcting problem areas. And I think you have to be careful because you don’t want that to get back. For example I found out one mum was leaving the children at home alone while she was doing the shopping so I had to address that with her and she got really angry with me and told me to get out of the house. So it was difficult because I had to mend that relationship.”</i></p>

*“The people. Finding the right staff at all levels can be very difficult and is very important. Also the management of staff, with limited resources it is impossible to monitor all levels off staff at all times. Children are the least problematic at this level; it's more with the adults.”*

*“At the beginning it was challenging to start to build up trust with the children and the foster mothers. My other big challenge is the language, I am fluent in Afrikaans and English but my Xhosa children only have basic English, we struggle to communicate and I feel that if I could communicate with them I would be able to maybe go into deeper emotions. I do ask the mums for help with the language and I have shared these challenges with my colleagues.”*

*“It's difficult working with social development office and statutory social workers (for grants, court orders), can be quite frustrating. Also having to oversee the crèche, I don't like having to be the bad guy and telling people what to do especially when I'm the new person coming in. I'm still figuring things out but I do share the obstacles with management.”*

*“The adults. Children are the easiest part of the job. Foster mothers [can be difficult] but mainly the biological family members and just managing the relationships between family members and the children. I think one of my coping skills is to be highly efficient in communication with the adults, keeping things civil, also protecting myself because I have parents who will turn around and say “but you said this and that...” when I didn't so they can be manipulative and difficult often, so just being really efficient in the manner of dealing with that.”*

Other concerns expressed by the social workers were the children's psychosocial functioning, future independence, falling through the cracks of the education system, and the unmet needs of children with FAS and ADHD.

**What do you most worry about for the children you support in the future?**

*“I worry most about their psychosocial functioning, that we don't address everything and that they will not be well functioning adults. I'm worried that they won't find their emotional balance that they need to, they don't find the education that they need to function one day, and I'm worried that when they leave their house that they cannot face the world, so I'm worried that we miss something along the way. I think my biggest worry is the education; the South African education is really lacking and it is failing these children at this stage.”*

*“I hope that they'll be able to have healthy intimate relationships and that will they have a good idea of what marriage is like, or having lifelong partners, or will they understand give-and-take in relationships because I think so many of them have such bad examples of it and I know that it's so much harder to learn to have healthy relationships when you've had that and I worry that they don't expect the respect that they deserve, only what their parents had. I saw this film where they said you only accept the love you think you deserve and I think so many of them don't think they deserve better so I'm worried about that and their future.”*

*“I think just seeing their visible pain and just how disappointed and let down by their family they are. I think the hard part for me is knowing that they're so forgiving of their family even when their family has treated them so badly. And I wish the parents would come and build a better relationship with their children. And things like father's day and mother's day are such a painful time for them; they still think about their parents even though some of them have done heinous crimes against them. So that's hard.”*

*“I think my biggest worry with my children is the Fetal alcohol syndrome or ADHD because most of them are doing really badly in school and I find a lot of them can't do mainstream schooling but they are not disabled enough to get into special school, so they are falling through the cracks. So I'm worried about them because obviously if you don't have a good education it's very difficult get a good job so I worry about what's going to happen to them.”*

#### **4.3.2 Best forms and sources of psychosocial support**

When social workers and administration were asked about their opinions on the characteristics of the best forms and sources of psychosocial support, each participant listed the foster mother as the most important person providing the most significant form of psychosocial social support. The second most significant source reported was the social workers themselves. Additional important people identified were other HFH staff such as house assistants, community members, mentors, teachers and other community programme associates. One social worker mentioned church members as a significant person.

**Who do you feel provides the most significant forms of psychosocial support for the children?**

*"I think the foster mothers actually, first and foremost, because in your definition you talked about children who are happy healthy social functioning individuals and as a social worker you can't make them happy but the mothers care and provision of a safe and secure environment is psychosocial therapy in itself. So yea I think the mothers provide the most but in addition on a more psychological level, the social workers do provide support that maybe the foster parents don't have the specific training to do. And then the associates the different teams of people who support the homes, I think a lot of them are really fantastic associates who are really invested in the foster parents and the children and they are there to provide good adult role models for the children and support."*

*"Ok I would say definitely the foster mothers first, on whatever degree she can; it might not be professional input but the stability and listening to the child and being there every morning for the child, I think it's very important. I want to think that social workers do give some input more from the professional side. And then I've also seen where the children are involved in mentoring programmes, they also do help with the functioning. But it has to be committed volunteers that they see regularly, I think it's all part of them being able to build new relationships and so forth. And then we see the odd good teacher who was a good influence on them. I think just general people that show them belonging, show that they are interested in their well-being."*

*"I think first it would be the foster mums, and then probably myself as a social worker, and then the teachers they get quite involved sometimes. And then some of them do get outside counselling from other organizations such as child line and the Red Cross behavioural clinic."*

*"Foster mothers, assistants, social workers, volunteers, church members, even peer support."*

*"The foster mothers then the social workers, the external psychologists we bring in, the ChildLine, play therapists, and rape crisis. Often outside help is limited for example the Red Cross child behavioural unit is a 6 month wait list and is a limited session."*

Regarding social workers' opinions on the programs, activities and services that best support the psychosocial well-being of children, the social workers listed a wide range of activities but placed most emphasis on the importance of ensuring that the environments at home, at school and within the community create a sense of belonging. The programs and activities included counselling and support from ChildLine, a national non-profit that provides a series of programmes targeted at protecting and supporting children; the Red Cross behavioural

clinic; HopeToAfrica, a local community centre; school and community sports and arts programs; as well as the various programs provided by HFM including camps, youth groups, mentorships, and tutoring.

<p><b>What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being of the children?</b></p>
<p><i>“I think first it has to be the emotional support from the first day they arrive. I think the emotional and the education are very important. And also then the social, that they feel they belong at the house and belonging at their school, in their environment and that they get the peer support that they need. So, involving them in different activities where they can meet other children and also to develop their social functioning.”</i></p>
<p><i>“The mentorship program, both mothers and children say it is very beneficial. Volunteers come and go, helping with homework, tutoring, etc. The afterschool care is a good support system but it needs to be made more productive. Most of the things kids are involved with are through HFH including camps, which are organized once a year. There’s a youth group with tutoring, a dog program which educates them about training and caring for dogs.”</i></p>
<p><i>“Outside counselling from other organizations such as ChildLine and the Red Cross behavioural clinic and you could also include the sports, spiritual dancing and art activities that some of them are involved in.”</i></p>
<p><i>“In Masiphumelele they’ve got this thing called HopeToAfrica which is in the community, it’s fantastic they are making connections with positive role models who are actually living in the community so they get to see them regularly, but they also get involved in lots of drama and dance and things like that. So helping the kids have stuff like that locally is really more important than us putting on our program I think, because that’s something for them that’s actually makes them feel like integrated community members. One of the things I think is very good for them is the social work students, they are actually regarded as volunteers but they are doing their practical [component of their degree].”</i></p>
<p><i>“The partnerships with other local organizations and within the HFH family. Normal activities such as swimming lessons and sports programs create inclusion in the community and help build their confidence.”</i></p>

### 4.3.3 Awareness for policy makers

In response to the question on what they want policy makers to be aware of, or incorporated into future policy developments, regarding the needs of orphaned and vulnerable

children these social workers expressed frustrations with systems outside of their control. Specifically they mentioned frustrations with the legal systems and its failure to convict adults who commit crimes against children; the foster care system, and its failure to access and follow up with the psychosocial needs of children once placed in care; and the health care system, and its failure to address the problem of FAS in South Africa. The respondents provided substantial amounts of information for this interview question and the full responses are provided here to ensure the weight and detail of their concerns and recommendations are documented.

**What would you most like policy makers who work to support vulnerable children in South Africa to know about the needs of OVCs?**

*“FAS is a huge problem in South Africa, I think we have the highest prevalence in the world but we have absolutely nothing for these children. I think we have one school that caters for the needs of these children and it only opened the other day, and only accepts about 10-15 children. We have no resources available for them, we don't have care facilities, because some of these children present, I don't know I feel that it hasn't been recognized as something like Down's syndrome or autism. I don't think it's being recognized by government and so what's happening is these children are growing up to become adults who themselves are either just fading away back into the community and don't do anything or are becoming alcoholics themselves and creating another generation, so there isn't any help out there for them. I think policy makers need to actually recognize the problem, and if I think about it you don't really see it in the media. I mean sometimes you'll see articles or in the newspaper but it's not something that's really spoken about and it's a huge problem.”*

*“Need extra support in terms of occupational therapy, and physical therapy. Need to get some of the children into special needs schools because they have the resources to properly help them but this is a challenge to get them into these schools.”*

*“I think it's not so much to do with the foster care but it's to do with the courts, and how in a perfect world if we had more convictions for child abuse. It's horrendous that not more of the family members and perpetrators are not behind bars. I've got two cases, a serious case that has been to court, and both were let out, and for me that's something I'd really love to see change. It's almost like a one-stop service that children get when they've been abused where they get off too easy and there's a need for forensics, judges, doctors and psychologists to get involved to take the case all the way through to trial. I don't feel like the legal system works, that nothing really changes, the children suffer, when I think some of the kids could stay with their families if the right things were in place. I think that's what policies need to focus on. Our [South African] Children's Act is really strong; we've got a new Children's Act in 2010; it's a really great act and it covers all aspects in modern policy but I don't feel that our justice department and our system isn't implementing it.”*

*“I think regarding foster care, I think one of the policies that we struggle with, one of the laws, is the involvement of the biological parents; where they always have the right to have access to their children except if they pose a danger to their children then access will be denied. But it's very difficult for us when a biological parent comes and wants access to the child because we have to facilitate that access and it's difficult to explain to a child that hasn't seen their dad in 8 years why she has to now see her father. So I think that's one of the challenges that we have. Also that the law puts in place facilities that the child has to go through, such as counselling, a thorough medical check and all of those things once placed in foster care, but once a child is put in foster care the system kind of forgets about the child and the needs of the child in the future. So I would like that there were policies that ensure the child goes for a total psychosocial assessment so that once they are placed in foster care the child's needs are identified and so that there are already procedures in place to address those needs. So a multidisciplinary input for that child from the beginning, not when the problems start.”*

When the interview questions that related to the psychosocial well-being of the children were analyzed, several clear themes emerged from the social workers' responses. The conclusions that can be drawn from these themes will be discussed along with the identified themes from the foster mother responses in chapter 5.

#### **4.3.4 The effects of trauma and children's emotional and behavioural problems**

One apparent theme was the social workers' frequent association of children's early experiences and traumas with behavioural problems and concerns for their future psychosocial development. One interview question asked social workers about the behaviours and problems

they have observed among the children. A follow-up question enquired about their opinions on the impact or role of the loss or removal from biological parents and family members. The respondents most frequently reported emotional and behavioural disturbances, which they recognized as resulting impacts from past experiences including abuse, neglect, FAS, and food insecurity. Examples of specific behaviours included food hoarding, challenges adjusting to routine, bed wetting, poor functioning in school, and poor social skills with other children.

<b>Select responses to a variety of different interview questions</b>
<i>“I think the biggest thing is that the children that are placed in our homes were removed from circumstances which were unhealthy for them, so they come to these homes with that baggage from their previous homes, and that can be emotional or physical health issues. But mostly its emotional baggage from the abuse or neglect that they had previously and how that has affected their functioning and also their functioning in school, and also how they function in the house with the other children.”</i>
<i>“Experiences they’ve had in the past; abuse, neglect, FAS, etc. It impacts them largely and their development.”</i>
<i>“Children coming in with issues of hoarding food due to previous food insecurity, and also being so used to strangers that they don't have reasonable sense of fear or precaution around strangers.”</i>
<i>“All the attachment theory stuff is really obvious when the child comes to alternative care. Often children have no routine before they come in, so the adjustment to routine and a routine family is really hard for some of the children, or if they had a rhythm and routine adjusting to the change. Bed wetting often is an issue. Food insecurity is a huge thing, especially when they first come in, often that takes at least a year or more to resolve. Those are the ones you really see straight away.”</i>
<i>“Every child has a specific situation, but they all have loss. It’s a loss of a parent, of the friends, of the school, their social setting where they were involved. So it’s a loss of a lot, it’s a combination of all of these things. Obviously the parental loss is there but it's amazing how children can rise, how they can make new parental relationships with their foster parents.”</i>
<i>“I feel the removal has placed a significant role on their psychosocial well-being because it is basically the source of difference for these children, some still have biological parents, it’s very hard for them to be apart but it just wasn’t safe or healthy for them to stay where they were.”</i>

In line with the theme of “the importance of love” drawn from the foster mother responses, social workers also placed significant value on the role of informal emotional support provided by the foster mothers. There is a noticeable similarity between the foster mother’s talk of “love” and the professional social workers talk of “emotional support”. The difference appears to mainly be a contrast in language; a simple difference between everyday language in comparison to professionalized language. Social workers all expressed that they felt the multiple sources of psychosocial support will play an important role in the children’s future development, but the most significant source of emotional support is provided from the foster mothers themselves...

*“...since that is where they gain a sense of belonging, and where they gain a safe space to start rebuilding trust and developing their psychosocial well-being”.*

The social workers also felt that it was the ultimate goal of the HFH network is to keep children out of the detrimental environments they come from and to provide them with positive alternative care with a dedicated parent which they considered better than a group institutional environment.

*“My favourite part about this job is seeing children thrive, children who are resilient and seeing them from when they come in, and change and develop over the first few weeks and months, that's one of the most rewarding parts of the job. Just showing me what a safe secure loving stable family life can do for children.”*

Two interview questions posed to the social workers also highlighted their appreciation and concern for the foster mothers. When social workers were asked about their fears and hopes for the foster mothers they expressed concern that the foster mothers would leave, since they are technically employees, not life-long legally-bound guardians of the children. They also expressed concern about the foster mothers’ own emotions and self-confidence. Social workers recognized the difficulty of raising 5-6 children, in a single household with a limited budget, in addition to physical health challenges and emotional toll of raising these children. They emphasized that the children need a consistent stable environment and that they worry that the difficult behavioural problems that the children present will be too much for the foster mothers to

raise the children through to adulthood. They also expressed that they hope the mothers recognize their own value, learn something from the experience, gain a sense of empowerment, and feel more like respected professionals in their field as carers.

<b>What do you most worry about for the mothers you support in the future?</b>
<i>“I worry that they feel overwhelmed and they will reach a point where they can't do it anymore, and I think my biggest concern is that they feel they haven't done a good job, that they feel they had to quit.”</i>
<i>“I suppose part of me for some of the mums who have been with some of the children for quite a while now I think I do feel sad for them if they child does leave or go back to the biological family because it would be like losing a child.”</i>
<i>“I hope that they feel that they've learned something from being a foster mother, that it enriches their lives and that they feel that they have learned something and that they can be a valuable member of society, to teach other moms and other individuals about what it really means to be a mother.”</i>
<i>“I think I hope that they get a sense of accomplishment from this, and I hope that they will realize that not everyone can do this and they should feel like special people because they are.”</i>

#### **4.3.5 The role of formal psychosocial support**

In addition to the emphasis placed on the informal psychosocial support provided by the foster mothers, social workers also placed significant value on the more formal psychosocial supports including therapy provided by social workers and psychologists. The social workers placed significant emphasis on their own role as a counsellor as they provide both children and foster mothers an encouraging environment to voice emotions that they may otherwise be unable or hesitant to express. Each social worker described her main role and responsibility to be a provider of general support and supervision to the homes and felt that the psychosocial support they provide is helpful to both the foster mothers and the children. The administrator also underscored the importance of social workers and the need for additional occupational support.

Select responses to a variety of different interview questions
<i>"I would like to have our own in-house counsellor to provide counselling for children and the foster mothers. Currently we just have social workers but I would like a psychologist or formal counsellor that is solely employed by HFH even if just part-time. Someone who has experience and an in-depth knowledge of abuse and a context-specific understanding."</i>
<i>"There hadn't been a social worker for several months in this community because the previous one had left so I noticed that they really like having that support, knowing there is someone there for them to talk to; both the mums and the children want that support and the reassurance is important for the mothers."</i>
<i>"I haven't had the chance to go in-depth counselling with the children yet. I prefer to support the children through the mothers, by giving mothers advice on how to address children's needs."</i>
<i>"I think a lot of the foster parents they are worried that they are doing something wrong, so providing a lot of reassurance and encouragement is really important."</i>
<i>"I think we do need more professional involvement with our children, like occupational therapists, psychologists, medical staff, especially specialists like ENT's [ear, nose and throat specialists] for the development of children. Ja, I think our biggest need is other professionals to get on board from HomeFromHome and into our homes, so that we can really provide [support for] the whole psychosocial development and really attend to all of their needs. But we [social workers] only have a limited scope of practice; we can only go that far."</i>
<i>"More personnel, occupational therapists, more special attention to FAS needs and children struggling in school, not just for excelling children."</i>
<i>"I think we are doing pretty well supporting the foster parents, the social workers see them [the children] once a week which is pretty high for any country. I think how we run the support groups and the topics that we cover are very good."</i>

#### 4.3.6 Challenges related to children's biological families

Reflecting the responses of the foster mothers, the social workers also identified biological family members and the multiple issues surrounding their involvement or lack of involvement as a major challenge. Their concerns were similar to those of the foster mothers, especially that there is a lot of uncertainty surrounding what will happen to the children when

they turn 18, the children's level of independence, and the potential negative impacts of returning to live with biological family members or returning to unsafe communities. They also mentioned that many children have difficulty dealing with the loss of family members and find it upsetting when viewing foster siblings have visitations with their biological relatives.

**Select responses to a variety of different interview questions**

*"I'm concerned about the children aging out. What will happen when the children reach 18 and its time to leave the homes? It is worrisome for all the parents and we are conscious as we are approaching this now for the first time. None of our children have yet aged out since we are a fairly new program. We are now in the midst of developing a program for moving children out of the homes which will involve individual assessment. Unfortunately the Children's Act cuts them lose at 18, for funded children's homes children are forced to leave at 18 but we have kept them longer currently. We need to ensure there is practical support and psychosocial support once they leave".*

*"I know the foster mothers are worried about what will happen to the children, that they will not be able to function or be independent, especially the children with special needs."*

*"I think regarding foster care, I think one of the policies that we struggle with, one of the laws, is the involvement of the biological parents, where they always have the right to have access to their children except if they pose a danger to their children then access with be denied. But it's very difficult for us when a biological parent comes and wants access to the child because we have to facilitate that access and it's difficult to explain to a child that hasn't seen their dad in 8 years why she has to now see her father..."*

*"I think for a lot of them, most of them, [the most difficult psychosocial challenge] is the biological families, I think quite a few of them have questions about their biological families that we can't answer, either because we don't know the information or because the information is not something you want to tell a child, like for example you don't want to tell a child 'oh you have a mum she just doesn't want you' so yea their family. And then a lot of our children have problems at school specifically concentration problems and I think a lot of them are quite frustrated about that, I think they know that they have these problems and I think they don't really know what to do about it."*

*"...some of them definitely struggle with issues with the biological family. Some them it isn't an issue but others it can be quite awful."*

*“...Experiences they’ve had in the past; abuse, neglect, FAS, impacts them largely and their development. I feel the removal [from biological family members] has played a significant role because it is basically the source of difference for these children, some still have biological parents, it’s very hard for them to be apart from them but it just wasn’t safe or healthy for them to stay where they were.”*

#### **4.3.7 The importance of community integration**

A theme related to the role of the community and the importance of community integration emerged from comments in responses to several interview questions and underscored the central theme of how important the social workers believe it is for the children to feel supported by and integrated into their local communities.

##### **Select responses to a variety of different interview questions**

*“The communities are mixed. Some are incredibly positive, children are embraced, feel normal and included. That’s on the positive side. On the negative side, children have been taken out of a chaotic or abusive home and remain in the same community. This can still influence them and be detrimental. If the abuser is still in the same community we will change their location.”*

*“In Masiphumelele they’ve got this thing called HopeToAfrica which is in the community; it’s fantastic they are making connections with positive role models who are actually living in the community so they get to see them regularly, but they also get involved in lots of drama and dance and things like that. So helping the kids have stuff like that locally is really more important than us putting on our program I think, because that’s something for them that’s actually makes them feel like integrated community members.”*

*“They can turn to the community for assistance including transportation, babysitting, the homes are well known and mums have good relationships with neighbours, the children play with other kids in the community. The community is also supportive of us being here, I think that they are happy people are watching over the children and the teachers feel reassured.”*

*In some communities the houses are part of the community and the community helps and supports them where in other places the houses are seen as something different or something to be scared of, that the children aren't allowed to play at other houses. So all communities see the homes differently and I think the big thing is that the children must feel that they are part of the community and that they are treated the same as all the other children in the community. That's one of the big roles of the foster mothers, is to educate and advocate their house within the community, I think some of the foster mothers are really struggling to do that but others it's easier for them. I think where there are two foster mothers close to each other it helps a lot because they can support each other every day.*

*For the mums that I support, the homes are quite isolated from the communities. I think the mums I work with aren't in communities that are so open[minded] so I think it's quite sad because they're not getting much support there from the community.*

*There's quite a lot of homes where the children are quite involved in a lot of community programs, like library club or drama club, those things are sort of normal family community life so the community has resources and opportunities available for them it's very good for their psychosocial development. On the flip side it's very detrimental when they don't have the community involvement.*

#### **4.3.8 Failing systems**

The responses from the social workers and the administrator reflected a generalised and strong concern that many South African systems are inadequate, in that they are failing the needs of OVCs. As expressed in some of the responses reported above, the social workers felt strongly that there is significant room for improvement in the legal, health, transportation, foster care, and education systems, and that each of these systems is crucial in supporting the healthy development of these children. Below is a collection of these responses that indicate frustration with the existing structures and service delivery failures for children and special needs children.

### Select responses to a variety of different interview questions

*"We need more support from outside social workers who specialize in different areas, court work, statutory work, since it's difficult to get reports and grants written. We need more support for interfaces; schools, hospitals, clinics; to improve these services would help out mums and the children. Health care is failing us; mothers would rather go to the pharmacy a lot of the time because they get better treatment and care. Education is also failing our children, the government is not providing these basic services, we are left having to try and do it all ourselves. For some of the children we believe to be special needs we can't even get them assessed let alone find them placements and the support that they need. So many children are falling through the cracks."*

*"It's difficult working with social development office and statutory social workers (for grants, court orders), can be quite frustrating."*

*"Need extra support in terms of occupational therapy, and physical therapy. Need to get some of the children into special needs schools because they have the resources to properly help them but this is a challenge to get them into these schools."*

*"...I think my biggest worry is the education, the South African education is really lacking and it is failing these children at this stage."*

*"FAS is a huge problem in South Africa, I think we have the highest prevalence in the world but we have absolutely nothing for these children... I don't think it's being recognized by government and so what's happening is these children are growing up to become adults who themselves are either just fading away back into the community and don't do anything or are becoming alcoholics themselves and creating another generation, so there isn't any help out there for them. I think policy makers need to actually recognize the problem..."*

*"I think for me, [the biggest need we have is] more resources... some of my children see occupational therapists (OT) and she [the therapist] does it for free but she can't afford to give assessments and then see the children for however many sessions to actually complete OT with them. And it's quite impossible to get them appointments at Red Cross because the waiting list is quite ridiculous. So getting someone on board who could either do it for free or for less [money] once a month and I think generally we need more help with education."*

*"I think my biggest worry with my children is the Fetal alcohol syndrome or ADHD because most of them are doing really badly in school and I find a lot of them can't do mainstream schooling but they are not disabled enough to get into special school, so they are falling through the cracks. So I'm worried about them because obviously if you don't have a good education it's very difficult get a good job so I worry about what's going to happen to them."*

*“I think it's not so much to do with the foster care but it's to do with the courts, and how in a perfect world if we had more convictions for child abuse. It's horrendous that not more of the family members and perpetrators are not behind bars. I've got two cases, a serious case that has been to court, and both were let out, and for me that's something I'd really love to see change. It's almost like a one-stop service that children get when they've been abused where they get off too easy and there's a need for forensics, judges, doctors and psychologists to get involved to take the case all the way through to trial. I don't feel like the legal system works, that nothing really changes, the children suffer, when I think some of the kids could stay with their families if the right things were in place. I think that's what policies need to focus on. Our [South African] Children's Act is really strong; we've got a new Children's Act in 2010; it's a really great act and it covers all aspects in modern policy but I feel that our justice department and our system aren't implementing it.”*

*“I think the mums struggle balancing all the different challenges including teenagers, finances, budgeting their money, and transportation. Often they have to get to the hospital or clinics. A lot of it is just about the children's behaviour and navigating the different stages of childhood development, and for some of them definitely issues with the biological family. But some issues are outside of their control.”*

This chapter aimed to provide a platform to present participant perspectives on the role of psychosocial support for orphaned and vulnerable children in South Africa. Specifically, it illustrated some of the central concerns, suggestions and opinions of a group of foster mothers, social workers and administration working for a South African NGO. The responses from foster mothers, social workers and program staff provided insight into some of their frontline experiences and included informed ideas on how to best support vulnerable children and the challenges they face in doing this. The next chapter will synthesize and analyze these responses in relation to the three central research questions of this study.

## 5.0 CHAPTER 5: DISCUSSION

This research set out to explore what the perspectives of frontline staff and caregivers on the psychosocial care of OVCs. This chapter will explore the participant’s responses in relation to the three central research questions; (1) what problems do OVC caregivers and program staff encounter in delivering psychosocial support; (2) what do they believe are the characteristics of the best forms and sources of psychosocial support and; (3) what do program staff and caregivers want policy makers to be aware of or incorporated into future policy developments regarding the needs of orphaned and vulnerable children? This analysis is then followed by a discussion of the c themes that emerged from all interview questions.

### 5.1 Challenges in Delivering Psychosocial Support

One of the primary focuses of this research project was identifying the challenges that OVC caregivers and program staff encounter in delivering psychosocial support. Table 2 summarizes some of the key challenges experienced by participants in their respective roles.

<b>Foster Mothers</b>	<b>Social Workers</b>	<b>Administrator</b>
<ul style="list-style-type: none"> <li>• Children’s behavioural/emotional problems</li> <li>• The foster mothers’ own psychosocial well-being</li> <li>• Managing the health and medical aspects of care</li> <li>• Providing for the family within a very limited budget</li> <li>• Managing the multiple tasks as a single parent, sibling disputes, &amp; difficult teens</li> <li>• The adjustment phase</li> <li>• The children’s biological family members</li> <li>• Concerns about the aging out process</li> </ul>	<ul style="list-style-type: none"> <li>• Building trusting relationships with the children and foster mothers</li> <li>• Communication and a language barriers</li> <li>• Finding the balance between being the confidant and supervisor</li> <li>• Dealing with biological parents, foster mothers, and managing complicated relationships</li> <li>• Challenges working with the Department of Social Development, statutory social workers, grants and court orders</li> <li>• Concerns about the children’s psychosocial functioning, future independence, the education system, and the unmet needs of children with FAS and ADHD.</li> </ul>	<ul style="list-style-type: none"> <li>• Finding the right staff (social workers, foster mothers, administration)</li> <li>• Being able to consistently monitor all levels of staff with limited resources</li> </ul>

As presented in the responses in chapter 4 and summarized in Table 2, the respondents revealed a series of challenges in their roles. The foster mothers frequently reported challenges related to parenting in general including: providing for the children within a very limited budget; handling teenagers and their difficult behaviours; and managing the multitude of tasks required for raising 5-6 children as a single parent. The challenges unique to foster parenting orphaned and vulnerable children included; handling the children's behavioural and emotional problems; dealing with the children's biological family members; having uncertainties and concerns around the aging out process; ensuring a comfortable adjustment phase for a new child, and managing the health and medical aspects of care (including transportation, dealing with poor medical services, and challenges of providing medical care themselves).

As previously discussed in the Methodology section of this thesis, the children placed into foster care at HFH were made vulnerable through various circumstances, including early childhood traumas such as sexual and physical abuse, neglect and parental loss, as well as through serious illnesses or disorders such as TB, HIV/ADS, and FAS. Although the psychosocial well-being of the children was not assessed in this study, both the foster mothers and social workers reported behavioural problems and emotional distress in the children in the HFH program. These behavioural problems were highlighted by both groups as one of the major challenges they face in caring for the children and as one of the major concerns for the children's future. In addition, both groups mentioned the children's learning problems and difficulties in school as areas of concern.

Another major challenge reported was the foster mothers' own psychosocial well-being resulting from the various challenges they must manage in their roles. The central suggestions made by foster mothers to help mediate these challenges included; increasing staff, volunteers, and home assistants; providing mothers with more leave time; increasing financial support; providing more motivation and positive feedback, scaling up group counselling sessions, and providing specific training such as HIV education, methods for dealing with behavioural problems, and grief counselling. The responses from both foster mothers and social workers made it clear that the issue of OVCs is not just a challenge experienced by the children themselves, but that caring for so many orphaned and vulnerable children is also a major strain

on the generation who is caring for them. Both the foster mothers and the social workers emphasize that caring for these children places significant stress on the foster mothers and the social workers supporting them. The responses from the foster mothers in this study draw a clear picture of the stress they experience and are reflective of caregiver burnout found in previous research studies with OVC caregivers. This further supports the argument for increasing psychosocial support for caregivers.

The four HFH social workers interviewed disclosed a series of challenges in providing psychosocial support for the children and foster mothers whom they support. Challenges reported included the initial trust building with children and foster mothers; the weight of emotional disclosures from children and mothers; language barriers and communication challenges; finding the balance between being the confidant and supervisor; handling confrontations with biological parents; and managing the complicated relationships between different adults and children were all reported as serious challenges. An overarching difficulty that social workers reported was the challenge of working within the confines of the social development office and frustration with the failures of service deliveries such as education, health care and legal support. Significant administrative challenges expressed by the administrator included finding the right staff (social workers, foster mothers, administration), and being able to consistently monitor all levels of staff with limited resources. While the respondents provided a clear picture of the challenges they faced in providing this support, they also expressed a strong understanding of the importance of providing psychosocial support for the OVCs in their care.

### *5.2 Best forms and Sources of Psychosocial Support*

It was evident that both foster mothers and social workers supporting OVCs in the HFH programme were highly aware of the importance of the role of psychosocial support for the children and also for the foster mothers themselves. Both groups articulated this in answers to questions that addressed psychosocial support and raised its role spontaneously in discussion of other questions. The responses that identified their opinions on the best forms and sources of psychosocial support are illustrated in Table 3.

<b>Table 3 Best Forms and Sources of Psychosocial Support</b>		
<b>Foster Mothers</b>	<b>Social Workers</b>	<b>Administrator</b>
<u>Forms (activities):</u> <ul style="list-style-type: none"> <li>• Children’s sessions with social workers &amp; psychologists</li> <li>• Play therapy</li> <li>• School</li> <li>• Youth programs</li> <li>• Church</li> <li>• Volunteer programs</li> <li>• Talking one-on-one</li> </ul> <u>Sources (people):</u> <ul style="list-style-type: none"> <li>• Themselves (foster mothers)</li> <li>• Social workers &amp; psychologists-</li> <li>• Foster fathers/ male role models</li> <li>• Church members or a priest</li> <li>• Staff from partner organizations/ community programs</li> <li>• HFH management staff, assistants and volunteers.</li> </ul>	<u>Forms (activities):</u> <ul style="list-style-type: none"> <li>• Counselling and support from; ChildLine, the Red Cross &amp; HopeToAfrica</li> <li>• Local community centres;</li> <li>• School and community sports and arts programs</li> <li>• Various programs provided by HFH (camps, youth groups, mentors &amp; tutoring)</li> </ul> <u>Sources (people):</u> <ul style="list-style-type: none"> <li>• Foster mothers</li> <li>• Social workers</li> <li>• HFH assistants</li> <li>• Community members</li> <li>• Mentors</li> <li>• Teachers</li> <li>• Other community programme associates</li> </ul>	<u>Forms (activities):</u> <ul style="list-style-type: none"> <li>• Partnerships with other local organizations and within the HFH family</li> <li>• Normal activities such as swimming lessons, that create a sense of inclusion in the community and build their confidence</li> <li>• Play therapy</li> </ul> <u>Sources (people):</u> <ul style="list-style-type: none"> <li>• Foster mothers</li> <li>• Social workers</li> <li>• External psychologists</li> <li>• ChildLine</li> <li>• Rape Crisis</li> <li>• Red Cross behavioural Unit</li> </ul>

The participants mentioned a variety of forms and sources of psychosocial support including; the sessions with social workers and psychologists, community programs such as sports and arts programs, counselling and support from other organizations including ChildLine and the Red Cross, as well as informal sources of psychosocial support such as school, church and simply talking one-on-one with children. One of the interesting findings was that all participants emphasized the importance of psychosocial social support, although in different terminology.

While the social workers explicitly stated that psychosocial support plays a significant role in the children’s health and development, the foster mothers emphasized the important role of ‘love’ and attentive care for the children. That is, quite understandably, the social workers articulated their opinions of psychosocial support in more theoretical “professionalized” terms, while the foster mothers spoke of their understanding in more personal and concrete terms. As

informal psychosocial care and support is defined as ‘support provided through interpersonal interactions that occur in caring relationships in everyday life, at home, school and in the community’ (Richter et al., 2006) , the foster mother’s understanding of the children’s primary need for “love” encapsulates theoretical conceptions of informal forms of psychosocial support.

Social workers articulated a more detailed and formal description of the best forms of psychosocial support and emphasized that the children need both informal psychosocial support coming from the foster mother, the family unit, and the community to enable a sense of belonging. Social workers also suggested that the children need better access to formal psychosocial support including psychologists, individual therapy, and specialists, especially for children with special needs or specific disorders such as FAS. Foster mothers did place value on the social workers and a few mothers expressed wanting more availability of psychologists for children but they more frequently expressed the view that what the children need most is love and care and that they themselves were the primary source of psychosocial support for the children. In general, the two groups expressed a very similar understanding of the children’s needs, but expressed them in different terms.

Both groups of the respondents were very aware of the challenges and problems experienced by the children in their care as well as the psychological implications of the traumas, loss, neglect, and serious physical illnesses they had experienced. Both the foster mothers and social workers recognized the behavioural problems and emotional disturbances as outcomes of the children’s personal histories and negative experiences. They also acknowledge the increased risk for future development of psychological health problems and the implications this could have on the children’s independence and success as adults. It was also very apparent from the interviews that both the foster mothers and social workers were very committed to the children and took their work very seriously with a high level of compassion and dedication.

*I worry most about their psychosocial functioning, that we don't address everything and that they will not be well functioning adults, I'm worried that they won't find their emotional balance that they need to, they don't find the education that they need to function one day, and I'm worried that when they leave their house that they cannot face the world, so I'm worried that we miss something along the way.*

The interview responses support the view that the theory of psychosocial resilience from the child development literature dealing primarily with victims of abuse of early trauma in western

countries is an applicable framework for understanding the needs of OVCs in South Africa. Although the responses of the foster mothers and the social workers were expressed somewhat differently by the two groups, each reflected an understanding of, and was reflective of, psychosocial child developmental theory.

### 5.3 Suggestions and Concerns for Policy Makers

The third research question of this study aimed to identify some suggestions and concerns of front-line staff and caregivers in respect to policy and future policy development for OVCs and their psychosocial health needs. Participants were asked what they would like policy makers who are aiming to support OVCs and their psychosocial development, to be aware of, or to consider when developing future policy. Table 4 summarizes the key recommendations and concerns expressed by participants.

<b>Table 4 Policy Recommendations</b>		
<b>Foster Mothers</b>	<b>Social Workers</b>	<b>Administrator</b>
<ul style="list-style-type: none"> <li>• Wanting more awareness about the difficulty of the job itself as a foster parent</li> <li>• The need for increased psychosocial support for caregivers</li> <li>• That providing love/support is the most important</li> <li>• Difficulties of keeping children in the same community</li> <li>• Wanting more group educational sessions for children and FMs</li> </ul>	<ul style="list-style-type: none"> <li>• Changes to legislation regarding biological parents</li> <li>• More follow up policies and assessments</li> <li>• Extra occupational therapy and physical therapy</li> <li>• Easier access to special needs schools</li> <li>• More facilities, recognition, and support systems for FAS children</li> <li>• Improvements to the legal system, more convictions for child abuse, better enactment of the children's act</li> </ul>	<ul style="list-style-type: none"> <li>• More support from outside social workers who specialize in different areas, court work, statutory work</li> <li>• Need more support for interfaces; schools, hospitals, clinics</li> <li>• Health care is failing us. Mothers would rather go to the pharmacy a lot of the time because they get better treatment than at hospitals.</li> <li>• Better education</li> <li>• Improvements to special needs support, very long waiting list</li> </ul>

When foster mothers were asked what they want policy makers to be aware of, the primary response was for increased awareness of the difficulty of the job itself as a foster parent

and the need for better support for caregivers. The foster mothers' responses highlighted the value and need for increased psychosocial support both in the form of informal psychosocial support (group sessions of mothers sharing experiences and advice) and formal psychosocial support (sessions with the social workers as well as parenting skills workshops that incorporate how to recognize and respond to children's different emotions and behavioural problems).

In discussions of policy recommendations with the social workers, their advice was geared more towards larger scale social services. The social workers explicitly expressed frustration with the gap between the rights endorsed in government policy and the actual implementation of these policies. The social workers highlighted the system-wide failures in services including health, education, legal, and social services that were impediments to meeting children's needs. The social workers and administrator expressed their frustrations with the legal system and its failure to convict child abusers; the foster care system and social services their failures to assess and follow up with the psychosocial needs of children once placed in alternative care; the education system and its failure to meet the educational needs of vulnerable and special needs children, and the health care system and its failure to address the various health needs of vulnerable children. The policies and implementation issues they pointed out were the need for OVC policy to widen its narrow focus on HIV/AIDS orphans, to consider other vulnerable children and address the large-scale problem of FAS in South Africa. They also expressed serious concern for the children and their future.

In addition to making specific comments regarding policy, participants mentioned their concerns in general for the children. Both foster mothers and social workers expressed serious concern for the children and their futures not only because of their OVC status but also given the scale of the overall social, political and economic problems in South Africa. As just mentioned, a fundamental theme of the social worker's responses was frustration with the gap between the frameworks and social policies (defined as rights) in place and the poor provision of actual services. The foster mothers also stressed these failures, not in the same way, but by describing their day-to-day struggles with the health, legal and education systems. The foster mothers mentioned their frustrations with the health care system and the gaps in services for themselves and the children.

Given the scale of the social problems and system failures experienced by millions of South Africans, these women are likely representative of a larger population of caregivers and social workers that share feelings of frustration and concern for the children under their care.

This research project did not ask the respondents for their perspectives on the political environment or assess their opinions on social activism; thus it is not possible to know specific ideas they have on avenues for affecting change or determine their level of mobilization and political involvement. However, given the fact that the South African constitution guarantees social and economic rights, it is understandable that the social workers and foster mothers might focus their efforts and frustrations on demanding the implementation of services, rather than on broader political or social activism. Focusing on the politics behind the challenges may seem pointless to these women when there is already specific legislation in place. The social workers in this research study did, however, suggest as a priority the need to address the gap between policy and implementation. What is certain is that there are significant obstacles and barriers for those who are committed to developing effective change and ameliorating the future for millions of OVCs.

In spite of the significant policy initiatives by governments, international agencies and civil society actors, the foster mothers and social workers report that there are significant gaps between these policies' aspirations and the reality of service provision on the ground. Furthermore, although there is a general consensus in policies on the importance of programs to promote psychosocial development in OVCs in South Africa, there is no clearly defined framework of unified guidelines, goals, policies and programs to achieve the goals. Since this study has revealed that this group of frontline staff and caregivers feel there is a large gap between high-level policy intentions and actual implementation practice on the ground, it may be reasonable to suggest that policy makers should consider investigating why this gap is occurring.

#### *5.4 Identified Themes*

In addition to the interview questions that specifically targeted the three central research questions, participants were asked a variety of questions to ensure that they had the opportunity to discuss a wide range of opinions and ideas on the role of psychosocial support. From these

responses several themes were identified in the research findings (Chapter 4). Similar themes emerged for both groups of respondents, for example both groups frequently mentioned biological families as a major challenge. The similar themes from both groups are grouped together so that conclusions can be made from participants as a collective group. The variety of emerging themes are grouped into the following sections; the role of psychosocial support, alternative forms of caregiving, the connection with child development theory, the different forms of alternative childcare, the role of community and the church, the gap between policy and implementation, gendered issues, the aging out process, and issues concerning biological families. These identified themes warrant further investigation as they may be considerations for closing the gap between policy and implementation and contribute to the development of support services and policies for OVCs. The following section will lay out a series of identified issues and set out the central conclusions that can be made based on the findings and analysis of this research.

#### **5.4.1 The role of psychosocial support**

An analysis of the respondent's experiences, opinions and concerns on the role psychosocial support suggests a few potential avenues for consideration and further research. At the program level, specifically for the HFH organization, this study suggests that there are various potential avenues to strengthen support for both OVCs and caregivers. The first is through increasing the availability and access to psychosocial supports for both children and foster mothers. The foster mothers and social works in this study all placed a significant value on psychosocial support for the children they supported. These findings reinforce research that underscores the need for increased provisions of psychosocial support systems for OVCs in South Africa and elsewhere. While it is crucial for OVCs to first be placed in safe environments and receive basic needs such as food, shelter, and supervision, without also providing some form of psychosocial support many of these children will be at a high risk for the development of mental health problems and poor psychosocial well-being. The participants concern for the future of these children, specifically their mental health, education, community integration, and future independence argues for increased attention and focus on avenues to ensure the

psychosocial development needs of OVCs are met. Connecting these perspectives to the OVC literature, it could be argued that supporting the psychosocial health needs of OVCs is an important component needed to break the interconnected negative cycles of OVCs, disease, mental illness, poverty, violence, crime, unemployment and poor access to basic services. Breaking these cycles are necessary to increase development at the individual, community and nation-wide level.

Furthermore, in recognizing the psychosocial support needs of vulnerable children it is also very important that the needs of those providing psychosocial support, specifically here the foster mothers, are supported. The reported high incidence of stress and burnout in the general population of OVC caregivers, as well as the foster mothers' own suggestions for increased support groups merit further policy consideration of the role of informal and formal psychosocial supports for caregivers. In this study the foster mothers frequently mentioned the value of having group sessions with other foster mothers and requested more opportunities for these sessions. Foster mothers stated that these sessions are extremely helpful, and that even in sessions that occur without a social worker or formal counselling, it is extremely therapeutic to share stories with other foster mothers who can relate to their own experiences.

HFH may want to explore opportunities to create or increase informal support sessions for foster mothers within local communities. This could simply suggest the need to provide the logistics for group sessions i.e. transportation, venue, childcare and planning. One participant made the suggestion that these can be spearheaded by the foster mothers themselves. She emphasized that sessions without social workers can be very helpful because they allow foster mothers to freely share similar experiences and support one another. As the social workers pointed out, sometimes it is difficult for staff to manage the role between supervision and support, while maintaining a trusting relationship with foster mothers. At HFH, this is also coupled with the issue of language barriers for some social workers. This suggests that foster mothers may not feel as open discussing detailed experiences and daily challenges with social workers. Exploring avenues for foster mothers to engage in more frequent group sessions to support each other is arguably a promising consideration for reducing caregiver burnout. This may prove to be a cost-effective option to increase informal psychosocial support for caregivers.

The same strategy of having self-directed groups for children could also be a low-cost opportunity to increase psychosocial supports for children. At the afterschool programme of HomeFromHome, the Educare centre provides an opportunity for group sessions with older children that could be peer mediated, or supervised with the on-site social worker, foster mothers or even volunteers. Perhaps even a discussion with the children about what they see as potential opportunities for group counselling would provide further ideas to support children's psychosocial development. Further research is needed to identify the most cost-effective and best forms of psychosocial support for both caregivers and children.

#### **5.4.2 Child development theory**

This research was based on central concepts of resilience and psychological child development. The participants' responses from this study are in line with the existing child development literature that suggests positive socio-environmental characteristics are associated with better mental health outcomes in children who have experienced early life traumas. The care and support provided by the foster mothers, the social workers, the HFH Program, and associated organizations, can be considered as the provision of formal and informal psychological and social-environmental supports. The safe and supportive family homes provide an environment for children to develop psychosocial buffers that may significantly reduce the risk of these children from developing serious psychological disorders in later-life. Both groups of participants clearly felt that this is the case. The foster mothers emphasized that the most important part of their role is to provide love for the children and mention that, over time, the children are able to cope with their past. Two of the social workers in fact directly referred to aspects of child development theory and mentioned attachment styles as well as how the program is providing a stable environment for these children to develop positive psychological health.

The challenges the participants described illustrate the importance of identifying and evaluating the buffers that would benefit these children. The foster mothers' daily experience supporting the children and the characteristics they identified as the best forms and sources of psychosocial support also provide insight into the specific psychosocial buffers that may create resilience in OVCs. The social workers' frequent integration and counselling sessions with the

children also provide the social workers with a credible perspective on what particular factors support the development of healthy psychosocial well-being in OVCs. The challenges identified, as well as the best forms and sources of support expressed by participants may be useful areas of consideration for those interested on increasing psychological resilience in OVCs.

### **5.4.3 Different forms of alternative child care & determinants of vulnerability**

A central consideration for examining the role of psychosocial support is the value that frontline caregivers and staff at HFH place on the role of the foster mother and what this says about foster care in general. The emphasis placed on the role of the foster mother may suggest that these participants believe that family-unit foster care creates an environment that is more conducive to healthy psychosocial development for OVCs than institutionalized group care. Although the role and demographics of foster parenting versus institutionalized care has been well researched internationally, the psychosocial implications of the different forms of alternative care in South Africa have been the subject of only a limited body of research (UNICEF, 2010a).

Furthermore, research is necessary to better understand opinions of frontline caregivers, social workers, and children, as well the placement procedures of children into different forms of care. Specifically in South Africa, abandonment rates and the consideration of the common conception that orphanages provide superior care for children warrants further research. In order to determine the role and effectiveness of foster family units in comparison to institutionalized children's homes in supporting psychosocial development it will be necessary to determine the proportion and numbers of children placed in these different systems, the structures of these systems, and to follow the long term development of the children. Unfortunately, this information is not currently available. Hopefully better data collection and information management will enable the identification of the most successful programmes for the care of vulnerable children in South Africa. UNICEF has recognized that this is a priority and is promoting this research in South Africa. This research study supports the argument for increased research and data collection of the different forms of alternative care in South Africa, with a

specific need to further explore the role of the foster mother that was noted by the participants of this case study. This consideration is further explored in Appendix 1.

Similarly there may be a need to better understand how and why children are placed into different forms of care and the different determinants of orphanhood and vulnerability. The children supported by HFH were noted to have been made vulnerable and orphaned by various factors including FAS, TB, and sexual, physical and mental abuse. While it is important to ensure that vulnerable children who are placed into alternative care have the right and ability to keep their personal histories and experiences confidential, it is also extremely important to have appropriate information management systems in place to collect and manage data on children placed in formal care.

The South African Children's Act and the SA Government recognize that to identify best strategies for intervention and to provide the best forms of support for the millions of OVCs, having an accurate understanding of the challenges is imperative. One such challenge is the fact that the HIV/AIDS epidemic has drawn international attention and attracts substantially more funding than less-well researched contributors of vulnerability in children (Moses & Meintjes, 2010). It is also crucial to address and incorporate into policy the other illnesses and causes of vulnerability for large numbers of children including FAS, TB, child abuse, and children with disabilities and special needs. Accurate records of determinants of OVCs are needed to inform the policies and procedures for supporting vulnerable children and their development. Particularity it warrants further investigation to inform the foster care systems, institutional centres, and best practices for training professionals and caregivers supporting OVCs.

#### **5.4.4 Role of the community and the church**

Another area that warrants further consideration is the role of the community and potential opportunities to increase community engagement. Many of the participants stated that it is important for the children to feel a sense of belonging within their homes, schools and communities. Avenues for such involvement include engaging with community churches, schools, after-school programs, and existing organizations, as well as creating initiatives to increase community awareness and education on the role of the foster homes. A few foster

mothers disclosed that they felt their community was not accepting of them, and that there is still a lot of stigma and poor education around HIV/AIDS. In contrast, other foster mothers said their communities were extremely accepting and supportive and that this assistance was a major support. Providing education and awareness to community members on OVCs can reduce stigma, and increase availability of informal supports.

A similar theme that was identified in participants' responses was the significant role of the church community. Several of the foster mothers listed the church and church members as one of the most significant sources of psychosocial support for both themselves and the children. A number of foster mothers also mentioned the church as playing an important role in the community for supporting them and their efforts as well as the psychosocial needs of the children. One foster mother mentioned her belief in God as an important support for herself and hoped that the children would share this belief. They also listed the church as the main source of recruitment into the HFH programme. These multiple roles of the church are significant when discussing the importance of addressing context specific environmental factors of OVCs in cross-cultural settings.

Whereas the researcher comes from a highly secular background, the foster mothers and the HFH organization itself adopt a religious framework that is structured around Christian values. When the organization started to expand from the initial few homes in Khayelitsha, it spread to new communities through local churches and community centres. HFH also advertises the foster mother positions as a religious ministry rather than a job, to ensure foster mothers are invested in the children and are not solely motivated by financial compensation. The church might also have the potential for providing additional psychosocial support through avenues of informal counselling, moral guidance, community engagement, and even additional educational, financial and social support for OVCs and foster mothers.

This is not to suggest that religion and the church are necessary components of psychosocial support; it is, however, to suggest that the role of the church should not be overlooked when developing interventions for OVCs or placing them in foster care. The church in South Africa and elsewhere may in some situations act as a psychological buffer, providing community support and inclusiveness (Kim, 2008). In other contexts it may act as a negative body that is not understanding or accepting of OVCs such as having stigmatized views of

orphans or HIV-positive persons (Kang Dufour et al., 2013). The apparently positive role of the church reported by the foster mothers at HFH suggests the church may act as a significant source of psychosocial support for OVCs in South Africa. The church may also be a valuable consideration for exploring innovative avenues of programme implementation, education, awareness raising and recruitment to support the psychosocial needs of OVCs. Responses in this study indicated that this might be the case.

#### **4.4.5 Gap between policy and implementation**

A central consideration this research has identified for policy development is that there is a need to address the gap between policy and implementation in South Africa. The participants frequently expressed that their needs are not being met on the ground. It is important that the obstacles preventing the implementation of the high level policies are identified and mitigated. Several participant expressed the issue is a lack of resources, which suggests there is a need to identify ways to ensure front-line staff have the necessary resources to deliver on their commitments. This applies to all levels of implementation; foster mothers, social workers, program administration, organizations, provincial and national departments, which all require adequate finances and resources to implement their policies and procedures. Recognizing the budget constraints of the South African government and the multiple on-going social issues, it is probable that limited finances and stretched resources is a key issue. Identifying the specific areas that are not properly equipped is a first crucial step to filling this gap.

Similarly, the participant's frustrations with the system wide failures of transportation, education, health care and legal systems within the context of the South Africa economic challenges suggest there may be a larger scale issue of funding that is unlikely to change in the short term. This emphasizes the need of further commitment to identifying cost-effective solutions for improving the access and quality of basic social services, as well as the psychosocial supports for OVCs. In addition to identifying cost-effective solutions, there may also be opportunities to bridge this gap through policy analysis and development. The problematic areas of policy that were identified in this research were the policies surrounding gender, the aging-out process, and biological families.

#### **5.4.6 Gender issues**

The central gender conclusion that can be made based on the findings of this study, is it that more research is needed that examines the role of gender in OVCs and OVC psychosocial care, as well as further investigation into solutions for gendered challenges. For example, research that investigates the causes and outcomes of the high amounts of violence against women could identify avenues that will decrease the number of OVCs. Based on the responses from the foster mothers and social workers at HFH, the most frequently reported gender issues were: concerns about girls being raped, girls having early or unwanted pregnancies, and the lack of father figures for the boys. The existing research, along with the concerns expressed by respondents of this study, could suggest that the HFH program and other foster care programs would benefit from providing additional information and program support to ensure gender concerns are addressed and that the potential risks or harms are prevented. The findings also support the need to consider gender in future OVC policy development and programming. Taking into account the participant responses, this study proposes that there is a need to specifically examine; the role of males and father figures in OVC care, the role of sexual violence and OVCs (including unwanted pregnancies, FAS, abandonment, and cyclical violence), early or unwanted pregnancies in OVCY populations, and gender mainstreaming policies for psychosocial support.

Another high-level gendered conclusion speaks to the female burden of caring for OVCs. Cross-culturally the responsibility of child care has most frequently fallen into the hands of women, and in places with serious orphan-care crises, this gendered burden has only intensified the feminization of care (Akintola, 2006; UNAIDS, 2004). In developing and developed countries alike, there is an on-going perception that this feminization of care is normal and natural, and it is even often embedded in policy and procedures. For example, although HFH allows couples to apply to be foster parents, they only advertise caregiver positions to women. This could be due to concerns about protecting children from male child abusers and pedophiles. However, it could be argued that if there are effective screening measures for women, these measures or even specifically tailored screening measures for males, should be sufficient and effective. Another consideration is the fact that a man who is employed by an organization such

as HFH would be more frequently monitored than males in the general public. Furthermore, it could be argued that including men in the orphan care crisis may be an avenue to challenge and transform social norms. Specifically, male involvement and education could diminish the negative attitudes towards women and children, which perpetuate the widespread violence and abuse. Because women and children, and especially young girls are at such increased risks for a variety of negative outcomes and challenges, gender mainstreaming and intersectionality are frameworks that warrant further exploration of the problem of OVCs and psychosocial health in South Africa.

The numerous risk factors that contribute to the problem of OVCs in South Africa such as HIV/AIDS, poverty, crime, violence, FAS, TB, and poor access to healthcare and education are also heightened risk factors for females in developing countries. A better understanding of the compounding impact of these multiple risks on women and OVCs is needed. Noting these interconnected variables emphasize the need to analyze the problem of OVCs and their development needs from a multidimensional framework. One such framework that would allow an exploration of these multiple interconnected, and compounding factors is intersectionality. Intersectionality has emerged in feminist theory as an analytic strategy to address the interrelation of multiple, crosscutting power relations such as race, class, gender, and sexuality (Brenner, 2000). It aims to investigate the how these different social locations build upon each other and how they shape individual experience and identity. For example an individual who can be characterised as a female, a person of colour, a person living in poverty, a victim of abuse, with an HIV positive status, will have an ‘experience and identity’ different than a female with different power relations. If women of colour are at increased risk of living in poverty, and victims of abuse are at an increased risk of psychological illness, and HIV positive persons are at an increased risk for lower educational attainment, what is the intersectionality of these crosscutting identifiers? Intersectionality may be an appropriate framework for further research examining the role of gender in OVC populations and for predominantly female caregivers in South Africa.

#### **5.4.7 The aging-out process**

The foster care system and the specific policy around the aging-out process were frequently reported as a major concern for the foster mothers and the HFH personnel. Many participants also said that children often asked questions about what would happen to them after they turned 18. These concerns are not unique to the HFH organization. As discussed in Chapter 2, there are many issues of contestation and complexity regarding the aging-out process of foster children in South Africa. Acknowledging the complexity of the aging-out process, it is understandable why foster mothers frequently reported confusion and concern about the aging-out process. It is also likely that this is a common concern shared by other caregivers outside the HFH organization. The majority of foster parents in South Africa are not supported by an NGO such as HFH, and must navigate the policies and procedures through the Department of Social Development. This suggests that they would not have such easily accessible support and direction on the options available for children once they turn 18. Further research is necessary to determine the scale of the expressed concerns, if the existing foster care policies reflect the needs of caregivers, and if the policies and procedures are clear and accessible to all caregivers.

Although HFH will have to adhere to the national laws and procedures for children turning 18, there are opportunities to consider for decreasing confusion and anxiety around the aging-out process. These include the development of specific aging out policies (specific to the organization), creating detailed guidelines for policy implementation, and providing clear explanations to caregivers and even children on these policies. The HFH NGO mentioned that because they are a fairly new organization they have not yet had any children leave the foster homes or go through the aging-out process. Defining the specific ways in which they will implement national foster care policies may prove to be highly beneficial for children, caregivers and staff.

Although the existing foster care policies are quite complex and are often challenging to implement, it is also important to note that the South African policies for foster care and the aging out process are relatively progressive. The challenges of providing a properly functioning foster care system are not unique to South Africa (Day et al., 2012; Denault, 2012; Megahead & Cesario, 2008; Okpych, 2012). However, considering the substantial number of orphaned and

vulnerable children in South Africa and the high prevalence of HIV/AIDS, TB, FAS, and child abuse, there may be a greater need to develop specific national policies and procedures to ensure the system is effectively supporting OVCs into adulthood.

#### **5.4.8 Biological families**

A similar theme that relates to the concerns expressed about the aging-out process involves the living biological family members of the children. Several participants expressed concerns that children may return to unsafe or unhealthy environments in order to live with their biological relatives after they turn 18. Specifically, there is fear of children returning to unsafe communities or returning to live with previous abusers. Other challenges related to biological family members were the current and on-going relationships between children and their families. A few foster mothers gave detailed accounts of the challenges biological parents pose; including issues of money, nutrition, tracking children's location and general confrontation. Another concern was about visits by biological parents and the impact on different children. Both foster mothers and social workers felt it was difficult for children who do not have biological family members, and said that witnessing foster siblings have visits with biological family makes some of the children very jealous. Participants explained that this experience is quite upsetting for children. They also mentioned that many children have questions about what happened to deceased or disconnected family members, and foster mothers are unable to provide informed responses or support.

These concerns suggest that understanding the various challenges posed by living biological families may require consideration of the development of specific policies that could mitigate such challenges. For example, HFH may want to explore options for visitation procedures, targeted counselling for children regarding biological families, policies for the amount of disclosure to foster mothers and children about biological family history, and specific training or parenting workshops for foster mothers on how to manage these challenges.

## 6.0 CHAPTER 6: CONCLUSION

This research explored the experiences, opinions and concerns of a group of social workers and foster mothers working directly with orphaned and vulnerable children in South Africa regarding the available psychosocial support and needs of these children. The case study and the exceptional women who provided their personal accounts and experiences provide a new contribution to the OVC knowledge base for policy makers and program providers. The findings may be of direct value for the HomeFromHome NGO, and other organizations that recognize the psychosocial development needs of OVCs such as REPSSI, UNICEF and the Department of Social Development. The identified challenges, concerns and suggestions contribute to the research gaps in frontline perspectives, and the identified themes for further investigation may prove to be beneficial for policymakers, funders, NGOs, and government departments at both the local and international level.

This qualitative case study focused on the following central research question: what can the experiences, opinions and concerns of OVC caregivers and program staff tell us about psychosocial support and the role of psychosocial support programs for OVCs in South Africa? More specifically, it focused on identifying: 1) the problems OVC caregivers and program staff encounter in delivering psychosocial support; 2) what they believe are the characteristics of the best forms and sources of psychosocial support and; 3) what program staff and caregivers want policy makers to be aware of or incorporated into future policy developments regarding the needs of orphaned and vulnerable children.

All respondents emphasized the importance of psychosocial support for the children and identified the foster mothers (i.e. having a family-unit with a dedicated caregiver) as the most significant form of support for these children in foster care. In addition, foster mothers indicated that what they needed most was to strengthen their own capabilities to support the children through increased psychosocial support for themselves in the form of group sessions of counselling, education and skills training. Both the social workers and foster mothers emphasized that their biggest concern for the children is the children's future independence and psychosocial well-being after they are released from care at the age of 18. Social workers expressed frustration with the failures in system delivery that result in inadequate provision of

basic care for children, for example, the legal systems that are failing to convict child offenders, the education system and how it is letting children fall through the cracks, and the foster care system that is not adequately monitoring or following up with children to ensure safe and healthy placements.

Consistent with previous research, the participant responses highlighted the emotional and behavioural challenges faced by caregivers of the OVCs. Responses indicated a keen awareness and insight into the importance of psychosocial support for these children and the many levels at which this psychosocial support is needed. The foster mothers and social workers were also very aware of the challenges of providing this support. While not necessarily articulated in formal, theoretical or professional terms, the responses were consistent with current theories of psychosocial buffers and resilience. The conceptual framework of child development proved relevant for considering the implications of these responses and for discussing psychosocial support for OVCs. South Africa has developed and approved policies, frameworks, and programs for the care of OVCs, which include recognition of the need for psychosocial support. The participants of this study illustrate, from their direct first-hand experience, the many challenges in implementing these policies and providing the level of support needed by these OVCs.

Known research gaps include exploring the factors that exist to reduce caregiver burnout; opportunities for child-participant research; longer-term research that follows children into adulthood and examines the aging-out process for OVCs in alternative care; and the role of gender in OVC psychosocial development. Several areas warranting further research that were identified in this study also include; the gap between policy and implementation, the role of the community and the church, alternative and best forms of child care, and the issues surrounding living biological family members. To ensure that policy and development initiatives are having real impacts, it is important that research continues to evaluate the effectiveness of policies and programmes on real outcomes for those whom they are designed to assist. This research also underscores the importance of listening to the advice and needs of those directly involved in providing the support to orphaned and vulnerable children in order to improve program effectiveness and provisions of psychosocial supports. This includes foster mothers, social workers, administration, directors, and of course children themselves. Incorporating participants

and front-line staff into policy developments and program delivery, and monitoring, is necessary to guarantee efforts and resources are being used to their best capacity, and helps ensure that policy translates into real impacts on the ground.

## APPENDIX 1 - Different Forms of Alternative Child Care

One of the themes that emerged strongly from responses from both the social workers and the foster mothers was a view that the stability of having a foster mother who cares for them on daily basis and who is the main source of psychosocial support was extremely important. As each participant stressed the importance of children having a foster mother or an attentive individual caregiver, this suggests they would not believe group homes would be the best forms of alternative care for OVCs as orphanages do not typically have enough caregivers for daily individual care, love and attention.

The original design for this research included a comparison between an NGO that acted as an orphanage and the HFH NGO that acts as a small foster care system. Due to the unsuitability of the orphanage programme, it was not possible to conduct this comparison or come to any concrete conclusions regarding the different forms of alternative care. Respondents were not directly asked for an opinion on orphanages, or to compare the two forms of alternative child care; however, both foster mothers and social workers expressed a strong view that these children require individual attention and benefit from having a parental figure(s) with a home that creates a sense of belonging. Although it was not directly stated and may be a speculative assumption, it is arguable that their responses reflected an implicit opinion that foster family units provide better psychosocial care for OVCs than institutionalized group children's homes.

[Who provides the most significant psychosocial support for the children]:  
*"Myself (foster mother) first. Then church. But it's me, they are like my children, it's like they are mine. I tell them to talk to me so I can help, I take them to the park to play, and they come with me to church. Even the neighbours' children come to talk with me sometimes. I am happy to help them, I am so happy because they take me as their own mother."*

[Who provides the most significant psychosocial support for the children]:  
*"Myself, [foster mother] and their foster father. Emotionally I feel we support them because I am with them all the time. I know each one's different face when it's showing what's wrong."*

[The most important part of my job as a foster mother] *"...is to take care of the children, to love them and to be there for them. Every day I must treat them as my own. Love is the most important thing, they must know love. Some of them did not learn love from their biological mothers, some of them have no parents and now they've got anger. Don't just say, you must show it."*

*"It is very hard for them. We must look after them properly, if they have a shoulder to cry on they can forget [their past and their HIV status]. They are children, you must show them they have a mother they need love. Some of them have lots of anger."*

*“Most of our houses, the children get support on all the psychosocial levels, it’s not just emotional support, we try to send them to schools where they get the needed support, and the educational support that they need. I think the biggest emotional support that they get is at the foster home, with their foster mother because that’s where they get that sense of belonging, feeling that this is my house now, I can start to rebuild what I lost, they need to be in a safe space.”*

These responses are in line with existing literature that suggests foster-home style care may be better for the psychosocial development of OVCS. A substantial body of research argues that family unit foster care creates an environment that is more conducive to healthy psychosocial development than institutionalized group care (Garvin et al., 2012; Johnson et al., 2006; Smyke et al., 2002). Other research emphasizes the detrimental effects of institutional group care. Orphanages and ‘child and youth care centres’ are usually unable to provide a level of individual attention since there are typically more children living in a large group setting with multiple caregivers who provide rotational supervision (Smyke et al., 2002). The multiple rotating schedules are not conducive for focused attachment relationships between a child and caregiver and disrupt healthy psychosocial development (Smyke et al., 2012).

Institutional deprivation, a term applied to a child’s social and emotional deprivation that occurs from the lack of an attentive individual care occurring in institutionalized children’s homes, is widely reported to lead to higher attachment disorders, psychological disorders, and delayed development (Bowlby, 1952; Chisholm, 1996; Rutter et al., 2007; Smyke et al., 2012; Spitz, 1945). For children adopted out of institutional care, parenting quality can moderate the effects of early social and emotional deprivation (Garvin et al., 2012). This suggests that re-placing previously institutionalized children into foster homes with an attentive caregiver may mediate effects of emotional deprivation and poor attachment.

Each of these studies underscores that foster care family homes are better environments for the healthy psychosocial development of OVCs. A 2010, an exploratory study examining the provision of residential (institutional) care for children in South Africa found that many social workers believe institutionalized care is better for OVCs. Moses and Meintjes (2010) reported that children in South Africa are often placed in institutional care by social workers because they believe that this type of placement is the best option for HIV-positive children (Moses & Meintjes, 2010). Residential facilities were understood by the majority of social workers in the study to be better equipped than families to provide safe and quality care for an HIV-positive child. As a result, attempts to return HIV-positive children to their own families or to secure alternative family-based foster placements were infrequent (Moses & Meintjes, 2010).

Although some research has found that social workers in South Africa place more value on group institutionalized care, the social workers at HomeFromHome seem to have the opposite opinion. The HFH social workers placed great value on family style foster homes for vulnerable children. This difference could be due to their experience working with HFH and the supports and programs they provide to each family and foster mother. HFH provides direct psychosocial

support services for the children and foster mothers with parenting skills workshops, relevant information sessions, assistance with medical care, support group sessions, and individualized counselling from the social workers that target the psychological and specific health needs of the children and mothers. This extra support may not be readily available for most foster families in South Africa.

In order to determine the role and effectiveness of foster family units in comparison to institutionalized children's homes in supporting psychosocial development it will be necessary to determine the proportion and numbers of children placed in these different systems and the structures of these systems and to follow the long term development of the children. Unfortunately, this information is not currently available. Hopefully better data collection and information management will enable the identification of the most successful programmes for the care of vulnerable children in South Africa. UNICEF hopes to assist the South African government in identifying these 'best practice' models to inform the development of national policies and guidelines on cluster foster care support, early intervention, and prevention programmes. It will be beneficial for these initiatives to include the experiences and suggestions made by those working directly with OVCs such as the participants in this current study.

## APPENDIX 2 - Interview Questions for Foster Mothers

---



### **Thesis Title:**

**Caregiver Perspectives on Psychosocial Support  
Programming for Orphans and Vulnerable  
Children in South Africa**

### **INTERVIEW QUESTIONS & GUIDELINES**

**Cherie Martin**

University of Ottawa

MA Globalization and International Development

### **Introductory Questions/Comments:**

- Molo Mama, Ndiyavua ukukwazi.
- Ndingu Cherie, unjani?
- Ndisafunda ukuthetha isiXhosa
- Enksoi
- Thank you very much for agreeing to talk with me and setting aside your time today to help me in my study.
- Outline what will occur; before we begin I want to take some time to make sure you are comfortable participating in this interview, so we will first go over the consent form and then we will begin the interview which should take no more than an hour. Feel free to stop me to ask questions at any time.
- Time estimation 1 hour
- Provide informed consent form; go over it with them.
- Do you have any questions before we start?
- I will be recording the conversation and taking a few notes as we talk, is this fine with you?

### **Interview Questions: For Foster Mothers**

1) I'd first like to ask a few general questions about what you do here at Home from Home.

- When did you start working here?
- How did you find out about HomeFromHome and why did you choose to work here?
- What are your main responsibilities? Please describe your job to me.
- How many children are in your care?
- Did you have special training for your position?
- What is your favourite part of this job?
- What do you think is the most important part of your job?
- What do you believe is the main goal of the HomeFromHome Program?

I'd now just like to explain that my study is focusing on psychosocial support. There are many different definitions for the term psychosocial but I want to let you know which definition I have decided to use. Please let me know if this is unclear.

The 'Psychosocial' (developmental needs for children): are the things that children need in order to develop into healthy, happy, creative, and socially functioning individuals who have healthy relationships and positive hopes and goals for their futures.

So essentially it is the psychological, emotional, and the social aspects of care and support for the children. When we talk about psychosocial support you can think of it as "emotional support".

A lot of research focuses on education, food, finances, housing, or medication, but studies have shown that the psychosocial aspects of development are also extremely important.

Do you have any questions about the term psychosocial?

2) How do you think the impact of losing family members because of HIV/AIDS has affected the children's psychosocial well-being?

3) Do you think providing psychosocial (emotional) support is an important part of your job?

4) Who (people) do you feel provides the most significant forms of psychosocial support for the children? Feel free to list yourselves, and as many others you feel are most relevant.

- If unsure use example prompts (friends, church, biological family, teachers, neighbours, social worker, etc.)

5) Do you feel that your community is supportive of you?

6) What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being of the children?

- If unsure: use prompts (workshops, church, talking to children about feelings, family conversions, one-on one conversations)

7) What do you find the most challenging aspect of your role a caregiver/staff member?

- How do you manage this challenge?

- Have you shared this challenge with the social worker or any other staff at HomeFromHome?

8) Whom do you talk to when you feel overwhelmed?

9) The last time you saw a child get emotional (sad, angry, scared), to whom did that child turn for help?

10) Do you speak to your children about their emotions?

- 11) Do you speak to your children about HIV/AIDS?
- 12) How do you feel when you talk to the children about these issues? What is that like for you?
- 13) What have the children said they have the most difficulty with?
- 14) Do the children express their own concerns about their future with you?
- 15) What do the children say they are most worried about in the future?
- 16) What do you most worry about for the children you support in the future?
- 17) What do you most hope for the children in your family/program in the future?
- 18) Do you have any ideas or suggestions of what else you would like made available to yourself or other staff/caregivers that would strengthen your own support efforts?
  - Prompt: Do you have any suggestions of how support in general could be provided more effectively?
- 19) Based on your own experience what would you most like policy makers who work to support vulnerable children in South Africa to know about the needs of orphaned and vulnerable children of HIV/AIDS?
- 20) Is there anything else you would like to say here in this interview?

### **Debrief & Final Questions**

That concludes the questions for this interview. I would like to sincerely thank you for your participation and for sharing your thoughts with me.

Do you have any questions for me at this time? I would be happy to answer them for you.

Please remember that your responses will be kept confidential and anonymous. I will leave you with this copy of the consent form and you can always contact me via telephone or email.

When I have completed my written thesis a copy will be provided to your organization and if you would like your own copy feel free to contact me directly.

Thank you again for your participation. I sincerely appreciate your time and willingness to assist me in the research project.

**APPENDIX 3 - Interview Questions for Social Workers**



**Thesis Title:**

**Caregiver Perspectives on Psychosocial Support  
Programming for Orphans and Vulnerable  
Children in South Africa**



**INTERVIEW QUESTIONS &  
GUIDELINES**

**Cherie Martin**

University of Ottawa  
MA Globalization and International Development



## Introductory Questions/Comments

- Time estimation 1 hour
- Provide informed consent form; go over it with them.
- Do you have any questions before we start?
- I will be recording the conversation and taking a few notes as we talk, is this fine with you?

## Interview Questions: For Social Workers

1) I'd first like to ask a few general questions about what you do here at Home from Home.

- When did you start working here?
- How did you find out about HomeFromHome and why did you choose to work here?
- What do you believe is the main goal of the HomeFromHome Program?
- What are your main responsibilities? Please describe your job to me.
- Roughly how many foster mothers and children do you see?
- Did you have special training for your position at HomeFromHome (in addition to your qualification)?
- What is your favourite part of this job?
- What do you think is the most important part of your job?

I'd now just like to explain that my study is focusing on psychosocial support. There are many different definitions for the term psychosocial so I want to let you know which definition I have decided to use.

The 'Psychosocial' (developmental needs for children): are the things that children need in order to develop into healthy, happy, creative, and socially functioning individuals who have healthy relationships and positive hopes and goals for their futures.

2) What behaviours and problems have you observed among these children that might be different from other children regarding either psychosocial well-being?

- prompt: do you feel the loss and removal from biological family has played a significant role in this difference? Please explain why or why not?

3) Do you feel that the psychosocial support you provide is helpful? Please explain.

4) Who do you feel provides the most significant forms of psychosocial support for the children? Feel free to list yourselves, and as many others you feel are most relevant.

- 5) Do you feel that the community of the foster mothers plays an important role in the psychosocial support and development of the children? Please explain.
- 6) What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being of the children?
- 7) What do you find the most challenging aspect of your role as a social worker?
  - How do you manage this challenge?
  - Have you shared this challenge with other staff at HomeFromHome?
- 8) Whom do you talk to when you feel overwhelmed?
- 9) To your understanding when a child gets emotional (sad, angry, scared), to whom does that child typically turn to for help?
- 10) Are the children you work with able to open up and discuss their emotions with you?
- 11) Do you speak to the children about HIV/AIDS?
- 12) What is the most difficult aspect about talking to these children about sensitive issues?
- 13) What have the children said they have the most difficulty with?
- 14) Do the children express their own concerns about their future with you? If yes, what do they say they are most worried about in the future?
- 15) What do you most worry about for the children you support in the future?
- 16) What do you most hope for the children in the program in the future?
- 17) Are the foster mothers you work with able to open up and discuss their emotions with you?
- 18) Do you speak to the mothers about HIV/AIDS? Please explain.
- 19) What is the most difficult aspect about talking to the mothers about sensitive issues?
- 20) What have the mothers said they have the most difficulty with?
- 21) Do the mothers express their own concerns about the children's' future with you? If yes, what do they say they are most worried about in the future?
- 22) What do you most worry about for the mothers you support in the future?
- 23) What do you most hope for the mothers in the program in the future?
- 24) Do you have any ideas or suggestions of what else you would like made available to yourself or other staff/caregivers that would strengthen your own support efforts?

- Prompt: Do you have any suggestions of how support in general could be provided more effectively?

25) Based on your own experience what would you most like policy makers who work to support vulnerable children in South Africa to know about the needs of orphaned and vulnerable children?

26) Is there anything else you would like to share here in this interview?

27) Do you have any questions for myself?

### **Debrief & Final Questions**

That concludes the questions for this interview. I would like to sincerely thank you for your participation and for sharing your thoughts with me.

Do you have any questions for me at this time? I would be happy to answer them for you.

Please remember that your responses will be kept confidential and anonymous. I will leave you with this copy of the consent form and you can always contact me via telephone or email.

When I have completed my written thesis a copy will be provided to your organization and if you would like your own copy feel free to contact me directly.

Thank you again for your participation. I sincerely appreciate your time and willingness to assist me in the research project.

**APPENDIX 4 - Interview Questions for the Administrator**



**Thesis Title:**

**Caregiver Perspectives on Psychosocial Support  
Programming for Orphans and Vulnerable  
Children in South Africa**



**INTERVIEW QUESTIONS &  
GUIDELINES**

**Cherie Martin**

University of Ottawa

MA Globalization and International Development

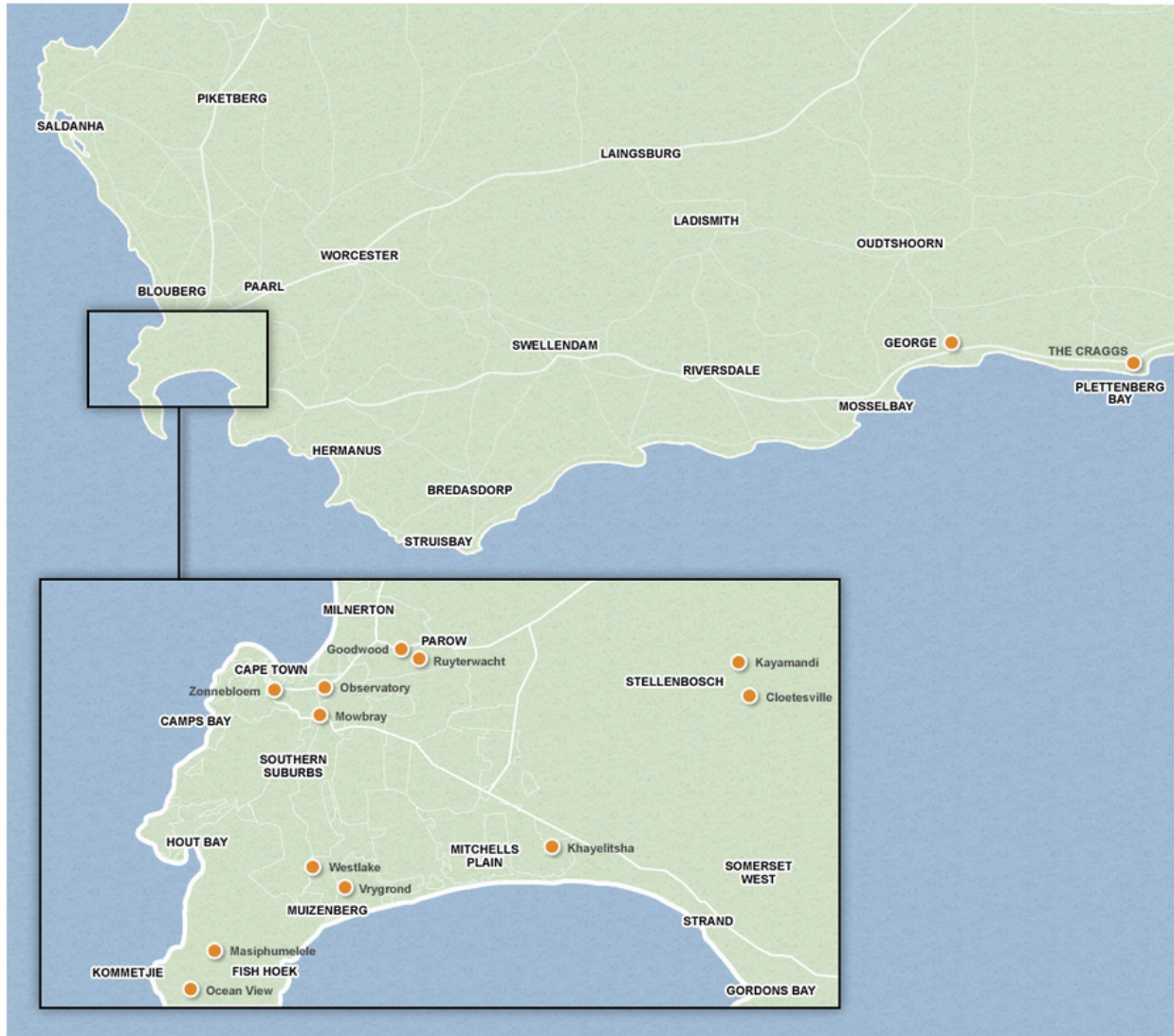


## Additional/Modified Questions for Administrative Staff/ Heads

- 1) What is the main goal of HFH?
- 2) Do you think providing psychosocial support is an important part of the HomeFromHome Program?
- 3) Who (people) do you feel provides the most significant forms of psychosocial support for the children?
- 4) Do you feel that the community of the foster mothers plays an important role in the psychosocial support and development of the children? Please explain.
- 5) What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being of the children?
- 6) What do you find the most challenging aspect of your role at HFH?
  - a. How do you manage this challenge?
- 7) To your understanding when a child gets emotional (sad, angry, scared), to whom does that child typically turn to for help?
- 8) To your understanding do the children learn about HIV/AIDS? If yes how and where?
- 9) What do you most worry about for the children in this program in the future?
- 10) What do you most hope for the children in the program in the future?
- 11) What do you most worry about for the mothers you support in the future?
- 12) What do you most hope for the mothers in the program in the future?
- 13) What are the rules/policy regarding children when they turn 18?
- 14) What follow up is there for children after they leave the homes?
- 15) Can children choose to stay with their foster mothers after 18 if the mother approves this?
- 16) Can you please explain to me the staff structure of HomeFromHome (HFH) and how this differs in different communities?
- 17) Can you explain to me how children typically enter into HFH foster care?
- 18) Can you please explain to me the interview process for hiring foster mothers?
- 19) From an administrative point of view, what are the most challenging aspects for HFH?  
What is the main source of funding for HFH?

- 20) How are meetings with social workers and psychologists determined for foster children and mothers? (is it scheduled/ needs-based, etc.)?
- 21) Do you have any ideas or suggestions of what else you would like made available to yourself or other programs that would strengthen your own support efforts?
- 22) Do you have any suggestions of how support in general could be provided more effectively?
- 23) Based on your own experience what would you most like policy makers who work to support vulnerable children in South Africa to know about the needs of orphaned and vulnerable children and supporting them?
- 24) Is there anything else you would like to share here in this interview?
- 25) Do you have any questions for myself?

## APPENDIX 5 - Map of the HomeFromHome Communities



## APPENDIX 6 - Initial Findings Report

### INITIAL FINDINGS/ GENERAL TAKE AWAY POINTS

After interviews were completed with foster mothers, the researcher was invited to participate in a group parenting session and to present initial results and discuss with participants. For this meeting the following document was prepared to provide social workers, foster parents and administration with an overview of responses from the foster mothers. The suggestions and informal take away points were orally shared with participants, and all attendees were invited to ask any last questions about the research project. A hard copy was provided to the administrator at their request.

#### Interview Questions:

1) General background questions:

- a) I'd first like to ask a few general questions about what you do here at Home from Home, When did you start working here? **Range between 5 months and 5 years**
- b) How did you find out about HomeFromHome and why did you choose to work here? **Mostly from Church (flyers) or through a friend**
- c) What are your main responsibilities? Please describe your job to me. **To provide love and care for children, cook, clean, give medication, take to hospital, etc.**
- d) How many children are in your care? **Average of 5-6**
- e) Did you have special training for your position? **Not prior to position. Few days training at start with another foster mother**
- f) What is your favourite part of this job? **Providing love, playing, fun times with children**
- g) What do you think is the most important part of your job? **To love them, to give medication**
- h) What do you believe is the main goal of the HomeFromHome Program? **To give children safe home and to get education, to help them develop into good people**

2) How do you think the impact of losing family members because of HIV/AIDS has affected the children's psychosocial well-being? **Negatively, many reported children are confused and many feel abandoned, curious about biological family. Some not orphans of HIV.**

3) Do you think providing psychosocial(emotional) support is an important part of your job? Please explain. **All said yes. Little/no explanation or said they need love to feel safe and to grow.**

4) Who (people) do you feel provides the most significant forms of psychosocial support for the children? Feel free to list yourselves, and as many others you feel are most relevant. **Myself (mother), social worker, church, community programs, psychologist.**

5) Do you feel that your community is supportive of you? **Mixed responses, some felt very supported by community, others not at all. Those supported expressed this made a big difference, made their job a lot easier and more rewarding/ felt more appreciated. Others who did not feel support expressed more stress.**

6) What (programs/activities/services) do you believe are the best support programs that help the psychosocial well-being of the children? **Volunteers/mentors who help with homework/play, community programs, church & Sunday school, talking with social workers, talking with mothers.**

7) What do you find the most challenging aspect of your role as a caregiver/staff member?

**Administering medication (for HIV-positive children), dealing with teenagers misbehaviour/disrespect of rules, making ends meet on the budget, transportation to hospital, needing a break/being overwhelmed.**

- How do you manage this challenge? **Prayer, talking with close friend/another foster mum, social worker, dealing on their own.**

- Have you shared this challenge with the social worker or any other staff at HomeFromHome? **Mixed results, mostly said try to handle on their own first, then ask for help /report if necessary.**

8) Whom do you talk to when you feel overwhelmed? **Close friend, social worker, church, family member.**

9) The last time you saw a child get emotional (sad, angry, scared), to whom did that child turn for help? **Mixed responses: Kept to themselves, talked to mothers and social worker.**

10) Do you speak to your children about their emotions? **Mixed results. Some who said yes said they were unsure how or what to say.**

11) Do you speak to your children about HIV/AIDS? **Mixed but more no's than yes. Most felt children were too young or that they learnt at school so wasn't necessary.**

12) How do you feel when you talk to the children about these issues? What is that like for you? **Difficult, not sure what they are supposed to say, don't have all the answers for their questions.**

13) What have the children said they have the most difficulty with? **Dealing with their existing biological family and questions about where they came from. Some have contact; some don't. They often have questions mothers are unable to answer and don't want to lie. Being teased/bullied at school/by peers for living in foster care.**

14) Do the children express their own concerns about their future with you? **Most said they have positive goals for the future.**

15) What do the children say they are most worried about in the future? **The HIV-positive children who are aware of their status have expressed concerns about their future – concerns about marriage, children, and death.**

16) What do you most worry about for the children you support in the future? **Concerns about returning to biological family, if this will be a good environment for them, if they don't have any family what they will do. Also concerned if they will stay healthy (take medication properly).**

17) What do you most hope for the children in your family/program in the future? **That they will be safe, independent, successful- finish their education, have families of their own.**

18) Do you have any ideas or suggestions of what else you would like made available to yourself or other staff/caregivers that would strengthen your own support efforts?

- **More frequent support group meetings for foster mothers**
- **More retreats/activities for mothers to meet and discuss issues, shared struggles**
- **Group meetings for children to meet other foster children of same age**
- **Sharing contacts of foster mothers for easier communication**
- **Each home/community to have an assistant so it is easier when mothers need a break even just for an hour when overwhelmed**
- **Support for teens, and parenting workshops for dealing with teens**
- **More clear rules and support for dealing with biological families and what will happen when they turn 18.**
- **Foster families shouldn't be in same community as biological family, is unhealthy and confusing for children**
- **Increased grant/budget, very tight and stressful**

- Assistance with transportation to doctors office or babysitting when taking children to doctor
- More volunteers/afterschool help to help with kids homework and education. Not enough time to do house chores and help with homework.

19) Based on your own experience what would you most like policy makers who work to support vulnerable children in South Africa to know about the needs of orphaned and vulnerable children of HIV/AIDS?

That this is a really difficult job, and that all children need to be loved. These children shouldn't be treated differently and need continued support

20) Is there anything else you would like to say here in this interview?

Words of advice from mothers to other mothers

- you must treat the children like your family and love them as your own, you can't treat this like a job or you will never make it through and will never be happy
- the children will pick up on your mood and your care, if you are disrespectful they will be disrespectful
- Children don't always know how to speak about their emotions, sometimes they just act angry and rude and it is their way of asking for attention so you must stop them and try to calm them and talk to them about what is really upsetting them.
- They must know they are loved, they feel that no one has loved them so it is our job to make them feel special, loved and safe.
- You must love God and he will give you strength.
- Talking to other mothers and social workers makes it easier
- We need to feel appreciated or it is hard to stay motivated

## References

- Adato, M., Carter, M. R., & May, J. (2006). Exploring poverty traps and social exclusion in South Africa using qualitative and quantitative data. *Journal of Development Studies*, 42(2), 226–247. doi:10.1080/00220380500405345
- Africa Check. (2013). Factsheet South Africa: official crime statistics for 2012/13. Retrieved May 27, 2014, from <https://africacheck.org/factsheets/factsheet-south-africas-official-crime-statistics-for-201213/>
- Ainsworth, M., Beegle, K., & Koda, G. (2005). The impact of adult mortality and parental deaths on primary schooling in North-Western Tanzania. *Journal of Development Studies*, 41(3), 412–439. doi:10.1080/0022038042000313318
- Akintola, O. (2006). Gendered home-based care in South Africa: more trouble for the troubled. *African Journal of AIDS Research*, 5(3), 237–247. doi:10.2989/16085900609490385
- Al, V. E. T., Viljoen, D. L., Gossage, J. P., Ph, D., Brooke, L., Ons, B. S. H., ... Robinson, L. K. (2005). Fetal alcohol syndrome epidemiology in a south african community : a second study of a very high prevalence area. *Journal of Studies on Alcohol*, 66, 593–604.
- Alonso, J., Petukhova, M., Vilagut, G., Chatterji, S., Heeringa, S., Üstün, T. B., ... Kessler, R. C. (2011). Days out of role due to common physical and mental conditions: results from the WHO World Mental Health surveys. *Molecular Psychiatry*, 16(12), 1234–46. doi:10.1038/mp.2010.101
- Altbeker, A. (2005). Puzzling Statistics: Is South Africa really the world ' s crime capital? *South Africa Crime Quarterly*, (11), 1–8.
- Andrews, G., Skinner, D., & Zuma, K. (2006). Epidemiology of health and vulnerability among children orphaned and made vulnerable by HIV/AIDS in sub-Saharan Africa. *AIDS Care*, 18(3), 269–76. doi:10.1080/09540120500471861
- Avert. (2012). HIV & AIDS in South Africa. Retrieved April 07, 2014, from [http://www.avert.org/hiv-aids-south-africa.htm#footnote137\\_ykrju5k](http://www.avert.org/hiv-aids-south-africa.htm#footnote137_ykrju5k)
- Battersby, J. (2011). *The State of Urban Food Insecurity in Cape Town* (pp. 1–42). Kingston and Cape Town.
- Berkman, S., Boswell, N. Z., Brüner, F. H., Gough, M., McCormick, J. T., Pedersen, P. E., ... Zimmermann, S. (2008). The fight against corruption: international organizations at a crossroads. *Journal of Financial Crime*, 15(2), 124–154. doi:10.1108/13590790810866863
- Bhorat, H., & Cassim, A. (2014, January 27). South Africa's Welfare Success Story II: Poverty-Reducing Social Grants. *Brookings: Africa in Focus*. Retrieved from

<http://www.brookings.edu/blogs/africa-in-focus/posts/2014/01/27-south-africa-welfare-poverty-bhorat>

- Bowlby, J. (1952). *Maternal Care and Mental Health* (pp. 1–63). Geneva: World Health Organization.
- Brenner, J. (2000). Intersections, locations, and capitalist class relations: Intersectionality from a Marxist perspective. In *Women and the Politics of Class* (pp. 350–375). New York: Monthly Review Press.
- Bruin Cardoso, I. (2010). *National Plan of Action for Orphans and Vulnerable Children. Establishing, reviewing and implementing National Plans of Action for orphans and vulnerable children in Southern and East Africa* (pp. 1–36). Pretoria. Retrieved from <http://resourcecentre.savethechildren.se/sites/default/files/documents/3191.pdf>
- Carmondy, P. (2002). Between globalisation and (Post) apartheid : the political economy of restructuring in South Africa. *Journal of South African Studies*, 28(2), 255–275. doi:10.1080/0305707022014069
- Central Intelligence Agency. (2014). The world fact book: South Africa. *CIA*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/sf.html>
- Cheney, K. E. (2012). Killing them softly? Using children's rights to empower Africa's orphans and vulnerable children. *International Social Work*, 56(1), 92–102. doi:10.1177/0020872812459063
- Children's Institute. (2014). Statistics on Children in South Africa: Demography - Orphanhood. *University of Cape Town*. Retrieved from <http://www.childrencount.ci.org.za/indicator.php?id=1&indicator=4>
- Chisholm, K. (1996). *Attachment security and indiscriminately friendly behavior in children adopted from Romanian orphanages*. Simon Fraser University.
- Clacherty, G., & Donald, D. (2005). *Impact Evaluation of the VSI ( Vijana Simama Imara ) organisation and the Rafiki Mdogo group of the HUMULIZA orphan project Nshamba, Tanzania*.
- Cluver, L. (2011). Children of the AIDS pandemic: practical support and psychosocial interventions are desperately needed to help those dealing with the fallout of AIDS. *Nature Publishing Group. Academic OneFile*. Retrieved from <http://go.galegroup.com/ps/i.do?id=GALE|A258909959&v=2.1&u=otta77973&it=r&p=AO NE&sw=w&asid=26a91a132a310a67f3ebad1e412c6455>

- Cluver, L., & Gardner, F. (2007). The mental health of children orphaned by AIDS: a review of international and southern African research. *Journal of Child & Adolescent Mental Health*, 19(1), 1–17. doi:10.2989/17280580709486631
- Cluver, L., Gardner, F., & Operario, D. (2009). Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa. *AIDS Care*, 21(6), 732–41. doi:10.1080/09540120802511885
- Cluver, L., Orkin, M., Moshabela, M., Kuo, C., & Boyes, M. (2013). The hidden harm of home-based care : Pulmonary tuberculosis symptoms among children providing home medical care to HIV / AIDS-affected adults in South Africa. *AIDS Care*, 25(6), 748–755.
- Corbin Dwyer, S., & Buckle, J. L. (2009). The space between : on being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1), 54–63.
- Crais, C. (2011). *Poverty, war, and violence in South Africa*. Cambridge ; New York: Cambridge University Press.
- Crais, C., & McClendon, T. (2013). *The South Africa reader: history, culture, politics*. Durham: Duke University Press.
- Crime Stats SA. (2013). Crime Stats Simplified. Retrieved May 27, 2014, from <http://www.crimestatssa.com/national.php>
- Danermark, B., Ekstrom, M., Jakobson, L., & Karlsson, J. C. (2002). *Explaining Society: An Introduction to Critical Realism in the Social Sciences* (pp. 1–232). London & New York: Routledge.
- Day, A., Riebschleger, J., Dworsky, A., Damashek, A., & Fogarty, K. (2012). Maximizing educational opportunities for youth aging out of foster care by engaging youth voices in a partnership for social change. *Children and Youth Services Review*, 34(5), 1007–1014. doi:10.1016/j.childyouth.2012.02.001
- Denault, J. (2012). *Policy Brief: Adoption and Foster Care in Canada* (pp. 1–3).
- Department of Social Development, . (2010). *CHILDREN ' S ACT 38 OF 2005* (pp. 1–201).
- Desai, V., & Potter, R. B. (2006). *Doing Development Research* (pp. 1–324). London: SAGE Publications.
- Doku, P. N. (2010). Psychosocial adjustment of children affected by HIV/AIDS in Ghana. *Journal of Child & Adolescent Mental Health*, 22(1), 25–34. doi:10.2989/17280583.2010.493662

- Dowdney, L. (2000). Annotation: childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry*, 41(7), 819–830. doi:10.1111/1469-7610.00670
- Drew, R. S., Makufa, C., & Foster, G. (1998). Strategies for providing care and support to children orphaned by AIDS. *AIDS Care*, 10(Supplement 1), S9–S15. doi:10.1080/09540129850124325
- Eaton, L. a, Kalichman, S. C., Sikkema, K. J., Skinner, D., Watt, M. H., Pieterse, D., & Pitpitan, E. V. (2012). Pregnancy, alcohol intake, and intimate partner violence among men and women attending drinking establishments in a Cape Town, South Africa township. *Journal of Community Health*, 37(1), 208–16. doi:10.1007/s10900-011-9438-7
- Economist. (2014, April). Corruption in South Africa: Nkandla in the wind, 40.
- Eimhjellen, S. (2014). Violence, conflict and unrest in South Africa. *Reportage Online: Magazine of the Australian Centre for Independent Journalism*. Retrieved from <http://www.reportageonline.com/2014/03/violence-conflict-and-unrest-in-south-africa/>
- FASD Prevention Symposium. (2008). *Policy Brief: Fetal Alcohol Spectrum Disorders in Cape Town, South Africa*.
- Fassin, D. (2013). A case for critical ethnography: rethinking the early years of the AIDS epidemic in South Africa. *Social Science & Medicine (1982)*, 99, 119–26. doi:10.1016/j.socscimed.2013.04.034
- Faul, M. (2013, March). South Africa violence against women rated highest in the world. *Huffington Post*. Johannesburg. Retrieved from [http://www.huffingtonpost.com/2013/03/08/south-africa-violence-against-women\\_n\\_2837804.html](http://www.huffingtonpost.com/2013/03/08/south-africa-violence-against-women_n_2837804.html)
- Frith, A. (2014). Census 2011: City of Cape Town. Retrieved April 03, 2014, from <http://census2011.adrianfrith.com/place/199>
- Frontline. (2013, December 6). Nelson Mandela's Mixed Legacy on HIV/AIDS. *PBS*. Retrieved from <http://www.pbs.org/wgbh/pages/frontline/biographies/nelson-mandelas-mixed-legacy-on-hiv/aids/>
- Garvin, M. C., Tarullo, A. R., Van Ryzin, M., & Gunnar, M. R. (2012). Postadoption parenting and socioemotional development in postinstitutionalized children. *Development and Psychopathology*, 24(1), 35–48. doi:10.1017/S0954579411000642
- Gewirtz, A. H., & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence*, 22(3), 151–163. doi:10.1007/s10896-007-9065-3

- Gilbert, R., Spatz Widom, C., Brown, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet*, 373, 68–81.
- Hermenau, K., Hecker, T., Ruf, M., Schauer, E., Elbert, T., & Schauer, M. (2011). Childhood adversity, mental ill-health and aggressive behavior in an African orphanage: Changes in response to trauma-focused therapy and the implementation of a new instructional system. *Child and Adolescent Psychiatry and Mental Health*, 5(1), 29. doi:10.1186/1753-2000-5-29
- Heymann, J., Earle, a, Rajaraman, D., Miller, C., & Bogen, K. (2007). Extended family caring for children orphaned by AIDS: balancing essential work and caregiving in a high HIV prevalence nations. *AIDS Care*, 19(3), 337–45. doi:10.1080/09540120600763225
- HFH. (2014). Home from Home. Retrieved January 05, 2014, from <http://homefromhome.org.za/index.php>
- Jagwanth, S. (2003). *Democracy, Civil Society and the South African Constitution: some challenges* (No. 65). Retrieved from <http://unesdoc.unesco.org/images/0012/001295/129557e.pdf>
- Janssen, T. L., van Dijk, M., Al Malki, I., & van As, a B. (2013). Management of physical child abuse in South Africa: literature review and children’s hospital data analysis. *Paediatrics and International Child Health*, 33(4), 216–27. doi:10.1179/2046905513Y.0000000091
- Johnson, R., Browne, K., & Hamilton-Giachritsis, C. (2006). Young children in institutional care at risk of harm. *Trauma Violence Abuse*, 7(1), 34–60.
- Kang Dufour, M.-S., Maiorana, A., Allen, C., Kassie, N., Thomas, M., & Myers, J. (2013). How faith based organizations’ doctrines regarding sexuality affect their participation in the public health response to HIV in the Eastern Caribbean. *Sexuality Research and Social Policy*, 10(3), 221–232. doi:10.1007/s13178-013-0123-8
- Kennedy, D. (2005). The international human rights movement; part of the problem? In *The Dark Side of Virtue: Reassessing International Humanitarianism* (pp. 3–35). Princeton: Princeton University Press.
- Kim, J. (2008). The protective effects of religiosity on maladjustment among maltreated and nonmaltreated children. *Child Abuse & Neglect*, 32(7), 711–20. doi:10.1016/j.chiabu.2007.09.011
- King, E., De Silva, M., Stein, A., & Patel, V. (2009). *Interventions for improving the psychosocial well-being of children affected by HIV and AIDS*. ( Review ). *Public Health* (pp. 1–18).

- King, M., & Schafer, W. (1992). Religiosity and perceived stress : a community survey. *Sociological Analysis*, 53(1), 37–47.
- Kuo, C., & Operario, D. (2009). Caring for AIDS-orphaned children: A systematic review of studies on caregivers. *Vulnerable Children and Youth Studies*, 4(1), 1–12. doi:10.1080/17450120802270418
- Kuo, C., & Operario, D. (2010). Caring for AIDS-orphaned children: an exploratory study of challenges faced by carers in KwaZulu-Natal, South Africa. *Vulnerable Children and Youth Studies*, 5(4), 344–352. doi:10.1080/17450128.2010.516372
- Kuo, C., Operario, D., & Cluver, L. (2012). Depression among carers of AIDS-orphaned and other-orphaned children in Umlazi Township, South Africa. *Global Public Health*, 7(3), 253–69. doi:10.1080/17441692.2011.626436
- Lee, C. M., & Asgary, V. (2009). Family-based approaches to the prevention of depression in at risk children and youth. In C. Essau (Ed.), *Treatment of adolescent depression* (pp. 179–216). Oxford, United Kingdom: Oxford University Press.
- Lee, T., Foster, G., Makufa, C., & Hinton, S. (2002). Families, orphans and children under stress in Zimbabwe. *Evaluation and Program Planning*, 25, 459–470.
- Lowenthal, B. (1999). Effects of maltreatment and ways to promote children's resiliency. *Childhood Education*, 75(4), 204–209.
- Mahery, P., Jamieson, L., & Scott, K. (2011). *Children's Act Guide for Child and Youth Care Workers* (pp. 1–56). Cape Town. Retrieved from [http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/2011/ca\\_guide\\_cycw\\_2011.pdf](http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/2011/ca_guide_cycw_2011.pdf)
- Marais, H. (2011). The two economies and the challenge of faster growth. In Z. Books (Ed.), *South Africa Pushed to the Limit* (pp. 69–91). London.
- Masten, A. S., & Coastworth, D. (1998). The development of competence in favorable and unfavorable environments. *American Psychologist*, 53, 205–220.
- May, P. a, Blankenship, J., Marais, A.-S., Gossage, J. P., Kalberg, W. O., Barnard, R., ... Seedat, S. (2013). Approaching the prevalence of the full spectrum of fetal alcohol spectrum disorders in a South African population-based study. *Alcoholism, Clinical and Experimental Research*, 37(5), 818–30. doi:10.1111/acer.12033
- Mayosi, B. M., Lawn, J. E., van Niekerk, A., Bradshaw, D., Abdool Karim, S. S., & Coovadia, H. M. (2012). Health in South Africa: changes and challenges since 2009. *Lancet*, 380(9858), 2029–43. doi:10.1016/S0140-6736(12)61814-5

- Megahead, H. a., & Cesario, S. (2008). Family Foster Care, Kinship Networks, and Residential Care of Abandoned Infants in Egypt. *Journal of Family Social Work, 11*(4), 463–477. doi:10.1080/10522150802428418
- Mitlin, D., & Mogaladi, J. (2009). *Social movements and poverty reduction in South Africa* (pp. 1–47). Retrieved from [http://www.sed.manchester.ac.uk/research/socialmovements/publications/reports/Mitlin\\_Mogaladi\\_SouthAfricamappinganalysis.pdf](http://www.sed.manchester.ac.uk/research/socialmovements/publications/reports/Mitlin_Mogaladi_SouthAfricamappinganalysis.pdf)
- Mogale, R. S., Burns, K. K., & Richter, S. (2012). Violence against women in South Africa: policy position and recommendations. *Violence against Women, 18*(5), 580–94. doi:10.1177/1077801212453430
- Moran, P., & Eckenrode, J. (1992). Protective personality characteristics among adolescent victims of maltreatment. *Most, 16*(July 1987), 743–754.
- Moses, S., & Meintjes, H. (2010). Positive care? HIV and residential care for children in South Africa. *African Journal of AIDS Research, 9*(2), 107–115. doi:10.2989/16085906.2010.517475
- Munro, L. T. (2001). Focus on Economic Sociology: A Principal-Agent Analysis of the Family. Implications for the Welfare State. *American Journal of Economics and Sociology, 60*(4), 796–814.
- Munro, L. T. (2009). The “Human Rights-Based Approach to Pogramming”: a contradiction in terms? In S. Hickey & D. Mitlin (Eds.), *Rights Based Approaches to Development: Exploring the Potential and Pitfalls* (pp. 187–206). Sterling, VA: Kumarian Press.
- Munro, L. T. (2012). *Children after the Long Socio-economic Crisis in Zimbabwe: Situation Analysis and Policy Issues* (pp. 1–20). Institute of Environmental Studies, University of Zimbabwe.
- NACCA. (2009). *National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa 2009-2012* (pp. 1–21).
- Noyoo, N. (2006). Civil society and poverty reduction in South Africa. Fondation Maison des Science de L’Homme. Retrieved from <http://www.sarpn.org/documents/d0002086/index.php>.
- Nyambedha, E. O., Wandibba, S., & Aagaard-Hansen, J. (2001). Policy implications of the inadequate support systems for orphans in Western Kenya. *Health Policy (Amsterdam, Netherlands), 58*(1), 83–96. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11518603>

- OECD. (2011). *Special Focus : Inequality in Emerging Economies (EEs)* (pp. 47–82). Retrieved from <http://www.oecd.org/social/soc/49170475.pdf>
- Okpych, N. (2012). Policy framework supporting youth aging-out of foster care through college: Review and recommendations. *Children and Youth Services Review*, *34*(7), 1390–1396. doi:10.1016/j.childyouth.2012.02.013
- Onuoha, F. N., & Munakata, T. (2010). Gender psychosocial health of children orphaned by AIDS. *Vulnerable Children and Youth Studies*, *5*(3), 256–267. doi:10.1080/17450128.2010.498903
- Operario, D., Pettifor, A., Cluver, L., MacPhail, C., & Rees, H. (2007). Prevalence of parental death among young people in South Africa and risk for HIV infection. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *44*(1), 93–8. doi:10.1097/01.qai.0000243126.75153.3c
- Oxford Dictionaries. (2014). “subjectivism.” *Oxford University Press*.
- Pearce, M. J., Little, T. D., & Perez, J. E. (2003). Religiousness and depressive symptoms among adolescents. *Journal of Clinical Child and Adolescent Psychology*, *32*(2), 267–276. doi:10.1207/S15374424JCCP3202
- Positivism. (2014). *Encyclopaedia Britannica*. Retrieved September 08, 2014, from <http://www.britannica.com/EBchecked/topic/471865/positivism>
- Rajagopal, B. (2006). Counter-hegemonic International Law: rethinking human rights and development as a Third World strategy. *Third World Quarterly*, *27*(5), 767–783. doi:10.1080/01436590600780078
- Rape Crisis. (2012). Rape in South Africa. Retrieved May 27, 2014, from [http://rapecrisis.org.za/rape-in-south-africa/#\\_ftn1](http://rapecrisis.org.za/rape-in-south-africa/#_ftn1)
- Republic of South Africa. (1994). Government Gazette Staatskoerant: White Paper on Reconstruction and Development. Pretoria: Creda Press.
- Regional Psychosocial Support Initiative (REPSSI). (2011). *REPSSI Strategy 2011-2015 From Strength to Strength* (pp. 1–8). Randburg, South Africa.
- Republic of South Africa. Constitution of the Republic of South Africa (1996). South Africa: Statutes of the Rebliv of South Africa: Constitutional Law. Retrieved from <http://www.gov.za/documents/constitution/1996/a108-96.pdf>
- Richardson, A., & Bowden, J. (1983). *A new dictionary of Christian theology*. London England: SCM Press.

- Richter, L. (2004). Chapter 2: the impact of HIV/AIDS on the development of children. In *A Generation at Risk? HIV/AIDS, Vulnerable Children and Security in Southern Africa* (pp. 9–31).
- Richter, L. (2008). Child Abuse in South Africa : Rights and Wrongs, *17*(September 2007), 79–93. doi:10.1002/car
- Richter, L., Foster, G., & Sherr, L. (2006). *Where the Heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. The Hague, The Netherlands: The Bernard Van Leer Foundation.
- Rutter, M., Kreppner, J., Croft, C., Murin, M., Colvert, E., Beckett, C., ... Sonuga-Barke, E. (2007). Early adolescent outcomes for institutionally-deprived and nondeprived adoptees. *Journal of Child Psychology and Psychiatry*, *44*(12), 1200–1207. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2007.01792.x/full>
- Ruud, K. W., Srinivas, S. C., & Toverud, E. lydia. (2009). Antiretroviral therapy in a South African public health care setting – facilitating and constraining factors. *Southern Medical Review*, *2*(2), 29–34.
- SADC. (2009). *SADC Business Plan on Orphans, Vulnerable Children and Youth 2009-2015: Implementation of the Stratgic Framework and Programme of Action*. Gaborone, Botswana. Retrieved from [http://www.sadc.int/files/9413/5293/3506/SADC\\_Business\\_Plan\\_on\\_OVC\\_Youth\\_2009-2015.pdf](http://www.sadc.int/files/9413/5293/3506/SADC_Business_Plan_on_OVC_Youth_2009-2015.pdf)
- Sagy, S., & Dotan, N. (2001). Coping resources of maltreated children in the family: a salutogenic approach. *Child Abuse & Neglect*, *25*(11), 1463–80. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11766011>
- SANAC. (2011). *Draft Zero for Consultation: National Strategic Plan for HIV and AIDS , STIs and TB , 2012-2016*. Context (pp. 1–82). Pr.
- SANAC. (2012). *National Strategic Plan on HIV, STIs and TB 2012-2016*. Retrieved from [http://www.sahivsoc.org/upload/documents/National\\_Strategic\\_Plan\\_2012.pdf](http://www.sahivsoc.org/upload/documents/National_Strategic_Plan_2012.pdf)
- SARPN. (2005). *Policy Framework for Orphans and other children made vulnerable by HIV and AIDS South Africa “Building a caring society together”* (pp. 1–54). Pretoria.
- Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research Methods for Business Students* (5th ed.). Financial Times Prentice Hall.

- Schenk, K. D. (2009). Community interventions providing care and support to orphans and vulnerable children: a review of evaluation evidence. *AIDS Care*, *21*(7), 918–42. doi:10.1080/09540120802537831
- Schenk, K. D., Michaelis, A., Nelson Sapiiano, T., Brown, L., & Weiss, E. (2010). Improving the lives of vulnerable children : implications of horizons research among orphans and other children affected by AIDS. *Public Health Reports*, *125*(April), 325–336.
- Seekings, J. (2007). *Poverty and inequality after apartheid* (No. 200). Cape Town. Retrieved from [http://www.sarpn.org/documents/d0003024/Poverty\\_inequality\\_Seekings\\_Sep2007.pdf](http://www.sarpn.org/documents/d0003024/Poverty_inequality_Seekings_Sep2007.pdf)
- Sharma, S. (2012). Rising inequality in South Africa: Drivers, trends and policy responses. Retrieved September 08, 2014, from [http://www.consultancyafrica.com/index.php?option=com\\_content&view=article&id=1142:rising-inequality-in-south-africa-drivers-trends-and-policy-responses-&catid=87:african-finance-a-economy&Itemid=294](http://www.consultancyafrica.com/index.php?option=com_content&view=article&id=1142:rising-inequality-in-south-africa-drivers-trends-and-policy-responses-&catid=87:african-finance-a-economy&Itemid=294)
- Sherr, L., Mueller, J., & Varrall, R. (2009). Evidence-based gender findings for children affected by HIV and AIDS - a systematic overview. *AIDS Care*, *21 Suppl 1*(July 2014), 83–97. doi:10.1080/09540120902923105
- Smyke, A., Dumitrescu, A., & Zeanah, C. (2002). Attachment disturbances in young children. I: The continuum of caretaking casualty. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*(8), 972–82. doi:10.1097/00004583-200208000-00016
- Smyke, A., Zeanah, C., Gleason, M. M., Drury, S., Fox, N., Nelson, C., & Guthrie, D. (2012). A randomized controlled trial comparing foster care and institutaonal care for children with signs of reactive attachment disorder. *American Journal of Psychiatry*, *169*(5), 508–514.
- Snow, D. A., & Benford, R. D. (1992). Master frames and cycles of protest. In A. D. Morris & C. M. Mueller (Eds.), *Frontiers in Social Movement Theory* (pp. 133–155). New Haven: Yale University Press.
- South African History Online. (2013). South Africa’s Key economic policies changes since 1994-2013. Retrieved from <http://www.sahistory.org.za/article/south-africa’s-key-economic-policies-changes-1994-2013>
- South African Police Service (SAPS). (2013). *Crime Statistics Overview RSA 2012-2013* (pp. 1–120). Retrieved from [http://www.saps.gov.za/resource\\_centre/publications/statistics/crimestats/2013/downloads/crime\\_statistics\\_presentation.pdf](http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2013/downloads/crime_statistics_presentation.pdf)

- South African Social Security Agency (SASSA). (2014). *Statistical Report 5 of 2014: Fact Sheet: A statistical summary of social grants in South Africa* (p. 2584). Retrieved from <http://www.sassa.gov.za/index.php/knowledge-centre/statistical-reports>
- Southern African Development Community (SADC). (2010). *Development of a SADC Minimum Package of Services for Orphans and Vulnerable Children and Youth: The Situation of Orphans and Other Vulnerable Children and Youth in the SADC Region DRAFT 4 : October 2010* (pp. 1–54). Retrieved from [http://www.sadc.int/files/3413/5293/3508/SADC\\_OVCY\\_Situation\\_Analysis\\_Report\\_Revised\\_13Oct\\_2010.pdf](http://www.sadc.int/files/3413/5293/3508/SADC_OVCY_Situation_Analysis_Report_Revised_13Oct_2010.pdf)
- Spitz, R. (1945). Hospitalism; an inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child*, 1, 53–74.
- StatsSA. (2008a). *Mortality and Causes of Death in South Africa , 2006 : Findings from Death Notification. Mortality* (pp. 1–74). Pretoria. Retrieved from <http://www.statssa.gov.za/publications/P03093/P030932006.pdf>
- StatsSA. (2008b). *Statistical release mortality and causes of death in South Africa , 2006 : Findings from death notification* (pp. 1–75). Pretoria. Retrieved from <http://www.statssa.gov.za/Publications/P03093/P030932006.pdf>
- StatsSA. (2010). *Millennium Development Goals: Country Report 2010* (pp. 1–139). Pretoria. Retrieved from [http://beta2.statssa.gov.za/MDG/MDGR\\_2010.pdf](http://beta2.statssa.gov.za/MDG/MDGR_2010.pdf)
- StatsSA. (2012). *South Africa's young children : their family and home environment (2012)* (Vol. 07, pp. 1–70). Retrieved from <http://www.unaids.org/en/regionscountries/countries/southafrica/>
- Surkan, P. J., Mukherjee, J. S., Williams, D. R., Eustache, E., Louis, E., Jean-Paul, T., ... Fawzi, M. S. (2010). Perceived discrimination and stigma toward children affected by HIV/AIDS and their HIV-positive caregivers in central Haiti. *AIDS Care*, 22(7), 803–15. doi:10.1080/09540120903443392
- Thompson, L. (2000). *A History of South Africa*. Johannesburg: Jonathan Ball.
- Thomson, J. D. S. (2004). Coloured homicide trends in South Africa. *South Africa Crime Quarterly*, (7), 9–14.
- Thurman, T. R. (2007). *Assessing the Psychosocial Benefits of a Community-Based Mentoring Program for Youth-headed Households in Rwanda. Presentation for the School of Public Health and Tropical Medicine at Tulane University. Tropical Medicine*. New Orleans, Louisiana.

- Tiessen, R. (2005). Mainstreaming Gender in HIV/AIDS Programs: Ongoing Challenges and New Opportunities in Malawi. *Journal of International Women's Studies*, 7(1), 8–25.
- UNAIDS. (2004). *HIV / AIDS , Gender and the Care Economy HIV / AIDS , Gender and the Care Economy*.
- UNAIDS. (2010a). *AIDS scorecards: overview: UNAIDS report on the global AIDS epidemic* (pp. 1–52). Geneva: United Nations. Retrieved from [http://www.unaids.org/documents/20101123\\_GlobalReport\\_em.pdf](http://www.unaids.org/documents/20101123_GlobalReport_em.pdf)
- UNAIDS. (2010b). *Chapter 2: Epidemic Update. Seven* (pp. 16–61). Geneva. Retrieved from [http://www.unaids.org/documents/20101123\\_GlobalReport\\_Chap2\\_em.pdf](http://www.unaids.org/documents/20101123_GlobalReport_Chap2_em.pdf)
- UNAIDS. (2012). South Africa HIV and AIDS estimates (2012). Retrieved from <http://www.unaids.org/en/regionscountries/countries/southafrica/>
- UNAIDS. (2014). *Getting to Zero: South Africa HIV Estimates and Projections (2004-2016) Results at a Glance*. Geneva.
- Unicef. (2001). *Child workers in the shadow of AIDS: listening to the children*. Nairobi, Kenya: Unicef: Eastern and Southern Africa Regional Office.
- UNICEF. (2010a). Alternative care: the context. *South Africa Unicef*. Retrieved from [http://www.unicef.org/southafrica/protection\\_6633.html](http://www.unicef.org/southafrica/protection_6633.html)
- UNICEF. (2010b). South Africa: protection for orphans and vulnerable children: alternative care. Retrieved from [http://www.unicef.org/southafrica/protection\\_6633.html](http://www.unicef.org/southafrica/protection_6633.html)
- United Nations. (1989). Convention on the Rights of the Child. Retrieved from [http://www.unicef.org/crc/index\\_30160.html](http://www.unicef.org/crc/index_30160.html)
- United Nations Development Programme (UNDP). (2014). Table 3: Inequality-adjusted Human Development Index. Retrieved November 11, 2014, from <http://hdr.undp.org/en/content/table-3-inequality-adjusted-human-development-index>
- Van der Vegt, E. J. M., Van der Ende, J., Ferdinand, R. F., Verhulst, F. C., & Tiemeier, H. (2009). Early childhood adversities and trajectories of psychiatric problems in adoptees: evidence for long lasting effects. *Journal of Abnormal Child Psychology*, 37(2), 239–49. doi:10.1007/s10802-008-9272-2
- Van Dyk, A. C. (2007). Occupational stress experienced by caregivers working in the HIV/AIDS field in South Africa. *African Journal of AIDS Research*, 6(1), 49–66. doi:10.2989/16085900709490399

- Western Cape Government, . (2014). Western Cape Government: Overview. Retrieved from [http://www.westerncape.gov.za/your\\_gov/70](http://www.westerncape.gov.za/your_gov/70)
- WHO. (1978). Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 (pp. 6–8).
- WHO. (2006). *Mental Health and Psychosocial Well – Being among Children in Severe Food Shortage Situations* (pp. 1–8).
- WHO. (2013a). *Global Tuberculosis Report 2013*. Retrieved from [http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf?ua=1)
- WHO. (2013b). *Xpert MTB / RIF increases timely TB detection among people living with HIV and saves lives: Information note*. Retrieved from [http://www.who.int/tb/challenges/hiv/Xpert\\_TBHIV\\_Information\\_Note\\_final.pdf?ua=1](http://www.who.int/tb/challenges/hiv/Xpert_TBHIV_Information_Note_final.pdf?ua=1)
- Wild, L. G., Flisher, A. J., & Robertson, B. A. (2011). Risk and resilience in orphaned adolescents living in a community affected by AIDS. *Youth & Society, 45*(1), 140–162. doi:10.1177/0044118X11409256
- Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health, 93*(2), 200–208. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2518588&tool=pmcentrez&rendertype=abstract>
- Wood, E. (2009, June). Capitalism and Social Rights. *Solidarity*. Retrieved from <http://www.solidarity-us.org/site/print/2150>
- World Bank. (2012). HIV Prevalence: World DataBank. Retrieved from <http://databank.worldbank.org/data>
- World Bank. (2014). World Bank Data Bank. Retrieved April 16, 2014, from <http://data.worldbank.org/>
- World Economic Forum. (2011). *The Global Economic Burden of Non-communicable Diseases* (pp. 1–48). Geneva Switzerland.
- Yin, R. K. (1994). *Case Study Research Design and Methods*. (D. S. Foster, Ed.) (Second Ed.). Thousand Oaks, London and New Delhi: Sage Publications.
- Zolotova, E. (2011). Fetal alcohol syndrome: dashed hopes, damaged lives. *Bulletin of the World Health Organization, 89*(6), 398–9. doi:10.2471/BLT.11.020611