DECISIONS TO CARE FOR HIV/AIDS ORPHANS

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ABSTRACT

There is substantial evidence to indicate that South Africa is facing the prospect of a large number of children, now and in the future, who will be orphaned as a result of the HIV/AIDS pandemic. In all likelihood, these children would have experienced psychological trauma through the illness and death of people close to them, and the social isolation that accompanies HIV-infection and AIDS-related illness and death. The ideal would be for as many of these children as possible to experience some type of family life in which to grow and mature into responsible adults. The aim of the present study was to explore a range of factors that might influence prospective carers' decisions to care for children orphaned by HIV/AIDS. These include features of prospective carers; features of the orphaned child; and forms of assistance that may be required. By means of a postal survey, the present study explored existing adoptive and foster parents' (N=175) willingness to care for an HIV/AIDS orphan. Results show that close to 69% of respondents indicated a willingness to care for an HIV/AIDS orphan. Although some differences were noted depending on the HIV status of the child and whether the respondent was an adoptive or foster parent, on the whole they also indicated a preferred willingness to care for an HIV-negative female child, up to the age of 6 years old, of the same culture and from the same family as themselves, and without surviving relatives or siblings. Free medical care and schooling for the child were the suggested forms of assistance required. The Theory of Planned Behaviour (Ajzen, 1991), explored in the present study, did predict intentions to care for either an HIV-negative or HIV-positive orphan. However, certain components of the models did not have good predictive ability calling into question the usefulness of the model as a means to explain and predict intention to care for an HIV/AIDS orphan. Implications of the study provide recommendations for persons involved with children orphaned by HIV/AIDS.

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CHAPTER 1

THE HIV/AIDS PANDEMIC AND ITS IMPACT ON CHILDREN

1. INTRODUCTION

This chapter will begin by exploring the extent of the HIV/AIDS pandemic globally, in sub-Saharan Africa, and in South Africa. The figures and projections used to describe the extent of the pandemic in this country are based on HIV positive prevalence rates amongst pregnant women attending ante-natal clinics in the public sector throughout South Africa (Whiteside & Sunter, 2000). Although these figures are acknowledged to be imperfect, it is generally agreed that the data is sufficient to estimate the current and future size and impact of the pandemic (Steinberg, Kinghorn, Soderlund, Schierhout & Conway, 2000).

Particular emphasis is then given to the fact that HIV/AIDS is a disease that inordinately affects three groups of persons: very young children; child-bearing and -rearing age groups; and women. The chapter goes on to focus on how the impact of HIV/AIDS on the latter two categories of persons translates into probable complex and multiple consequences of HIV/AIDS for four groups of children: children affected by HIV/AIDS, children orphaned by HIV/AIDS, children infected with HIV/AIDS, and children infected with and affected by HIV/AIDS.

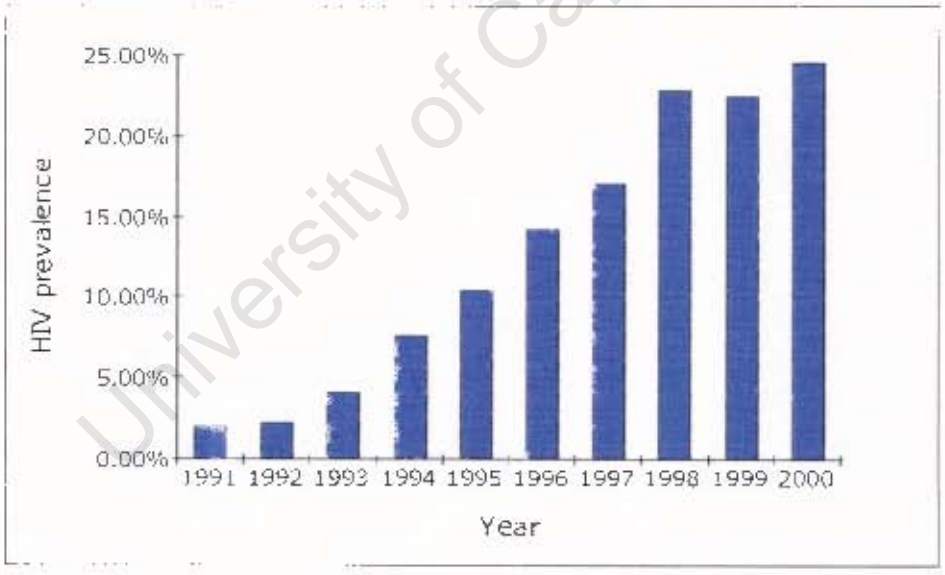
2. THE HIV/AIDS PANDEMIC

Recent statistics provided by the joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) suggest that the world is facing a pandemic of unprecedented proportions that has probably accounted for the death of more than 21.8 million people to AIDS since the beginning of the pandemic more than two decades ago (UNAIDS, 2000). Three million of these deaths are thought to have occurred in the year 2000 alone. The fact that 5.3 million new HIV infections occurred during 2000, and that 36.1 million people were living with HIV/AIDS at that time, has serious possibilities for the number of HIV/AIDS deaths likely to occur within the next decades.

In sub-Saharan Africa alone, it is estimated that 3.8 million adults and children became newly infected with HIV during the year 2000 (UNAIDS, 2000). By the end of the same year, an estimated 25.3 million people from this region were living with HIV/AIDS. Additionally, during this same period, millions of Africans who had been HIV infected in earlier years began to fall ill and an estimated 2.4 million people died of AIDS-related illnesses during 2000.

According to Smart (2000: 16), in South Africa we have ".....the fastest growing HIV/AIDS epidemic in the world with more people infected than in any other country, with the exception of India". This revelation, and the fact that prevalence rates have increased more than 30 times since the beginning of the epidemic (Stannard, 2001), is clearly demonstrated by Figure 1 below. The Figure shows the results of the South African Annual Antenatal Survey from 1991 to 2000 conducted by the Department of Health and is taken from a recent LoveLife publication entitled "Impending catastrophe revisited. An update on the HIV/AIDS epidemic in South Africa" (2001: 35).

Figure 1: Results of the South African Annual Antenatal Survey: 1991 - 2000



As alarming as the above figure appears, the Minister of Health in South Africa, felt that, at the time, the lower figure for 1999 was an indication that the epidemic was reaching a plateau and that "we are on top of issues...we are getting there" (The Cape Times, March 21, 2001). However, according to Dorrington, it was more likely that the 1998 estimate was too high (Mail & Guardian, March 23 to 29, 2001). He questioned the view that infection rates were being brought under control. The figure above, which includes figures for the year 2000, appears to confirm Dorrington's conclusion.

weight to the argument about prevalence rates demonstrated in Figure 1 adds accepted plateau at around 25% to 30% (AIDS Analysis Africa, 1999). This report used data from Botswana and Swaziland's ante-natal clinic surveys to demonstrate that in both countries, the prevalence rate amongst these groups of women - although now slowing - was over 33% in 1998. In fact, in some sites in Botswana, HIV prevalence amongst women attending ante-natal clinics was close to 50% (at Selebi Phikwe) and just over 40% in Francistown. The authors conclude that "It is not safe to assume that there is a natural peak in HIV prevalence below 30%...and should be a source of real concern to the other countries in the region." (p. 12).

In South Africa, it is estimated that more than 4.7 million adults and children are infected with HIV at present (Department of Health, 2000). This figure is projected to reach between 6 and 7.5 million people over the next ten years unless some major behaviour change and/or a cure is found in the interim (Steinberg et al. 2000). Another study undertaken for ING Barings in 2000 estimates that 8 million people will be infected with HIV by the year 2010 (The Economist, February 24, 2001).

The number of deaths in South Africa each year from AIDS is expected to rise from between 90 000 and 120 000 in the year 2000 to between 384 000 and 383 000 in the year 2005 and to between 545 000 and 635 000 in 2010 (Steinberg et al., 2000; Grimond, 2001). A report in the Sunday Times (July 9, 2000: 1), synthesising figures from the Department of Home Affairs at the time, revealed that "the number of South Africans who die before they reach the age of 50 almost doubled in the past 10 years - an increase attributed directly to HIV/AIDS". Additionally, The Cape Times (April 17, 2001) reported that the death rate in Cape Town alone due to HIV/AIDS (excluding Khayelitsha, the northern suburbs, and South Peninsula) has nearly trebled in the last two years from 168 in 1997/1998 to 474 in 1999/2000. The article goes on to report that, according to the Kwa-Zulu Natal MEC for Agriculture and Environmental Affairs, in Durban death rates had increased 240% since 1994, mainly due to AIDS.

At the time of writing, the most current statistics, contained in a report on AIDS mortality prepared by the Medical Research Council, have unfortunately not yet been made available to the South African public. However, a copy of the report – "The Impact of HIV/AIDS on Adult Mortality in South Africa" – was leaked to the Mail and Guardian (October 5 to 11, 2001). According to the Mail & Guardian, the authors of the report "...estimate that in 1995 Aids caused 9% of deaths in South Africa in the age group 15 to 49, rising to 19% in 1997, to 33% in 1999 and 40% last year" (p. 2). It is

further predicted that by the year 2010, AIDS will have killed between 5 and 7 million South Africans.

It should be borne in mind that AIDS mortality figures tend to be conservative rather than a realistic picture of the tragedy as the records are taken from death certificate data that do not cite AIDS as the cause of death. People do not die from AIDS, but from opportunistic infections / diseases that afflict people as a result of HIV infection (Thompson, Westwell & Viney, 1994; Whiteside & Sunter, 2000).

But of more significant consideration is the fact that the estimated 4.7 million currently HIV infected people will become ill and die during the next ten years making the AIDS-related death rate likely to soar during the next decade and beyond. To this end Levine & Foster (1997) note that, even if infection rates were to level off in the next few years, because of the long incubation period of HIV-infection, death rates will not begin to level off before 2020 (in Foster & Williamson, 2000).

3. HOW ACCURATE ARE THESE HIV/AIDS FIGURES?

Most of the figures and projections quoted above are based on HIV positive prevalence rates amongst pregnant women attending ante-natal clinics in the public sector throughout South Africa. With the use of sophisticated statistical techniques, the figures are extended to include the general population: males, females and children (Whiteside & Sunter, 2000).

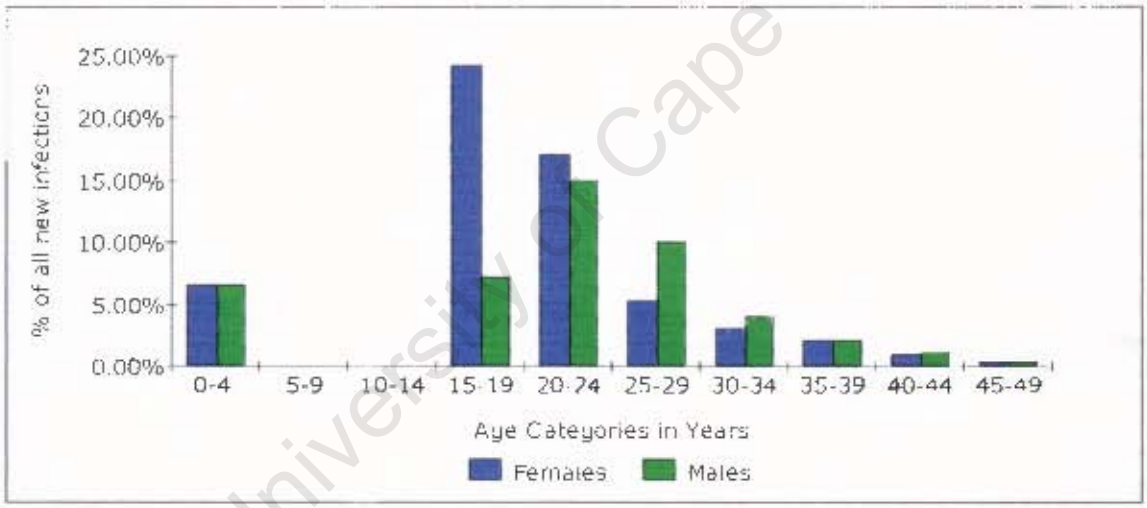
It is recognised that these data may be imperfect. For example, the ante-natal survey assumes that the prevalence of HIV infection is the same for pregnant as for non-pregnant women of similar age. It is known that HIV positive women are less fertile than those women not infected with the virus (Giese, 2001; Smart, 2000). It is also known that HIV positive women are less likely to attend ante-natal clinics than their non-infected cohorts (Giese, 2001). Additionally, the data comes from pregnant women attending public sector clinic and this accounts for only 80% of pregnant women (Giese, 2001). Consequently the data may underestimate the prevalence in women - particularly older women and sexually active girls in their early teens who have not yet attended ante-natal clinics - and thus among the population as a whole (Mail & Guardian, March 23 to 29, 2001). Other reports offer evidence of higher prevalence rates particularly in sub-groups and certain provinces. For example, the HIV prevalence rate for women between the ages of 20 and 24 in Carltonville in Gauteng was estimated

to be as high as 57% (Sunday Times, July 2 2000). However, it is generally agreed that the data from the ante-natal surveys are sufficient to estimate the current and future size and impact of the epidemic (Steinberg et al., 2000; Whiteside & Sunter, 2000).

4. HIV/AIDS: A YOUNG PERSON'S DISEASE

Figure 2, taken from Steinberg et al. (2000), illustrates the proportion of all new infections (i.e. HIV incidence rates) by gender and age. Three considerations are highlighted by these statistics demonstrating those most vulnerable to the impact of HIV/AIDS: the very young; child-bearing and -rearing groups of persons; and women. Each of these particularly vulnerable groups will be discussed in turn.

Figure 2: Proportion of all new HIV infections in South Africa by gender and age



Firstly, HIV/AIDS affects the very young. The approximate 7% new infections that will affect the age group 0 to 4 years old, is a reflection of those who acquire the infection from their HIV- infected mothers prenatally, during birth or through breast-feeding. They are also thought to have a very short life-span with one-third of infants infected with HIV dying before their 1st birthdays and the balance by their 5th birthday (Giese, 2001). During this time they are often sickly. These children would be those whose mothers are also suffering from HIV-induced illnesses; they are very likely to suffer the consequences of living in an HIV/AIDS infected household and/or community and to lose their parent(s) to an AIDS-related illness during their short lifespans. These latter two considerations will be discussed further in section 5.

Secondly, HIV/AIDS affects the reproductive sector of the population most critically. "HIV is a [virus] that mostly affects younger people with around half of all adults who acquire HIV becoming infected before they turn 25. These young people typically die before their 35th birthday" (Steinberg et al., 2000; p. 3) with over 60% of new HIV infections occurring in those aged 15 to 25. At present, approximately 13% of all South Africans between the ages of 20 and 49 are estimated to be infected with HIV. This percentage is expected to reach between 22% and 27% by the year 2010 (Steinberg et al., 2000). It is these young people who are in the prime of their reproductive lives and will be parents to the children of this country. But they are likely to die before the age of 35 and will leave behind young children and infants who will be in need of alternative care. With 53% of South Africa's population under the age of 25, the future impact that HIV/AIDS infection will have on young people and particularly children is enormous (Steinberg et al., 2000).

Finally, HIV/AIDS affects women - particularly younger women - more severely than men. The Figure clearly demonstrates the disproportionate vulnerability of younger women between the ages of 15 and 24 years: the incidence of HIV infection in this group of young women is much higher than for men of similar age. Smart (2000) suggests that women become infected at an earlier age than men due to biological reasons (sexually transmitted HIV passes more easily from men to women than from women to men) and cultural reasons (continued neglect and denial of women's rights including gender discrimination). Additional social reasons such as sexual abuse and rape occurring at ever-younger ages for girls must also be relevant and are expanded upon further in section 5 below.

Among the total population of women and men, it is estimated that 12 to 13 African women are infected with HIV/AIDS to every 10 men (Smart, 2000). Although prevalence rates vary considerably by province, all provinces report a higher incidence of HIV in women (particularly younger women between the ages of 15 and 24) than men. This is particularly alarming in light of the predominance of female-headed households in South Africa as well as the traditionally prescribed burden of childcare and health care being placed almost exclusively on women. In short, it is known "that the female of society will head up the caring of orphaned or abandoned children" (Halkett, 1999; p.8). However, if it is the female of society who are particularly vulnerable to HIV infection then they will exhibit a correspondingly higher death rate. The problem of caring for the large number of orphaned and/or abandoned children will be exacerbated by these factors.

5. CONSEQUENCES OF HIV/AIDS FOR CHILDREN

The consequences of HIV/AIDS for children are complex and multiple. Giese (2001) identifies three particularly vulnerable groups of children:

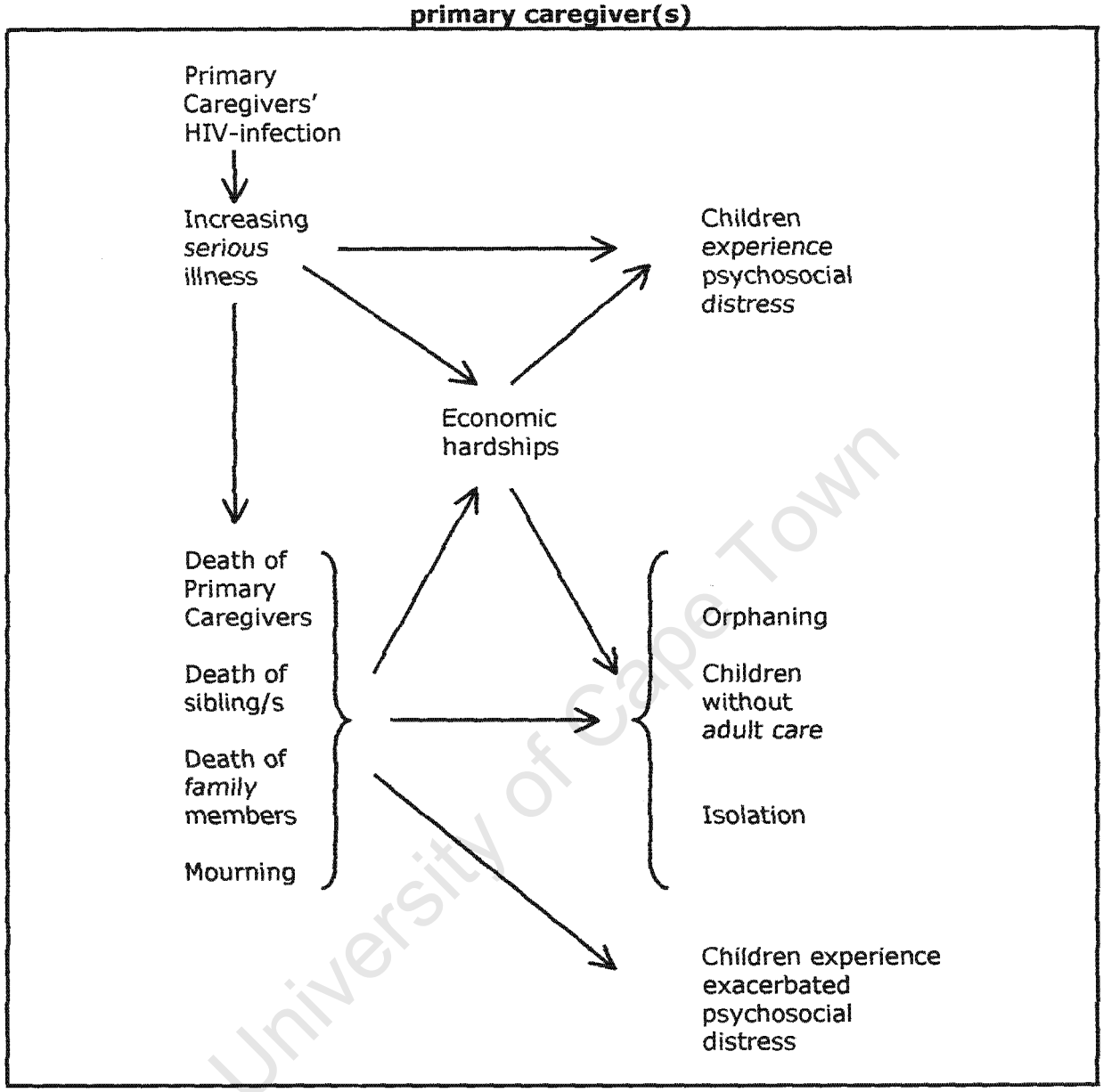
- children affected by HIV/AIDS i.e. those living in households where member(s) are HIV-infected,
- children orphaned by HIV/AIDS, and
- children infected with HIV.

The following discussion will follow this categorisation and add a fourth group of children particularly vulnerable to the consequences of HIV/AIDS: children infected with *and* affected by HIV/AIDS. Each of these groups of children and their particular vulnerabilities are considered in turn below.

5.1. Children Affected by HIV/AIDS

Although not formally defined as such, many authors consider children *affected* by HIV/AIDS to be those who are living in households or close communities where there are HIV-infected members (for example, Giese, 2001; Halkett, 1999; Smart, 2000). Living amongst people who are infected with the virus and/or suffering from full-blown AIDS can have serious and lasting consequences for children. These consequences appear to center around three issues: exacerbated poverty, loss and bereavement, and isolation. Each of these will be explored in turn below. Figure 3 suggests a progression of negative effects for children of HIV-infection in their primary caregivers.

Figure 3: Progression of negative effects for children of HIV infection in their primary caregiver(s)



HIV/AIDS and Poverty

There is extensive evidence to suggest that children living in poverty suffer disproportionately poorer health, stunted growth, and malnutrition (Giese, 2001; Richter & Griesel, 1994). These conditions, in turn affect the cognitive, emotional and social functioning of children. However, the following discussion will focus on the psycho-social effects of living in poverty not only for parents, but children as well.

According to Whiteside and Sunter (2000), about 50% of South Africa's population live in the poorest 40% of households and earn less that R355 per adult per month. A further 27% of the population live in 20% of the "ultra poorest" households and earn less than R194 per adult per month. Additionally, and tying in with these figures, is that between 60% and 70% of South Africa's children live in poverty (Statistics South Africa in Giese, 2001).

Clearly, the majority of South Africans both young and old live in poverty conditions and extending the current HIV prevalence rates to these circumstances, means quite simply that the majority of persons infected with HIV are also poor (Harber, 1999a). However, it is also widely documented that households in which one and often both parents are HIV infected, are more prone to poverty conditions than households that have no HIV-infected members for the following reasons:

* Firstly, HIV usually infects more than one member of a household: if one parent is infected, due to sexual transmission of the virus, the other parent will also be infected (Giese, 2001; Halkett, 1999; Steinberg et al., 2000; Schonteich, 1999; Whiteside & Sunter, 2000).

* Secondly, one or both of these members of the household are either primary caretakers or breadwinners for the family unit (Giese, 2001; Steinberg et al, 2000). Becoming intermittently and progressively more ill depletes the income for the household, and compromises the quality of care of the children in the household.

* Thirdly, it has been found that when a family member has AIDS, the household income may fall between 52% and 67% (Giese, 2001; UNICEF, 1999). Additionally, the financial impact of an AIDS-related death in a family is 30% greater than from death from other causes (Steinberg et al., 2000).

* Finally, the family is also exposed to quadrupled expense in an attempt to manage HIV illness(es) such as medical treatment, transport to health care facilities, special nutritional requirements, and finally funeral costs (Giese, 2001; Steinberg et al. 2000).

Consequently, HIV infection may have the effect of reducing more households to poverty and plunging those already poverty-stricken into complete destitution. The psychological distress for both parents and children in these circumstances is heightened and often debilitating. It is worth noting that as HIV-infection progresses towards full-blown AIDS, it produces continuous and ever-more incapacitating circumstances not only

for the infected persons, but also those around them. Richter (1997) notes that there has been relatively little research into endemic chronic stress in the event of continuous economic scarcity. Given the nature of HIV and the discussion above, continuous economic scarcity would almost certainly be a situation in which many HIV-infected households would find themselves: endemic chronic stress would surely be a feature of these homes.

It has been widely acknowledged that poor parents experience unique stresses associated with being poor that compromise the quality of care for their children (Giese, 2001; McLoyd, 1995; Richter, 1994). South African studies point to high levels of stress among poverty-stricken groups and according to Richter (1994: 40) "...the stress of poverty plays a major role in directly undermining the quality of child care". Over time, negative life events associated with poverty leave parents depleted of emotional reserves and prone to negative emotional states such as helplessness and hopelessness, decreasing self-esteem, depression, endemic stress, and anxiety. These negative emotional states have serious implications for parenting to the extent that

* the ability of a parent to be supportive, consistent and child-centred in his/her parenting is depleted (McLoyd, 1995; Richter, 1994),

* parenting styles often become affectively distance, punitive involving physical punishment, and inconsistent (McLoyd, 1995; Richter, 1994),

* child abuse and neglect often occur more often in impoverished households (McLoyd, 1995; Richter, 1994), and

* female-headed households are known to be at greater risk for living in conditions of poverty (McLoyd, 1995).

Much of the literature documenting the effects of parental depression on children has focused on maternal depression excluding the possible impact of paternal depression on children. For the purposes of the following discussion, given that mothers are traditionally the primary caretakers of children in the African context, the focus will be the effects of material depression on children.

Parents' own depressive condition is considered to affect their children's behaviour in a number of ways. Babies of depressed mothers have been found to be less active, smile less, frown more, be more fussy and tense, and less securely attached to their

mothers (Cole & Cole, 1996). These negative interactional styles are often carried over into other areas of social functioning and into later childhood. To this end older children of depressed mothers often have difficulty with their peers, exhibiting aggressive behaviours towards them; they are often in trouble at school because their attention wonders and they fidget in class; they also run the risk for developing depression themselves (Cole & Cole, 1996).
Despondency, despair, helplessness and hopelessness may be communicated to children through parents' personal and social behaviour (McLoyd & Wilson, 1990 in Richter, 1997).

Closely tied to parental depression is the recognition that this depression often reduces parents' emotional availability and responsiveness to their children (Richter, 1994). Depressed mothers often distance themselves from their family members and may neglect them openly (Garmezy & Masten, 1994). Understandably, parents report difficulty in being nurturant, patient and available when they are constantly distracted by worries over financial matters (Richter, 1994). However, according to Ainsworth, Bell and Staton (1974) as cited in Richter (1994: 42), these emotional states probably affect children "....through disruptions in the attachment system". It may be useful then to explore some of the effects of insecure attachment on infants and children.

Much of the literature documenting these effects originate from the United States of America, England, Asia, and Europe and have produced conflicting results. Examining the cross-cultural validity of attachment theory, researchers such as Sagi (1990), Takahashi (1990), and Grossman and Grossman (1990) conducting studies in Israel, Japan and West Germany respectively, "....seemed to raise some doubt regarding Bowlby's universality hypothesis and the alleged universal applicability of the 'Strange Situation' procedure" (Van Ijzendoorn, 1990: 2). Not only does there appear to be evidence of cross-cultural, between countries differences in attachment frequencies and patterns, but also intra-cultural, within countries differences (LeVine & Miller, 1990).

Tomlinson (1997) uses evidence from these and other studies to question the relevance of the Strange Situation, attachment research in the South African cultural context. He notes that, at the time of his writing, there was a distinct lack of comprehensive research in South Africa that had explored multiple caregiving (which is common in sub-Saharan Africa) and how this influences the behaviour of infants in the Strange Situation. However, given that attachment is a key issue in the first 18 to 24 months of an infant's life and that, in sub-Saharan Africa these early months would arguably have been spent primarily in the company of an infant's primary caregiver, a brief exploration

of existing studies conducted in industrialised countries is presented. Particularly as, in the context of HIV/AIDS, attachment disruption may well be a relevant consideration if the infant's primary caregiver is also intermittently and progressively ill during these early months of a child's life.

Summarising a number of studies, Radke-Yarrow, Cummings, Kuczynski and Chapman (1997), report that early insecure attachment relationships (as a result of affectively distant child-rearing practices) are hypothesised to result in children developing a basic view of themselves as unlovable, and of others as rejecting and responsive. In younger children this affective distance may confuse and distress them; in older children, this behaviour may be misunderstood and provoke resentment.

Additionally, both Clarke-Stewart and Friedman (1987), and Zeanah and Emde (1994), citing a number of studies, demonstrate that insecurely attached infants are less socially and emotionally competent. At age three, insecurely attached toddlers are less likely to elicit positive responses from peers or provoke antagonistic and resistant responses. At pre-school age, these children were often described as tense, helpless and fearful and, at school-going age, they exhibited lower self-esteem and were more likely to exhibit psychological problems.

Two further issues are worth exploring at this point. Firstly, as Richter (1994) notes, the mother of a sickly and demanding child may, even in normal circumstances, find it difficult to be responsive to such a child. Secondly, mothers who perceive their children as unlikely to survive due to HIV-infection may save their energy and emotions for caring for their other healthy children. Shepher-Hughes (1992) explains that this type of maternal detachment may be functional in the stressful circumstances where there are high infant mortality rates. This may well be the case in HIV-infected households and communities and it may result in neglect.

As mentioned earlier, stressed, poor parents are more likely to be inconsistent and punitive in their parenting practices than parents of better socio-economic standing. The effects of harsh and inconsistent parenting on children has been shown to be predictive of a number of socio-emotional problems in children (McLoyd, 1995). For example, adolescents have been found to exhibit increased rates of delinquency, drug use, depressive symptoms, moodiness, hypersensitivity, and feelings of inadequacy. Among younger children, quarrelsome, negativistic and explosive behaviours have been found (McLoyd, 1995). Abused and neglected children exhibit more aggression, anger, frustration and non-compliance behaviours than children who have not been abused

(McLoyd, 1995). According to Lutzker, Bigelow, Swenson, Doctor and Kessler (1999: 523), other long-term consequences of abuse and neglect may include "suicidal behaviour, emotional problems, interpersonal problems and academic difficulties".

Having considered some of the adverse consequences, for both parents and children, of being poor, caution must be shown in ascribing these negative parenting and child outcomes to ALL poor parents and consequently ALL HIV-infected parents and households. All the cited studies above acknowledge that these outcomes are very often *likely*, but are not inevitable. At this point it is worth noting that there are no South African studies examining the impact of parental or child HIV-positive status on either parenting or child outcomes.

HIV-Related Illness in Households and Communities

Long before children experience the death of a parent, and even members of their extended family and/or members of their immediate community, they may spend many months of uncertainty and anxiety as these important people in their lives suffer intermittent illnesses (Foster & Williamson, 2000; Halkett, 1999; Harber, 1999a; Whiteside & Sunter, 2000). In a paper entitled "Children orphaned by AIDS. Frontline Responses from Eastern and Southern Africa" this tragedy for children of watching parents ail and die is succinctly described

> "...because HIV infection progresses from initial infection to mild HIV-related illness to the life-threatening illnesses called "AIDS", children can live with long periods of uncertainty and intermittent crises, as both parents sicken and die. In sub-Saharan Africa, where effective relief for pain or other symptoms is often unavailable, children who live through their parent's pain and illness frequently suffer from depression, stress and anxiety" (UNICEF, 1999)

There have, to date, been few empirical studies of the coping modes of children in *HIV-infected* households where, given the nature of HIV-infection and illness, they would necessarily be exposed to witnessing ever more debilitating ailments afflict those close to them. Altschuler and McFadyen (1999: 239) are equally puzzled by the "....limited exploration of parental illness in both the medical and psychological literature" whilst recognising that most research has focused on *childhood* illness. However, the effects of chronic parental illness and disability on children, seem to be both complex and age-related and may well be relevant for children in HIV-infected households and communities.

One of the most difficult tasks for parents is whether, and how much, to tell a child about their illness (Rolland, 1999). In the context of HIV-infection and the stigma attached to the disease, children are often not told about their parent's illness. Rolland suggests that children have an uncanny ability to sense danger despite parents' unwillingness to confirm the nature of their illness. He adds that this "blocked communication" only adds to a child's anxiety and can cause severe emotional problems for a child "fuelled by catastrophic fears and fantasies about the parent's condition" (p.257). He goes on to add that uninformed young children may often be concerned that they have caused their parent's illness.

Other authors have investigated children's understanding of illness positing that a child's understanding of illness develops on a similar path as their knowledge and understanding of body parts and their functions. For example, according to Bibace and Walsh (1980, 1981) cited in Black (1994), children between 4 and 7 years old may attribute the cause of illness to magic or believe it is a punishment. Children between 7 and 10 years old see illness as contagious and it is not until adolescence that children begin to understand that illness may result from more complex causes. However, Eiser (1989) does point to the possibility that children's repeated experience of illness may promote a far more mature and younger understanding of illness and the consequences thereof. A further consideration is that children who live in animistic cultural communities in Africa, where witchcraft is used to explain misfortune and illness, are likely to ascribe such causes to AIDS-related illness and death (Van Dyk, 2001).

From the above, then, the implications for children affected by HIV/AIDS are that young children may not perceive their parent(s) maladies as life-threatening. Only later, probably around the age of 10 will they fully understand that their parent(s) illnesses may result in death. And according to Miller and Murray (1999), once children reach adolescence, secrets about HIV may be harder to maintain. This, due to these children's more sophisticated understanding of illness and death as well as HIV/AIDS awareness campaigns targeting this age-group of children. However, as more and more people are succumbing to the effects of HIV/AIDS infection and illness, children's more frequent experience of these effects may increase, leading them to become more aware of the dangers of losing parent(s) and family members at ever-younger ages.

Loss and Bereavement in HIV/AIDS Households and Communities

"One of the most profound stressors a child ever has to face is the partial dissolution of a family through the death of a parent" (Garmezy & Masten, 1994;196). Given the unnaturally large number of people who will be dying from AIDS-related illnesses in the

near future in South Africa, children who endure the death of their parent(s) from AIDS-related illnesses, will more than likely also experience the death of family members and/or members of their immediate community. The stress of parental death will necessarily be compounded by the real possibility of witnessing multiple deaths. Koocher and Gudas (1992: 1025) have commented on adult misunderstandings of children's comprehension of death:

> "Three oft-held erroneous assumptions include beliefs that children do not comprehend death, that adults do comprehend death, and that even if children were able to understand death, it would be harmful for them to be concerned about it" (Koocher & Gudas, 1992: 1025)

In light of these observation it is not surprising that children are often not told that their parents have died. According to Marcus (2001), in most communities in Africa and in many other parts of the world, it appears that it is customary not to communicate with children about death and grief. Foster and Williamson (2000) suggest that this is so because there are certain taboos around discussing impending death in African culture as people who discuss death are believed to lay themselves open to charges of witchcraft. Although there appears to be a break in this traditional practice, excluding children from the realities of HIV/AIDS illness and death is very likely to leave children unprepared, anxious, confused, and without any support (Altschuler & McFadyen, 1999; Marcus, 2001; Nieves, 2000; UNICEF, 1999).

As with children's understanding of illness, children also tend to exhibit age-related understanding of death closely tied to their cognitive development and comprehension of abstract concepts such as universality, inevitability and irreversibility (Garmezy & Masten, 1994; Koocher & Gudas, 1992). Reviewing various sources, Garmezy and Masten (1994) following a Piagetian framework, suggest that between the ages of 5 and 7 years old, children begin to understand the universality, finality and biological characteristics of death. By age 8, children comprehend the irreversibility of death. Parental death even at this age is very likely to generate anxiety, fear and depression in children.

Children between the ages of 10 and 14 are thought to be particularly susceptible to the adverse effects of parental death. It is parental loss at this age that may provide the breeding ground for later depression especially "....if that later period is marked by additional stressors that can heighten despair and a sense of failure." (Garmezy & Masten, 1994). Given the various other adverse sequelae of HIV/AIDS for children

providing them with a range of additional stressors as described above, it is likely that these children may well suffer from depression in later life.

Infants and young children are also not invulnerable to the effects of parental death. According to Bowlby, the memory of a parent's death (loss) can remain with young children with consequences shown in behavioural changes from protest to an often misunderstood quietness reflecting despair (in Garmezy & Masten, 1994).

As explained earlier, the nature of HIV infection is such that children will often face the prospect of grief not only for one parent, but for both. The nature of the epidemic will also expose these children to the possibility of grieving for siblings, peers, and/or close relatives. Many children who are orphaned and are living with elderly grandparents and/or HIV-infected members of the extended family may be exposed to the death of these alternate carers as well. Bereavement and mourning can therefore often be extended, overlapping and continuous. The effects of mourning and bereavement in these circumstances can only be further complicated for children from HIV-infected households, and/or communities.

Yet, to date, there have been no systematic studies addressing these extended, overlapping and continuous mourning processes and the effects they may have on children. Recent studies concerned with the effects of parental death on children, have focused on the death of one parent (Dowdney, 2000); others have compared sudden death of a parent with parental death after a protracted, chronic illness (Pfeffer, Karus, Siegel & Hiang, 2000; Ronan, 2000); still others have used retrospective data to investigate adult outcomes after parental loss at an early age (Hurd, 1999; Maier & Lachman, 2000; Ronan, 2000). Other recent studies have explored multiple losses including the death of both parents (Collins-Jones, 1997; Dominguez, 1999; Mahon, 1999).

Lacking any systematic studies focusing specifically on the expected complicated mourning processes for children in HIV-infected households and communities, some of the effects of parental death as described by the above studies will be pursued. This, in light of the fact that, many of these effects will surely be of relevance to children affected by HIV/AIDS. Only those studies that have explored parental death that is likely to be similar to the death of parent(s) as a result of HIV/AIDS are explored. These include death of one parent (Dowdney, 2000; Maier & Lachman, 2000) or both parents (Domingeuz, 1999; Mahon, 1999), some specifically after protracted illness rather than from sudden causes.

Dowdney (2000), in an attempt to expose the limitations and gaps in recent bereavement literature, notes that psychological outcomes in children who have experienced the death of a parent are varied. Reviewing various sources, she concludes that 1 in 5 bereaved children is likely to develop a psychiatric disorder; the highest rates of reported difficulties are found in boys; and in the year following bereavement, children commonly display grief, distress and dysphoria. Maier and Lachman's (2000) retrospective study found that (single) parental death prior to the age of 17 amongst their sample of close to 3000 adults aged between 30 and 60 years, predicted a higher likelihood of depression for women and more autonomy for men. Hurd's (1999) similar study found that depression was not an inevitable outcome of childhood bereavement.

Dominguez (1999) found that children who lose parents are at risk for developing psychosomatic illness, have poor social adjustment, and may fail to reach their potential development. Mahon (1999) used a case study approach to examine secondary losses for two children following the death of both their parents. Although noting that childhood bereavement is characterised by prolonged pain and tainted experiences, secondary losses - especially isolation - had exacerbated the bereavement for these children. Finally, Collins-Jones (1997) found that as a group, her sample of 52 uninfected American children (mean age: 10.29 years) in HIV-infected households were characterised by clinically elevated levels of psychological distress. Although her findings were related to having multiple family members diagnosed as HIV-positive, the death of family member(s) due to AIDS was one of the factors that contributed to these children's greater risk for developing behavioural and/or emotional problems.

The Stigma of HIV/AIDS Infection and Isolation

Another of the negative effects of living in an HIV-infected household is the well-documented pervasive stigma attached to HIV-infection and AIDS-related death which often results in isolation for the family members (Draft discussion paper, July 2000; Halkett, 1999; Harber, 1999a; Smart, 2000; Whiteside & Sunter, 2000). Coupled with the stigma of poverty, this can have serious consequences for family members - particularly children - who at this time are probably most in need of support from others.

The majority of families affected / infected with HIV/AIDS live in poverty and may face additional unfair prejudice, discrimination, and stigmatisation due to their status. According to Giese (2001) children living in poverty are teased by their peers and are frequently marginalised by members of their community even though, as mentioned earlier, most of those who are particularly vulnerable to HIV-infection are poor.

Confirming this, Foster, Makufa, Drew, Kambeu and Saurombe (1996) found that Zimbabwean orphans were stigmatised based on their orphan status and poverty situation rather than from being associated with HIV/AIDS.

Coupled with the stigma associated with poverty, is the pervasive stigma attached to HIV infection and AIDS-related death. Children living in households where there are HIV-infected members, are thus subjected to the double burden of prejudice and stigmatisation from being poor and having a member (or members) of their families infected by HIV. Shame, fear and rejection often surround people infected with the virus and is coupled with irrational fear of contamination (UNICEF, 1999). Shame is often felt as AIDS is predominantly a sexually transmitted disease (Powell, Morreira, Rudd & Ngonyama, 1994).

According to Harber (1999a), some of the consequences of this stigma may be that parents do not disclose their HIV status and often do not call on the wider family for help - putting greater responsibility on the children. Harber adds that orphans are at greater risk of being rejected / abandoned by their kin. These consequences of the stigma attached to HIV have a number of negative outcomes for HIV infected households. Firstly, mothers, for fear of abandonment by or physical abuse from their children's fathers should they disclose their HIV positive status, do not have the freedom to choose risk-reducing behaviours. These behaviours include breastfeeding, condom use, and further pregnancies. Secondly, home based carers' offers of help are often rejected (Giese, 2001) because accepting help from these carers', demonstrates to others in the community that there is HIV-infection and illness in the household.

The most serious implications of this rejection by, and stigma-related self-imposed isolation from, family and community members may be found in the adverse effects it may have for factors that promote resilience. In the event of negative life events and stressors, the role of social support has been documented as providing a means of mediating the adverse effects of these life conditions (Powell et al., 1994; Werner, 1997; Werner, 2000). However, because of rejection by kin and also the wider community, families where there is HIV infection are often not given any form of support, whether instrumental and/or emotional and become further isolated. It appears then that social support that may have helped HIV infected or affected families, and particularly children, is neither offered nor available thereby complicating the variety of negative events to which HIV/AIDS subjects them.

There have been a number of studies that have focused on either social support for persons with AIDS (PWA's) and/or the relative value and access of persons providing support. Most of them have been generated in the United States of America, Canada, and Britain and have an almost exclusive focus on adults: particularly middle-class, gay, men but also intravenous drug users with none being specific to children (for example Britton, Zarski, Hobfoll, 1993; Friedland, Renwick & McColl, 1996; Green 1993; Lamping, Gilmore, Grover, Tsoukas, Faultz, Hamel & Di Merco, 1992; Schreurs & De Ridder, 1997; Stowe, Ross, Wodak, Thomas & Larson, 1993). It is therefore debatable whether these findings and commentaries are relevant to the context of HIV/AIDS in the developing world (including South Africa) where HIV/AIDS predominantly infects and affects heterosexual persons irrespective of gender; poorer people; and children. However, although Green (1993) notes that research into the link between social support and the psychological well-being of PWA's is still in its infancy, some researchers and commentators have indicated that social support can be a significant mediating factor against the stressors of a chronic illness such as AIDS.

Two such examples are firstly, Lamping et al. (1992) who found that social support was a strong predictor of psychological well-being amongst their random sample of 73 HIV-positive adult patients. And secondly, Friedland et al. (1996) who found evidence of the importance of emotional social support and positive health outcomes amongst their sample of 120 HIV-positive persons. These researchers also found that friends and partners, rather than family, were the most frequent providers of support for their sample.

5.2. Children Orphaned By HIV/AIDS

Before exploring the consequences of HIV/AIDS for children in terms of orphaning, it is important firstly to clarify what is meant by an orphan and then to explore the extent and projections of orphaning both globally and in South Africa.

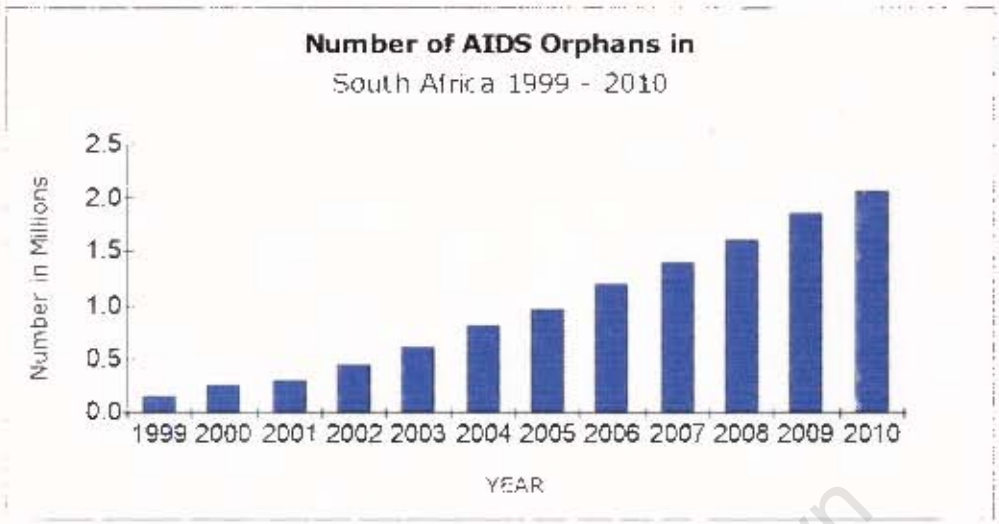
For the purposes of this study the definition followed by UNAIDS, WHO, and UNICEF will be followed. These organisations define AIDS orphans as children who have lost their mother to AIDS before the age of 15 years (UNICEF, 1999). It is also important to note that other reports and even AIDS orphan projections, use differing definitions of orphanhood from those including orphans from all causes (Halkett, 1999); children 14 years and younger who have lost either their mother or father to AIDS (Halkett, 1999); and any child younger than 18 or who is still at school and who has lost either or both parents (Ali, 1998). However, most orphan estimates use the age range "under 15 years" as do they "*maternal* orphanhood" (Foster & Williamson, 2000). This choice of

age range and parent's gender has implications for orphan estimates and projections. According to Foster & Williamson (2000: S276), "Definitions that exclude paternal orphans under-estimate total orphan numbers by 45-70%; definitions which exclude 15-17 year old children under-estimate this figure by 25-35%".

At a global level, the tragedy of HIV/AIDS is further highlighted when considering that by the year 2000, 13 million children will have lost their mother or both parents to AIDS and 10.4 million of them will be under the age of 15 (UNAIDS, UNICEF and BLCA, 1999). For Africa, this catastrophe is confounded by the fact that 90% of orphaned children are in sub-Saharan Africa.

In South Africa, it is thought that by the year 2015 orphans will comprise between 9 and 12 percent of the total population (between 3.6 and 4.8 million children) (South African Law Commission, 1999 in Smart, 2000). These projected figures may at first glance appear to be exaggerated. However, other projections and estimates all report similarly alarming results. The United States Bureau of he Census (Hunter, 1997 in Halkett, 1999) estimated the number of orphans in South Africa by the year 2000 as a result of all causes at 1.8 million children and by 2010, at 2.6 million children. Similarly, as part of a paper for the United Nations Development Programme, an actuarial projection by Metropolitan Life estimated the number of orphans (i.e. children up to the age of 14 years old who have lost their mother due to AIDS) by 2010 to be just under 2 million (Whiteside and Sunter, 2000). This estimate is close to the one from the Institute for Security Studies that calculated the projected number of orphans due to AIDS by 2010 to be just over 2 million (Die Burger, August 23, 2000). Figure 4 below, taken from Schonteich (1999: 1) demonstrates the "unprecedented wave of orphaned children" in South Africa.

Figure 4: Number of Orphans in South Africa: 1999 to 2010



Even if these figures prove to be overestimates or simply way off target, there is enough evidence to indicate that a large number of children in South Africa, now and for many years to come, will grow up without the beneficial experience of family life. In fact, with AIDS-related death rates expected to increase for at least the next two decades, the proportion of orphans will remain high until at least 2030 (Foster & Williamson, 2000).

Two major concerns relating to the large number of prospective orphans are that many of these children may end up living on the streets (Foster & Williamson, 2000; Giese, 2001; Hasewinkel, 2000; Steinberg et al. 2000; Whiteside, 2000; Wood & Mason, 1997). The other concern, proposed by Schonteich (1999: 1) is that orphans "Growing up without parents, and badly supervised by relatives and welfare organisations...." will be at greater risk than average for engaging in criminal activities. Exploring the long-term effects for children growing up without the love and care of adults, Richter (2001: 33) suggests that "They may develop antisocial behaviours which.....could cause social problems on an unprecedented scale."

However, there appears to be a lack of systematic, empirical studies of HIV/AIDS orphans and their particular psycho-social vulnerabilities. According to Foster & Williamson (2000), this is as a result of a focus on the social and economic impact of HIV/AIDS on children: psychological needs appearing to be less obvious and less immediate. However, there have been numerous anecdotal reports particularly in the print media documenting the plight of HIV-orphaned children. These reports clearly demonstrate the adverse effects of orphaning for some children.

Some systematic studies have begun to emerge from countries to the North of South Africa, and tend to focus on the extent of orphaning, and the ways in which these children are being accommodated and/or serviced within their communities of origin (for example, Ali, 1998; Foster, Shakespeare, Chinemana, Jackson, Gregson, Marange & Mashumba, 1995; Foster et al. 1996; McKerrow, 1996a; McKerrow & Verbeek, 1995; and Parry, 2000). However, little empirical work has been done to advance our knowledge of the psycho-social consequences of orphaning particularly in the context of HIV/AIDS. If the report commissioned by the Nelson Mandela Children's Fund (2001) is anything to go by, this trend may be changing. In this report, through self-reports and interviews with service providers and members of child-headed households, some of the issues confronting orphaned, child-headed households in South Africa are explored. Some of these consequences are detailed in chapter 2 in the discussion of child-headed households and will not be expanded upon here.

Be that as it may, the most tragic consequence of HIV infection for children is often orphaning as their HIV-infected mothers and/or fathers succumb to AIDS. For the older groups of children they may be thrust into the role of carer for their siblings - even if only temporarily. Aldridge and Becker (1999) cite a number of commentaries who point to the possible long-term effects of children's premature adoption of caring roles (for example, Arnaud, 1959; O'Neill, 1985; and Power, 1977). These appear to be lack or loss of schooling, over-compliance, loss of emotional spontaneity, and interference with peer relations. Sometimes being ill themselves, this additional responsibility will weigh even more heavily on their young shoulders. For the younger groups of children, they will be forced to turn their demands for care to their older siblings who are often unable to adequately take on this role - particularly if they themselves are HIV positive and often ill.

5.3. Children Infected With HIV/AIDS

One of the other groups of children identified as being particularly vulnerable, are those infected with HIV/AIDS. If one refers back to the Figure 2 on p. 5 it is evident that the age group 0 - 4 years is the most at risk for HIV/AIDS infection. As explained earlier, these children are most commonly at risk due to mother-to-child transmission (MTCT) of the virus.

These children have very short lifespans. In sub-Saharan Africa and South Africa due to adversities such as poverty, malnutrition, and difficult access to health-care services amongst other things they often die before their first birthdays, but some do survive to see their 5th birthdays. During this time they are sickly becoming more so as the

disease progresses thus probably requiring more care than uninfected children. These demands for additional care would more than likely be provided by parent(s) who are themselves HIV-compromised; and/or from siblings who are young and inexperienced in childcare; and/or from extended family members who may be reluctant alternative carers or simply lacking in resources and/or energy to adequately cope with a sick and dying child.

It is this age group too - particularly new-born infants - who are most likely to be abandoned by their HIV positive mothers (Halkett, 1999). Recent data revealed that between 3000 and 4000 babies and children were abandoned during 1997 doubling in number between 1997 and 1998 (Smart, 2000). It appears from various newspaper reports and a recent discussion with Ms. Halkett that abandonment has increased significantly and is becoming a much more severe problem in present times (Halkett, 1999; Saturday Argus, June 19/20, 1999; Saturday Argus, July 15/16, 2000). In fact, the South African National Council for Child and Family Welfare report a 67% increase in child abandonment over the last three years (Giese, 2001). There is no indication as to whether these increases are due to the HIV-positive status of the children's mothers and their increasing numbers, or the worsening economic conditions in which they find themselves for a variety of reasons, or both. Whatever the cause, these abandoned babies, having often been forsaken in life-threatening locations or in over-crowded hospital wards across the country, are frequently placed in institutional settings or temporary emergency foster-care family environments until such time as alternative arrangements can be made for them (Halkett, 1999).

Again referring to Figure 2 on p. 5, children between the ages of 5 and 14 appear to have little risk of becoming infected with HIV. However, it is entirely likely that the age group 10 to 14 would begin to be vulnerable to infection. Particularly in light of data from three sources that illustrate the onset of sexual activity appearing to be at an extremely young age in South Africa. In Swaziland age-specific data revealed a number (albeit a small number) of pregnant females in the age group 11-14 (AIDS Analysis Africa, 1999). In another release by Lovelife it was reported that in a recent survey, 4 out of every 10 young people were having sex before the age of 12 (Lovelife, 2001). The Buga study in ex-Transkei revealed that boys started sexual intercourse at an average age of 13.43 years and girls at a mean age of 14.86 years (Smart, 2000).

It seems likely then that sexual activity may well begin at ages as young as 11 or 12 years old although Whiteside & Sunter (2000) call for more accurate and South African based surveys and research to better determine this type of information. Nevertheless,

given that HIV/AIDS is spread in the majority of cases through sexual encounters, it is quite evident that this group of children/young adults will be at greater risk of HIV-infection than the available data in Figure 2 suggests. Some of the reasons for this risk are given below:

- Sexual abuse and rape often occurs at this young age as a result of the myth that sex with a virgin will cure one of AIDS or that younger girls will not be infected and will therefore not pass on the infection (Giese, 2001: Whiteside & Sunter, 2000).

- The slightly older girls will often be forced through economic dependence into early marriage and/or reliance on male economic support robbing them of control over the circumstances and/or safety of sex (Foster & Williamson, 2000: UNAIDS, 2000).

- Young girls may enter into prostitution even at a young age often due to the dire economic circumstances of their families (Foster & Williamson, 2000; Whiteside & Sunter, 2000).

- Children who have suffered the psychosocial sequelae of HIV/AIDS may be drawn to deviant drug-taking behaviours although Foster & Williamson (2000) citing two sources - Kirya (1996) and Forsyth, Damour and Naglre (1996) - and Richter (2001) note that internalised behaviour disturbances such as depression, anxiety and low self-esteem seem to be more common in orphans rather than acting out and deviant behaviour.

- Some may be at risk for acquiring HIV simply from caring for HIV-infected parent(s) and/or siblings particularly if they have no notion of how to avoid infection from this source.

However, should these 10 to 14 year olds become infected they too would require more caring than uninfected children from parent(s) who are themselves HIV-compromised and/or from extended family members who may be reluctant alternative carers or simply lacking in resources and/or energy to adequately cope with a sick and dying child. They too will be sickly and their life expectancy from HIV infection to full-blown AIDS and death will be between 6 and 8 years - often less depending on the quality and quantity of nutrition and access to health-care services and medications. There is a possibility that they may become parents to their own children requiring the nurturing and care that any young infant demands. Often, if their parent(s) are very ill or have died, they may be caring for siblings - some of whom may also be HIV positive and ailing. Being

older they would be more aware of and responsive to some of the psychosocial consequences of HIV/AIDS explored above.

5.4. Children Infected With and Affected By HIV/AIDS

In addition to the consequences of being HIV infected, many children will also have suffered, in varying degrees and depending on their ages, adverse psychosocial consequences of HIV/AIDS and/or orphaning as detailed above. These are the children who form the fourth groups of particularly vulnerable children: those infected with *and* affected by HIV/AIDS. They would face the double burden of their own illness as well as the often overwhelming consequences of living with HIV/AIDS within their own households as well as within their immediate communities.

6. CONCLUSION

The preceding discussion has highlighted the extent of the HIV/AIDS pandemic both globally and locally. The central focus however, has been on the possible and under-researched negative psycho-social sequelae for children of HIV/AIDS. They include the effects of living in poor households often made poorer from the impact of HIV-infection in the household; the effects of illness, death and bereavement in the context of overlapping, ongoing and multiple deaths in their families and/or communities; and the effects of isolation and limited support as a result of the pervasive stigma attached to HIV/AIDS. These negative psycho-social consequences for children are shown to be compounded when children are also orphaned and/or are infected with the virus themselves.

All of the adverse effects of living in HIV-infected households and communities as described above, will follow these children into whatever alternative caring situations they may enter following the death of their parent(s). Many of these negative effects will impact on potential alternative carers' decisions to care for them. This will be pursued in the next chapter.

CHAPTER 2

MODELS OF ALTERNATIVE CARE FOR CHILDREN IN NEED

1. INTRODUCTION

The preceding chapter has highlighted the fact that South Africa is facing the prospect of an extremely large number of orphaned children within the next decade and beyond. These children would also have experienced psychological trauma through the illness and death of people close to them, as well as the social isolation that accompanies AIDS related illness and death. Although the ideal would be for as many of these children to experience some type of family life in which to grow and mature into responsible adults, the reality may be quite different.

This chapter considers existing models of care available to children in South Africa: informal foster care and kinship care, formal foster care, and adoption. It will be shown that these existing models of alternative family care are either under-utilised, under-promoted or are simply becoming over-extended. It will also be established that, although each of these forms of alternative care are not without problems, they do encompass an environment that provides children with some form of family life.

Much of the following discussion is informed, and admittedly biased by the opening statement to the Convention on the Rights of the Child which makes a strong statement about family life:

> "Recognising that a child, for the full and harmonious development of his/her personality, should be brought up in a family environment, in an atmosphere of happiness, love and understanding" (cited in Neilson, 2000: 1).

Likewise, the South African Constitution (Act 108 of 1996), recognising a child's right to family care, places an obligation on government to ensure that "Every child has the right to family care or parental care, or to appropriate care when removed from the family environment" (cited in Giese & Hasewinkel, 2001). This "family care or parental care" forms the focus of the following discussion particularly with regard to children orphanedby HIV/AIDS and their right to this type of childhood caring experience.

2. EXISTING MODELS OF ALTERNATIVE FAMILY CARE

Historically in South Africa, alternative parenting within family contexts for children in need has been provided by adoption, foster care, informal foster care, and kinship care within the extended family. The first two options are heavily entrenched in first-world models of alternative family care and have been under-promoted and therefore under-utilised by the majority of South African families. This will be expanded upon below. The latter two options center around the fact that childcare within black African culture has historically been viewed as a social task performed by the entire extended family rather than an individual family one (Brink, 1998; Halkett, 1999; McKerrow, 1996a; McKerrow & Verbeek, 1995; Pakati, 1984; Thomas & Mabusela, 1991; Tolfree, 1995). It is these latter two forms of alternative family care that will be explored first.

2.1. Kinship Care Within Extended Families and Informal Foster Care

Within these models of alternative family care there is no legal transfer of either custody or guardianship of the child to his/her substitute parents: it is an informal arrangement between members of a child's extended family with no application for government assistance (Halkett, 1999; Smart, 2000).

These forms of alternative family care have been practiced for many centuries throughout Africa and center around two groups of children in need of alternative care. Firstly, should a child be orphaned, abandoned, abused, or neglected for example, he or she is absorbed into the extended family network and cared for by kin (Halkett, 1999; Pakati, 1984; McKerrow, 1996a; McKerrow & Verbeek, 1995; Tolfree, 1995). In this instance, children are seen to be in need of alternative care for reasons of parental inadequacies and is close to the common notion of formal foster care which will be explored further below. In the context of HIV/AIDS, with the focus on child abandonment and orphaning, kinship care rather than other types of informal foster care (discussed next) is, and has been, arguably the most likely response to children orphaned by HIV/AIDS.

Secondly, Foster & Williamson (2000) and Sishuta (1996) make reference to a number of studies that show that many informal foster care arrangements in sub-Saharan Africa have been made for a variety of additional reasons. Some of these include: to provide domestic and other assistance to the foster family; to be better disciplined by the foster family; to learn a trade or attend school; to gain some advantages should the foster family be wealthier than the one from which the child originated; to forge social and familial alliances. This form of alternative family is one in which the caring arrangement

is not a life-time one with children returning at some stage to their familial homes. Given the reasons for this form of alternative care, it is unlikely to be used as a response to children orphaned by HIV/AIDS.

Many authors have pointed to the extensive informal foster and kinship care arrangements that exist in South Africa as well as countries to the north of South Africa (Foster & Williamson, 2000; Halkett, 1999; Harber, 1999a, 1999b; McKerrow, 1996b). However, statistics reflecting these informal or kinship foster placements are not readily available. Some indication of this type of alternative care can be obtained from McKerrow & Verbeek's study conducted in 1994 / 1995 which found that 19.3% of all children under the age of 17 years were not living with their parents in eight communities in Kwa-Zulu Natal. Additionally, Henderson's (1999) research found that the ten to sixteen year old children she interviewed in New Crossroads Cape Town, had already spent one third of their lives away from their parents.

Characteristics and Motivations of Kinship Carers

Due to the paucity of studies with regard to this form of alternative care, it is difficult to make any assumptions about the particular characteristics and motivations of these groups of carers. However, the foregoing discussion, and evidence from local studies and commentaries (for example, Foster et al. 1995; Halkett, 1999; Harber, 1999a, 1999b; Rankin, 1983; Richter, 2001; Sishuta, 1996; Smart, 2000; Thomas & Mabusela, 1991) and in the United States of America (Berrick, 1998; Gebel, 1996; McLean & Thomas, 1996), do provide some notion of these carers' characteristics and motivations. Most of these studies have been conducted on caretakers who are formally fostering children of their kin. Common characteristics include:

- They are most often elderly maternal grandmothers.
- In South Africa, more often than not they live in rural areas where access to health care and adequate schooling for children in their care is difficult.
- They are likely to be impoverished themselves and are often in poor health.
- In all probability they would be minimally educated and unemployed.

The primary motivation in the case of kinship care, evidenced from both the South African and overseas studies, appears to be a strong sense of family duty and obligation.

Advantages and Disadvantages of Kinship Care

One of the major problems in South Africa associated with this form of care as a means to alleviate the HIV/AIDS orphan crisis is that "The AIDS epidemic has now stretched

the resources of extended families to the limit..." (Harber,1999a: 7) It is agreed by other authors that the extended family is becoming overwhelmed (Halkett, 1999; Harber, 1999a; Smart, 2000) and possibly reaching saturation point (Halkett, 1999; McKerrow, 1996a; McKerrow & Verbeek, 1995; Harber, 1998). Elderly relatives are finding themselves having to provide care for more and more sibling groups. They themselves are in impoverished conditions, are often elderly and lack energy, and frequently report an inability to discipline the children in their care (Barnett and Blaikie, 1994 in Harber, 1999a). Besides which the next generation of grandparents will be severely depleted by AIDS and so this source of alternative care will not be available in the long term (Harber, 1999a). Harber reports too, that in many African countries AIDS has produced the situation where there is no-one remaining within an extended family who is willing or able to care for orphaned children (for example, Berer and Sunandra, 1993; Barnett and Blaikie, 1994; Foster, Makufa, Drew, Kambeu & Saurombe, 1995). The stigma surrounding HIV/AIDS has also produced the situation where relatives are reluctant to, or will not care for children orphaned by HIV/AIDS (Harber, 1998; McKerrow & Verbeek, 1995).

Yet there persists the notion that kinship care is preferred not only by black African people themselves, but also by those who are working at the grassroots level of providing alternative family sources for orphaned children (McKerrow & Verbeek, 1995; McKerrow, 1996a; Halkett, 1999). In fact many of these authors suggest a type of hierarchy of alternative care ranging from kinship care within the extended family, to care by families within the community from which the orphan/s originate, to care by strangers, and finally to institutionalisation.

The obvious advantage associated with kin care is that the children remain in the family unit. They would probably continue to have access to other relatives and siblings - many of whom will also be cared for by their carers. Children would therefore have a sense of security and continuity that may be lacking in both formal foster care placements and, to some extent, in adoption.

2.2. Formal Foster Care

In South Africa, formal foster care is an established practice and allows for the placement of a child with alternative caregivers when life circumstances dictate that this is necessary for the child's care, protection, and development. This involves the legal transfer of guardianship of the child to the foster parents as well as assistance from the government (Halkett, 1999). Children are removed from their parental homes and placed with alternative caregivers (who are awarded a foster care grant) for a variety of

reasons: parents who abuse drugs or alcohol, child abuse and/or neglect, abandonment, illness or death of one or both parents (Tolfree, 1995; Wolkind & Rushton, 1994). Foster care is intended to be a short-term arrangement with the ideal being that the child is re-united with his or her biological parents once the family circumstances improve (Halkett, 1999; Scholtz, 1997; Tolfree, 1995). However, it is recognised that many placements are often long-term and children tend to spend many years in foster care placements (Hersov, 1994; Wolkind & Rushton, 1994).

The South African model of formal foster care is much the same as is practiced in many Western countries today. Additionally, as will be explored below when dealing with adoption, welfare services in this country including formal foster care, have an historical legacy of not having been available to, nor provided for black African children in need of alternative family care. In countries in Sub-Saharan Africa, formal foster care is not a widely practiced nor a recognised form of alternative family care for most children in need of alternative care.

Scholtz (1997) reports that at the end of March 1997, there were 73 354 foster children in 42 998 foster families in South Africa. Additionally, according to Halkett (1999), the Child Welfare Movement saw a steady increase in the number of children placed in formal foster caring arrangements between 1995 and 1998 with a 54% increase in first time foster care placements between 1995 and 1996/97; and a 60% increase between 1996/7 and 1997/98. This was largely due to foster care services becoming more accessible and better known to black African families than was previously the case. Also, that many informal, kinship carers are arguably becoming more inclined to access the foster care grant to assist them in caring for their kin.

Fostercarer Demographics and Motivation

A substantial number of reports on foster carer demographics have emanated from the United States of America, the United Kingdom and Australia (Bebbington & Miles, 1990; Churchill, Carlson, & Nybell, 1979; Evans & Tierney, 1995; Hampson & Tavorina, 1980; Kirby, 1997; Peterson & Pierce, 1974; Wolkind & Rushton, 1994). These studies show that on average, foster parents are most likely to be around 45 years of age (with foster mothers being slightly younger than fathers). The family would consist of a married couple reflecting a high degree of stability in their marital relationship, three biological children (approximately 10 years old) and possibly as many as two additional foster children. The foster parents would most likely be slightly less well educated than the population norm with foster mothers inclined to be unemployed and the majority of foster fathers being employed in "blue collar" occupations. Foster mothers were likely

to have some experience in child-related occupations such as nursing, home-care and/or child care. Some of the studies also found that a significant proportion of their samples had grown up in families with four or more siblings and were thus familiar with large family functioning with fluid family boundaries. Many had also experienced "unhappy" childhoods. On the whole, the family home consisted of 3 or more bedrooms.

In many respects the literature demonstrates that the South African foster carer resembles the above profile with few exceptions (Bandawe & Louw, 1997; Rankin, 1983; Sishuta, 1996; Thomas & Mabusela, 1991). South African foster carers are more likely to be older (between 50 and 60 years old) particularly if they are kinship carers. In fact they are very likely to be the grandparents of their respective foster children. In line with the greater age of these carers, many were widowed, unemployed, and receiving a pension grant. The family home was somewhat smaller than that reported in the United States, United Kingdom and Australian studies.

A number of studies on foster care emanating from the United States of America, Britain and Australia make use of some measure to explore their respective samples' motives for foster parenthood (Dando & Minty,1987; Evans & Tierney, 1995; Gilligan, 1996; Gillis-Arnold, Crase, Stickdale, & Shelley, 1998; Hampson & Tavormina, 1980; Helton Stromberg, 1994). Only two of the Southern African studies - Bandawe and Louw (1997) and Sishuta (1996) -explored this dimension of their foster carer samples.

Some of these researchers developed scales from which their respondents could either select their agreement/disagreement to a particular statement describing a predetermined, possible motivation (Gillis-Arnold et al., 1998) or select three motivations from a predetermined list that they felt were their chief reasons for entering foster care (Gilligan 1996). Other researchers were able to elicit their respondents' motivations through personal interviews or open-ended questions (Bandawe & Louw, 1997; Dando & Minty, 1987; Hampson & Tavormina, 1980; Helton Stromberg, 1994; Sishuta, 1996).

To give the reader an indication of the most common reasons given for fostering, the three most frequently cited from each of the studies are reported in Table 1 below:

Table 1: Foster care motivations

Bandawe & Louw (1997)	Childlessness Wanting more children Sense of family duty & obligation
Dando & Minty (1987):	Altruism / social conscience *Wanting a larger family including childlessness* Wanting to nurture children
Evans & Tierney (1995)	Altruism & social conscience Empathy Wanting more children
Gilligan (1996)	*Wanting to help under privileged children* Wanting a child / more children Knowing of a child needing a home
Gillis-Arnold et al. (1998):	Rescuing abused and/or neglected children Companionship for adult Replacing grown children
Hampson & Tavormina (1980)	Love of children Companionship Desire to help someone
Helton Stromberg (1994)	*Love for children* Desire to care for babies & children
Sishuta (1996)	Desire to render a service Financial gain Sense of duty & obligation

Two additional points bear mentioning here. Firstly, Gilligan (1996) mentions the possibility that his sample's high level of altruistic motivation may be as a result of the sample being drawn from rural areas. These areas have been found to have a greater tendency to regular religious practice and thus the altruistic motivation may be more due to religious factors. Secondly, in the two South Africa studies reviewed - Bandawe & Louw (1997) and Sishuta (1996) - a sense of family duty and obligation was high on the list of motivations for their samples of respondents, perhaps reflecting the collectivist nature of Southern African societies. The majority of parents in both Bandawe and Sishuta's samples were biologically related to their foster children and may explain why "family duty" was posited as an important motivation in these two studies.

Although one cannot make generalisations based on eight studies, it appears that altruism is a common motivation among foster parents. This is followed closely by either childlessness or a desire for more children. The African experience, however, does appear to be different with family duty and obligation mentioned as a motivation.

Formal Foster Care and Child Outcomes

Wolkind and Rushton (1994) have reviewed a number of international studies examining the difficulties experienced by foster children. It will be evident that many of these problems (as well as those peculiar to living in HIV-infected households or communities) would follow the children into foster care placements. Foster children come to the placement carrying the emotional scars of their past with them. It would be erroneous to conclude that the enumerated child problems would necessarily result from being placed with foster carers. A summary of child problems is as follows (Wolkind & Rushton, 1994):

- Behavioural disturbances seem to be high on the list particularly for permanently placed children. Rowe, Cain, Hundleby and Keane (1984) found that foster children have a higher incidence of temper tantrums, bed-wetting, lack of concentration, destructiveness and stealing. Hampson and Tavormina (1980: 111) add "emotional or nervous problems" and "misbehaviour or acting out" as additional problems that foster mothers identified in their foster children.

- Holbrook's unpublished study (cited in Wolkind & Rushton, 1994) found that foster children scored lower on measures of self-esteem than children living with their biological children or adopted children. They also tended to have problems with peer relations and did less well at school than a comparative groups of children.

- Many studies cited by Wolkind & Rushton (1994) explore the alarmingly high break-down rates among foster caring situations (for example, Berridge & Cleaver, 1987; Fanshel & Shinn, 1978; Trasler, 1960; Parker, 1966). Hersov (1994) estimates the breakdown rate in fostercare to be as high as 50%. He goes on to examine the consequences of breakdown and concludes that these foster children are at greater risk in terms of security, stability and continuity.

- Wolkind & Rushton (1994) acknowledge the paucity of research on abuse in foster care. However, abuse and sexual abuse by foster fathers and a child of the foster family were noted.

- Additionally, foster parents often enter foster care for financial gain. The grant paid to foster carers, in this instance, is often used to supplement the family income rather than provide for the additional child in the home. To the extent that there have been reports of foster children being denied food, clothing, schooling in favour of the foster family's other children.

With reference to South African formal foster care, there have been no studies dealing specifically with the problems that face children in such care. However, it is unlikely that they would be any different from those cited above and are likely to be more extensive and varied with the addition of the psychosocial consequences of living in HIV-infected households and communities as described in chapter 1.

The obvious advantages of foster care are that children are removed from a family situation that is disruptive and detrimental to their development and placed with a family that is expected to be more stable, caring and nurturing. Providing children with on-going adult supervision and care, discipline and guidance that is presumed to exist in formal foster care would be a distinct advantage for many of them.

2.3. Adoption

Adoption refers to the legal transfer of both guardianship and custody of a child to the adoptive parents (Halkett, 1999; Pakati, 1984, Tolfree, 1995). In essence this means that an adopted child will have the same rights of inheritance as the other children in his/her adoptive family: the legal process allows the child to be taken into his/her new home and treated as if born into the new family. Adoptive parents will have the same responsibilities and rights as other parents (Halkett, 1999).

In the past, both in South Africa and in the United States of America and Britain, adoption has largely been confined to the adoption of young infants by childless, white, middle-class, married couples (Harber, 1999b; Brink, 1998; Hersov, 1994; Quinton, Rushton, Dance & Mayers, 1998; Watson, 1996). In South Africa, adoption practice has been strongly influenced by concepts and policies developed in the West, particularly Britain the United States of America. These practices have focused on the typical western ideal of the two-parent nuclear family.

Until recently little has been done to promote adoption of black children in South Africa. There are a number of reasons for this. Firstly, adoption carries with it the legacy of a welfare system that was developed largely for whites in South Africa (Brink, 1998; Harber, 1999b). Legal adoption services were virtually inaccessible to black South Africans and many are still unfamiliar with the notion of this form of caring. Secondly, it was thought that this mode of alternative parenting was not necessary as the extended family met the needs of black children (Harber, 1999b). In a sense, this perception justified the Government's neglect of black children in need. Finally, many aspects of modern adoption practice are considered contrary to black traditions and customs. As an example, modern adoption practice emphasises openness in adoption which is

contrary to the stigma and resultant secrecy that commonly surrounds infertility and childlessness in black African culture (Bandawe & Louw, 1997; Brink, 1998; Halkett, 1999; Harber, 1999b; Pakati, 1984; Parry, 1998). These same authors also comment that, adopting a child who does not have direct family or clan links, is unacceptable to most black African families as there is a strong belief that an adopted child will be rejected by the ancestors (also in Drum, 5 December 1996: 10-13). Evidence of this may be found in McKerrow's (1995: 28) study conducted in Kwa-Zulu Natal where "The majority of households, 73.5% will readily care for the children of a family member, but are less willing to care for the children of friends, 49.5%, and of strangers, 42.3%"

In response to the AIDS crisis and the growing number of orphans needing alternative family care in South Africa, criteria for eligibility to adopt are changing (Brink, 1998; Halkett, 1999; Harber, 1999b). Modern adoption practice now includes the possibility of a wider range of persons being eligible to adopt: single parents, gay and lesbian parents, and parents of different cultures. These issues are presently being addressed in the on-going review of the Child Care Act as evidenced by Mosikatsana's (2000) consultative paper prepared for the project committee on the review of the child care act. Other standards for prospective adopters are also changing particularly those relating to the socio-economic class of future adopters that often excluded poor but willing prospective adopters (Brink, 1998; Halkett, 1999; Harber, 1999b). These changes in adoption practice are clearly evidenced in the 1996 Guide to Adoption Practice in the Child Welfare movement South Africa prepared by the South African National Council for Child and Family Welfare. In this document, each of the eligibility requirements to adopt refer repeatedly and strongly to the need for *flexibility* in the recommended criteria (pp 55-60).

Adoption is being made more accessible and this method of providing family life for orphans needs to be one option that is considered. Harber's case study of the Child and Family Welfare Society in Kwa-Zulu Natal clearly demonstrates that active promotion of adoption for black children has found success and that previously perceived obstacles to adoption of black children are not insurmountable (Harber, 1999b). In this paper she concludes,

> "If adoption is to become a more mainstream service for children affected by HIV/AIDS in South Africa, there's an urgent need to find ways in which African and Western notions of child care can be married" (p. 14).

In adoption there is a need to develop options more appropriate for black African communities. As Halkett (1999:38) comments, building on the extensive knowledge and experience in the field of adoption in this country, "The challenge...to secure adoption as a means of care for some children, is to synthesise western and traditional thought and to come up with our very own South African approach". There is also a need to recognise the part that can be played by those previously excluded from the adoption triangle as outlined above. Additionally, there is a need to promote the notion of adoption for older children and children with special needs often termed "hard to place". This will be explored further under the heading "Special Needs Alternative Care" below.

Characteristics and Motivations of Adoptive Parents

To date there appears to have been no systematic research dealing specifically with the demographic characteristics of adoptive parents both in South Africa and abroad. Many studies originating in the United States of America and Britain have explored adoption outcomes retrospectively in terms of disruption and/or adoptive parental satisfaction with adoption (Barth & Berry, 1988; Borland, O'Hara & Triselliotis, 1991; Howe, 1997; Lawder, Lower, Andrews, Sherman & Hill, 1969; Quintin et al., 1998). Others have explored various aspects of adoption such as single parent adoption (Groze, 1991); special needs adoption (Barth, 1991; Lightburn & Pine, 1996; McKenzie, 1993); adoption for large sibling groups (Ward, 1987); transcultural adoption (Bagley, 1993; Curtis, 1996; Simon & Altstein, 1996) and disclosed adoption (Berry, 1993; Gross, 1993; Sachdev, 1991). None have specifically focused on the demographic characteristics of their respective samples.

In South Africa, there is a paucity of empirical studies dealing with adoption: Pakati (1984 and 1996) seemingly the exception. More recently, commentaries about adoption in South Africa have emerged that have explored the history and current status of adoption (Brink 1998; Halkett, 1999; Harber, 1999b); transracial placements (Ledderboge, 2001); and legal aspects of adoption (Mosikatsana, 2000). Many of these characteristics of adoptive parents are a function of the recommended criteria that adoption agencies use in assessing the eligibility of prospective adopters. Given that South African adoption practice has been influenced by policy and practice guidelines from the United States of America and England, it is not surprisingly that these criteria are very similar both in South Africa and abroad (see, A guide to adoption practice, Scotland, 1970; A guide to adoption practice in the Child Welfare movement, South Africa, 1996). From a perusal of the above-cited studies and commentaries, the following characteristics of adoptive parents are noted:

- They are generally older than those parents who have biological children. The likely reason for this is that they may have spent some years trying to conceive children of their own and/or undergoing medical treatments in attempt to do so (A Guide to Adoption Practice in the Child Welfare Movement South Africa, 1996).

- Infertility appears as a common characteristic of adoptive parents in studies and commentaries from abroad (Hersov, 1994; Lawder et al., 1969; Watson, 1996) and in South Africa (Brink, 1998; Halkett, 1999; Harber, 1999a; Pakati, 1984). In fact, Watson (1996) notes that definitive proof of infertility was often used as one of the criteria for eligibility to adopt. However, Halkett (1999) notes that, in South Africa, some adoptive parents who already have biological children may decide to adopt further children once their own are older.

- In South Africa, the majority of adoptive parents are from the white racial group (Harber, 1999b). The reason for this has already been explored in the preceding discussion. However, once classifications of 'race' were abandoned in the late 1980's adoption trends along racial lines have become difficult to obtain (Harber, 1999b). A different picture may therefore be emerging.

- Borrowing from adoption policy in the United States of America and Britain, in South Africa, the criteria for adoption has required that prospective adoptive parents meet a means test (Mosikatsana, 2000). Although this requirement is becoming more flexible in this country (Halkett, 1999; Harber, 1999b), the result is that many adoptive parents are generally from better socio-economic backgrounds than similar biological parents in the general population.

- A further requirement in current South African adoption practice is that prospective adoptive parents are of good repute and fit and proper persons (Mosikatsana, 2000). This translates into adoptive parents being of sound health, having no criminal background, and in a stable marital relationship.

Adoptive Parent and Child Outcomes

It is recognised that adoption does not come without its own inherent "problems". A review of the literature indicates that one of the major disadvantages of adoption is that adopted children may experience identity confusion sometimes coupled with an almost pathological searching for their biological parent/s (Bagley, 1993; McRoy, Zurcher & Lauderdale, 1984; Rosenberg & Horner, 1991; Sorosky, Baran & Pannor, 1975, 1984).

Many adopted children are concerned to know their backgrounds and often seek information about, or face-to-face meetings with their families of origin (Alty & Cameron, 1995; Sachdev, 1991). With the more recent move towards disclosure in adoption whereby the adopted child's biological parent/s are able to have contact with the adoptive parents and their child (to greater or lesser degrees), this has largely been circumvented.

The move towards disclosure in adoption (also referred to as open adoption) was motivated by a surge of studies in the late 1970's emanating in the United States of America and England. These studies were informed by the recognised ongoing distress that birth mothers experienced after relinquishment of their infants as well as the call in the United States to open previously sealed adoption records to adoptees searching for their biological parents. Further, with the increasing decisions by birthmothers to keep their infants, the change in societal attitudes towards out-of-wedlock pregnancy and single parenthood, the increased use of contraception and the greater availability of abortion on demand, there is a shortage of adoptable infants. Birthmothers are increasingly becoming a major part of the decision-making process in adoption (Bagley, 1993; Baumann, 1997; Berry, 1993).

The practice of "Open adoption refers to both the practice of preplacement sharing of information and contact between biological and adoptive parents of a specific child, and continued sharing and contact over the child's life" (Berry, 1993: 231). Whilst most authors agree with this very broad definition, many acknowledge that openness falls more accurately along a continuum (Cushman, Kalmuss & Namerow, 1997; Gross, 1997; Rompf, 1993) to the extent that the number of permutations is virtually limitless (Siegel, 1993).

Because of the infancy of disclosed adoption practices, there have not been many studies done around this form of adoption (Gross, 1997; Siegel, 1993). Many studies have small samples and results are therefore, not generalisable (Alty & Cameron, 1995; Gross, 1993). Most of the studies involve self-selected participants who may have already been predisposed to open adoption and therefore 'skew' the results in favour of openness (Alty & Cameron, 1995; Grotevant, McRoy, Elde & Fravel, 1994). Research has also been almost exclusively conducted with birthparents and adoptive parents (Gross, 1993) with none exploring the perceptions of the adoptees themselves.

On the whole, in the United States of America and Britain there is a distinct move towards this form of adoption practice. In South Africa, there is no readily available

evidence that open adoption is being advocated and practiced here. At present, a recent discussion with Morag Scordilis at the Cape Town Child Welfare Adoption Centre points to a flexible approach employed by most registered adoption organisations and practitioners. At present, adoptees who were adopted within the traditional non-disclosed parameters, are able to contact their biological parents only with the agreement of their adoptive parents if they are younger than 18 years old. After they reach the age of 21, their adoptive parent's agreement is no longer a prerequisite. Contact is mediated by the original adoption agency.

However, disclosed adoptions have their own set of problems. It has been found that children (particularly younger children) may find it difficult to incorporate two sets of parents into their lives (Berry, 1991; Kraft, Palombo, Mitchell, Woods, Schmidt & Tucker, 1985; Rosenberg & Horner, 1991). Adoptive parents have been found to experience bonding difficulties with their adopted children given the biological parent/s interference in their relationships (Gross, 1993; McRoy, Grotevant & White, 1988). In South Africa, mention has already been made of the reluctance of black African adoptive parents to acknowledge their adopted children's biological parenthood. Many of the latter disadvantages would not be the case with adoption of HIV/AIDS orphans purely because their parents will have succumbed to the disease. However, should there be surviving siblings and/or other relatives these considerations may still be pertinent.

The distinct advantage of adoption, particularly in the present and future HIV/AIDS situation is that adopted children have a very good chance of life-time care within a family unit with the very rare possibility of being "handed back" or placed in other alternative caring situations.

2.4. Special Needs Adoption and Foster Care

Traditionally, some children requiring alternative parenting have been "hard to place". The North American Center on Adoption has categorised "hard to place" children, as those who are black over the age of 10; white over the age of 13; emotionally disturbed and mentally retarded children of all ages; children with physical handicaps; and sibling groups of three or more (Churchill et al., 1979). Other hard to place children include infants, those with an HIV positive status and Fetal Alcohol Syndrome babies (Barrett, McKerrow & Strode, 1999). Some African studies have found that boys are more difficult to place than girls and older children are more difficult to place than younger ones (McKerrow, 1996a; McKerrow & Verbeek, 1995; Pakati, 1984; Sishuta 1996).

It has been demonstrated in the preceding chapter that children infected with and/or affected by HIV/AIDS are very likely to be emotionally impaired due to their exposure to disease, death and family break-down; will, in some cases, almost certainly have limiting medical conditions; will often be "older" but will also be infants; and will often have a number of siblings. These children will most certainly fit the category "hard to place" and an exploration of special needs foster care and adoption is particularly relevant to these special needs children.

Given the paucity of Southern African studies on either foster care or adoption, it is not surprising that there is no systematic research nor commentaries emanating from this region on alternative care for special needs children. With the expectation that studies and commentaries originating in the United States of America, Canada and the United Kingdom would provide useful information for the South African, HIV/AIDS context, a brief description of these follows.

Helton Stromberg (1994), citing a number of experts in the United States of America and Canada, suggests that the increase in concern and effort to find either foster care or adoption placements for children with special needs during the 1980's was motivated by a number of factors. For example, the increase in the numbers of infants and children at younger ages entering foster care was due to the dramatic increase since 1985 in the incidence of substance abuse during pregnancy and a consequent increase in the number of drug-exposed and drug-addicted infants born. Also, medical advances have increased the survival rates of seriously impaired neonates and children with serious paediatric disorders. More recently, there has been a noted increase in the numbers of infants and children who are HIV-positive or who have AIDS.

Before exploring the information that this research has to offer, it is worth noting that there is no concrete evidence of how difficult it is to place these children in alternative caring situations. For example, some indication of the percentage of special needs in comparison to non-special needs children placed in either foster care or adoption would have been instructive but appears to be lacking.

However, research points to two avenues of alternative placement for special needs children: foster care or adoption. Foster care is most often required for two groups of special needs children. These groupings of children follow research that tends to provide reports following these distinctions. However, due recognition should be given to the fact that children who have chronic illnesses and/or physical and mental

impairments may also be those who exhibit behavioural and emotional disorders and vice verse.

Firstly, foster care is often required for those children who have chronic illnesses or who are physically and/or mentally impaired. They are often inappropriately housed in institutional and hospital settings mainly because of the difficulty in finding family placements for them (Gurdin & Anderson, 1987; Helton Stromberg, 1994; Yost & Hochstadt, 1987). Yet in spite of these reported difficulties, each of the cited studies revolve around various aspects of actual placement for these children in foster families. For example, Gurdin & Anderson (1987) report some optimism for future recruitment and placement of HIV-positive children. This follows from the fairly successful recruitment drive to find persons to care for HIV-positive children who had spent between 2 months and 2 years in hospital settings. Important implications from Helton Stromberg's (1994) study of 30 families caring for 88 children with special medical care needs are that successful and experienced foster parents are not only good candidates for recruitment themselves, but can also be effective recruiters of other special needs foster parents. Focusing on a programme developed to provide seriously medically ill children with foster parents, Yost and Hochstadt (1987) point to the need to provide these foster families with a wide variety of on-going medical, material and psychological support in order to ensure their success.

The second group of special needs children requiring foster care placements are those who, for a variety of reasons, have severe behavioural and/or emotional problems (Hill, Nutter, Giltinan, Hudson & Galaway, 1993; Ray & Horner, 1990; Quinton et al., 1998). These children are most likely to need foster care placements after some years of adverse parenting from their birth parents or after disruption(s) in their original foster care placements. They are therefore mostly older children and many will be adolescents.

Perhaps pointing to the poor prognosis for these children's placement opportunities, a number of studies have found that older age at placement and high levels of behavioural difficulties are the most frequently identified predictors of poor placement outcome as evidenced by disruption rates (Borland et al., 1991; Fratter, Rowe, Sapsford & Thoburn, 1991) and/or from parental satisfaction (Howe, 1996 and 1997).

However, Quintin et al. (1998) make mention of a number of retrospective studies of adolescents and young adults pointing to late placement successful outcomes (for example, Kadushin, 1970 and Triseliotis and Russell, 1983). Hill at al. (1993) found

breakdown rates in specialist foster care placements of 40% in the United Kingdom and 27% in North America. Although still high, these disruption rates are still substantially lower than the average of 50% reported in "normal" foster placements mentioned earlier. Research by Ray and Horner (1990) found an encouraging indication of positive child outcome in effective therapeutic foster placements for severely emotionally impaired sexually abused children. Seventy-five percent of 11 assessed children had shown improvement on the California Child and Adolescent Profile (CCAP) measure after 1 year in placement.

The second avenue of placement for special needs children is via adoption. Again there are two groups of children for whom adoption may be promoted. Firstly are those children, as described above, who have chronic illnesses or who are physically and/or cognitively impaired and often inappropriately accommodated in institutional or medical care settings. Secondly, are those children who have spent a number of years in foster care and for whom there is little likelihood of a return to their biological families (Barth, 1991; McKenzie, 1993). It is these children who become available for permanent placement via adoption and because of their years in the fostercare system are often older.

Confirming the difficulties in finding adoptive parents for older children, Avery's (2000) examination of 80 "hardest to place" children had spent on average 11.8 years waiting for permanent, adoptive homes. These children tended to have substantial disabilities, be male, African American, and older when they first entered foster/residential care.

However, according to Barth (1991) and Hersov (1994) research has consistently revealed that special needs carers, on the whole, report positive experiences and satisfaction with their adoption / foster care arrangements. For example, Lightburn and Pine (1996), examining 55 families in which 114 physically or cognitively disabled children were adopted during 1976 and 1988, found that none of the adoptions had disrupted and that the adoptive parents reported being mostly very satisfied with the adoptions.

These reported positive experiences of special needs carers and the low disruption rates clearly demonstrate not only that there are parents who are willing to care for children with a variety of special needs, but also that children with special needs are not necessarily "hard to place". Perhaps, as Avery (2000) suggests, within the "hard to place" discourse resides a skepticism amongst caseworkers that these children are likely to find families willing to care for them. This skepticism in turn may be translating into

reduced recruitment efforts for these children. The apparent difficulty in placing these children may, in fact, have little to do with their particular characteristics defining them as hard to place.

Characteristics and Motivations of Special Needs Carers

The following enumeration of specialist carer characteristics has been found in studies conducted in the United States of America and England.

- These carers appear to be younger, on average, than both formal and informal foster carers of 'normal' children (Helton Stromberg, 1994; Krysik, 1997)

- They are generally better educated and are employed in managerial and/or professional occupations (Helton Stromberg, 1994; Krysik, 1997).

- The foster mothers in this group often have experience in either child care, nursing and/or home care (Evans & Tierney, 1995; Helton Stromberg, 1994: Gurdin & Anderson, 1987).

- McKenzie's (1993) review found that many adopters were first foster carers to their respective special needs children.

There was no specific mention of motivations involved with a choice to enter this form of foster care. Perhaps one may assume that these carers are motivated similarly to formal foster carers: by particularly high levels of altruism and a dedication to special needs children.

2.5. Innovative and Other Models of Alternative Care

A number of innovative forms of alternative care are beginning to emerge in South Africa informed by the responses to the orphan crisis in countries North of our borders (Ali, 1998; Harber, 1998; Parry, 1998; Russell & Schneider, 2000; Smart, 2000). These options are being considered by South African care providers and policy makers who rightly recognise that conventional models will not provide sufficient sources of alternative care for these children. As the focus of the present study is alternative **parental and family** care options, these emerging kinds of alternative care will only briefly described here. Many of them do not encompass family care / parental care in the traditional sense.

Independent living by orphans (child-headed households)

In this instance, when parent/s die, the children continue to live together in the familial home with an older siblings taking on the responsible position of "parent" to his/her younger brothers and sisters (Russell & Schneider, 2000). Although the extent of child-headed households in South Africa are not known, there is clear evidence that they do exist (Nelson Mandela Childrens Fund, 2001).

Although there may be advantages to keeping sibling groups together in this manner, the above report cites a number of unique problems, from the perspective of the service providers who were interviewed and who were involved with the children, facing child-headed households. These point to their particular vulnerability and are as follows:

- Extreme poverty, poor nutrition, stunting and hunger, and poor housing.
- Discrimination, stigmatisation, exploitation, and physical and sexual abuse by neighbours and relatives.
- Lack of parental supervision, guidance and protection.
- Disruption of normal childhood and adolescence for the caregiver/s.
- Educational failure.

The report goes on to cite a number of unique challenges facing these children and, in particular the child head. These challenges focus on the loss of parental support and guidance, deprivation of parental love and care, and deprivation of normal childhood.

Independent living by orphans with external supervision and support

In this instance, orphans remain together (as above), but are visited on a regular basis by a community volunteer (Russell & Schneider, 2000). Many of the above vulnerabilities will also plague these children although it is thought that visits from an adult community member may counter some of them. However, there is no systematic research on the outcomes for these children.

State or NGO sponsored community-based support structures: for example, Cluster Foster Care

Here, a surrogate mother is placed with a number of orphans in the community. These orphans may be from different families or a sibling group. She is provided with a home where she lives with the orphans taking care of them as though they were her own (Russell & Schneider, 2000). An advantage here again, is that siblings remain together. The additional advantage would be the consistent presence and care from an adult person. The children are likely to be able to continue schooling and have their

nutritional needs met. This form of care closely resembles traditional foster care as described earlier, and is one that closely provides family and parental care for orphaned children.

Institutional care

Institutions are considered the least desirable form of care for orphans. As Harber (1999a :21) notes, "……research world-wide has shown that institutional care can have a deleterious effect on a child's physical, emotional and psychological well-being." Besides which, not only are orphanages expensive to build and maintain, they often remove children from their communities and extended families (Neilson, 2000).

Many authors do recognise, however, that institutional care may provide for children who might otherwise remain in hospital settings or end up living as street children. Additionally, given the predicted large number of orphans, some authors feel that institutional care should not be entirely dismissed (Neilson, 2000).

3. CONCLUSION

Despite the emergence of cluster and other forms of care for children orphaned by HIV/AIDS, established forms of formal placement (for example, kin and non-kin foster care and adoption) will remain important options for South Africa. Motivations for foster care and adoption have been investigated focusing mainly on traits such as altruism. In the next chapter, an alternate way of looking at motivations will be explored using a well-validated social psychological theory - the Theory of Planned Behaviour.

CHAPTER 3

THE THEORY OF PLANNED BEHAVIOUR (TPB)

1. INTRODUCTION

This study is an investigation of the factors that influence decisions to care for AIDS orphans. As noted in the previous chapter, motivational factors have included altruism, kin obligations, and financial gain (through foster care grants). However, studies of altruism are trait oriented and are limited in their predictive power for behaviour. For this reason, the Theory of Planned Behaviour (TPB) was considered as an alternative approach.

No studies have been located to date that use the TPB to explain alternative parenting decisions. Together with the Theory of Reasoned Action, it is the most validated and extensively researched of the social cognitive models of behaviour (Sutton, 1997; Conner & Sparks, 1996 in Bandawe, 2000). These theories have extensive empirical backing to show their effectiveness in predicting a wide range of behaviours. Those consulted indicate the wide variety of behaviours investigated: moral behaviour (Vallerand, Deshaies and Cuerrier, Pelletier & Mongeau, 1992), driving behaviour (Parker, Manstead & Stradling, 1995), AIDS-related sexual behaviour (Bandawe, 1992), dietary behaviours (Armitage & Connor, 1999; Povey, Connor, James & Shepherd 2000), Cannabis and alcohol use (Armitage, Connor, Loach & Willetts, 1999; Connor & McMillan, 1999), household recycling (Terry, Hogg & White, 1999) and leisure participation (Ajzen & Driver, 1991) to name a few.

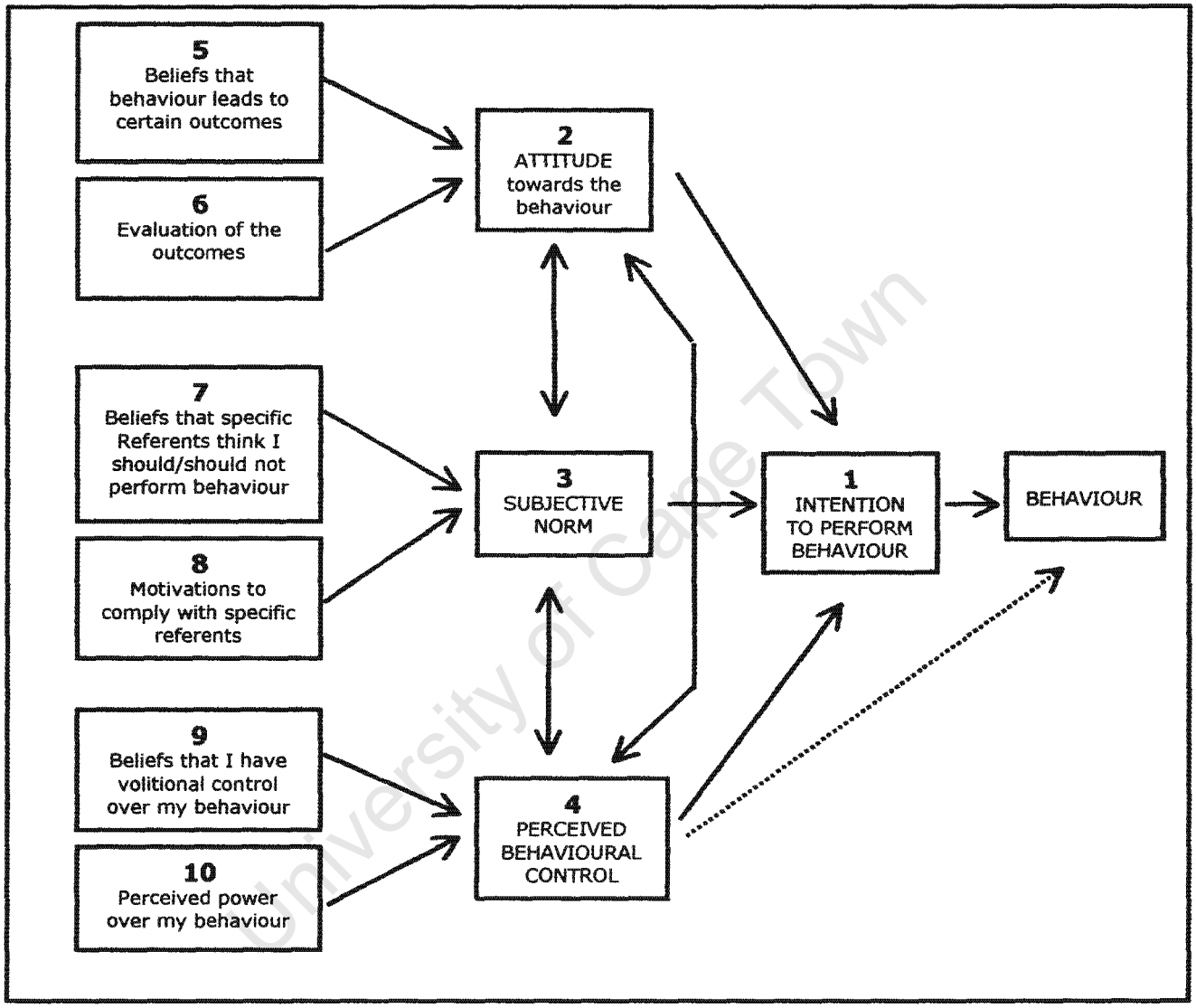
Given that the TPB has proved to have extensive explanatory and predictive value, as well as providing an opportunity for informing interventions and possible avenues for behaviour change (Ajzen, 1991), it was considered a valuable aspect of the present study's investigation of decisions to care for HIV/AIDS orphans.

2. THE THEORY OF PLANNED BEHAVIOUR (TPB)

The TPB is designed to explain and predict behaviour in specific contexts. It is an extension of the Theory of Reasoned Action (TRA) made necessary by the latter models' limitations in exploring behaviours over which people have incomplete elective control (Ajzen, 1991). A structural diagram, representing the components of the theory, is

presented in Figure 5 and is adapted from Ajzen (1991). It includes the antecedents, or belief-based aspects, to the principal predictors of intention to perform a given behaviour.

Figure 5: The Theory of Planned Behaviour



Intentions and Perceived Behavioural Control

Central to the TPB is the concept intention. It is proposed to be the principal predictor of actual behaviour as it is regarded as the motivation necessary to engage in a particular behaviour (Ajzen, 1991). In other words, the more one intends to engage in a particular behaviour, the greater one's motivation to engage in that behaviour, and the greater the likelihood that one will actually engage in that behaviour.

However, behavioural intention can only be converted into actual behaviour if the person can decide at will whether to perform the behaviour or not. Often there are what Ajzen terms "non-motivational" factors that may prevent intention from being expressed in actual behaviour (1991: 182). For example, one may fully intend to adopt an AIDS orphan, but the family home may simply not be large enough to accommodate another child or the family income may be insufficient to provide adequately for another child. Each of these non-motivational factors would prevent one's intention from becoming behaviour. Together, these non-motivational factors represent people's *actual* control over the behaviour in question.

According to Ajzen (1991), of greater psychological interest than actual control, however, is the *perception* of behavioural control and its influences on intention. It is this *perception* of behavioural control that plays an important part in the TPB. Ajzen (1991) goes to some length to separate this construct from other notions of control. For example, he suggests that it differs from Rotter's (1966) concept of perceived locus of control. Whereas locus of control is a universal expectancy that remains stable across a variety of situations and behaviours, perceived behavioural control often varies across situations and behaviours and has more to do with people's unique understanding of the ease or difficulty of performing a given behaviour.

He goes on to suggests that perceived behavioural control in the context of the TPB is most accordant with Bandura's (1997, 1982) concept of perceived self-efficacy. These self-efficacy beliefs are concerned with self-evaluations of how well a person believes he/she can execute particular behaviours: i.e. their confidence in their ability to perform particular behaviours. Ajzen therefore views self-efficacy and perceived behavioural control as synonymous and places them in "a more general framework of the relations among beliefs, attitudes, intentions, and behaviour (1991: 184). However, more recently, researchers have examined the distinction between, and relative importance of, self-efficacy and perceived behavioural control in this component of the theory (Armitage & Connor, 1999; Armitage et al., 1999; Connor & Armitage; 1998; Giles & Rea, 1999; Povey et al., 2000). These studies provide evidence for separating these two dimensions of perceived behavioural control as independent predictors of intentions and/or behaviour.

From Figure 5, it can be seen that performance of behaviour is posited as a joint function of intentions (#1) and perceived behavioural control (#4). The relative importance of either of these two in predicting actual behaviour may vary across situations and different behaviours. Of course, in order to assess the relative

importance of either of these two constructs would require some measure of actual behaviour. In the present study, assessment of actual behaviour was not undertaken and findings on the relative importance of either intentions or perceived behavioural control in predicting actual behaviour will not be explored further. However, as one of the determinants of intentions, perceived behavioural control will be explored together with the other suggested determinants of intentions to perform a given behaviour - attitudes and subjective norm.

Determinants of Intentions

The TPB supposes three conceptually independent determinants of intention (depicted in Figure 5). The first of these determinants is the *attitude* (# 2) towards performing a given behaviour. In this case attitudes refer to either favourable or unfavourable evaluations or judgements about a particular behaviour. The second determinant is *subjective norm* (# 3). It refers to the perceived social pressure to either perform or not perform the behaviour in question. The third determinant is *perceived behavioural control* (# 4). This was explored in detail above and refers to the perceived ease or difficulty of performing a given behaviour. According to Ajzen (1991), perceived behavioural control also reflects past experience and expected impediments to performing the behaviour. Logically, the more positive an attitude and perceptions of social pressures, and the greater perceived behavioural control, the more likely a person would intend to engage in a particular behaviour. From behaviour to behaviour and across situations, the relative importance in determining intentions of each of these three elements are expected to vary (Ajzen, 1991). These determinants of intentions are referred to as either direct or global measures.

Direct measures of attitudes most often use a number of five or seven point semantic differential items along a continuum of pairs of adjectives with respect to performing a given behaviour. Most authors have used a combination of affective, cognitive, and general components of attitudes with continua ranging, for example, from pleasant to unpleasant, from beneficial to harmful, and from good to bad (for example, Ajzen & Driver, 1991; Armitage & Connor, 1999; Armitage et al. 1999; Bandawe, 2000; Madden, Ellen & Ajzen, 1992; Povey et al., 2000). A mean of each respondent's scores on the items is used as the direct measure of "attitudes".

Similarly, subjective norms are most often measured along several seven point semantic differential items. In this instance, respondents are most often asked whether "people who are important to me" or "people whom I respect" would want / not want; think that I should/should not; would approve/disapprove of my performing the given behaviour

and are very similar in nature across the studies consulted to date (for example, Ajzen & Driver, 1991; Armitage & Connor, 1999; Parker et al., 1995; Povey et al., 2000; Terry et al., 1999). A mean of each respondent's scores is used as the direct measure of "subjective norm".

Perceived behavioural control is measured correspondingly. A number of scaled items are most often used to explore this dimension of the theory and relate to control beliefs and/or self-efficacy around performing a given behaviour. Again, these items in the studies consulted to date, appear very similar in nature and tap dimensions of personal control over and, ease/difficulty in performing the given behaviour (for example, Ajzen & Driver, 1991; Armitage & Connor, 1999; Madden et al., 1992; Povey et al., 2000). As with the previous two variables, a mean of each respondent's scores is employed as the direct measure of "perceived behavioural control".

Many recent studies over the past decade have explored other and different determinants of intentions and behaviour. In fact, Ajzen (1991) suggests that the TPB is open to further expansion if additional predictors of behaviour and/or intentions can be identified. Accordingly, many researchers have added a variety of potential predictors to their TPB models in order to test the sufficiency of the existing model. Some of these include self-efficacy (Armitage & Connor, 1999; Connor & Armitage, 1998; Giles & Rea, 1999; Povey et al., 2000), personal and descriptive norms (Connor & Armitage, 1998; Connor & McMillan, 1999; Parker et al., 1995), past behaviour (Connor & Armitage, 1998; Connor & McMillan, 1999; Ouellette & Wood, 1998), anticipated regret (Parker et al., 1995), self-identity (Armitage & Connor, 1999; Connor & Armitage, 1998; Connor & McMillan, 1999; Terry et al., 1999), and desires and anticipated emotions (Perugini & Bagozzi, 2001). In most cases these additional predictors have contributed to the prediction of behaviour intentions and actual behaviour.

Belief-based Attitudes, Subjective norms, and Perceived Behavioural Control

The TPB also explores the antecedants of each of the principal predictors of intentions. According to Ajzen (1991), this examination allows for an explanation, rather than just prediction of human behaviour. These antecedants are equally important in determining intentions and behaviour and revolve around salient beliefs and information pertinent to the behaviour in question. To the extent that the structures underlying each of the three principal preditctors of intention are envisaged as a composite of expectancy and value (Hewstone, 1986). These composites are referred to as the belief-based measures of the principal predictors (Ajzen, 1991).

To this end and referring to Figure 5, *behavioural beliefs* (# 5) are said to influence attitudes towards the behaviour; *normative beliefs* (# 7) aggregate the determinants of subjective norms; and *control beliefs* (# 9) provide the foundation for perceptions of behavioural control (Ajzen, 1991). Each of these beliefs, in turn, is formulated along an expectancy-value framework (Peak, 1955 in Hankins, French & Horne, 2000). To the extent that *attitude* is proposed to be a function of the belief that the behaviour leads to certain outcomes - expectancy - multiplied by the evaluations of these outcomes (#6) - value.

Additionally, *subjective norms* are a function of the belief that salient referents think the person should/should not perform a particular behaviour (expectancy) multiplied by the person's motivation to comply with those referents (value) (#8). Finally, *perceived behavioural control* is a function of particular control expectancy multiplied by the perceived power of the particular control factor (value) (#10) to facilitate or hinder any given behaviour. Each of these products are then summed and the mean is used as an indicator of the belief-based "attitudes" towards performing a given behaviour, "subjective norm", and "perceived behavioural control".

Ajzen and Fishbein (1980) provide clear guidelines as to how these constructs should be measured. Preparatory work should be carried out either with the respondents themselves or with a representative group from the population to be studied and their salient beliefs along each of the dimensions of the theory elicited. From the most frequently mentioned salient beliefs, items are constructed to explore respondent's differing expectancies and to quantify these differences (usually using 5 or 7 point semantic differential item scales) according to the value or strength of each expectancy.

However, Ajzen (1991) was perturbed and disappointed by the generally low to moderate correlations obtained between the belief-based and direct measures of each variable in the TPB. Rather than questioning the notion that beliefs have a causal effect on the three determinants of intentions and/or behaviour, he suggests that these moderate correlations may be indicative of a failure of the expectancy-value composition to adequately describe the processes "....whereby individual beliefs combine to produce the global response" (p. 198).

A recent commentary by Hankins et al. (2000) has followed up on these concerns expressed by Ajzen and calls into question the statistical usefulness of these multiplicative composites as determinants of intention and/or behaviour in the TPB.

These authors suggest that, whilst the expectancy/value represents something that is not represented by either expectancy or value measures alone, ".....the product of the two does not result in a useful measure of it." (p. 157). If the expectancy and value measures are entered as separate variables in the traditionally used regression, they believe that this does not model the theory as was intended. Should the multiplicative composites be entered, they represent something other than what is intended. And if all three are entered into the regression, again, this would not model the theory as was intended. Drawing on work by Eagly & Chaiken (1993) and Towriss (1984), these authors suggest that a simple measure, rather than a multiplicative composite, based on the self-reported beliefs of participants in the actual study should be used.

3. SUMMARY

The TPB has been used extensively to predict and explain a variety of human behaviours. To date, none have been found to explain or predict behaviours and/or intentions to care for children in need. However, given the theory's utility in possibly directing interventions and/or changes in behaviour, it was thought to provide a valuable extension to the present study's investigations. Before proceeding to the study itself, the aims of the study are re-stated.

4. THE AIMS OF THE CURRENT STUDY

The discussion in previous chapters has pointed to the fact that the HIV/AIDS pandemic in South Africa is reaching catastrophic proportions resulting in an alarming number of children being orphaned now and in the near future. These orphaned children, affected by and/or infected with HIV/AIDS are a particularly vulnerable group for a variety of reasons. Forms of alternative care (foster care and adoption) will remain an option for the care of HIV/AIDS orphans. Informed by one of the basic tenets in the South African Constitution that a child has the right to **family** and **parental** care, alternative **family** care models need to be considered for the care of HIV/AIDS orphans. Investigations of factors that influence decisions to care are very important in order to guide practice and child care placement.

These considerations have informed the present research, the aim of which is to explore a range of factors that might influence decisions to care for children orphaned by HIV/AIDS. More specifically,

- to describe the demographic characteristics of those respondents who indicated a willingness to care for either an HIV-negative and an HIV-positive orphan,
- to explore these persons perceptions as to who should take responsibility for these children,
- to inquire into these persons perceptions whether the existing supports to foster carers are adequate and those that would make caring for these children more attractive,
- to explore the characteristics of orphaned children that would either facilitate or hinder prospective carers' decision to care for them,
- to investigate the relationship between potential parent and child characteristics and how these impact on a willingness/unwillingness to care for an orphaned child,
- to investigate the decision-making processes of willing/ unwilling carers in terms of their attitude towards caring for an orphaned child, the influence of respected others' in their decision-making process, and the effects of perceived control over their behaviour/decision in these situations, and finally
- on the basis of the findings from the study, to provide relevant recommendations for the alternative parental care of children orphaned as a result of the HIV/AIDS pandemic.

CHAPTER 4

METHOD

1. INTRODUCTION

A number of approaches to sampling could be considered in a study of this nature. One would be to sample the general population in order to assess the characteristics of those who would or would not be willing to care for orphaned children in the HIV/AIDS pandemic. An alternative would be to sample persons who have already shown a willingness to care for non-biological children in need. In this study the latter approach was chosen.

The central reason for this decision was that adoptive and foster parents are arguably more likely than others to make themselves available for the care of orphaned children. They have already taken the step to care for non-biological children. While a survey of the general population would indicate the proportion of persons with a positive or negative orientation to having a child placed in their care, this information might have relatively low predictive value for their actual behaviour, particularly in light of the probability that they would have had no experience of the challenges of fostering or adoption. In this study therefore, it was decided to focus on a population that has already demonstrated their willingness to either adopt or foster. Arguably these experienced and already committed groups would be more likely to have a realistic and hence more reliable approach to the questions posed in the study.

2. SAMPLE

The sampling for the study was therefore done purposively (Bailey, 1987). Two distinct groups, existing foster carers and adoptive parents, were selected from which samples were drawn. These groups of persons were judged to be those who best met the purposes of the study as explained above. They have already shown some exceptionality in that they have taken on the care and nurturance of children who are not biologically their own. From the previous chapter's discussion concerning foster carers' and adoptive parents' motivations, most foster carers have taken on children willingly, others out of a sense of family duty, and still others as a means to supplement family incomes. Adoptive parents, on the other hand, have adopted young infants

mainly due to an inability to have children of their own. More recently, adopters are also beginning to adopt slightly older children: many in spite of having biological children of their own but responding to the plight of orphaned and abandoned infants and children. Amongst these groups may also be those parents who have taken on the care of children who are "hard to place" (as described earlier).

Questionnaires were sent to 513 foster carers and 395 adoptive parents. These respondents were located in Cape Town, George, and Johannesburg and were selected on the basis of convenience and their ready agreement to participation. The foster carers and adoptive parents were accessed from the following sources:

- Child Welfare Society, Cape Town agreed to provide access of their registry of existing foster carers. From each of the social workers' case sheets, a total sample of 413 registered foster carers were selected representing all the foster carers on their data base.
- Child Welfare Society, George also agreed to participate in the research. One hundred of their registered foster carers (out of a total of around 400) were selected by George Child Welfare on the basis of a relatively high education level. This was done at the suggestion of the Director who felt that the questionnaires would not be completed by those persons who had little, or no education.
- Child Welfare Society, Cape Town also agreed to provide access to their files of around 150 adoptive parents who had adopted a child/ren through their agency during the last 3 years.
- The editor of a national newsletter - Adoption Network News - agreed to include the questionnaires in a posting of one of their quarterly newsletters. Their active data base consisted of 245 adoptive parents from around the country, but mostly confined to the Gauteng area.

It was further decided to survey foster and adoptive *mothers* only. The rationale for this has already been alluded to in the previous chapter and includes the following considerations worth repeating here:

* Although it is recognised that fathers are beginning to play a more pervasive role in the rearing of children, certainly in South African, this role is still considered almost exclusively the domain of mothers, and

* within the South African context, there is an unusually large proportion - by first world, Western standards - of female-headed households.

In order to protect the anonymity of their clients, Child Welfare in Cape Town required that the researcher address and mail the questionnaire booklets from their offices. George Child Welfare addressed the questionnaires from their offices and were themselves instrumental in selecting those to whom the questionnaires would be sent. The Director assured me that, other than education level (as mentioned above), this selection was done randomly. The questionnaires that were sent to the mailing list for Adoption Network News were simply included in the posting of one of their quarterly newsletters - this having been done by their offices in Johannesburg. All paid-up, active persons on the mailing list were included in the posting.

2.1. Sample Demographics

A questionnaire was developed comprising two forms, "A" and "B" and is discussed in detail under "Procedure" below. However, in order to provide a demographic description of the final sample, results from the demographic questionnaire from both forms "A" and "B" were combined to provide a description of the total sample of respondents (N=175). This was done as there was very little difference between the demographic characteristics of those respondents who completed form "A" and those who completed form "B". A brief description of the sample is provided in Table 2 below and the data is presented separately for each of the forms, 'A' and 'B', in appendix A for further interest to the reader. Of the 908 questionnaires mailed to potential respondents, 175 were returned. This represents a 19.27% response rate (form "A": N=80; 17.62% and form "B": N=95; 20.93%).

Table 2: Demographic Characteristics of Final Sample (N=175)

Adoptive Parents	N = 70	42.17%
Foster Parents	N = 96	57.83%
Mean Age:		
Respondents	47.12 years SD = 11.47	N = 160;
Partners	*45.03 years*	*N = 98* SD = 9.72
Married / Living With A Partner	61.25%	N = 98
Home Language:		
English	N = 79	47.88%
Xhosa	N = 42	25.45%
Afrikaans	N = 44	26.67%
Household Income:		
Mean income bracket	R2001 to R5000 p.m.	
Mode income bracket	*>R10000 p.m.*	
Education:		
Respondents: Mean Level of education	Std 7	
Matriculation	N = 53	45%
Partners: Mean Level of education	Std 8	
Matriculation	N = 63	58.88%

The above Table demonstrates that there was an over-representation of foster carers in the final sample: there was a significantly greater number of foster parents than adoptive parents ($\chi^2 = 8.14$; $p<.01$). As there were also some differences between adoptive and foster parents, these are listed and discussed further in the next chapter – "results".

3. ETHICAL CONSIDERATIONS

The issue of ethics was addressed along the following three dimensions. Firstly, a letter of introduction was included with each of the questionnaire booklets. In this, respondents were informed about the purpose of the research and the value of each respondent's reply, although entirely voluntarily sought. Secondly, respondents were asked to sign the cover of the booklet in acknowledgement of their willing participation. Here too, they were informed of the confidentiality and anonymity of their replies. Finally, access to actual respondent's name and address details was retained by the organisations that provided access to their databases. The researcher was thus not able to contact any of the individual respondents at any stage during or after the research was completed.

4. PROCEDURE

Method of Data Collection

As previously mentioned, the data for this study was gathered by means of a questionnaire that was mailed to participants. The rationale for choosing this method of data collection was as follows:

- The sample of respondents - foster carers and adoptive parents - are a diverse group of people geographically scattered across the general population. A mailed questionnaire using established databases allowed access to these groups of people.
- It was thought that the nature of the enquiry - willingness to care for an HIV/AIDS orphan - would be a sensitive issue for many. As HIV/AIDS carries such stigma and appears not to be openly or easily discussed in South African society, there seemed to be a particular necessity to maintain the anonymity of respondents. It was hoped that this guarantee of anonymity would allow respondents to answer sensitive questions more truthfully.

- Due consideration was made to the traditionally low response rate achieved by this method of data collection. Thought was also given to the exacerbation of this problem due to the complexity of the questionnaires. However, weighing the above two considerations against this, mailed questionnaires were still determined to be the most adequate method to use.

Two Questionnaire Forms

Two questionnaire booklets were developed (see appendices B and C). Apart from a few item differences between the two questionnaires, details of which will be expanded upon under item construction below, it is important to note here that one booklet assessed the opinions of respondents in terms of their willingness to care for a child who had been orphaned and who was **HIV-negative**. This booklet will be referred to as form "A". The other booklet assessed the opinions of respondents in terms of their willingness to care for a child who had been orphaned and who was **HIV-positive**. This booklet will be referred to as form "B". Within each of the sample sources, allocating which questionnaire form (either "A" or "B") would be sent to which respondents was done randomly. Half of the sample from each source received questionnaire form "A" and the other half, questionnaire form "B". This method was chosen as requiring each respondent to answer both forms would have been too complex and time-consuming.

Pilot Study

Azjen & Fishbein (1980) provide a useful framework for constructing a questionnaire that explores each of the essential elements of the Theory of Reasoned Action. As explained in chapter 3, the applicability of this theory was explored in the present study. Later in 1991, Ajzen extended this theory to incorporate control beliefs as an additional influence on behavioural intentions and re-titled the theory the Theory of Planned Behaviour (TPB). Using both the Theory of Reasoned Action and the Theory of Planned Behaviour to construct the items, and having conducted a pilot study where responses from 14 female carers and non-carers were obtained, the final questionnaire was developed.

The pilot study, following methods developed by Ajzen & Fishbein (1980), was conducted along the lines of self-report responses to a number of pertinent questions (see Appendix D). It consisted of 14 questions requiring respondents to specify what *they* thought would be the most important advantages and disadvantages of caring for either an HIV-negative or HIV-positive child orphaned by the HIV/AIDS pandemic, both for the child and themselves. They were also asked what they thought would make make it easy/difficult for them to care for either an HIV-negative or HIV-positive orphaned child. Additionally, some questions asked which people important to them would

approve/disapprove should they care for either an HIV-negative or HIV-positive orphan. Finally, respondents were asked, if they were already caring for a non-biological child, what they liked or disliked about such an arrangement.

The responses were simply listed and tallied. Those that were mentioned most frequently by all respondents were incorporated into the construction of the final TPB questionnaire. The pilot study revealed that there were certain advantages and disadvantages that were specific to caring for either an HIV negative or HIV positive orphan. For example, those carers who participated in the pilot study revealed that coping with the illness and death of a child could be a distinct disadvantage in caring for an HIV positive orphan. Other disadvantages cited as peculiar to caring for an HIV positive orphan were emotional strain, uncertainty, additional (substantial) medical expenditure, and the possibility of cross-infection. None of these were considerations in caring for an HIV negative orphan. An advantage in caring for an HIV positive child was suggested as the relatively short duration of the needed care rather than life-time or long-term care. Again, this was not a consideration for an HIV negative orphan. These differing responses had implications for the format of the final questionnaire (forms "A" and "B") discussed in section 5, "Design and Measures" below.

Constructing the Questionnaires

Both questionnaires were constructed and refined over a period of approximately three months. During this time, colleagues in the department of Psychology at the University of Cape Town as well as people working in the Child Welfare services and potential respondents were consulted. Although recognising that the resulting questionnaires were long (containing between 76 and 78 items) and fairly complex, these consultants reported, in the final event, that they appeared to contain clear and understandable instructions and were relatively easily understood.

Translation of the Questionnaires

The questionnaires were then translated into Afrikaans and Xhosa. Based on information from Child Welfare, Cape Town and George and the editor of Adoption Network News, translation into other of the official South African languages was not undertaken. These sources indicated that the foster carers and/or adoptive parents on their databases were either English, Afrikaans or Xhosa first language speakers only.

The Afrikaans translation was done by a colleague in the department of Psychology at the University of Cape Town who is completely fluent in both English and Afrikaans. The Xhosa translation was done by a research assistant at the Child Guidance Clinic at the

University of Cape Town who was also completely bilingual in both Xhosa and English. The Afrikaans version of the questionnaires was then back-translated by the researcher who, although an English home language speaker, is proficient in Afrikaans. The Xhosa version was back-translated by two service workers known to the researcher who were home language Xhosa speakers but also proficient in English. The back-translators were also helpful in refining spelling, grammar, syntax and meaning in the translated versions of the questionnaires.

Mailing: Main Study

All booklets were mailed during the month of March 2001. Included in the mailing was a self-addressed, stamped envelope allowing respondents to return the completed questionnaires at minimal inconvenience and no expense to themselves. Most returns were received during April and May 2001. However, a postal strike at the time of mailing meant that a number were received later. Towards the middle of June, that it became obvious that no further replies were going to be received and that those responses received would constitute the final sample.

Letter of Introduction and Incentive

In an attempt to make the completion of the questionnaires as attractive as possible, it was decided to include an incentive for respondents to comply. To this end the letter of introduction explained that ten respondents who had completed the entire questionnaire would be eligible for a "prize" of a R100 grocery gift voucher. The need to include an incentive has been documented as having positive effects on response rates (Bailey, 1987). Accordingly, the cover of each booklet contained space for respondents, should they wish to enter the lucky draw, to include their names and addresses. Again, persons who chose this option were assured of confidentiality. At the end of June 2001 ten respondents' questionnaires were randomly selected from those received - five Form "As" and five "Bs". Grocery vouchers to the value of R100 each were sent to these ten people.

5. DESIGN AND MEASURES

As explained earlier, two questionnaire booklets were developed - questionnaire booklet A and questionnaire booklet B (see Appendices B and C respectively):

* ***Questionnaire Booklet A*** **(form "A")** was specifically developed to assess the opinions of respondents in terms of caring for a child whose mother had died of AIDS, but who was **HIV negative** and did not have AIDS him/herself.

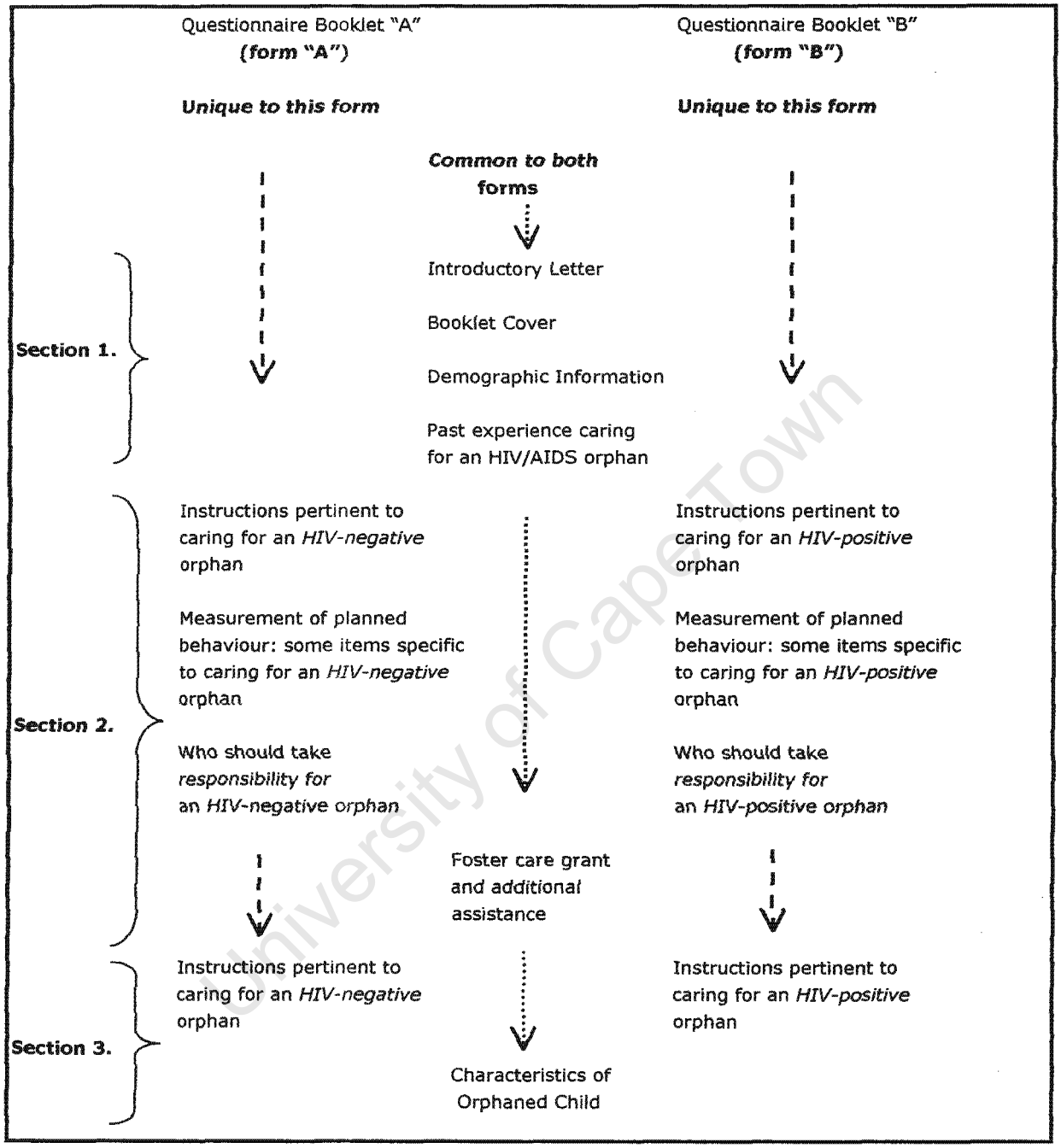
* ***Questionnaire Booklet B*** **(form "B")** was developed to appraise the opinions of the respondents in terms of caring for a child whose mother had died of AIDS and who was also **HIV positive** and had AIDS him/herself.

The need to develop two separate questionnaires each distinctly assessing information based on the HIV status of children orphaned by HIV/AIDS came from two considerations. Firstly, the information gained in the pilot study conducted in order to develop the questionnaire items for the Theory of Planned Behaviour indicated the need to explore different outcomes of caring for an HIV/AIDS orphan based on the orphan's HIV status. This was expanded upon above under "Procedure". Secondly, whilst constructing the questionnaires, it became apparent that their already complex nature was further complicated by an attempt to combine HIV negative and HIV positive child characteristics into one questionnaire.

Each booklet contained three distinct sections. The first section in each, the ***Demographic Questionnaire,*** asked a number of demographic details from respondents. Both questionnaire booklets contained this section, identical in each. The second section, referred to henceforth as the ***Measurement of Planned Behaviour,*** contained the required statements and response format for an analysis of decision-making processes in terms of the Theory of Planned Behaviour. As explained, the two booklets differed in terms of some items peculiar to either HIV negative or HIV positive orphans. The final section of the questionnaires, henceforth referred to as ***Characteristics of Orphaned Children,*** asked respondents to indicate whether they would be willing to care for a child either infected with, **or** affected by HIV/AIDS. If they indicated a willingness, they were asked to respond to a number of statements that assessed the preferred characteristics of a child for whom they would be willing to care. Both questionnaire booklets contained this section and, but for one item (duration of care), were identical in each. Each of these sections are expanded upon below.

In essence, then, the booklet comprised one questionnaire with two forms ("A" and "B") only slightly different from each other. As mentioned earlier, each of the forms were randomly mailed to respondents in equal numbers. The following Table 3 illustrates the similarities and differences between the two forms of the questionnaire.

Table 3: Similarities and Differences Between The Two Forms ("A" and "B") of the Questionnaire



5.1. Section 1: The Demographic Questionnaire

In order to compare those demographic characteristics of the respondents to those that have been identified by research as particular to persons caring for children in need, a demographic questionnaire was required. This same questionnaire would allow for an exploration of the influence of various demographic characteristics in potential carers'

caring decisions and behaviours. It would also allow for a descriptive "profile" to be constructed of existing carers, and persons who would be willing and/or unwilling to care. The reader is referred to Appendices B and C for the individual, specific items in the demographic questionnaire.

Six further questions were included in this section and were used to assess respondents' present and past experiences (both personal and vicarious) with caring for a child whose mother had died of AIDS. Initially, these questions were included in order to explore an additional component of the Theory of Planned Behaviour where past experience with, and/or intimate knowledge of a specific target behaviour have been closely associated with intentions to perform the target behaviour (Connor & Armitage, 1998; Connor & McMillan, 1999; Foster & Nel, 1995; Ouellette & Wood, 1998; Terry et al., (1999). Specifically, whether past experience or the experience of significant others are better predictors of intentions to perform particular behaviour(s) than are the customary predictors. Respondents were asked to indicate either "yes" or "no" to the following six statements:

> I am already caring / other members of my family are caring / some of my friends are caring for a child whose mother has died of AIDS
>
> and
>
> In the past I have cared / other members of my family have cared / some of my friends have cared for a child whose mother has died of AIDS

5.2. Section 2: Measurement of Planned Behaviour

It was felt that, for the purposes of this study, using the TPB would have positive investigative and practical value because

- A decision to care for an orphaned child infected with and/or affected by HIV/AIDS would certainly require a process of decision-making that requires carefully reasoned and planned action rather than spontaneous action. In this sense, it is also important to remember that the TPB has not to date been used to investigate decision-making processes that involve a possible life-time and 24-hour a day commitment to the effects of the decision. It seemed appropriate to include an analysis of alternative care decision-making based on a major social psychological theory in this study.
- The TPB would help to **explain** why some people are willing to care for orphaned children whilst others are not.

- It would aid in **predicting** who would and who would not be willing to care for orphaned children
- It may point to areas where the most effective **interventions** can be directed if necessary (internally i.e. at the level of attitudes or externally at the level of subjective norms).

However, before proceeding to the specific items in the questionnaire aimed at exploring the components of the TPB, respondents were alerted to the fact that this section dealt with their views about caring for orphaned children. These instructions contained two important pieces of information (refer to Appendices B and C, p. 3 of the questionnaire). The first piece of information described a scenario where a child's mother had died of AIDS. It went on to relate how this child appeared to have no known relatives willing or able to care for him/her. Also that the child appeared to have no-one to look after him/her and nowhere to go. This was hoped to describe a typical HIV/AIDS orphaning situation as follows:

> "The child in this part of the questionnaire is orphaned because his or her mother has died of AIDS. THE CHILD IS HIV NEGATIVE AND DOES NOT HAVE AIDS. It is unknown whether the child has other family members who would care for him or her. The child seems to have nowhere to go and no-one to look after him or her".

One point in this part of the instructions is the acknowledged incorrect description of the child's mother as having died of AIDS. It was felt that the more correct description, died of an AIDS-related illness, may have been confusing to many of the respondents. Not many people are aware of this distinction and are more au fait with the notion that AIDS is a fatal illness in itself rather than that it promotes other life-threatening illnesses.

The other piece of information provided to the respondents was a clear indication as to what was meant by **caring for** an orphaned child (refer too Appendices B and C, p.3 of the questionnaire). As stated earlier, this clarification was necessary as it was important not to stress either foster care or adoption - both of which are not seen as typical nor necessarily viable alternatives for caring for orphaned children. Also, it was felt that it was necessary to be very specific as to what the respondents were basing their decisions on. To quote:

"Caring for an orphaned child would mean taking the child into your own home and treating him or her as you would your own children; providing him or her with food shelter and clothing; schooling and medical care; and love, support and guidance".

Additionally, these instructions provided the necessary target (HIV/AIDS orphan), action (caring as described above), context (within one's own home), and time (imminent) of the behavioural criterion required for an analysis of behavioural intention in the TPB (Ajzen & Fishbein, 1980).

The construction of the specific items exploring the components of the TPB are detailed below.

Intention:

Intention was measured directly in the third section of the questionnaire "Characteristics of Orphaned Children" discussed further below (refer to Appendices B and C, p. 11 of the questionnaire). However, as this is central to the TPB, a discussion of this item is included here. Respondents were given the option of responding either "yes" or "no" to the following statement:

"I would be willing to care for the child described in the scenario if the child is...
HIV negative and does not have AIDS" (Form "A")
and
HIV positive and DOES have AIDS and is likely to become ill and will eventually die" (Form "B").

The answer to this statement (either "yes" or "no") was used as the indicator of intention to perform the target behaviour.

All the other items in this section of the questionnaire were measured by means of five-point scales. Scores were allocated from -2 to +2 for each item where positive scores reflected positive beliefs, states or actions (in terms of caring for the hypothetical HIV/AIDS orphan) and negative scores reflected the opposite.

Although the convention in most TPB research uses a seven-point scale, it was felt that a five-point scale would be more easily understood and less complicated for many of the respondents. This innovation was based on reports from many of the social workers involved with foster carers in both Cape Town and George. They advised that this group

of people is mostly minimally educated and would have difficulty with the more complex seven-point scale. Bandawe (2000), who also employed a five-point scale for his respondents - young primary school children - reported that other reasoned action research had used this variation without any apparent disadvantage (for example, Albaraccin, Fishbein, & Middlestadt, 1998; Godin & Kok, 1996; Klepp, Ndeki, Thuen, Leshabari & Seha, 1996).

Attitude:

This was measured directly be means of a three item scale (refer to Appendices B and C, p. 8, item 42 in both). The statement was divided into three sections allowing for a response along cognitive, affective, and general components of attitudes (Povey et al., 2000) as follows:

Item 42: For me to care for this child would be:
Scale: a very good thing to do .... a very bad thing to do
a wise thing to do .... a foolish thing to do
an enjoyable thing to do .... an unenjoyable thing to do

Behavioural Beliefs and Outcome Evaluations:

These were measured by means of a nine-item scale in Form "A" and an eight-item scale in Form "B". These behavioural beliefs encompass those most frequently mentioned in the pilot study and correspond to the affective and instrumental components of attitudes (Ajzen & Driver, 1991; Connor & Armitage, 1998).

Following the procedure for computing a belief-based measure of "attitude" (Ajzen, 1991; Ajzen & Fishbein, 1980), this measure was computed as the sum of the products of the scores for behavioural beliefs multiplied by the corresponding outcome evaluations of those beliefs. In Form "A", behavioural belief items are numbered 19 to 27 (refer to Appendix B, p.6); outcome evaluation items are numbered 33 to 41 (see Appendix B, pp. 7-8). In Form "B", behavioural belief items are numbered 20 to 27 (refer to Appendix C, p. 6); outcome evaluation items are numbered 34 to 41 (see Appendix C, pp. 7-8). An example of a behavioural belief item was:

Item 19: I would be able to provide this child with a loving and stable home

Assessing the corresponding outcome evaluation for this item was constructed as follows:

Item 33: To give this child a loving and stable home would be:
a very good thing to do .... a very bad thing to do

Reliability of the items was assessed using coefficient Alpha (reported later). As will be seen, to improve the reliability of this scale, some of the items were eventually discarded leaving five items in both Form "A" and Form "B". A mean of this belief-based measure of attitudes was also later correlated with the direct measure and is reported in the results section. The list of the retained salient beliefs is also presented for both questionnaire forms in the results section.

Subjective Norm:

Much of the criticism of the subjective norm construct has revolved around the traditional use of a single item to measure it (Connor & Armitage, 1998: Povey et al., 2000). The example of the latter authors was followed and three items were constructed including notions of important others' approval and sanction - all rated on a 5 point scale. A mean of the three items was used as a global measure of subjective norm (refer to Appendices B and C, p 4, items 1 - 3 in both questionnaire forms). The three statements were:

Item 1: People I respect would THINK that I should care for this child
Item 2: If I were to care for this child, people I respect would
Item 3: People I respect would WANT me to care for this child

Normative Beliefs and Motivation to Comply:

These were measured by means of three items based on the most frequently mentioned salient referents (husband/partner, family, and friends) in the pilot study. Following the procedure for computing a belief-based measure of "subjective norm" (Ajzen, 1991; Ajzen & Fishbein, 1980), this measure was computed as the sum of the products of the scores for normative beliefs multiplied by the corresponding motivations to comply with those beliefs. Normative belief items in both Form "A" and "B" are numbered 7 to 9 (refer to Appendices B and C, p. 5 respectively). Motivations to comply items are numbered 4 to 6 in both Form "A" and "B" (refer to Appendix B and C, p. 4 respectively). A mean of this belief-based measure of subjective norm was later correlated with the mean of the directly measured subjective norm items and is reported in the results section below. An example of a normative belief item was:

Item 7: If I were to care for this child, my husband/partner would
definitely approve .... definitely disapprove

The corresponding motivation to comply for this item was worded follows:

Item 4: With most things in life, I do what my husband/partner wants me to do always .... never

Perceived Behavioural Control:

This was measured directly by means of four items in both forms of the questionnaire. In line with the recent debate around the essential components of perceived behavioural control (as described in chapter 3), two of the items assess aspects of personal control and the other two encompass aspects of self-efficacy (refer to Appendices B and C, p. 5, items 10 to 13 in both questionnaire forms). An example of the former was:

Item 10: If I cared for this child, it would be entirely my own decision

An example of the latter was:

Item 13: I would feel very capable of caring for this child

Following the debate surrounding this construct (mentioned above), it was decided that either a mean of these 4 items would be used as a global measure of perceived behavioural control or, following factor analysis of the items, self-efficacy and personal control items would be used separately as predictors of behavioural intention. An unrotated Principal Components factor analysis was performed resulting in all four items loading significantly on to one factor. This is illustrated in Table 4 below. The four items clearly did not discriminate between self-efficacy and personal control and it was therefore decided to use a mean of the four items as a direct measure of perceived behavioural control.

Table 4: Factor Loadings of Belief-Based Items Assessing Perceived Behavioural control

Belief-based Item No.	Factor Loadings	
	Form A	Form B
1	.876	.813
2	.907	.853
3	.877	.923
4	.885	.888
Eigenvalues	3.15	3.03
Explained Variance	79%	76%

Loadings of >= .70 are taken as significant

Control Beliefs and Power of Control Beliefs

These were measured by means of five items in Form "A" and by means of six items in Form "B". These perceptions of control were identified by the pilot study participants who were asked what makes caring for a child easy/difficult. Affective as well as instrumental constraints/facilitators identified by the pilot study participants have been included in these items.

Again, following the procedure for computing a belief-based measure of "perceived behaviourl control" (Ajzen, 1991), this measure was computed as the sum of the products of the scores for control beliefs multiplied by the corresponding measure of the power of those beliefs. The 5 items in Form "A" measuring control beliefs are numbered 28 to 32 and those measuring the power of control beliefs are numbered 14 to 18 (refer to Appendix B, p. 7 and 5 respectively). In Form "B", the items measuring control beliefs are numbered 28 to 33 and those measuring the power of these beliefs are numbered 14 to 19 (refer to Appendix C, p. 7 and 5 respectively). An example of a control belief item was:

Item 28: If I were to care for this child, I would need the support of my family and friends

Assessing the corresponding power of this control belief was worded as follows:

Item 14: If I have the support of my family and friends, this would make it much easier .... much more difficult - to care for this child

Reliability of the items was determined using coefficient Alpha (reported later). As will be seen, to improve the reliability of this scale, some of the items were eventually discarded leaving three items in both Forms "A" and "B". A mean of this belief based measure of perceived behavioural control was also later correlated with the direct measure and is reported in the results section below.

The Foster Care Grant and Additional Assistance

Three further items were included at the end of this section of the questionnaires (refer to Appendces B and C, p. 9, items 43 to 45). The first of the items asked respondents to indicate either "yes" or "no" to the suggestion that the following persons or groups should take responsibility for the child described in the scenario: the child's other family members; friend's of the child's family; neighbours of the child's family; members of the child's community even if they are strangers; an orphanage; and/or the Government.

Secondly, if they were already caring for a foster child, they were asked to indicate whether the foster care grant provided by the Government was thought to be sufficient. Finally, they were requested to suggest what additional sources of outside support would aid them in their task.

These questions were incorporated into the questionnaire because, in South Africa, expectations of responsibility place less emphasis on the family and more on the State than in countries north of our border (McKerrow, 1998 in Halkett, 1999). This may well be because South Africa has a relatively well developed social security system. Also, many practitioners and policy makers consider that orphaned children should be cared for firstly by the children's extended family, secondly by the community from which the orphans originate, thirdly by foster carers and/or adopter even if they are strangers, and finally in institutions (Halkett, 1999; McKerrow, 1996; McKerrow & Verbeek, 1995; Parry, 2000; Smart, 2000). Many of these same authors suggest that this hierarchy will go a long way to alleviating the plight of orphaned children, particularly these children's family and community identified as primary carers, as long as there is some instrumental support. The most likely source of this support is the State.

5.3. Section 3: Characteristics of Orphaned Children

Before continuing to this final section of the questionnaire, respondents were again given specific instructions. They were first alerted to the fact that this part of the Booklet dealt with their views about orphaned children. The two pieces of important information from the Measurement of Planned Behaviour Questionnaire was repeated: the scenario describing an orphaned child; and what "caring for" would entail. Confidentiality of responses was again stressed (refer to Appendices B and C p. 10 in both).

Questionnaire Items

This part of the questionnaire, in both Forms "A" and "B", began by asking respondents one of the most central questions in the thesis. This has already been expanded upon in the section dealing with the Measurement of Planned Behaviour and will not be repeated here. The only additional consideration worth reporting is that willingness to care for an orphan not only provided an assessment of the predictor "intention" in the theory of planned behaviour, but also informed parts of the descriptive analyses in that a profile of potential carers who either would be willing to care for either an HIV negative or HIV positive child was explored.

The balance of the questionnaire (in both Forms "A" and "B") continued by asking respondents to answer either "yes" or "no" to a number of additional statements further characterising the child described in the scenario. This allowed for an exploration of the primary characteristics of an orphaned child that may influence potential carers' willingness to care for him/her. Each of the statements was created keeping the characteristics of "hard to place" children as described in chapter 2, firmly in mind. As described earlier, these children have been identified by research from abroad as well as children are arguably those least likely to be accommodated in alternative caring situations. An investigation of these child characteristics including those "easy to place" would have practical value for alternative care planners. Only those respondents who indicated a willingness to care for the hypothetical child needed to complete the balance of this part of the questionnaire.

Each of the statements explored issues relating to the gender of the child; the age of the child; whether the respondents would be willing to care for a child cross culturally; whether the respondents would be willing to care for a child of a similar or different background to themselves; whether the child had known siblings and whether they would need to either remain in contact with these siblings or not and/or whether the respondents would be willing to care for siblings as well; the closeness of the relationship to the child in terms of whether the child was from the same family / known to the respondent / from the same black African clan and/or a stranger to the respondent. In Form "A", respondents were then asked about the duration of care they would be willing to give. This item was not included in Form "B" as duration of care would be determined by the HIV-positive status of the hypothetical child. Finally, both questionnaires concluded with the possibility of alternative care should the respondents no longer wish to care for the child (refer to Appendices B and C, pp 11-12 in both).

Both questionnaire booklets concluded with thanks to the respondents for taking the time and effort to complete the questionnaire.

5.4. Preliminary Analysis of the Data

Reliability of the Measurement of Planned Behaviour section in both forms of the questionnaire was assessed using the Cronbach alpha coefficients for each of the sections. As indicated earlier, some of the items were discarded in an attempt to improve the reliability of this part of the questionnaire. The results indicating both pre- and post-removal of items were as follows:

Table 5: Alpha coefficients for the TPB items in both Forms "A" and "B"

	Initial results	Results after the removal of unreliable items
Form "A"		
Attitude	.85	.85
Behavioural Beliefs	.51	.80
Outcome Evaluation	.38	.70
Subjective Norm	.92	.92
Normative Beliefs	.90	.90
Motivation to Comply	.72	.72
Perceived Behavioural Control	.90	.90
Control Beliefs	.35	.81
Power of Control Beliefs	.69	.65
Form "B"		
Attitude	.82	.82
Behavioural Beliefs	.44	.71
Outcome Evaluation	.49	.46
Subjective Norm	.94	.94
Normative Beliefs	.87	.87
Motivation to Comply	.57	.59
Perceived Behavioural Control	.89	.89
Control Beliefs	.39	.83
Power of Control Beliefs	.58	.55

The column denoting the final alpha coefficients indicates reasonable correlation of test items. However, if Aiken's (1982) suggestion is followed, that attitude scales should show a reliability of between .79 (median) and .98 (high), then it is important to note that, despite removal of a number of items, some alpha coefficients remained below .79 although only one was below what he considers low, .47. For example, Power of Control Beliefs in form "A" (alpha .65); Outcome Evaluation in Form "B" (alpha .46); Motivation to Comply in Form "B" (alpha .59) and Power of Control Beliefs also in Form "B" (alpha .55). Although the generally high alphas give credibility to the results that emerge from the questionnaire some caution needs to be shown when interpreting results using this data.

CHAPTER 5

RESULTS

The results that follow will be reported following the sections in the questionnaire. Results from the personal questionnaire will be reported first, focusing on the differences between adoptive and foster parents in the final sample. Those pertaining to the reported willingness to care for an AIDS orphan will be reported next, followed by the data relating to the hypothetical orphan's characteristics. The final section will report the data from an investigation of the Theory of Planned Behaviour to predict intentions to care for an AIDS orphan.

1. DEMOGRAPHIC CHARACTERISTICS

The results from the demographic data are depicted in Table 6 below and include, in the fourth column, the varying significant differences between adoptive and foster parents. Although some of the respondents did not respond to all the enquiries, it was decided not to remove those cases with missing data from the data set. This accounts for the differing N's reported for the different demographic variables below.

Table 6: Demographic Characteristics: Adoptive and Foster Parents

	(A) ALL RESPONDENTS	(B) ADOPTIVE PARENTS	(C) FOSTER PARENTS	(D) DIFFERENCES (B - C) * p<.05 ** p<.01
	N = 175	N = 70 (42.17%)	N = 96 (57.83%)	χ^2=8.14**
With related children			N = 37 (38.54%)	
With unrelated children			N = 59 (61.46%)	

	(A) ALL RESPONDENTS	(B) ADOPTIVE PARENTS	(C) FOSTER PARENTS	(D) DIFFERENCES (B - C) * p<.05 ** p<.01
FAMILY SIZE				
No. biological children < 16 years	71	49	21	
Mean age	9.79 years	6.71 years	12.33 years	
No. of related foster children	56			
Mean age	10.08 years			
No. of unrelated foster children	118			
Mean age	8.06 years			
No. of adopted children	105			
Mean age	5.4 years			
AVERAGE AGE	47.12 years	41.65 years	51.64 years	t=2.609**
	N = 160	N = 69	N = 85	df=152
	SD = 11.47	SD = 7.80	SD = 10.96	
Married or living with a partner	42.75 years	40.05 years	47.81 years	t=2.631**
	N = 98	N = 56	N = 37	df=91
	SD = 9.72	SD = 6.69	SD = 10.93	
	61.25%	81.16%	43.53%	χ^2=7.76*
Partners	45.03 years	41.57 years	50.54 years	t=2.631**
	N = 98	N = 56	N = 37	df=91
	SD = 9.72	SD = 6.88	SD = 11.22	
RESPONDENTS > 50 YEARS OLD	33.75%	11.59%	52.94%	χ^2=51.66**
	N = 53	N = 8	N = 45	
AVERAGE LENGTH OF	17.14 years	15.88 years	19.72 years	t=2.631**
RELATIONSHIP	N = 98	N = 56	N = 37	df=91
	SD=8.95	SD=6.84	SD=11.27	
HOME LANGUAGE				
English	47.88%	85.71%	19.10%	χ^2=48.03**
	N = 79	N = 60	N = 17	
Xhosa	25.45%	5.71%	41.57%	χ^2=53.12**
	N = 42	N = 4	N = 37	
Afrikaans	26.67%	8.57%	39.33%	χ^2=41.02**
	N = 44	N = 6	N = 35	
HOUSEHOLD DENSITY				
Average no. persons	1.50 persons	1.07 persons	1.71 persons	t=3.005**
>18 years in household	N = 155	N = 68	N = 82	df=148
	SD = 1.40	SD = .94	SD = 1.49	
Average no. rooms	4.23 rooms	5.35 rooms	3.39 rooms	t=2.609**
(excl. bath & kitchens)	N = 157	N = 68	N = 84	df=150
	SD = 2.29	SD = 2.48	SD = 1.69	
HOUSEHOLD INCOME				
Average no. in household	1.34 persons	1.58 persons	1.11 persons	t=2.610**
employed	N = 155	N = 67	N = 82	df=147
	SD = .86	SD = .66	SD = .94	
Mean Income Bracket	R2001 to R5000 p.m.	R8001 to R10000 p.m.	R1001 to R2000 p.m.	
Mode: income bracket	>R10000 p.m.	>R10000 p.m.	R1001 to R2000 p.m.	
EDUCATION				
Average school achievement:	Std. 7	Std. 9	Std. 6	
respondents	N = 159	N = 70	N = 84	
Average school achievement:	Std. 8	Std. 9	Std 6.	
partners	N = 107	N = 59	N = 44	
Matriculation: respondents	45%	82.43%	16.67%	χ^2=52.08**
	N = 53	N = 57	N = 14	
Matriculation: partners	58.86%	86.44%	20.45%	χ^2=58.80**
	N = 63	N = 51	N = 9	
After school qualifications:				
None: respondents	57.86%	30.00%	80.95%	χ^2=49.64**
	N = 92	N = 21	N = 68	
partners	49.00%	20.34%	86.36%	χ^2=27.04**
	N = 53	N = 12	N = 38	

	(A) ALL RESPONDENTS	(B) ADOPTIVE PARENTS	(C) FOSTER PARENTS	(D) DIFFERENCES (B - C) * p<.05 ** p<.01
After school qualifications:				
Some: respondents	24.30% N = 38	38.57% N = 27	15.48% N = 13	χ^2=9.80**
partners	24.30% N = 26	36.98% N = 23	6.82% N = 3	χ^2=30.77**
University: respondents	18.24% N = 29	31.43% N = 22	3.57% N = 3	χ^2=28.88**
partners	26.17% N = 28	40.68% N = 24	6.82% N = 3	χ^2=32.67**
EMPLOYMENT				
Unemployed: respondents	50.94% N = 81	35.71% N = 25	65.06% N = 54	χ^2=21.29**
partners	14.15% N = 15	5.17% N = 3	25.58% N = 11	χ^2=9.14**
RELIGIOSITY				
Christian	86.42% N = 140	82.61% N = 57	90.91% N = 80	χ^2=7.72*
Muslim	6.17% N = 10	4.35% N = 3	6.82% N = 6	NS
Jewish	2.47% N = 4	4.35% N = 3	-- N = 0	χ^2=6.00*
Other / None	4.94% N = 8	8.70% N = 6	2.27% N = 2	χ^2=4.00*
Attended ceremonies once per week or more often	71.61% N = 116	52.86% N = 37	84.88% N = 73	χ^2=23.56**

As mentioned previously, the above table demonstrates that there was an over-representation of foster carers in the total sample. Much of the following discussion focuses on the many significant differences between the two groups of parents: adoptive and foster parents.

Although kinship care is practiced extensively in South Africa, it has traditionally been an informal arrangement between family members and not a formal agency-mediated arrangement with application for, and receipt of, the foster care grant. As the foster carers in this sample were all those receiving the foster care grant, it was expected that there would be fewer kinship carers (i.e. those caring for children related to either themselves or their partners) than those caring for children unrelated to either themselves or their partners. This proved to be the case with significantly more foster parents caring for unrelated as opposed to related children.

Age and Marital / Partner Relationships

Foster parents, whether married or living with a partner or not, and their partners (where applicable) were also significantly older than adoptive parents and their partners. A further finding was that a significantly more foster carers than adoptive parents were

over the age of 50. In chapter 2 it was shown that grandparents, who would arguably be over the age of 50, are generally over-represented in any group of foster carers and these two findings appear to confirm this for the current sample. The cut-off ages for eligibility to adopt would also have had an impact on these results. As a general rule, prospective adoptive parents should not be older than between 40 and 45 years old in order to be eligible to adopt an infant. With an average age of 5.4 years for this sample's adopted children, not many adoptive parents would be older than 50 years old.

Foster parents had also been married or living with a partner for significantly longer than had adoptive parents. Although the difference is significant, it is likely to be a result of the greater average age of foster carers in this sample, rather than an indicator of the relative greater stability of their marriages.

Home Language

There were significantly more English-speaking adoptive parents than foster parents. If language is used as an indicator of racial/ethnic group, then one could say that there were far more "white" adoptive parents in the current sample. This would not be entirely unexpected given that adoption has historically served this group of persons almost exclusively in this country.

Household Density

Foster parents had significantly more persons on average over the age of 18 years living with them than did adoptive parents. They also accommodated their families in fewer rooms on average than did adoptive parents. Both these results point to foster carers having higher household density than adoptive parents. This difference in household density will be explored further in the results section particularly in relation to its possible influence on respondents' willingness to care for, and being able to accommodate an additional child.

Household Income

Adoptive parents earned significantly more per month than did foster parents. Again, this may point to the fact that eligibility to adopt has historically required prospective adoptive parents to be "financial secure". Additionally, if this sample's adoptive parents are largely from the "white" racial/ethnic group (as proposed above), then this income disparity between adoptive and foster parents also reflects the historical and continuing disadvantage experienced by some racial/ethnic groups in this country.

Education and After School Qualifications

A synthesis of this aspect of the data, reveals that adoptive parents in this sample were significantly better educated on average than were foster parents. Specifically, adoptive parents and their partners (where applicable) had achieved higher levels of schooling; had also matriculated; and had some after school qualification and/or a university degree than had foster parents. Again, these findings may point to the continuing historical disadvantage of some racial/ethnic groups in this country or to prospective adoptive parents having traditionally to demonstrate adequate education levels.

Employment

A significantly greater proportion of both foster mothers and their partners (where applicable) than adoptive parents were unemployed. Interestingly, given the relatively better education obtained by adoptive mothers, the most frequently reported employment level for both adoptive and foster mothers was "unemployed". From chapter 2's discussion of foster carer demographics, this finding was not unexpected as the majority of foster mothers were found to be unemployed. However, a plausible explanation for adoptive mothers unemployment is not easy to find and may be a reflection of their commitment to child-rearing. Their household financial security would also make it far easier for them to choose not to be employed Also congruent with the foster carer demographics explored in chapter 2, was the fact that the most frequently reported employment category of foster fathers indicated "blue collar" occupations.

Religiosity

The sample as a whole appear to be religiously oriented with 95% indicating some religious affiliation and 71% reporting attending religious ceremonies once a week or more often. Similar religious affiliations are reported for both adoptive and foster parents. The only significant difference between these two groups of parents was that significantly more foster carers reported attending religious ceremonies once a week or more often than did adoptive parents.

2. EXPLORING WILLINGNESS TO CARE FOR AN AIDS ORPHAN

The following analysis of the descriptive data will focus on those respondents and their partners (where applicable) who indicated that they would be willing to care for either an HIV-negative or HIV-positive orphan. In other words, an analysis of the data from Form

"A" and Form "B" of the questionnaire presented together. Only where there are pertinent or statistically significant differences between those who were willing and those who were not willing to care for such a child, will these be reported in detail. Refer to appendix E where the data from both forms of the questionnaire is presented in table form.

2.1. Willingness to Care

Two of the central questions that this thesis was designed to answer was would people be willing to care for an HIV/AIDS orphan? If so, who were these people? It was expected that more people would be willing to care for an HIV-negative orphan than an HIV-positive one. Arguably caring for an HIV-positive orphan would be both physically and emotionally taxing with the child becoming progressively more ill and eventually succumbing to the virus. It was thought that this type of caring would not be one that people would necessarily willingly undertake. This proved to be the case amongst this study's respondents as the following descriptions and Figure 6 show. However, interesting differences between foster parents' and adoptive parents' willingness were also exhibited.

Willingness to Care For An HIV-Negative Orphan

Sixty-one of the 80 respondents (76.25%) who answered this question indicated that they would be willing to care for an HIV-negative child whose mother had died of AIDS.

Willingness to Care For An HIV-Positive Orphan

Fifty-one of the 82 respondents (62.20%) who answered this question indicated that they would be willing to care for an HIV-positive child whose mother had died of AIDS.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Although it appeared that more respondents were willing to care for an HIV-negative orphan than an HIV-positive one (76.25% and 62.20% respectively), a chi-square analysis proved this difference was not significant.

2.2. Adoptive and Foster Parents

A comparison of adoptive and foster parents was undertaken due to the likelihood of their differing motivations in wanting to care for an orphan. Arguably adoptive parents would care for a child only if that caring situation was a life-time commitment. If this were the case, it was expected that adoptive parents would be less inclined to care for an HIV-positive orphan whose lifespan would be short. Contrary to this, it was expected that foster parents, because of their familiarity with the more temporary nature of foster

care, would either show no distinct preference for either an HIV-negative or HIV-positive orphan or a preference for an HIV-positive child.

Willingness to Care For An HIV-Negative Orphan

Thirty-one (88.57%) adoptive parents and 26 (70.27%) foster parents indicated a willingness to care for an HIV-negative orphan. In this instance, there was no significant difference in willingness between adoptive and foster parents.

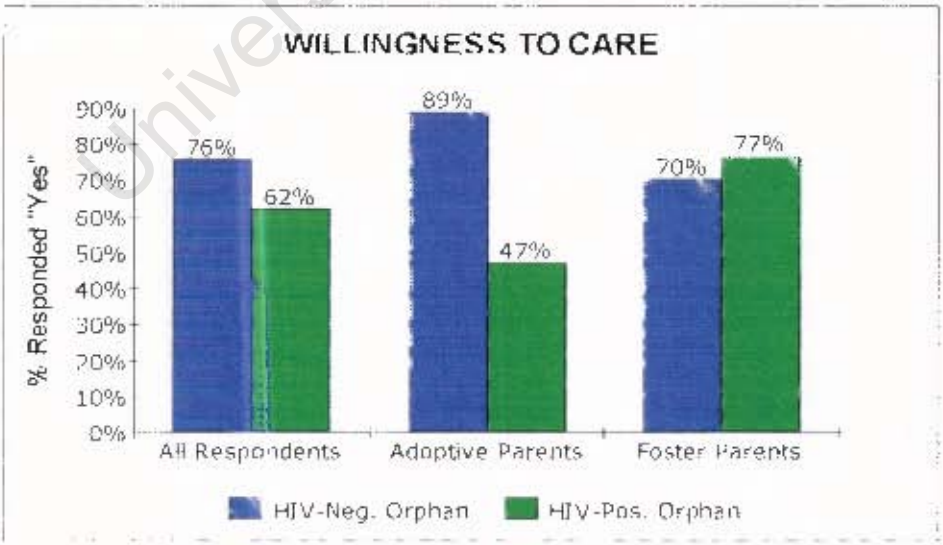
Willingness to Care For An HIV-Positive Orphan

Sixteen (47.06%) adoptive parents and 34 (77.27%) foster parents indicated that they would be willing to care for an HIV-positive orphan. In this case, significantly more foster parents than adoptive parents were willing to care for such a child ($\chi^2=7.61$; $p<.01$). This finding confirms the expectation that foster parents would be more willing than adoptive parents to care for an HIV-positive orphan.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

The results indicate that foster parents were equally willing to care for either an HIV-negative or -positive orphan (70.27% and 77.27% respectively). However, adoptive parents were significantly more willing to care for an HIV-negative than an HIV-positive orphan ($\chi^2=13.68$; $p<.01$). The following Figure 6 depicts these differences.

Figure 6: Willingness to Care for Either an HIV-Negative or HIV-Positive Orphan Amongst All Respondents, Adoptive Parents and Foster Parents



2.3. Age & Marital Status

It was expected that those respondents willing to care for an HIV/AIDS orphan would be younger than those who were not willing to do so. This expectation was based on the information from the pilot study described in the previous chapter, where time, energy and youth were cited as distinct facilitators in caring for a young child.

Form "A": Willingness to Care For An HIV-Negative Orphan

The mean age of the 58 respondents who indicated a willingness to care for an HIV-negative orphan was 46.26 years old (SD 12.27) with a range of between 24 and 76 years old. Thirty-six respondents (62.07%) were married or had partners whose mean age was 43.78 years old (SD 10.25) ranging between 29 and 76 years old. These 36 respondents' mean age was 42.25 years with a range of between 28 and 76 years old (SD 11.13). They had been married or living with a partner between 1 and 59 years with an average of 17.33 years (SD 11.61).

The following Table 7 demonstrates the differences between willing and unwilling respondents with regard to their and their partners' average age. Willing respondents appeared to be younger (M=46.26, SD12.27) than unwilling respondents (M=50.32, SD11.87) although a single sample t-test showed this difference was not significant. However, the partners of respondents who indicated a willingness to care for an HIV-negative orphan were significantly younger (M=43.78, SD10.25) than the partners of unwilling respondents (M=51.50, SD 14.07) (t=2.013; df=46; p<.05).

Table 7: Differences Between Willing and Unwilling Respondents: Age (Form "A")

	Mean Age Respondents	Mean Age Respondents Married/Living Together	Mean Age Partners
Willing	46.26 years (N=58; SD12.27)	42.25 years (N=36; SD11.13)	43.78 years (N=36; SD10.25)
Unwilling	50.32 years (N=19; SD11.87)	44.08 years (N=12; SD8.23)	51.50 years (N=12; SD14.07)

Form "B": Willingness to Care For An HIV-Positive Orphan

The mean age of the 49 respondents who indicated a willingness to care for an HIV-positive orphan was 46.88 years old (SD 9.77) with a range of between 31 and 72 years old. Thirty respondents (61.22%) were married or had partners whose mean age was

46.03 years old (SD 8.63) ranging between 30 and 69 years old. These respondents' mean age was 43.7 years (SD 8.96) and ranged between 31 and 67 years old. They had been married or living with a partner between 4 and 45 years with an average of 19.39 years (SD 9.44).

The following Table 8 demonstrates the differences between willing and unwilling respondents with regard to their and their partners' average age. Willing respondents appeared to be older (M=46.88, SD9.77) than unwilling respondents (M=44.60, SD10.81). The partners of respondents who indicated a willingness to care for an HIV-positive orphan also appeared to be older (M=46.03, SD8.63) than the partners of unwilling respondents (M=43.50, SD 10.38). Employing single sample t-tests, neither of these differences proved to be significant.

Table 8: Differences Between Willing and Unwilling Respondents: Age (Form "B")

	Mean Age Respondents	Mean Age Respondents Married/Living Together	Mean Age Partners
Willing	46.88 years (N=49; SD9.77)	43.70 years (N=30; SD8.96)	46.03 years (N=30; SD8.63)
Unwilling	44.60 years (N=30; SD10.81)	42.09 years (N=22; SD9.16)	43.50 years (N=22; SD10.38)

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Respondents and partners (where applicable) willing to care for an HIV-positive orphan were a little older and had been married for longer than those prepared to care for an HIV-negative orphan. More respondents willing to care for an HIV-negative orphan were married or living with a partner. However, these noted differences were very small and none were statistically significant.

However, interesting differences do appear between willing and unwilling respondents in terms of caring for either an HIV-negative or HIV-positive orphan. On the whole, respondents and their partners (where applicable) who were willing to care for an HIV-negative orphan were *younger* than those who were unwilling to do so. On the other hand, both respondents and their partners (where applicable) who were willing to care for an HIV-positive orphan were *older* than those who were unwilling to do so.

2.4. Home Language

Form "A": Willingness to Care For An HIV-Negative Orphan

There was no significant difference between language groups with 80.49% (N=33) of English-speaking; 70.83% (N=17) Xhosa-speaking respondents; and 73.33% (N=11) Afrikaans-speaking respondents indicating a willingness to care for an HIV-negative orphan.

Form "B": Willingness to Care For An HIV-Positive Orphan

There was also no significant difference between language groups with 55.26% (N=21) of English-speaking; 80% (N=12) Xhosa-speaking respondents; and 64.00% (N=18) Afrikaans-speaking respondents indicating a willingness to care for an HIV-positive orphan.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Figure 7 depicts the comparative willingness of the different language groups to care for an orphan who is either HIV-negative or HIV-positive. Similar proportions of English-, Xhosa-, and Afrikaans-speaking respondents indicated a willingness to care for either an HIV-negative or HIV-positive orphan to the extent that chi-square analyses revealed no significant differences between the language groups. However, English-speaking respondents were significantly more willing to care for an HIV-negative orphan rather than an HIV-positive orphan ($\chi^2=5.80$; $p<.05$).

Figure 7: Comparing Willingness to Care Across Home Language of Respondents and HIV Status of Orphan

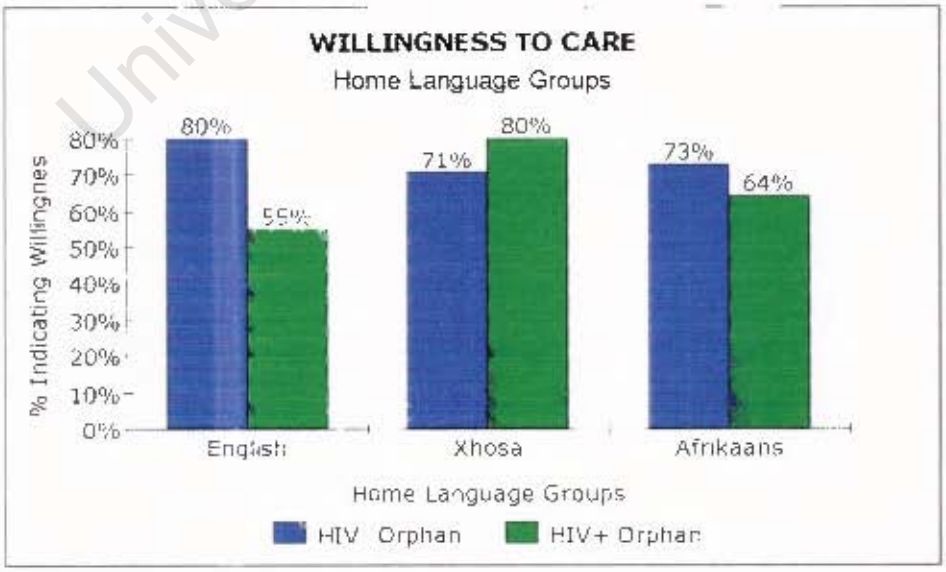
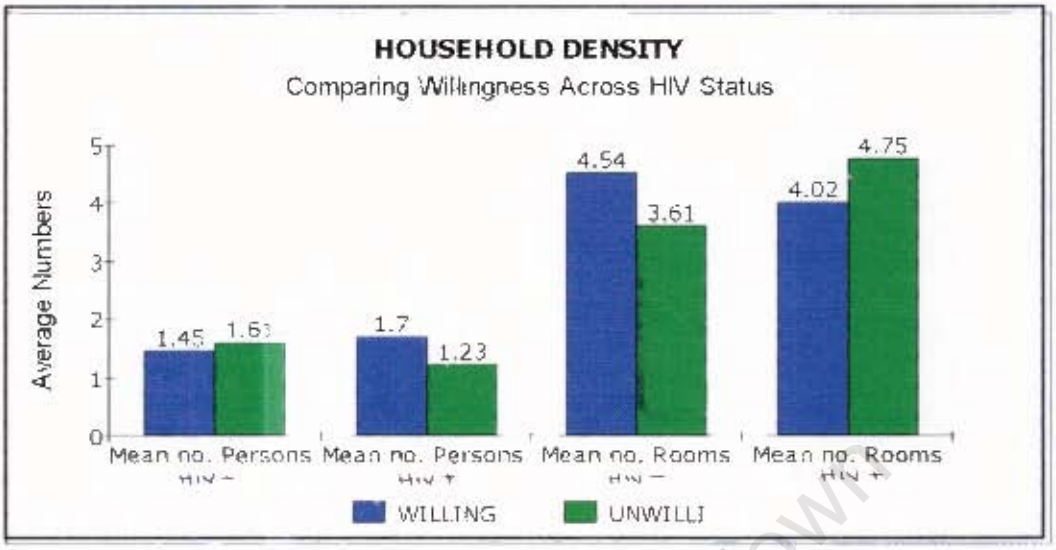


Figure 8: Household Density: Comparisons Between Willing and Unwilling Respondents from Forms "A" and "B"



2.6. Household Income

The household income of respondents was explored for much the same practical reasons as was household density: the ability to afford to care for an additional member of the family. It was expected that those respondents earning higher monthly incomes would be more willing to care for an orphan than those earning less. A further consideration was the fact that caring for an HIV-positive child would require much more expense (particularly in terms of health care) than would caring for an HIV-negative child, although due thought was given to the relatively short-term caring that an HIV-positive child would need.

Form "A": Willingness to Care For An HIV-Negative Orphan

The average number of persons living with willing respondents (N=56) who were employed was 1.46 ranging between 0 and 3 persons (SD=.83). Only 49 willing respondents reported their household income. The mean income bracket was between R5001 and R8000 p.m. although the most frequently reported income bracket was "more than R10000 p.m." The mean household income bracket for unwilling respondents (N=12) was between R1001 and R2000 p.m. with the most frequently reported brackets either between R1001 and R2000 p.m. or more than R10000 p.m.

Although this data could not be analysed statistically, willing respondents earned **more** on average per month than unwilling respondents supporting expectations. Figure 9

2.5. Household Density

Household density was investigated by exploring the average number of persons older than 18 who were staying with respondents; the mean number of rooms (excluding kitchens and bathrooms) that comprised respondents' homes; and the average number of children 16 years old or less living with respondents. An indication of household density was then obtained such that household density could be considered high should, for example, respondents indicate a small number of rooms and a relatively large number of adult persons and children occupying them. An indication of relatively low household density would reflect the opposite.

The need to explore this dimension of respondents' living arrangements came from practical considerations that would arguably influence respondents' willingness to care for an orphan. These considerations revolve around available space in the family home: a crowded or over-crowded house (high household density) would simply not be able to accommodate another child; a house with space to spare (low household density) would arguably not have to face this practical constraint.

Form "A": Willingness to Care For An HIV-Negative Orphan

Fifty-eight willing respondents reported on the number of persons older than 18 years living in their homes. The average number was 1.45 ranging between 0 and 9 persons (SD 1.42). Fifty-nine willing respondents reported on the number of rooms in their homes (excluding bathrooms and kitchens). The mean number of rooms was 4.54 ranging between 1 and 10 rooms (SD 2.36). The average number of children living with willing respondents (N=56) was 2.2 children ranging between 1 and 6 children (SD 1.29).

There were differences between willing and unwilling respondents with regard to household density. Unwilling respondents had, on average, more persons older than 18 years living in their homes (M=1.61; SD1.29) than willing respondents. They also had, on average, fewer rooms in their homes (M=3.61; SD1.42) than willing respondents. However, neither of these differences were significant. But worth noting is the possibility that having more persons living in less space may well have been instrumental in some respondents' reported **un**willingness. As both willing and unwilling respondents had the same average number of children 16 years old or less living with them (2.2 children), this dimension of household density was not considered to affect their willingness or unwillingness to care for an additional child.

Form "B": Willingness to Care For An HIV-Positive Orphan

Forty-seven willing respondents reported on the number of persons older than 18 years old living in their homes. The average number was 1.7 ranging between 0 and 6 persons (SD 1.443). Fifty willing respondents reported on the number of rooms in their homes (excluding bathrooms and kitchens). The mean number of rooms was 4.02 ranging between 1 and 12 rooms (SD 2.263). The average number of children living with willing respondents (N=48) was 2.65 children ranging between 1 and 10 children (SD 1.90).

There were differences here too between willing and unwilling respondents with regard to household density. Unwilling respondents had on average fewer children 16 years old or younger living with them (M=1.55; SD 1.12). Unwilling respondents had, on average, fewer persons older than 18 years living in their homes (M=1.23; SD1.43) than willing respondents. Unwilling respondents also had, on average, more rooms in their homes (M=4.75; SD2.62) than willing respondents. None of these differences were significant, but were contrary to the findings for those respondents who completed Form "A". For this group of respondents, then, it appeared that household density may not have contributed to an unwillingness to care for an HIV-orphan purely on practical grounds.

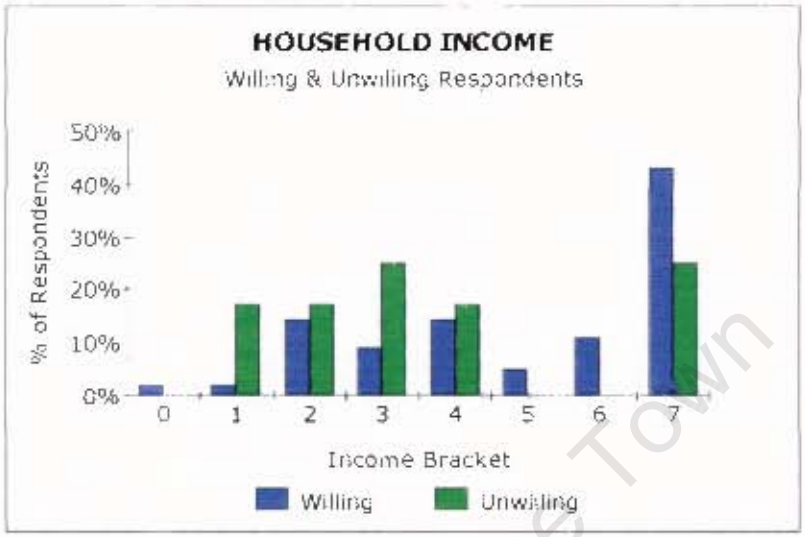
Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Respondents willing to care for an HIV-negative orphan seemed to accommodate less persons older than 18 years in more rooms than those willing to care for an HIV-positive orphan. However, these noted differences were very small and none were statistically significant.

However, interesting differences do appear between willing and unwilling respondents in terms of caring for either an HIV-negative or HIV-positive orphan. Respondents who were willing to care for an HIV-negative orphan had relatively low household density compared to those who were unwilling to do. This appeared to support the household "space" hypothesis mentioned earlier. However, contrary to this finding, respondents who were willing to care for an HIV-positive orphan had an indication of higher household density than those who were unwilling to do so. The following Figure 8 depicts these differences.

demonstrates the proportion of willing and unwilling respondents reporting each of the income brackets.

Figure 9: Differences Between Willing & Unwilling Respondents: Household Income Brackets (HIV-Negative Orphan)



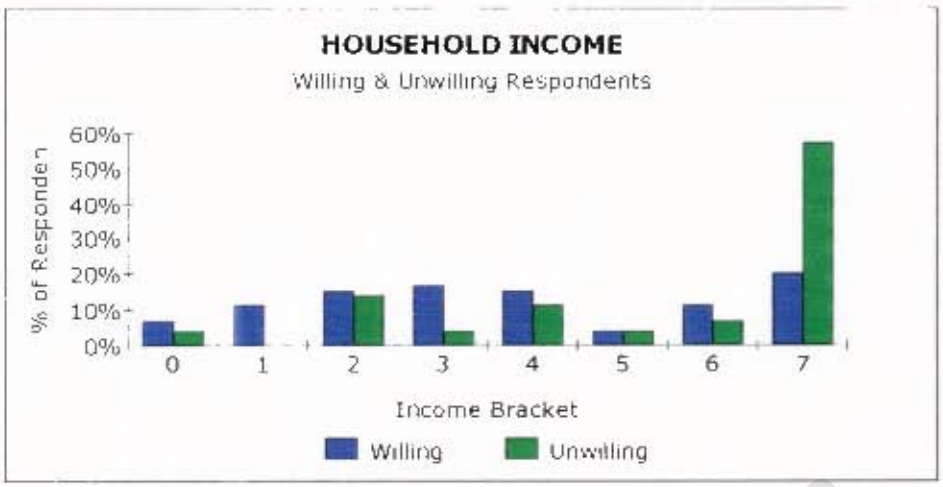
Key: 0: No income 1: R0 to R500 p.m. 2: R501 to R1000 p.m.
3: R1001 to R2000 p.m. 4: R2001 to R5000 p.m. 5: R5001 to R8000 p.m.
6: R8001 to R10000 p.m. 7: More than R10000 p.m.

Form "B": Willingness to Care For An HIV-Positive Orphan

The average number of persons living with willing respondents (N = 49) who were employed was 1.33 ranging between 0 and 5 persons (SD 1.008). Only 46 willing respondents reported their household income. The mean income bracket was between R2001 and R5000 p.m. although the most frequently reported income bracket was "more than R10000 p.m."

The mean household income bracket for unwilling respondents (N = 28) was between R5001 and R8000 p.m. with the most frequently reported bracket "more than R10000 p.m." Although this data could not be analysed statistically, contrary to the results for those respondents who completed Form "A", willing respondents earned **less** on average per month than unwilling respondents. The following Figure 10 demonstrates the proportion of willing and unwilling respondents reporting each of the household income brackets.

Figure 10: Differences Between Willing & Unwilling Respondents: Household Income Brackets (HIV-Positive Orphan)



Key: 0: No income 1: R0 to R500 p.m. 2: R501 to R1000 p.m.
3: R1001 to R2000 p.m. 4: R2001 to R5000 p.m. 5: R5001 to R8000 p.m.
6: R8001 to R10000 p.m. 7: More than R10000 p.m.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Although the comparisons for this data could not be analysed statistically, those respondents willing to care for an HIV-negative orphan earned, on average, more than those willing to care for an HIV-positive orphan (between R5001 and R8000 p.m., and between R2001 and R5000 p.m. respectively). This finding may be congruent with the expectation that an HIV-positive orphan would require less duration of care than an HIV-negative orphan in which case household income was not a crucial consideration. However, this finding is contrary to the expectation that caring for an HIV-positive orphan would require additional income to cover the additional expenses.

Those respondents willing to care for an HIV-negative orphan earned more on average per month than those unwilling to care for such a child. This confirms the expectation that life-time caring for an additional member of the family would require an adequate household income. However, this is contrary to the findings for those who completed Form "B" where willing respondents earned less on average per month than those unwilling to care for an HIV-positive child. The only explanation for this contradictory finding may be, as above, that caring for an HIV-positive orphan would be short-term commitment.

2.7. Education Level & After School Qualifications

How would respondents' education level and after school qualifications affect their decisions to care for an orphaned child? It was useful to explore this question expecting

that education level may not affect a willingness to care for an HIV-negative orphan. However, it was expected that education level may play a role in willingness to care for an HIV-positive orphan. Arguably, those better educated would be expected to have more accurate knowledge about HIV/AIDS. Would this more accurate knowledge lead to a more correct appreciation of the complications and risks involved for both an HIV-positive child and themselves? Would this more accurate knowledge lead persons to be less or more willing to care for an HIV-positive child?

Form "A": Willingness to Care For An HIV-Negative Orphan

The average school standard achieved by willing respondents (N=58) and their partners (N=43) was Std 8. Almost 52% (N=30) of willing respondents and 58.14% (N=25) of these respondents' partners had matriculated.

An analysis of willing respondents' after school qualifications revealed that 53.45% (N=31) had no qualifications, 18.96% (N=11) had some form of after school qualification and 27.59% (N=16) had a university degree. Forty-seven percent (N=20) of willing respondents' partners had no after school qualifications, 34.88% (N=15) had some form of qualification, and 18.60% (N=8) had a university degree.

Form "B": Willingness to Care For An HIV-Positive Orphan

The average school standard achieved by willing respondents (N=50) and partners (N=32) was Std 7. Forty-two percent (N=21) of willing respondents and 46.88% (N=15) of these respondents' partners had matriculated.

An analysis of willing respondents' after school qualifications revealed that 62% (N=31) had no qualifications, 32% (N=16) had some form of after school qualification and 6% (N=3) had a university degree. Fifty-six percent (N=18) of willing respondents' partners had no after school qualifications, 15.63% (N=5) had some form of qualification, and 28.13% (N=9) had a university degree.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Respondents willing to care for an HIV-negative orphan were better educated than those willing to care for an HIV-positive orphan. Significantly more respondents willing to care for an HIV-negative orphan had a university degree than those willing to care for an HIV-positive orphan ($\chi^2=11.71$; $p<.01$). However, investigating the proportion of respondents and their partners (where applicable) having matriculated and having none or some after school qualifications revealed no significant differences between those

willing to care for either an HIV-negative or HIV-positive orphan. Expectations as outlined above, were therefore not confirmed.

2.8. Employment

The traditional caring role of mothers has been viewed as one requiring mothers to be at home, unemployed and therefore devoted to the care of children. Although this is no longer considered to be the ideal nor necessary for the adequate care of children, this dimension of respondent's lives was investigated. Additionally, should a child be sickly, as would be the case for an HIV-positive child, home-care by a "mother" may be an important consideration in potential carer's decision to care for such a child. It was expected that many respondents would report being unemployed and that those indicating a willingness to care for an HIV-positive orphan would be more likely to be unemployed.

The most frequently reported employment category for respondents willing to care for an HIV-negative orphan was "unemployed": of the 56 willing respondents, 37.50% (N=21) were unemployed thus confirming the expectation outlined above. Likewise, the most frequently reported employment category for respondents willing to care for an HIV-positive orphan was "unemployed": of the 50 willing respondents, 56% (N=28) were unemployed thus also confirming the expectations outlined above.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

More respondents willing to care for an HIV-positive orphan were unemployed than those willing to care for an HIV-negative orphan. This difference was not significant but may be an indication that caring for an HIV-positive orphan would require more "availability" of a carer than would be the case for an HIV-negative orphan.

2.9. Religiosity

Religious commitment was investigated by asking respondents to indicate their religious affiliation as well as the frequency of religious ceremony attendance. It can be argued that persons with a strong religious commitment would attend religious ceremonies more often than those who do not. It can also be debated that committed religious persons may be more altruistic than those who are either less committed or have no religious affiliation. If altruism is a primary motivation amongst most parents to care for children in need, then one would expect this sample to show high levels of religious commitment.

Form "A": Willingness to Care For An HIV-Negative Orphan

The most often reported frequency of religious ceremony attendance for willing respondents (N=56) was once per week or more (64.27%, N=36). Ninety-two percent (N=51) of these respondents indicated some religious affiliation with only 4 (7.27%) indicating either no affiliation or one other than Christian, Muslim or Jewish.

Form "B": Willingness to Care For An HIV-Positive Orphan

The most often reported frequency of religious ceremony attendance for willing respondents (N=51) was once per week or more (80.38%, N=41). Ninety-six percent (N=49) of these respondents indicated some religious affiliation with only 2 (3.92%) indicating either no affiliation or one other than Christian, Muslim or Jewish.

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

Similar proportions of respondents indicating a religious affiliation were willing to care for either an HIV-negative and/or HIV-positive orphan. Both groups were equally religious based on their reported frequency of religious ceremony attendance.

2.10. Own Childhood Experiences

As explored in chapter 2 above, the fostercare literature has shown that these parents usually come from large families and are more likely to have had an unhappy childhood. Following this, it was expected that the current study's sample of parents would have had similar childhood experiences.

Respondents willing to care for an HIV-negative orphan (N=56) reported an average number of siblings of 4.33 ranging between 0 and 14 siblings (SD 3.18). Respondents willing to care for an HIV-positive orphan (N=46) reported an average number of siblings of 5.46 ranging between 0 and 19 siblings (SD 4.72). By recent standards, these could be considered "large" families. This finding supports the above expectation. However, contrary to the expectation that the current study's respondents would report unhappy childhood experiences, both sets of respondents reported equally very happy or happy childhoods (84% of respondents completing both forms "A" and "B").

Although respondents reporting a willingness to care for an HIV-positive orphan seemed to come from larger families, it is debatable whether this aspect of their lives would necessarily have influenced their positive decision. Childhood experienced had no effect on respondents' willingness to care for either an HIV-positive or -negative orphan.

2.11. Caring Experiences

As explored earlier in chapter 3, experience with and of certain behaviours has been found to influence people's willingness to indulge in that behaviour. Consequently, respondents' experience with and/or of caring for a child whose mother had died of AIDS was considered a possible important determinant in their reported willingness to care for such a child. It was therefore expected that those respondents who had either personal or vicarious, present or past, experience in caring for an HIV/AIDS orphan would report a greater willingness to care for such a child.

Form "A": Willingness to Care For An HIV-Negative Orphan

Fifty-nine willing respondents reported on present and past caring experiences. Only 3 (5.08%) were presently caring or had cared in the past for a child whose mother had died of AIDS. Only 2 (3.39%) had a family member presently caring for such a child. Ten respondents (16.95%) had friends who were presently caring and 12 (20.34%) had friends who had cared in the past for a child whose mother had died of AIDS.

The following Table 9 shows the differences between willing and unwilling respondents with regard to their own or vicarious experiences with caring for a child whose mother had died of AIDS. Chi-square analyses of these findings revealed that none of the differences were significant indicating that present, past, and/or vicarious experience probably had no effect on a decision to care for an HIV-negative orphan. Although worth noting is the fact that willing respondents had more personal and vicarious experience with caring for an AIDS orphan than did unwilling respondents providing some support for the expectations above.

Table 9: Differences Between Willing & Unwilling Respondents: Present, Past, and/or Vicarious Experiences (HIV-Negative Orphan)

	Self: Presently Caring	Self: Cared In The Past	Family: Presently Caring	Family: Cared In The Past	Friends: Presently Caring	Friends: Cared In The Past
Willing (N=59)	5.08% (N=3)	5.08% (N=3)	3.39% (N=2)	(N=0)	16.95% (N=10)	20.34% (N=12)
Unwilling (N=19)	(N=0)	5.26% (N=1)	(N=0)	(N=0)	10.53% (N=2)	5.26% (N=1)

Form "B": Willingness to Care For An HIV-Positive Orphan

Fifty respondents reported on present and past caring experiences. Only 6 (12%) were presently caring for a child whose mother had died of AIDS. A further 3 (6%) had cared

for such a child in the past. Six (12.25%) had family members who were presently caring a child whose mother had died of AIDS while 5 (10.20%) had family members who had cared for such a child in the past. Fourteen respondents (28%) had friends who were presently caring and 12 (24%) had friends who had cared in the past for a child whose mother had died of AIDS.

The following Table 10 shows the differences between willing and unwilling respondents with regard to their own or vicarious experiences with caring for a child whose mother had died of AIDS. Chi-square analyses of the findings indicated that none of the differences were significant suggesting that present, past, and/or vicarious experience had no effect on a decision to care for an HIV-positive orphan. However, as with the data for those respondents who completed Form "A", the data does indicate that willing respondents had more personal and vicarious experience with caring for an AIDS orphan than did unwilling respondents.

Table 10: Differences Between Willing & Unwilling Respondents: Present, Past, and/or Vicarious Experiences (HIV-Positive Orphan)

	Self: Presently Caring	Self: Cared In The Past	Family: Presently Caring	Family: Cared In The Past	Friends: Presently Caring	Friends: Cared In The Past
Willing (N=50)	12.00% (N=6)	6.00% (N=3)	12.00% (N=6)	10.00% (N=5)	28.00% (N=14)	24.00% (N=12)
Unwilling (N=30)	3.33% (N=1)	3.33% (N=1)	3.33% (N=1)	(N=0)	10.00% (N=3)	10.00% (N=3)

Comparing Responses: Did The HIV Status of The Child Influence Willingness?

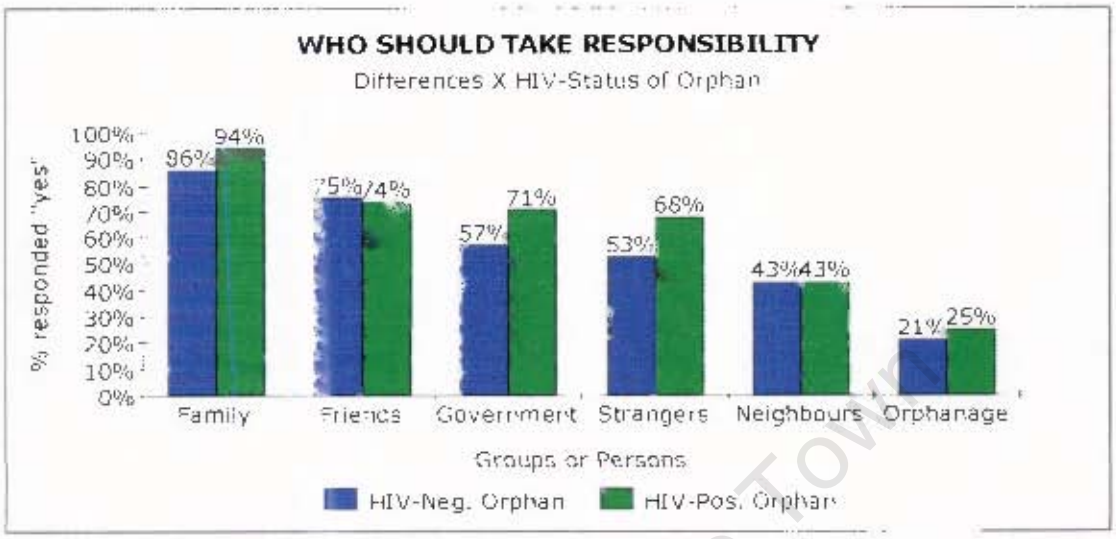
Although none of the differences were significant, respondents *willing* to care for either an HIV-negative or HIV-positive orphan seemed to have more (and similar) experience, both personal and vicarious, than unwilling respondents. This may point to the possibility that own and/or vicarious experience with caring for an AIDS orphan may contribute to a willingness to care.

3. TAKING RESPONSIBILITY FOR AIDS ORPHANS

Respondents who completed both forms "A" and "B" of the questionnaire were asked who they thought should take responsibility for an orphaned child who was either HIV-

negative and did not have AIDS or HIV-positive and DID have AIDS. The results are depicted in Figure 11.

Figure 11: Who Should Take Responsibility For an Orphaned Child



Comparing responses for either an HIV-negative or HIV-positive orphan revealed very similar results irrespective of the child's HIV status. Clearly both groups of respondents had similar notions as to who they thought should take responsibility for the orphaned child. The great majority of respondents felt that the responsibility, irrespective of the child's HIV status, lay with the child's family whom both groups of respondents also felt were the most important persons. Next in order of preference was friends of the child's family. The government was next in line, but here respondents felt that the government's responsibility was greater towards an HIV-positive child than an HIV-negative child (a chi-square analysis revealed that this difference was not significant). Members of the child's community, even if they were strangers, was next in order of preference. Respondents also indicated that the responsibility of strangers was also greater for an HIV-positive than an HIV-negative orphan although a chi-square analysis revealed that this difference was also not significant. Neighbours of the child's family and institutionalisation were the least preferred alternatives for both groups of respondents.

Respondents were also asked to indicate who, of their selected persons or groups, were the most important. Not many complied with this request. However, of the 30 respondents who completed form "A", 24 felt the child's family was the most important; 4 indicated the government; and the remaining 2 felt their self-report options were most important. These were "adoptive parents" and "anyone who can and wants to and is

able to". Of the 21 respondents who completed form "B", 14 indicated the child's family; 3 made their own suggestions which were "the church", "any warm human being", and "by mense wat omgee"; 2 mentioned the government; and one each felt that strangers or neighbours were the most important.

4. THE FOSTER CARE GRANT AND SUGGESTED ADDITIONAL ASSISTANCE

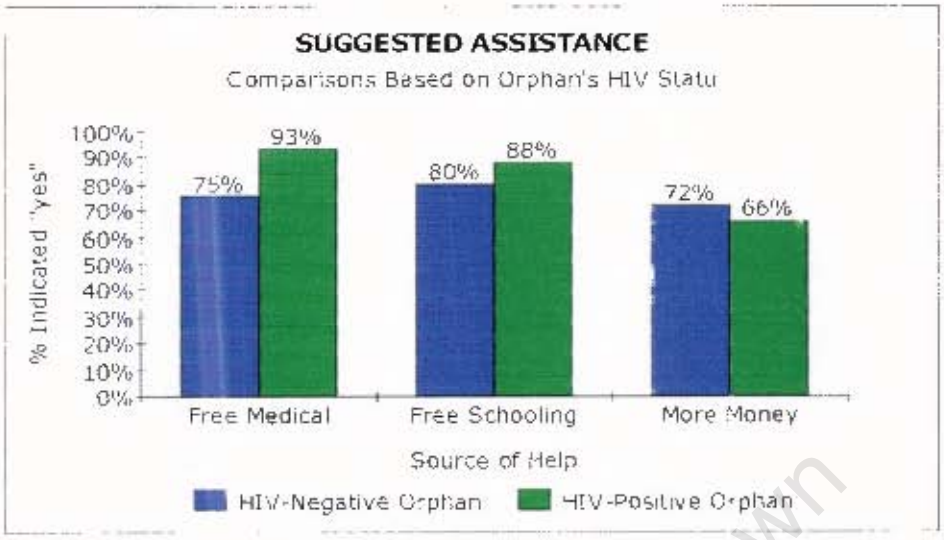
Respondents were asked whether they thought the existing foster care grant was sufficient. Although this question was aimed only at existing foster carers, many adoptive parents answered this query. All replies have been incorporated into the following analysis.

Thirty-four (77.27%) of respondents who completed form "A" of the questionnaire (N=44) felt that the grant was not sufficient. Twenty-nine (70.73%) of the respondents who completed form "B" of the questionnaire (N -41) felt the same way. Clearly both groups of respondents implied that the foster care grant should somehow be extended.

Respondents were then asked to indicate what additional assistance should be provided for parents caring for an orphan. Of the 44 respondents who completed this part of form "A", 32 (72.73%) suggested more money; 33 (75%) indicated that free medical care for the child would help; and 35 (79.55%) felt free schooling for the child should be considered. Asked to indicate which they felt was the most important, 47.06% (N 8) checked "free schooling"; 41.18% (N=7) marked "more money"; and only 2 (11.77%) tagged "free medical care". For this group of respondents, free schooling for an HIV-negative orphan appeared to be both the most mentioned and the most important source of assistance that could be provided.

Of the 41 respondents who completed this part of form "B" of the questionnaire, 27 (65.85%) indicated more money; 38 (92.68%) suggested free medical care for the child; and 36 (87.80%) felt free schooling for the child would be helpful. Asked to indicate which they felt was the most important, 81.75% (N=13) marked "free medical care"; only one each checked "more money" and "free schooling". For this group of respondents, free medical care for the HIV-positive orphan was overwhelmingly the most mentioned and the most important source of additional help that could be provided. Figure 12 depicts these results.

Figure 12: Suggested Additional Assistance: Comparisons for an HIV-negative Orphan and an HIV-positive Orphan



The Figure suggests that for both HIV-negative and HIV-positive orphans, free schooling and free medical care are more important than purely financial assistance. Respondents felt that these two sources of assistance were also more important for caring for an HIV-positive orphan than an HIV-negative one although chi-square analyses revealed these differences to be statistically insignificant. Monetary assistance was considered more important in caring for an HIV-negative orphan than an HIV-positive orphan.

5. CHILD CHARACTERISTICS

The results of the third section of the questionnaire - Characteristics of Orphaned Children - will form the focus of the following analysis of the data. Each of the characteristics of the child will be reported separately according to the HIV status of the child. In this way a profile of children most and least likely to be willingly cared for by the respondents will be created. Where pertinent, additional analyses will be provided for certain of the demographic characteristics of the respondents in an attempt to indicate how these may have influenced their decisions to care. Finally, pertinent and/or statistically significant differences in responses, based on the child's HIV status, will be included. The reader is referred to appendix F, where all the results from this section of both forms of the questionnaire is presented in table form.

Many of the child characteristics were selected for investigation based on various studies and commentaries already covered in chapter 2, under the discussion of "hard to place"

children. The rationale for examining each of the child characteristics will simply be stated and the reader is referred to chapter 2 to the discussion of the relevant studies and commentaries.

5.1. Gender of The Child

On the basis of a preference for female children, this aspect of orphaned children was explored. This preference was confirmed in the current study as reported below. However, because the gender categories were not mutually exclusive, statistical analyses of the difference in preference for either a male or female child were not possible.

Form "A" (an HIV-negative Child)

Of the 61 respondents who answered this sub-section of the questionnaire, 56 (91.80%) indicated that they would care willingly for the child if the child were female Fewer respondents (83.61%, N=51) were prepared to care for a male child.

Form "B" (an HIV-positive Child)

Of the 49 respondents who answered this part of the questionnaire, 45 (91.84%) indicated that they would care willingly for the child if the child were female. Fewer respondents (69.39%, N=34) were prepared to care for a male child.

Comparing Responses:

Whether the child was HIV-negative or HIV-positive made no difference to respondents' preferences based on the gender of the child: a female child rather than a male child was this sample's preferred choice irrespective of the child's HIV status.

5.2. Age of The Child

Based on the evidence that young children, but not infants were easier to place than older children and adolescents, this aspect of orphaned children was explored. It was expected that the current study's respondents would show similar preferences.

However, due consideration was given to the possibility that these expectations would be confounded by notions inherent in adoption and foster care and subscribed to by the current study's respondents. Traditionally, adoption has been viewed as a practice that places *infants* with new families. It was therefore expected that adoptive parents would show a greater willingness to care for infants up to the age of 1 year old rather than older groups of children. Foster care, on the other hand, places children in foster families only once children have been found to be in need of alternative caring. This is most likely to mean that these children are past infancy. The perceptions surrounding

foster care may well be that this form of care is predominantly for children older than around 1 year old. In the present study it was therefore expected that foster carers would show a greater willingness to care for children over the age of 1 year old.

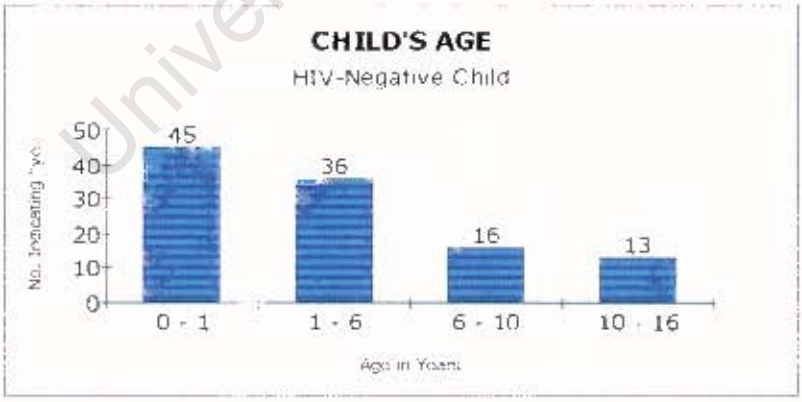
Additionally, given that caring for infants or young children (probably up to the age of 6 years old), would arguably require energy and stamina presumably characteristic of younger persons, age of potential carer was compared to age of orphaned child. It was expected that younger respondents would show a greater willingness to care for infants and younger children than would older respondents.

Finally, each of the above characteristics of the orphaned child and respondents was explored with regard to the child's HIV status. This was done in an effort to determine whether the child's HIV status influenced respondents' reported willingness in any way.

Form "A" (an HIV-negative Child)

Sixty respondents completed this sub-section of the questionnaire. Seventy-five percent indicated that they would care for a child who was between 0 and 1 year old; 60% a child who was between 1 and 6 years old; 26 67% a child aged between 6 and 10 years old; and 21 67% a child who was between 10 and 16 years old. Figure 14 depicts these results.

Figure 14: Preferred Age of an HIV-negative Child



Clearly this group of respondents were more willing to care for a younger child (up to the age of 6 years old) than an older child (from 6 to 16 years old) thus confirming the expectation outlined above. However, the expectation that infants would not be as

willingly cared for as young children did not appear to be confirmed and may be as a result of the different inherent notions surrounding adoption and foster care as outlined above.

Accordingly, Figure 14 below demonstrates the preferred age of an orphaned child as indicated by adoptive and foster parents. Chi-square analysis revealed that significantly more adoptive parents (90%; N=27) than foster carers (65.38%; N=17) were willing to care for a child between 0 and 1 year old (χ^2=5.01; p<.05). However, significantly more foster carers (37.77%; N=8) than adoptive parents (7%; N=2) were willing to care for a child between 10 and 16 years old (χ^2=5.52; p<.05). These findings appear to confirm the expected differences between adoptive and foster parents as outlined above. Grouping the data into two age ranges, foster carers appeared to be more willing than adoptive parents to care for an older child between the ages of 6 and 16 (χ^2=8.79; p<.01), again confirming expectations. However, there was no significant difference between these two groups of parents in terms of willingness to care for a younger child between 0 and 6 years old.

Figure 14: Preferred Age of HIV-negative Child: Comparisons Between Adoptive & Foster Parents

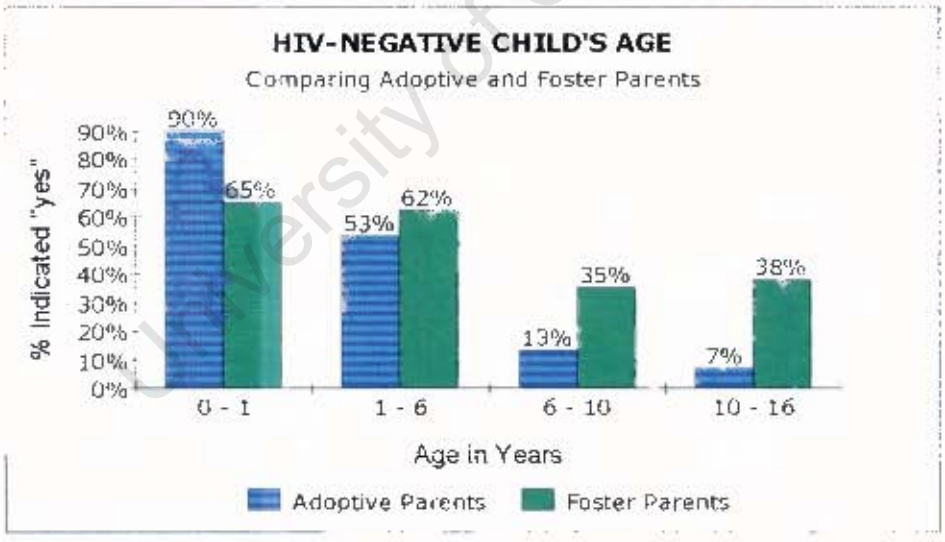


Table 11 below demonstrates the relationship between the respondent's average age and the age of the child for whom they indicated a willingness to care. Clearly, younger respondents were more willing to care for a correspondingly younger child. Older respondents were more willing to care for the older age groups of children. Single sample t-tests revealed that significantly younger respondents were willing to care for a child between the ages of 0 and 1 year old than any of the other age categories.

These findings confirm the notion that caring for a young child would arguably require more energy and stamina which younger persons would presumably have.

Table 11: Mean Age of Respondents and HIV-Negative Child's Age

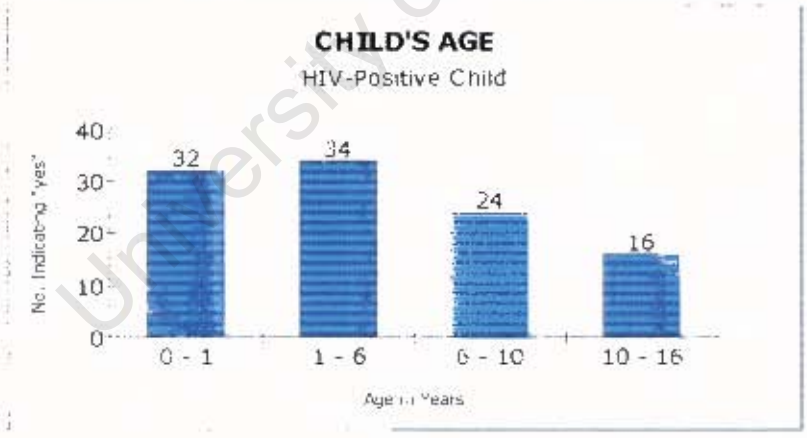
Child's Age	N	SD	Respondent's Mean Age
0 - 1 year	42	12.01	43.79
1 - 6 years	35	9.76	49.97*
6 - 10 years	15	13.98	53.07*
10 - 16 years	12	11.34	57.92**

* p<.05; ** p<.01

Form "B" (an HIV-positive Child)

Forty-nine respondents completed this sub-section of the questionnaire. Sixty-five percent (N=32) indicated that they would care for a child who was between 0 and 15 months old; 69.39% (N=34) a child who was between 1 and 6 years old; 48.98% (N=24) a child aged between 6 and 10 years old; and 32.65% (N=16) a child who was between 10 and 16 years old. Figure 15 depicts these findings.

Figure 15: Preferred Age of an HIV-positive Child



Clearly this group of respondents were more willing to care for a younger child (up to the age of 6 years old) than an older child (from 6 to 16 years old). This is congruent with the responses from those respondents who completed form "A" and confirms that there is a greater willingness to care for younger rather than older children. The HIV status of

the orphaned child appears to make little difference in this study's respondent's greater willingness to care for younger children to the age of 6 years old.

Figure 16 demonstrates the preferred age of an orphaned child as indicated by adoptive and foster parents. Chi-square analyses of the differences between adoptive and foster parents in terms of age preference revealed no significant differences. Although adoptive parents still showed a marked preference for a young child (0-15 months old), their willingness to care for the older age groups of HIV-positive children (6 to 16 years) was considerably higher than for the same age groups of HIV-negative children. Foster carers, on the other hand showed no remarkable differences in willingness between HIV-negative and HIV-positive children.

Figure 16: Preferred Age of HIV-Positive Child: Comparisons Between Adoptive and Foster Parents

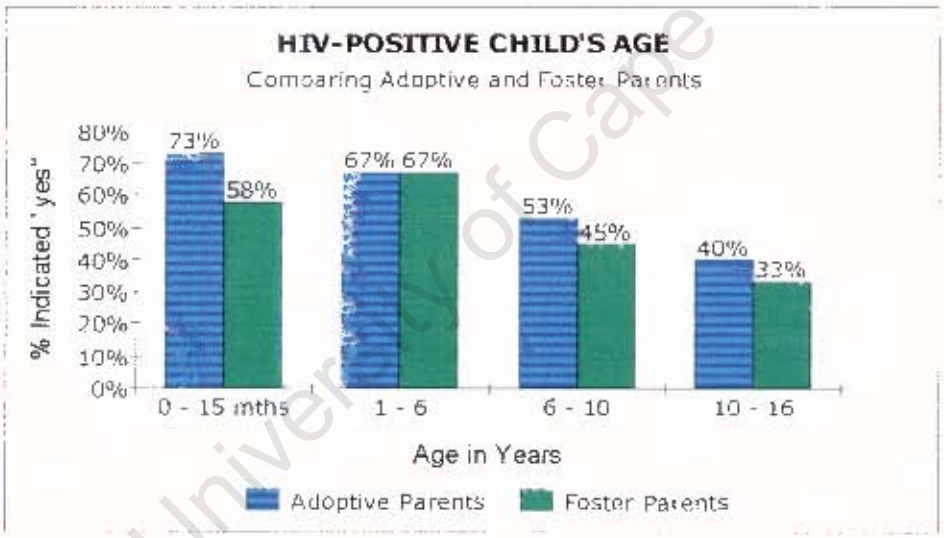


Table 12 below demonstrates the relationship between the respondent's average age and the age of the child for whom they indicated a willingness to care. There appeared to be no difference in the average age of the respondents in relation to the age group of children for whom they were willing to care. Single sample t-tests revealed that significantly younger respondents were willing to care for a child between the ages of 0 and 15 months old than between 10 and 16 years old.

Table 12: Mean Age of Respondents and HIV-Positive Child's Age

Child's Age	N	SD	Respondent's Mean Age
0 - 15 months	31	10.39	47.52
1 - 6 years	32	9.77	50.38
6 - 10 years	24	10.09	48.92
10 - 16 years	16	6.58	48.06**

* p<.05; ** p<.01

Comparing Responses

It was found that significantly more respondents were willing to care for an HIV-positive child between the ages of 6 and 10 years (48.98%; N=24) than they were to care for an HIV-negative child in the same age range (26.67%; N=16) (χ^2=5.78; p<.05).

Adoptive parents were more likely to care for an HIV-positive child between the ages of 6 and 10 years (53.33%; N=16) and between the ages of 10 and 16 years (40%; N=6) than an HIV-negative child in the same age ranges (13.33%; N=4 and 7%; N=2 respectively). Both chi-square analyses were significant at p<.05).

5.3. Culture / Race of The Child

Although the statements relating to this aspect of the orphaned child referred only to the culture of the child, this investigation was intended to encompass a willingness to care for a child from a different cultural group. As HIV inordinately affects black persons and children in this country and given the fragility of this group's ability to accommodate the growing number of orphans as described earlier, it was felt that this aspect of the orphaned child and potential carers bore exploration.

The following analysis of the data was undertaken to explore whether respondents of certain cultural/racial groups would be willing to care for children from different cultural/racial groups This was done in order to investigate the possibility of a wider range of persons being willing to care for the predominantly black orphan population.

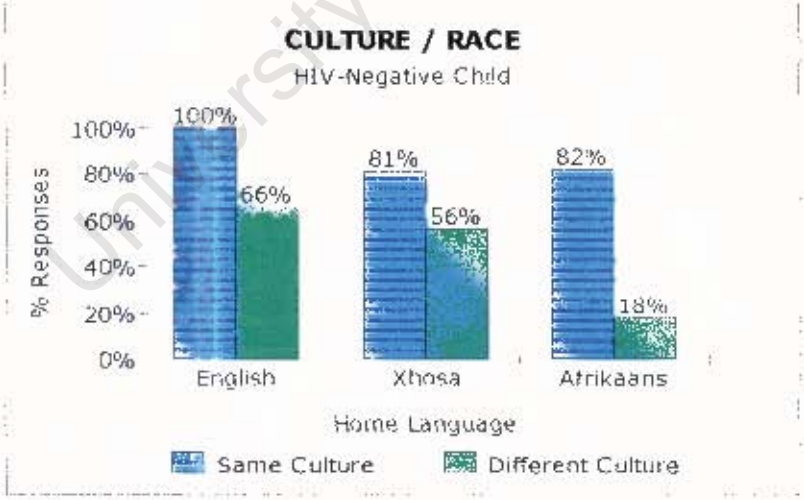
Form "A" (an HIV-negative Child)

Sixty respondents checked their preference in this part of the questionnaire. Fifty-four (91.53%) indicated that they would care for the child if he/she was of the same culture or race as themselves. Thirty-six (61.02%) were willing to care for a child of a different culture or race. Given that these culture or race categories were not mutually exclusive, statistical analysis of this difference was not possible. However, the disparity in percentages appears to point to a notable difference in cultural/racial preference with most respondents indicating a greater willingness to care for a child of the same culture or race as themselves.

Figure 17 below demonstrates that English-speaking respondents (100%; N=32) were more likely than both Xhosa (81.25%; N=13) and Afrikaans (81.82%; N=9) speaking respondents to care for a child of the *same* culture/race as themselves (χ^2=6.4; p<.05 and χ^2=6.10; p<.05 respectively). English-speaking respondents (65.68%; N=21) were also more willing than both Xhosa-speaking (56.25%; N=9) and Afrikaans-speaking respondents (18.18%; N=2) to care for a child from a different culture/race than themselves. Chi-square analysis of these differences showed only a statistically significant difference between English and Afrikaans speaking respondents (χ^2=4.32; p<.05).

English-speaking respondents were most willing to care for a child of either the same or different culture than themselves, although they showed a significant preference for a child of the same culture (χ^2=13.28; p<.01). Xhosa-speaking respondents were more willing to care for a child of the same culture, but not adverse to caring for a child of a different culture: chi-square analysis revealed no significant differences here. Afrikaans-speaking respondents, on the other hand, showed a greater willingness to care for a child of the same rather than a different culture to themselves (χ^2=6.13; p<.05).

Figure 17: Willingness to Care for an HIV-negative Child of the Same or Different Culture / Race: Comparing Language Groups



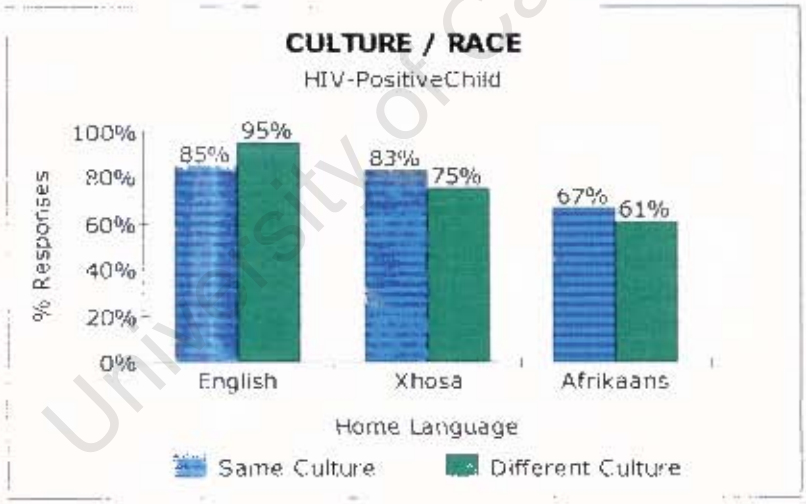
Form "B" (an HIV-positive Child)

Fifty respondents checked their preference in this part of the questionnaire. Thirty-nine (78%) indicated that they would care for the child if he/she was of the same culture or race as themselves. Exactly the same number were willing to care for a child of a different culture or race.

Comparing the above responses with the home language of respondents revealed that English-speaking respondents (85%; N=17) were more likely than Xhosa-speaking respondents (83.33%; N=10) to care for a child of the same culture/race as themselves (χ^2=4.09; p<.05). English-speaking respondents (95%; N=19) were also more willing than Afrikaans-speaking respondents (61.11%; N=11) to care for a child of a different culture/race than themselves (χ^2=6.55; p<.05). The following Figure 18 demonstrates these differences.

English-speaking respondents were more willing to care for a child from a different culture compared to the same culture than themselves; Xhosa- and Afrikaans-speaking respondents were equally willing to care for either a child from a different or same culture as themselves and both showed only a slight preference for a child from the same culture as themselves. Chi-square analyses of these differences were all not significant.

Figure 18: Willingness to Care for an HIV-positive Child of the Same or Different Culture / Race: Comparing Language Groups



Comparing Responses

More respondents indicated a willingness to care for an HIV-negative child (91.53%; N=54) rather than an HIV-positive child (78%; N=39) of the same culture / race as themselves. Of the different language groups, considerably more English-speaking respondents (100%; N=32) were willing to care for an HIV-negative child rather than an HIV-positive child of the same culture / race as themselves. It was also found that this group of respondents were more likely than the other language groups to care for an HIV-positive child (95%; N=19) rather than an HIV-negative child (65.68%; N=21) of a different culture / race than themselves (χ^2=5.98; p<.05).

5.4. Social Background of The Child

As an indication of social class respondents were asked whether they would care for the orphan if he/she came from a poorer, the same or better social background than themselves. This was explored in an attempt to tease out whether reluctance to care was based on the HIV status of the child or whether the child's (and the child's family of origin) social class would influence a willingness either negatively or positively. As "helping an under-privileged child" was reported in the pilot study as one of the foremost advantages in caring for an orphan, it was expected that respondents would be more likely to willingly care for children of the same or a poorer social class than themselves.

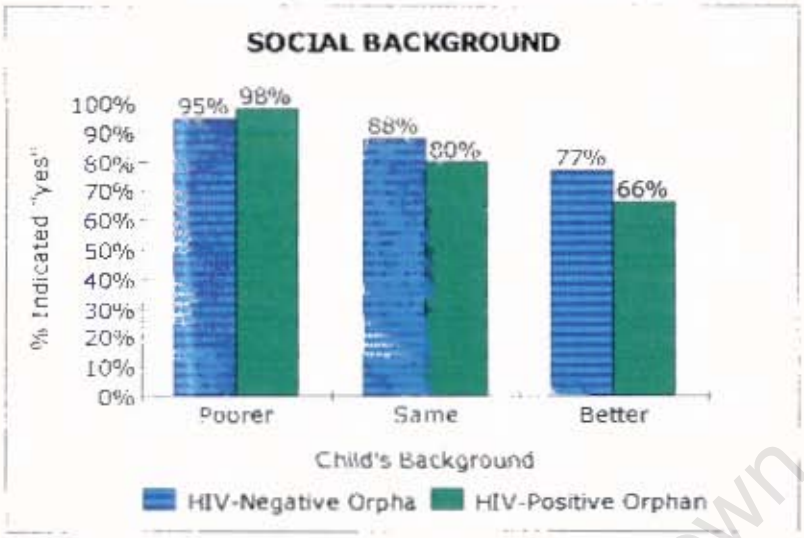
Form "A" (an HIV-negative Child)

Fifty-eight respondents marked their preference in this item of the questionnaire. Fifty-five (94.83%) indicated a willingness to care for a child who was from a poorer background than themselves; 50 (87.72%) from the same background; and 44 (77.19%) from a better background. This finding confirms the expectation outlined above. Figure 19 below depicts these results.

Form "B" (an HIV-positive Child)

Fifty respondents marked their preference in this item of the questionnaire. Forty-nine (98%) indicated a willingness to care for a child who was from a poorer background than themselves; 40 (80%) from the same background; and 33 (66%) from a better background. These findings confirm the expectation, although in this case (an HIV-positive orphan), respondents showed the greatest willingness to care for a child from a poorer background only. Figure 19 depicts these findings.

Figure 19: Preferences With Regard to Child's Social Background and Depending on Child's HIV Status



Comparing Responses

Within each of the social background categories (poorer, same and better) chi-square analyses revealed that there was no significant differences in willingness of respondents to care for the orphan based on the child's social class.

5.5. Relatives / Siblings of The Child

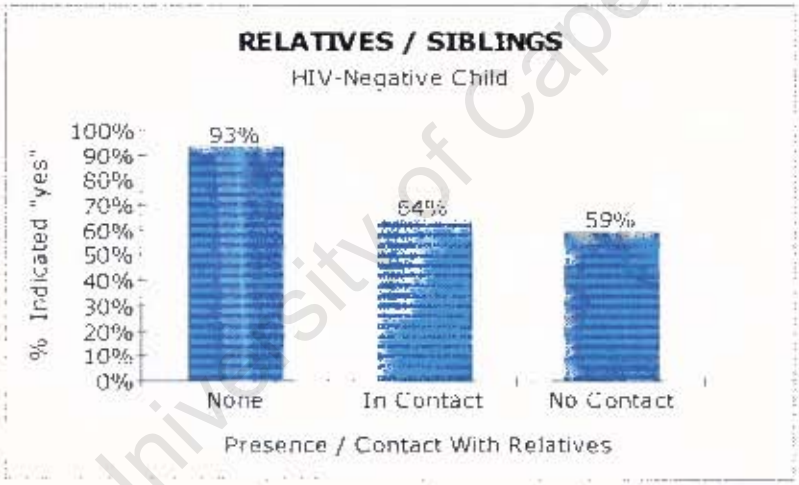
As explored in chapter 2, children from large sibling groups constituted those that are particularly hard to place in alternative caring situations. In the present study this dimension of the child's background was explored in an attempt to explore the expectation that respondents would be least willing to care for a child who had siblings and/or relatives. Additionally, as has been demonstrated earlier, the need to keep sibling groups together is an overriding concern of community members, alternative care practitioners and policy makers. Accordingly, results from these enquiries would provide some notion as to whether keeping siblings together in this type of family care situation, was a realistic option.

It was also expected that there would be differences in willingness to care for an orphan between adoptive and foster parents based on the presence and/or contact with siblings and relatives. The traditional nature of adoption, where a child is incorporated into a new family as if he/she was born into the family, would possibly exclude adoptive parents' willingness to maintain contact with the child's other family members. Foster carers, on the other hand, who are accustomed to the presence and contact between foster children and their families of origin were expected to show no such bias.

Form "A" (an HIV-negative Child)

Fifty-six (93.33%) of 60 respondents indicated that they would care for the child if he/she had no known relatives or siblings. Thirty-eight (64.41%) of 59 respondents indicated that they would be willing for the child to remain in contact with his/her relatives and/or siblings. Thirty-five respondents (59.32%) were not willing to keep contact with the child's relatives and/or siblings. Considerably more respondents were willing to care for the child if he/she had no relatives than if he/she had relatives with whom the child would remain in contact and if the child had relatives with whom he/she need not remain in contact. However, given that the categories were not mutually exclusive, statistical analysis of the difference was not possible. Clearly though, the present study's respondents showed a strong preference for the child to have no relatives/siblings. Figure 20 depicts these results.

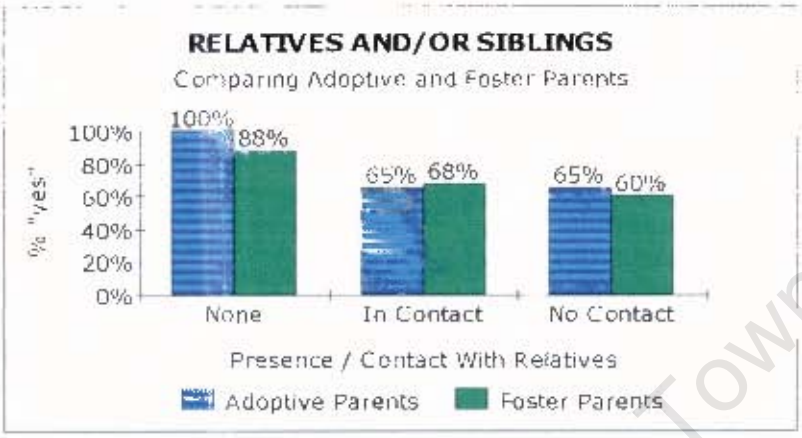
Figure 20: Presence and/or Contact With HIV-negative Child's Relatives and/or Siblings



Adoptive parents and foster carers were compared in terms of their preference for the child to either have no relatives, relatives with whom the child would remain in contact, and relatives with whom the child need not remain in contact. Although a full 100% (N=31) adoptive parents indicated that they would care for the child if he/she had no relatives, only 88.46% (N=23) foster carers checked this option. Very similar percentages of adoptive and foster parents (64.52% and 68% respectively) were not opposed to the child remaining in contact with relatives and/or siblings. Similarly, comparable percentages of adoptive and foster parents (64.52% and 60% respectively) would not want the child to remain in contact with his/her relatives and/or siblings. These finding are contrary to the expectations outlined above. Both adoptive and foster parents were equally more willing to care for a child if he/she had no relatives.

Surprisingly, adoptive parents were as willing as foster parents to care for a child if he/she had relatives/siblings. Figure 21 depicts these findings.

Figure 21: Presence and/or Contact With HIV-negative Child's Relatives and/or Siblings: Comparisons Between Adoptive and Foster Parents



An additional question in this section asked respondents whether they would also care for some of the child's siblings. Only 37.29% (N=22) of respondents were willing to do so. These findings point to the fact that, on the whole, respondents were most willing to care for an orphan who had no relatives/siblings. But, should the child have siblings, respondents were more willing for the child to maintain contact with them rather than care for them too.

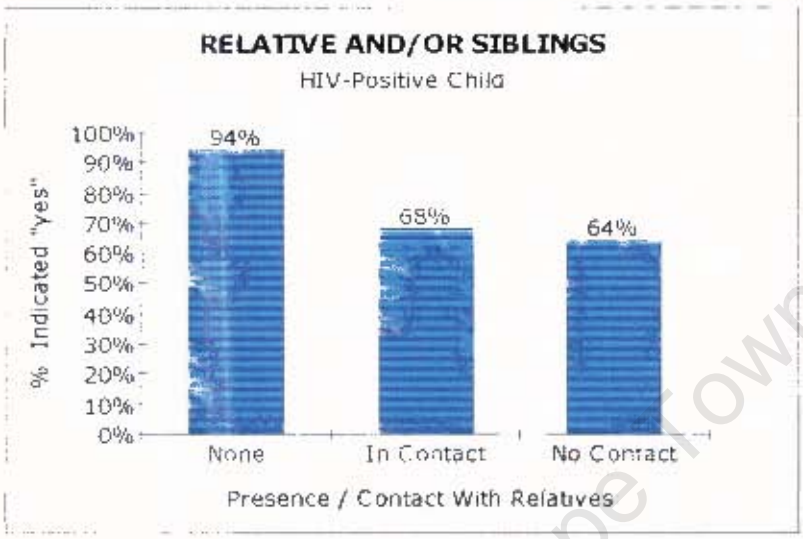
Exploring the possibility of caring simultaneously for some of the child's siblings between adoptive and foster parents, only 29.03% of adoptive parents indicated that they would care for some of the child's siblings whereas 52% of foster parents indicated similarly. However, although this difference appeared to be large, a chi-square analysis it proved it to be insignificant.

Form "B" (an HIV-positive Child)

Forty-seven (94%) of 50 respondents indicated that they would care for the child if he/she had no known relatives or siblings. Thirty-four (68%) indicated that they would be willing for the child to remain in contact with his/her relatives and/or siblings. Thirty-two respondents (64%) were not inclined to keep contact with the child's relatives and/or siblings. Notably more respondents were willing to care for the child if he/she had no relatives than if he/she had relatives with whom the child would remain in contact and if the child had relatives with whom he/she need not remain in contact. As with form "A", a statistical analysis of this difference was not possible. However, as with

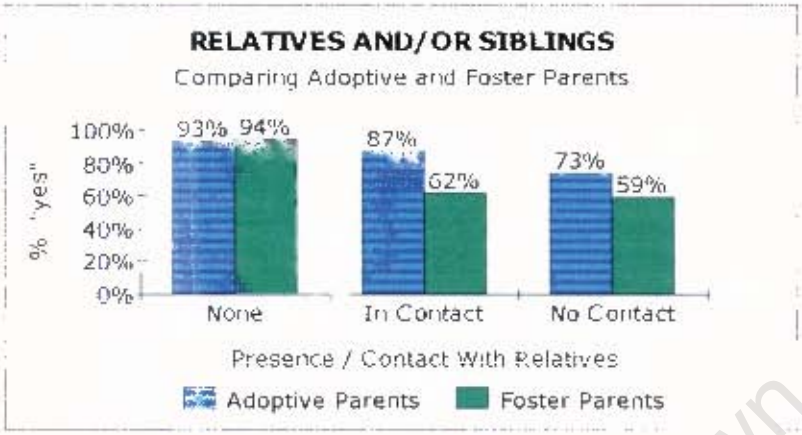
those respondents who completed form "A", these respondents were also most willing to care for a child if he/she had no relatives/siblings. Figure 22 depicts these findings.

Figure 22: Presence and/or Contact With an HIV-positive Child's Relatives and/or Siblings



Adoptive parents and foster carers were compared in terms of their preference for the child to either have no relatives, relatives with whom the child would remain in contact, and relatives with whom the child need not remain in contact. Similarly high proportions of both adoptive and foster parents indicated that they would care for the child if he/she had no relatives (93.33% and 94.12% respectively). More adoptive parents than foster parents were not opposed to the child remaining in contact with relatives and/or siblings (86.67% and 61.76% respectively). Also more adoptive parents than foster parents would not be amenable to the child remaining in contact with his/her relatives and/or siblings (73.33% and 58.82% respectively). These findings, although similar to those for an HIV-negative child, indicate that respondents irrespective of whether they were adoptive or foster parents, showed no overriding preference for the child to have no relative/siblings or to have relatives/siblings or to remain in contact with these family members. Figure 23 depicts these findings.

Figure 23: Presence and/or Contact With an HIV-positive Child's Relatives and/or Siblings: Comparisons Between Adoptive and Foster Parents



When asked whether they would also care for some of the child's siblings, 48% (N=24) indicated "yes" Exploring this further between adoptive and foster parents, only 33.33% of adoptive parents indicated that they would care for some of the child's siblings whereas 70.59% of foster parents indicated similarly. This difference was significant (χ^2=5.98; p<.05). These findings were similar to those for an HIV-negative orphan. However, in the case of an HIV-positive orphan, foster parents were more willing than adoptive parents to care simultaneously for the child's siblings.

Comparing Responses

An inspection of the data revealed that the HIV-status of the orphan in fact made no notable difference to respondent's willingness to care for the child with or without relatives/siblings.

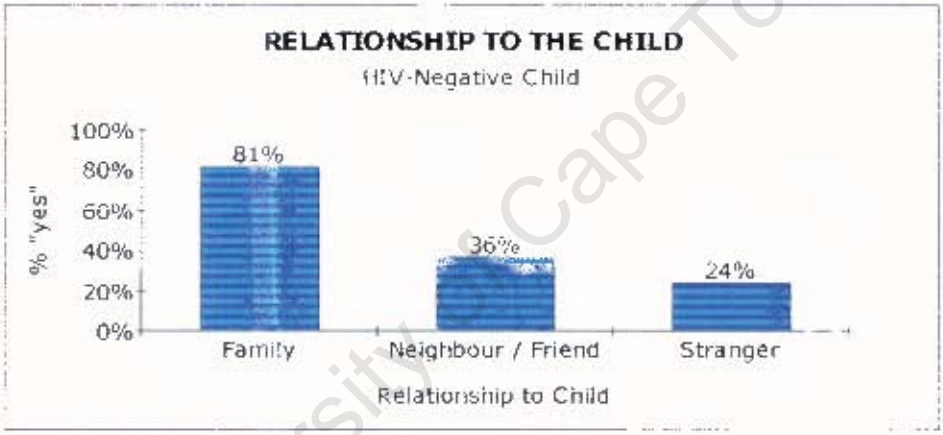
5.6. Relationship to The Child

Given the nature of both adoption and foster care in that non-biological children are cared for in these situations, would the respondent's relationship to the child influence their willingness to care for him/her? It was expected that respondents, whether adoptive or foster parents, would be equally likely to care for a child no matter how close (from their own family) or distant (a strange child) their relationship to him/her was. An additional consideration was that Xhosa-speaking respondents would be more willing to care for a child from their own family than one not from their own family or a stranger. This expectation was based on the assumption pointed to in the literature that incorporating non-biological children into black African families encompasses certain cultural constraints.

Form "A" (an HIV-negative Child)

Fifty-eight respondents replied to this sub-section of the questionnaire. Forty-seven (81.03%) indicated that they would care for the child if he/she was a member of their own family, e.g. an aunt's child. Twenty-one (36.21%) were willing to care for the child if he/she was a neighbour's or friend's child and fourteen (23.73%) were willing to care if the child was a stranger. Although a statistical analysis of these differences was not possible, it appeared that a larger proportion of respondents were prepared to care for the child if he/she was a member of their own family than if they were a friend's or neighbour's child or if they were strangers. These findings point to the predominant preference of respondents to willingly care for a child if he/she is a member of their own family thus refuting the expectation outlined above. Figure 24 refers.

Figure 24: The Relationship of an HIV-negative Child to The Respondent

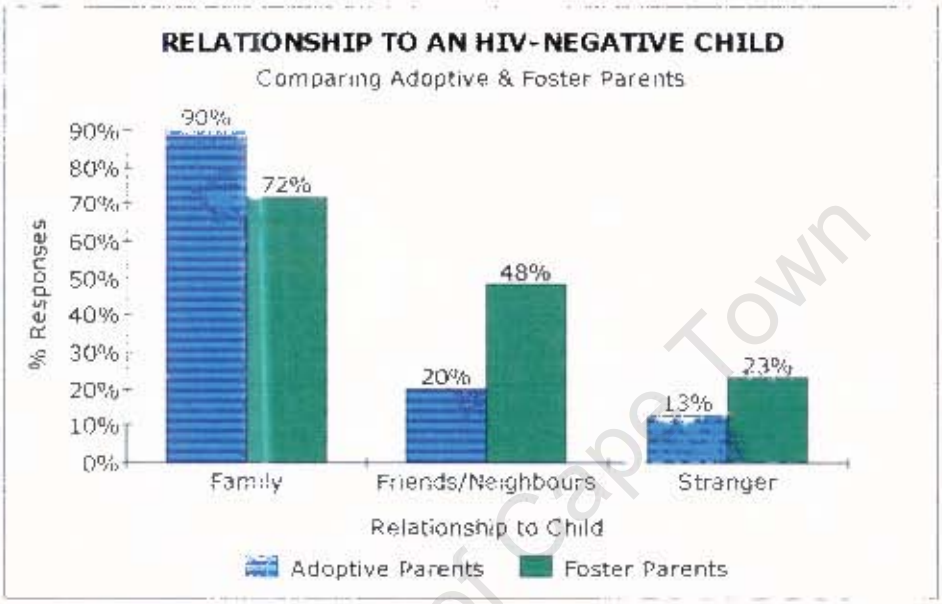


Adoptive parents and foster carers were compared in terms of their preference for the child to be either from their own family, a friend or neighbour's child, or a stranger. Adoptive parents were more willing to care for a child from their own families than they were either a friend's or neighbour's child or a strange child. Foster carers were more willing to care for a child from their own families than they were for a stranger. Clearly, both adoptive and foster parents showed the greatest willingness to care for an orphan from their own families.

The data appeared to indicate that adoptive parents (90%; N=27) were more willing to care for a child from their own family than were foster parents (72%; N=18). However, more foster carers (48%; N=12) than adoptive parents (20%; N=6) were prepared to care for a friend's or neighbour's child and more foster carers (23.08%; N=6) than adoptive parents (13.33%; N=4) seemed willing to care for a stranger. Again, although

statistical analyses of these differences were not possible due to the relationship categories not being mutually exclusive, these findings indicate that foster parents were more likely to care for a child that did not come from their own families than were adoptive parents. Figure 25 shows these findings.

Figure 25: The Relationship of an HIV-negative Child to The Respondent: Comparisons Between Adoptive & Foster Parents



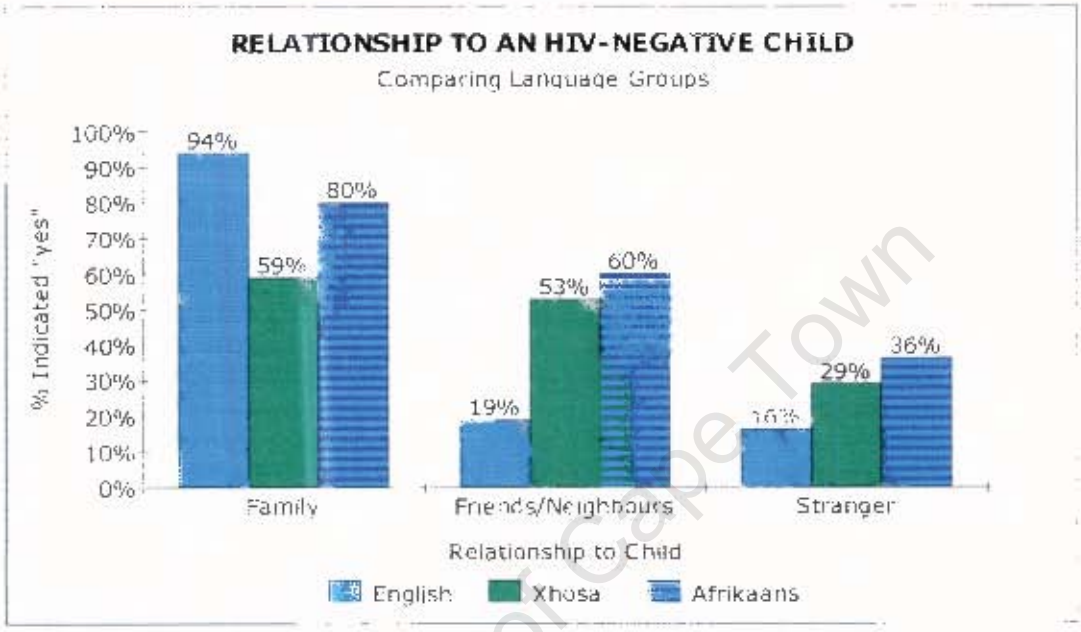
The difference between the three language groups in terms of their willingness to care for either a child from their own family, a friend's or neighbour's child, or a stranger was also explored. English-speaking respondents (93.55%; N=29) were more likely to care for a child from their own families than either a friend's or neighbours child (19.35%; N=6) or a strange child (16.13%; N=5). Clearly this finding demonstrates that English-speaking respondents appeared to show a strong preference for caring for a child from their own families.

There was no obvious difference in Xhosa-speaking respondents' willingness to care for either a child from their own family (58.82%; N=10), a friend's or neighbour's child (52.94%; N=9), or a stranger (29.41%; N=5). Xhosa-speaking respondents were therefore equally likely to care for any of the three children. This finding is contrary to the expectation outlined above.

Afrikaans-speaking respondents (80%; N=8) showed a preference for a child from their own family rather than a stranger (36.36%; N=4). There was no great difference in the

proportion of these respondents indicating a willingness to care for a child from their own family and/or a friend's or neighbour's child (60%; N=6). Figure 26 demonstrate these differences.

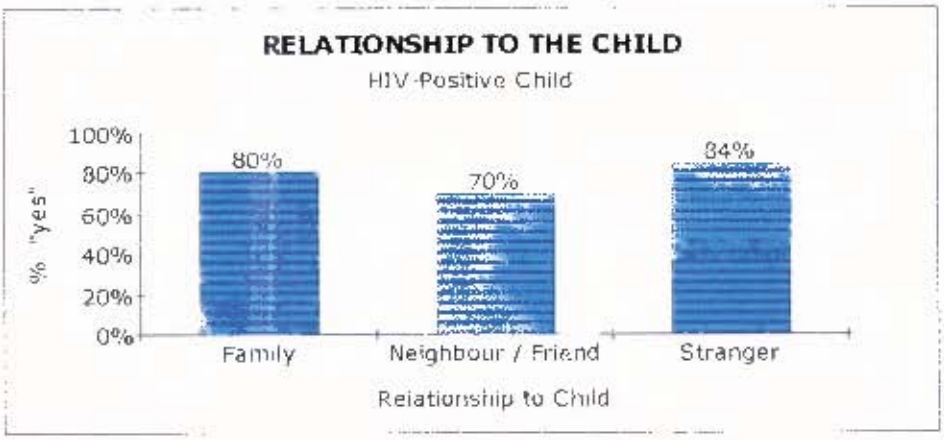
Figure 26: The Relationship of an HIV-negative Child to The Respondent: Comparisons Between Language Groups



Form "B" (an HIV-positive Child)

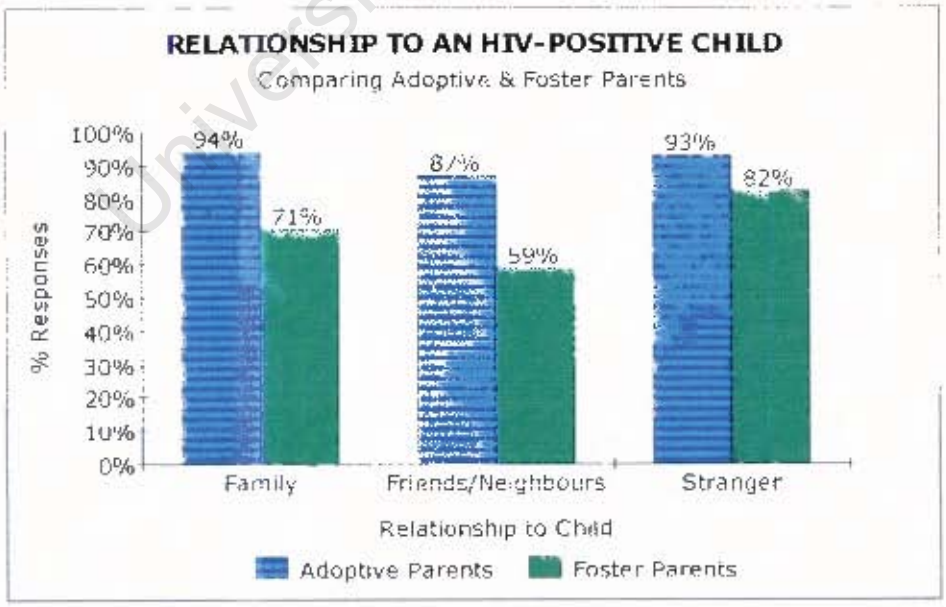
Fifty respondents replied to this sub-section of the questionnaire. Forty (80%) indicated that they would care for the child if he/she was a member of their own family, e.g. an aunt's child. Thirty-five (70%) were willing to care for the child if he/she was a neighbour's or friend's child and fourteen (84%) were willing to care if the child was a stranger. Clearly respondents were equally willing to care for a child whether he/she was from the same family, a friend or neighbour's child, or a stranger confirming expectations Figure 27 depicts these results. This finding is contrary to that from form "A" and indicates that respondents were willing to care for an HIV-positive orphan irrespective of their relationship to the child, but were only more willing to care for an HIV-negative child if he/she was a member of their own families.

Figure 27: The Relationship of an HIV-positive Child to The Respondent



Adoptive parents and foster carers were compared in terms of their preference for the child to either be from their own family, a friend's or neighbour's child, or a stranger. Although it appeared that a greater proportion of adoptive parents were more willing than foster carers to care for any of the three categories of children, it was not possible to subject these differences to statistical analyses. Both adoptive and foster parents were therefore equally willing to care for an HIV-positive orphan irrespective of their relationship to the child. Figure 28 depicts these findings.

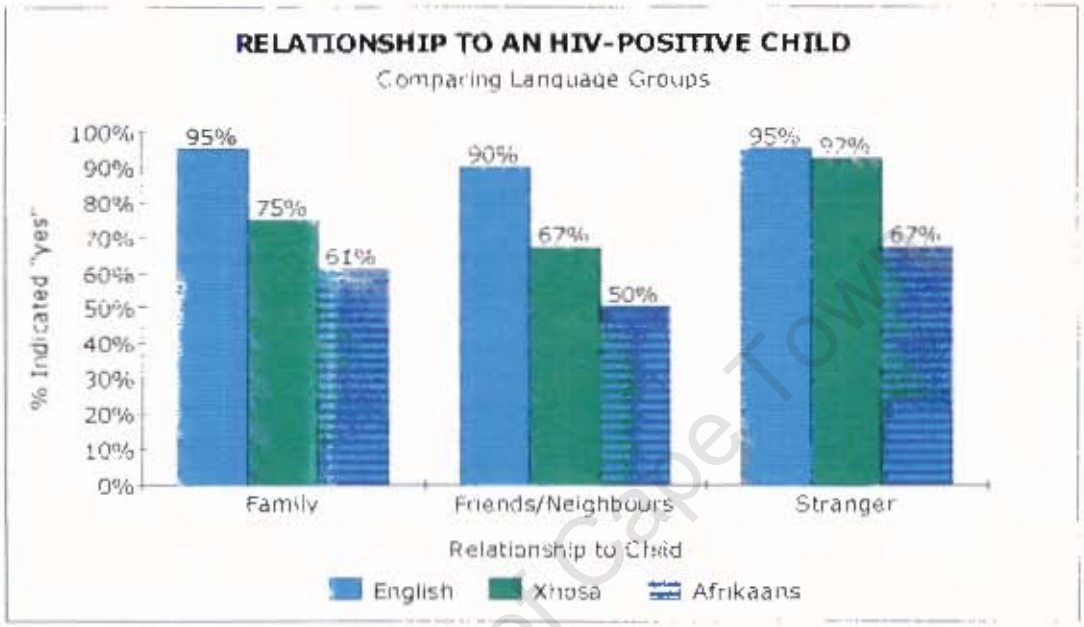
Figure 28: The Relationship of an HIV-positive Child to The Respondent: Comparisons Between Adoptive & Foster Parents



The difference between the three language groups in terms of their willingness to care for either a child from their own family, a friend's or neighbour's child, or a stranger was also explored. None of the language groups showed notable preferences for any of the

three categories of children: they appeared to be equally willing to care for a child from their own families, a friend's or neighbour's child and/or a stranger. Figure 29 demonstrate these differences.

Figure 29: The Relationship of an HIV-positive Child to The Respondent: Comparisons Between Language Groups



Comparing Responses

The HIV status of the child appeared to have made no difference to respondents' reported willingness to care for a child from their own families.

However, essentially more respondents indicated a willingness to care for a friend's or neighbour's HIV-positive child (70%; N=36) rather than their HIV-negative child (36.21%; N=21). It was only adoptive parents who reported the opposite: it appeared that this group of respondents were less likely to care for a friend's or neighbour's HIV-positive child (11%; N=13) than their HIV-negative child (20%; N=6).

Significantly more respondents reported a willingness to care for an HIV-positive child who was a stranger (84%; N=42) than an HIV-negative child who was a stranger (23.73%; N=14) (χ^2=39.36; p<.01). Investigating this trend further between adoptive

and foster parents, and the different language groups, it was found that these groups of respondents were significantly more likely to care for an HIV-positive child who was a stranger to them than an HIV-negative child (all chi-square analyses were significant at $p<.01$).

5.7. Alternative Care Options

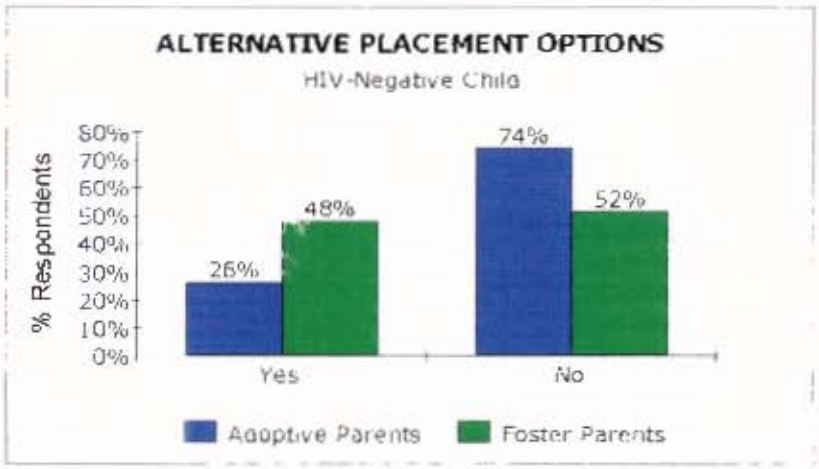
Given the reported high breakdown in foster care placements (described in chapter 2), this aspect of caring was investigated amongst the current study's respondents. It was expected that foster carers would be more likely to avail themselves of an option for alternative placements for children should they no longer wish to care for him/her. Again, given the nature of adoption, adoptive parents were expected to show greater commitment to indefinite care for an orphan. However, due consideration was given to the particular difficulties that caring for an HIV-positive orphan would entail. It was expected that respondents who indicated a willingness to care for an HIV-positive orphan would be more likely to opt for the availability of alternative care should they no longer wish to care for the child themselves.

Form "A" (an HIV-negative Child)

Given the option to care for the child only if there was some other child care agency or another family available to care for the child should the respondent no longer wish to do so, 62.71% (N=37) indicated that this would not be the case. It seemed apparent that a majority of these respondents would continue to care for the child indefinitely.

Comparing the responses between adoptive and foster parents revealed that fewer adoptive parents (25.81%, N=8) than foster parents (48%, N=12) indicated that they would avail themselves of alternative placement for the child should they no longer wish to care for him/her. Although this difference was not significant, adoptive parents appeared to be more willing than foster carers to care for the child indefinitely and confirms the expectations as above. Figure 30 depicts these findings.

Figure 30: Alternative Placement Options for an HIV-negative Child: Comparisons Between Adoptive & Foster Parents

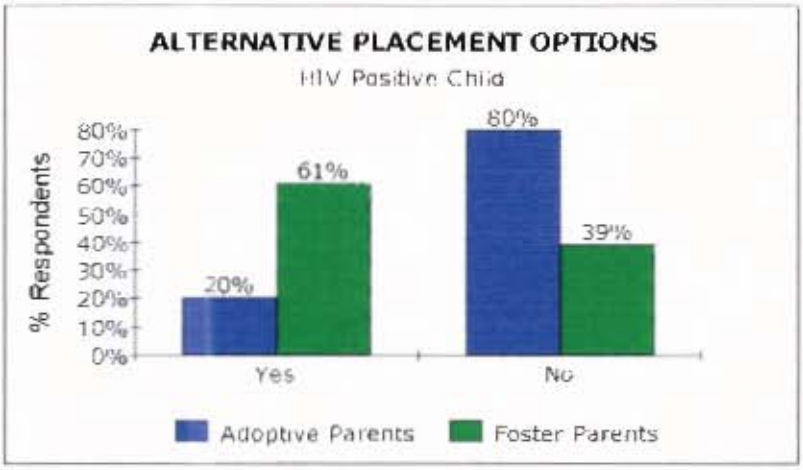


Form "B" (an HIV-positive Child)

Given the option to care for an HIV-positive orphan child only if there was some other child care agency or another family available to care for the child should the respondent no longer wish to do so, 48.98% (N=24) indicated that this would not be the case. It seemed apparent that approximately half of these respondents would continue to care for the child indefinitely.

Fewer adoptive parents (20%, N=3) than foster parents (60.61%, N=20) indicated that they would avail themselves of alternative placement for the child should they no longer wish to care for him/her. This difference was significant ($\chi^2=6.81$; $p<.05$) indicating that adoptive parents were more willing than foster carers to care for the child indefinitely again confirming expectations. The following Figure 31 refers.

Figure 31: Alternative Placement Options for an HIV-positive Child: Comparisons Between Adoptive & Foster Parents



Comparing Responses

The child's HIV-status made no difference to respondents' responses to this enquiry. Adoptive parents were more willing than foster parents to care for the orphan indefinitely - irrespective of the child's HIV status.

5.8. Duration of Care

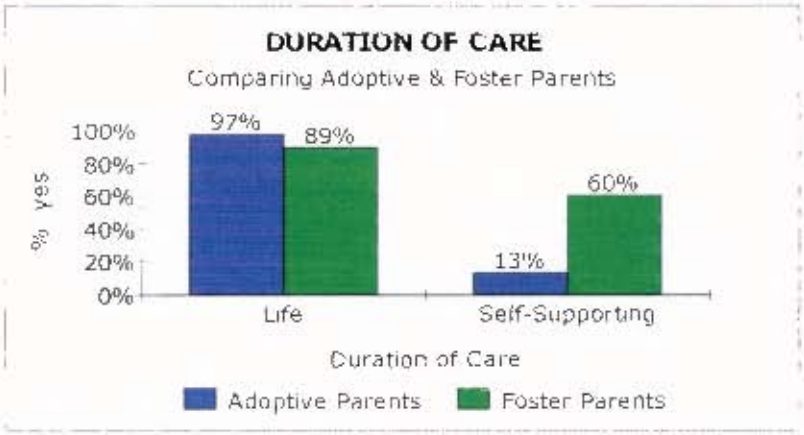
Closely related to the above option of alternative placement should respondents no longer wish to care for an orphan, the duration of care that respondents were prepared to offer was investigated. This option was only included in form "A" of the questionnaire as an HIV-positive child's limited life-span was thought to encompass care until the end of the child's life.

Form "A" (an HIV-negative Child)

Fifty-six (93.33%) of 60 respondents indicated that they would be willing to care for the child for the rest of their or the child's life. Nineteen (32.20%) of 59 respondents noted that they would care for the child until he/she was self-supporting after which their responsibility to the child would end. Clearly a significantly larger proportion of respondents considered their decision to care as a life-time responsibility ($\chi^2=47.70$; $p<.01$) rather than relatively short-term.

Exploring this commitment among adoptive and foster parents revealed that both sets of parents were equally likely to care for a child for the rest of their or the child's lives. Thirty (96.77%) adoptive parents saw their commitment as a life-time one as opposed to 23 (88.46%) foster carers. However, more foster carers than adoptive parents saw their responsibility to the child only until the child was self-supporting ($\chi^2=13.69$; $p<.01$). Only 4 (12.90%) adoptive parents viewed their commitment only until the child was self-supporting whereas 15 (60%) foster parents held the same view. Figure 32 depicts these results.

Figure 32: Duration of Care for an HIV-negative Child: Comparison Between Adoptive & Foster Parents



6. FACTORS INFLUENCING WILLINGNESS TO CARE FOR AN AIDS ORPHAN

Factors influencing the decision-making processes of respondents in their reported willingness to care for an HIV/AIDS orphan were explored using the Theory of Planned Behaviour. Two models of this theory were generated with regard to two distinct intentions determined by the HIV status of the hypothetical orphan:

- Firstly, the intention to care for an HIV/AIDS orphan who is **HIV-negative** and does not have AIDS is investigated.
- Secondly, the intention to care for an HIV/AIDS orphan who is **HIV-positive** and likely to become ill and eventually die is examined.

Each of the findings will be reported separately. Pertinent comparisons will also be made where relevant.

6.1. Factors Influencing A Willingness To Care For An HIV-Negative Orphan (Respondents to Form "A")

Descriptive Statistics and Inter-Correlations

The mean scores for each variable, their reliabilities, and the correlations among the variables are shown in Table 13. Although some of these statistics were reported in chapter 4 ("Methods"), they bare repeating here for the sake of continuity. On average, respondents reported a positive attitude towards caring for an HIV-negative orphan. Scores on subjective norms were also positive suggesting that the specific referents identified in the pilot study did influence respondents' reported willingness to care for the

hypothetical child. On average, respondents also reported fairly high levels of control over their decisions to care for an HIV-negative orphan. Alpha coefficients, assessing internal consistency and reliability of the directly measured items were high. Investigating the inter-correlations between the components of the theory of planned behaviour, the results indicate moderate to high correlations between them. All correlations were higher than the .30 that Ajzen and Fishbein (1980) regard as adequate to confirm the links between the components of the theory.

Table 13: Descriptive Statistics, Alpha Coefficients, and Inter-correlations

	Mean	SD	Alpha	1	2	3	4
1. *Intention*				---			
2. ATT	1.39	.89	.85	.409**	---		
3. SN	1.16	1.08	.92	.431**	.752**	---	
4. PBC	1.13	1.20	.90	.480**	.534**	.624**	---

**p<.01

ATT = Attitude: SN = Subjective Norm: PBC = Perceived Behavioural Control

Regressions to Predict Intentions

The intention to care for an HIV/AIDS orphan who was HIV negative and did not have AIDS was regressed against, attitude, subjective norm, and perceived behavioural control (N=61). The results of the regression of intentions onto the other variables are reported in Table 14 below.

Table 14: Prediction of Willingness to Care (Intention)

Step/predictor	R	R^2	R^2 change	F	Final beta
Prediction of intention					
1. ATT					.149
2. SN	.450	.203	.203	7.377**	.118
3. PBC	.515	.265	.062	6.858**	.322*

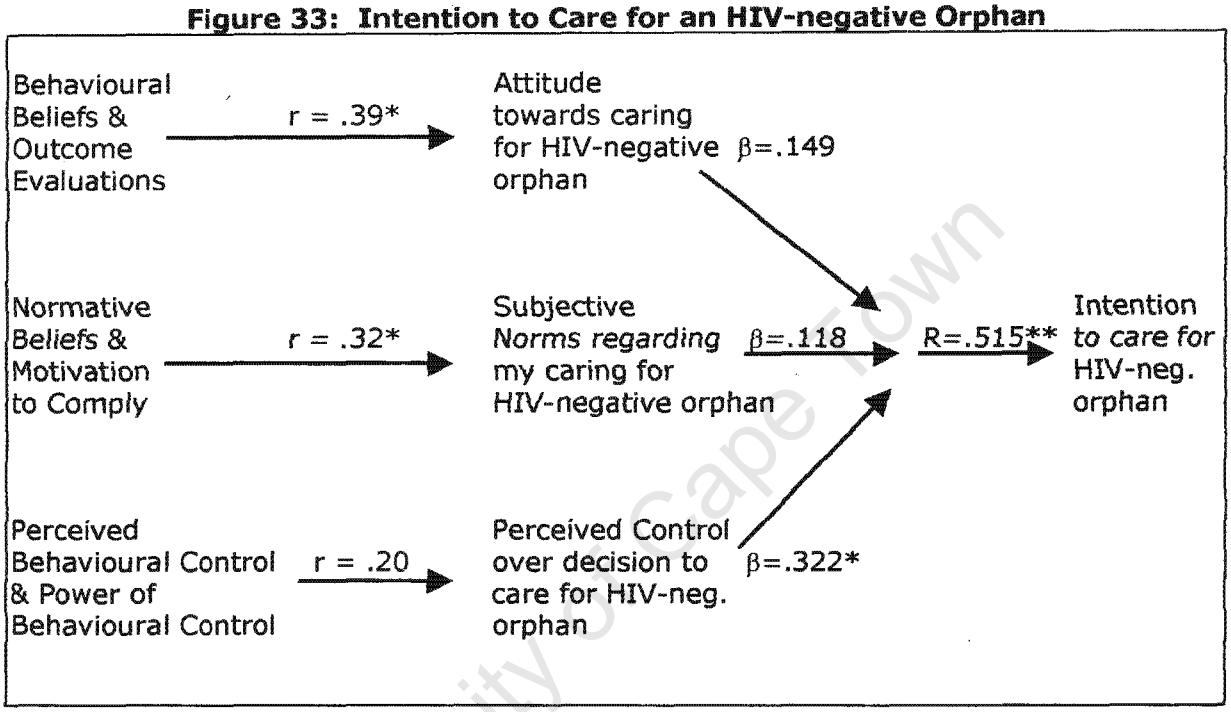
** p<.01 * p<.05

ATT: Attitude; SN: Subjective Norm; PBC: Perceived Behavioural Control

Attitude and subjective norms were entered first and explained 20.3% of the variance in intentions ($F(2,59) = 7.377$, $p < .01$). Perceived behavioural control was entered next and increased the amount of variance in intentions explained by 6% (R^2 change = .062; $F(3,57) = 6.858$, $p<.01$). Beta weight analysis of measures contributing to intention indicated that perceived behavioural control was the only contributor at a statistically significant .322 ($p<.05$). Neither attitude nor subjective norm contributed significantly towards intention to care for an HIV-negative orphan (β = .149 and .118 respectively).

For this sub-sample, therefore, intention to care for an HIV-negative orphan is greatly influenced by the extent to which respondents perceive that the decision to care for an HIV/AIDS orphan is something over which they have personal control. Despite certain components of the model not having good predicative ability, the model as a whole does predict intentions to care for an HIV-negative orphan ($F(3,57)=6.858$, $p<.01$). Figure 33 below describes this TPB model.

Figure 33: Intention to Care for an HIV-negative Orphan



* $p<.05$; ** $p<.001$

Exploring the intercorrelations between the direct measures and belief-based measures of the components of the theory reveals that the correlations between the belief-based measures of "attitude" and "subjective norm" and their corresponding direct measures are adequate to confirm the links between these components of the theory (Ajzen and Fishbein (1980) (r=.39 and .32 respectively). However, the same cannot be said for the links between the belief-based measure of perceived behavioural control and its corresponding direct measure (r=.20). This may be indicative of the difficulty in constructing belief-based measures of this dimension of the theory that adequately tap the direct measure and caution must be shown in interpreting results around perceptions of perceived behavioural control.

Multicollinearity

In an effort to understand why subjective norm and attitude did not contribute significantly to intention to care for an HIV-negative orphan, a further investigation of possible multicollinearity between the independent variables was undertaken (Pedhazur, 1982). Berry & Feldman (1985: 42) warn that high multicollinearity should be suspected if "*none* of the t-ratios for the regression coefficients for independent variables is sufficiently large to indicate statistical significance at the .05 percent level, yet the F-statistic for the full model is significant." Although one t-ratio for PBC was significant, further evidence of high multicollinearity was sought. An inspection of the bivariate correlations as well as the R^2 values when regressing each independent variable on the other two, revealed that a high degree of multicollinearity was not present and explanations and predictions from this regression model, for this sample, could be made with a degree of confidence. (Berry & Feldman (1985) suggest that correlations below a cut-off value of .80 among the variables may be sufficient to conclude that multicollinearity is not a problem. Also that none of the R^2-values were close to 1.00 suggested that a high degree of multicollinearity was not evident. Table 15 refers.

Table 15: Correlations Among the Three Independent Variables and R^2 values when Regressing Each Independent Variable on the Other Two

	1	2	3	R^2
1. *Attitude*	--			.572
2. Subjective Norm	.752**	--		.634
3. Perceived Behavioural Control	.534**	.624**	--	.399

**p<.01

Discriminant Validity of the Direct Measures' Items

As an indication of the discriminant validity of the items used to provide direct measures of Attitude, Subjective Norm and Perceived Behavioural Control, the ten items were subjected to principal components (varimax normalised) factor analysis. The results are reported in Table 16.

Table 16: Factor Loadings, Eigenvalues, and Explained Variance of Direct Measure Items

Direct Measure	Items	Factor 1	Factor 2
ATTITUDE	Att 1	.738	
	Att 2	.820	
	Att 3	.703	
SUBJECTIVE NORM	SN 1	.806	
	SN 2	.742	
	SN 3	.824	
PERCEIVED BEHAVIOURAL CONTROL	PBC 1		.828
	PBC 2		.845
	PBC 3		.842
	PBC 4		.799
Eigenvalues		5.913	1.372
% variance explained		*38.82%*	*34.04%*

(All factor loadings > .50)

The items measuring attitude and subjective norm loaded onto one factor suggesting that the items were not able to discriminate between the two constructs. This may well be the reason why attitude and subjective norm failed to contribute to intention as detailed above. The items measuring perceived behavioural control, on the other hand, all loaded onto one factor indicating a clear distinction between them and those items measuring the other two variables.

Correlations Between Individual Belief-Based Items and Direct Measures

In an attempt to investigate which of the belief-based items contributed most to the equivalent direct measure, correlations between the two were undertaken. The results of the correlations between the individual belief-based items and the direct measure of attitude towards caring for an HIV-negative orphan are presented in Table 17. Respondents' attitude towards caring for this child seemed to be strongly child-centred and altruistically motivated: although the correlations were low, they were positive and significant.

Table 17: Correlations Between Belief-Based Items and Attitude

For me to care for this child would mean that		
1. I would provide the child with a loving & stable home	.358	p<.01
2. I would provide the child with a sense of belonging & security	.272	p<.05
3. I would provide the child with a chance for normal life	.309	p<.05
4. I would help a needy child	.310	p<.05
5. I would be unsure about unknown medical & family background	.183	NS

The results of the correlations between the three belief-based items and the direct measure of subjective norm are presented in Table 18. It appeared that respondents' husband/partners did influence respondents' reported intentions to care for an HIV-negative orphan: this correlation was relatively high and positive. Other salient referents, friends and family, had little influence over respondent's reported willingness to care for the child. In fact, the greater respondents' willingness, the less the influence that friends seemed to have as evidenced by the negative correlation (albeit small),

Table 18: Correlations Between Belief-Based Items and Subjective Norm

1. Husbands/Partners	.648	p<.01
2. Friends	-.087	NS
3. Family	.102	NS

The results of the correlations between the individual belief-based items and the direct measure of perceived control over caring for an HIV-negative orphan are presented in Table 19. The two most important contributors to the control that respondent's felt they would have over their decision to care for this child, were adequate time and energy and contact with other families caring for a similar child.

Table 19: Correlations Between Belief-Based Items and Perceived Behavioural Control

1. I would need support of family & friends	-.035	NS
2. I would need time and energy	.266	p<.05
3. I would need contact with other families	.254	p<.05

6.2. Factors Influencing A Willingness To Care For an HIV-Positive Orphan (Respondents to Form "B")

Descriptive Statistics and Inter-Correlations

The mean scores for each variable, their reliabilities, and the correlations among them are shown in Table 20. Some of these statistics are reported in Chapter 3 (Method), but for ease in following the subsequent discussion, bare repeating here. On average, respondents reported a positive attitude towards caring for an HIV-positive orphan. Subjective norm scores were also positive demonstrating the influence that the specific referents, identified in the pilot study, had on respondents' reported willingness to care for the hypothetical child. On average, respondents also reported positive levels of control over their decisions to care for an HIV-positive orphan. Alpha coefficients, assessing the reliability of the directly measured items were high. Investigating the inter-correlations between the components of the theory of planned behaviour, the results indicate moderate to high correlations between them confirming the links between the directly measured components of the theory (Ajzen & Fishbein, 1980).

Table 20: Descriptive Statistics, Alpha-coefficients, and Inter-correlations

	Mean	SD	Alpha	1	2	3	4
1. Intention				---			
2. ATT	.89	1.04	.82	.518**	---		
3. SN	.53	1.38	.94	.482**	.693**	---	
4. PBC	.77	1.31	.89	.493**	.616**	.584**	---

**p<.01

ATT = Attitude: SN = Subjective Norm: PBC = Perceived Behavioural Control

Regressions to Predict Intentions

The intention to care for an HIV/AIDS orphan who was HIV positive and did have AIDS was regressed against, attitude, subjective norm, and perceived behavioural control (N=73). The results of the regression of intentions onto the other variables are reported in Table 21 below.

Table 21: Prediction of Willingness to Care (Intention)

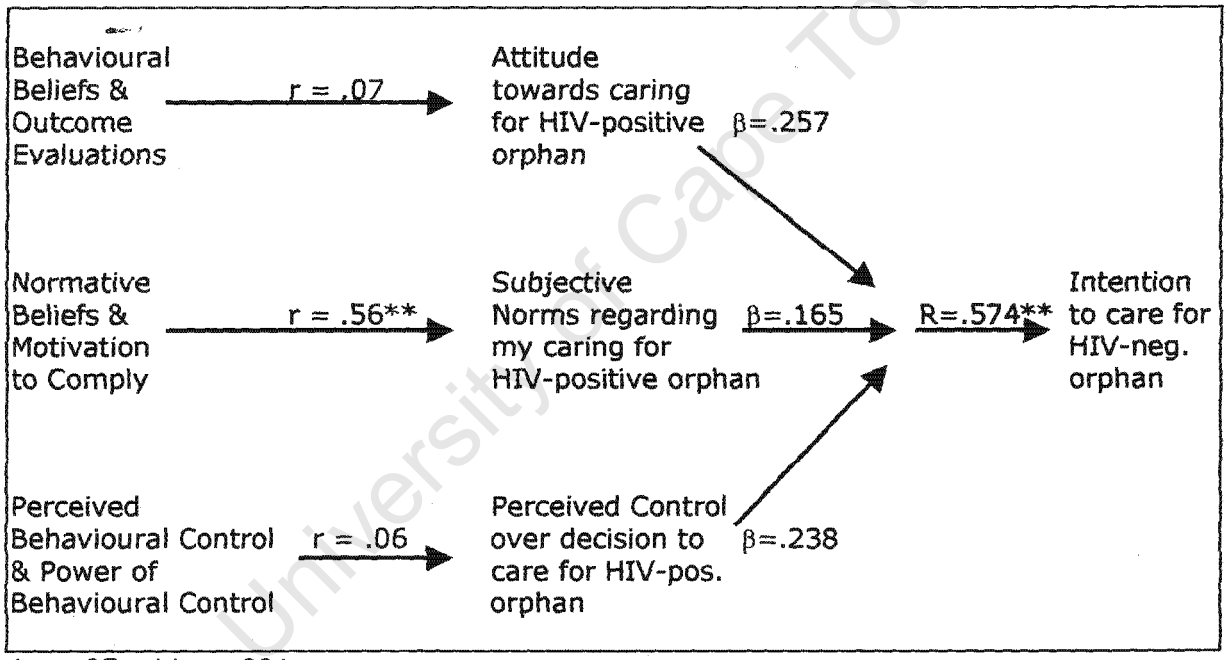
Step/predictor	R	R^2	R^2 change	F	Final beta
ATT					.257
SN	.545	.297	.029	14.814**	.165
PBC	.574	.330	.033	11.324**	.238

** p<.01 * p<.05

ATT: Attitude; SN: Subjective Norm; PBC: Perceived Behavioural Control

Attitude and subjective norm were entered first and explained 29.7% of the variance in intentions ($F(2,70) = 14.814$, $p < .0000$). Perceived behavioural control was entered next and increased the amount of variance in intentions explained (R^2 change = .033; $F(3,69) = 11.324$, $p < .0000$). Beta weight analysis of measures contributing to intention indicated that neither attitude nor subjective norm nor perceived behavioural control contributed significantly towards intention to care for an HIV-positive orphan (β = .257, .165, and .238 respectively). For this sub-sample, then, none of the components of the theory significantly influence intentions to care for an HIV-positive orphan, although on the whole, intention was significantly predicted by the TPB model $F(3,69)=11.324$, $p<.0000$. Figure 34 below describes the TPB model to predict intentions to care for an HIV-positive orphan.

Figure 34: Intention to Care for an HIV-POSITIVE Orphan



* p<.05; ** p<.001

Exploring the intercorrelations between the direct measures and belief-based measures of the components of the theory reveals that the correlation between the belief-based measure of "subjective norm" and its corresponding direct measure is adequate to confirm the link between these components of the theory (Ajzen and Fishbein (1980) (r=.44 and .30 respectively). However, the same cannot be said for the links between the belief-based measure of "attitude" and "perceived behavioural control" and their corresponding direct measures (r=.07 and .06 respectively). Caution must therefore be shown in interpreting results around these two components of the theory.

Multicollinearity

As with the data for those respondents who completed Form "A" of the questionnaire, in an effort to understand why attitude, subjective norm and perceived behavioural control do not contribute significantly to intention to care for an HIV-positive orphan, the degree of multicollinearity was explored between these independent variables. None of the t-ratios were significant and further evidence of high multicollinearity was sought. An inspection of the bivariate correlations as well as the R^2 values when regressing each independent variable on the other two revealed that a high degree of multicollinearity was not present and explanations and predictions from this regression model, for this sample, could be made with a degree of confidence. Table 22 refers.

Table 22: Correlations Among the Three Independent Variables and R^2 values when Regressing Each Independent Variable on the Other Two

	1	2	3	R^2
1. Attitude	--			.560
2. Subjective Norm	.702**	--		.533
3. Perceived Behavioural Control	.626**	.596**	--	.440

**p<.01

(Berry & Feldman (1985) suggest that correlations below a cut-off value of .80 among the variables may be sufficient to conclude that multicollinearity is not a problem. Also that none of the R^2-values were close to 1.00 suggested that a high degree of multicollinearity was not evident).

Discriminant Validity of the Direct Measures' Items

As an indication of the discriminant validity of the items used to provide direct measures of Attitude, Subjective Norm and Perceived Behavioural Control, the ten items were subjected to principal components (varimax normalised) factor analysis. The results are reported in Table 23.

Table 23: Factor Loadings, Eigenvalues, and Explained Variance of Direct Measure Items

Direct Measure	Items	Factor 1	Factor 2
ATTITUDE	Att 1	.617	
	Att 2	.790	
	Att 3	.634	
SUBJECTIVE NORM	SN 1	.844	
	SN 2	.872	
	SN 3	.849	
PERCEIVED BEHAVIOURAL CONTROL	PBC 1		.743
	PBC 2		.829
	PBC 3		.793
	PBC 4		.858
Eigenvalues		5.961	1.253
% variance explained		*39.96%*	*32.17%*

(All factor loadings > .50)

The items measuring attitude and subjective norm loaded onto one factor only suggesting that the items were not able to discriminate between the two constructs. This may well be the reason why attitude and subjective norm failed to contribute to intention as detailed above. The items measuring perceived behavioural control, on the other hand, all loaded onto one factor indicating a clear distinction between them and those items measuring the other two variables.

Correlations Between Individual Belief-Based Items and Direct Measures

In an attempt to investigate which of the belief-based items contributed most to the equivalent direct measures, correlations between the two were undertaken. The results of the correlations between the individual belief-based items and the direct measure of attitude towards caring for an HIV-positive orphan are presented in Table 24. Respondents' attitude towards caring for this child seemed to be related to the possibility of incurring financial costs. Interestingly, the more positive their attitude towards caring for the child, the less they felt they would be placing themselves and their families at risk of cross-infection.

Table 24: Correlations Between Belief-Based Items and Attitude

For me to care for this child would mean that		
1. I would be rejected by family & friends	.204	NS
2. I would incur financial burden	.273	p<.05
3. The child would have difficulty adjusting to new life	.146	NS
4. I would place self & family at risk of infection	-.318	p<.01
5. *I would endure emotional strain*	-.094	*NS*

The results of the correlations between the three belief-based items and the direct measure of subjective norm are presented in Table 25 below. It seemed that two referents - husband/partners and families - influenced respondents' reported intentions to care for an HIV-positive orphan. In particular the high positive correlation evidenced for husbands/partners suggests that these persons were particularly instrumental in influencing respondent's reported willingness to care for an HIV-positive orphan. As with the data from form "A", the greater these respondents' willingness, the less the influence of their friends in their decision. Clearly, individual commitment outweighs conformity to the wishes of others.

Table 25: Correlations Between Belief-Based Items and Subjective Norm

1. Husbands/Partners	.700	p<.01
2. Friends	-.025	NS
3. Family	.317	p<.05

The results of the correlations between the individual belief-based items and the direct measure of perceived behavioural control are presented in Table 26 below. None of the items were significantly related to these respondents' intention to care for the child.

Table 26: Correlations Between Belief-Based Items and Perceived Behavioural Control

1. I would need health care experience	.182	NS
2. I would need someone else to pay medical bills	-.181	NS
3. I would need support from friends & family	.158	NS

6.3. Summary

Despite certain components of the models not having good predictive ability, on the whole, they did predict intentions to care for either an HIV-negative or HIV-positive orphan. In that sense, the TPB has provided a useful tool for assessing willingness to care for these children. However, the fact that only perceived behavioural control was a significant contributor in the model to predict willingness to care for an HIV-negative orphan, calls into question the underlying assumptions of the theory – certainly in terms of assessing intentions to care for an AIDS orphan. In both models, neither attitudes towards caring for an orphan nor subjective norms regarding caring for such a child proved to be significant antecedents of intentions to care as proposed by both the TRA and the TPB. The disappointing low correlations between the belief-based and direct measures of the central components of the theory also makes any further worthwhile interpretations based on the individual items and the expectancy-value approach, difficult.

CHAPTER 6

DISCUSSION

The findings of the present study confirm that the two separate groups of parents - adoptive parents and foster parents - who made up the final sample are close in character to those from abroad and in South Africa. This suggests that they may indeed be representative of their respective populations. However, there are striking demographic contrasts between the two groups largely determined by their differing motivations and reasons for taking on the care and nurturance of non-biological children. The role of the policies and practices of the agencies placing children in their care have also gone a long way in determining who these people are. The only similarity between them is the fact that they have both taken on, and have experience with the challenges in parenting non-biological children in need.

In Chapter 2 it was seen that a strong motivation for adoptive parenthood was childlessness. However, this group in the present study also had 49 biological children and this may be an indication of the second, more recent motivation referred to. In spite of having biological children of their own, adoptive parents having smaller families and the material means to care for additional children may be beginning to respond to the plight of orphaned children in need and are adopting slightly older children. Although there are no specific studies or commentaries to verify this, discussions with Basil Fernie (The Trans-Cultural Adoptive Parents' Group, Pretoria), Anne Tudhope and Mary Cruikshank (Adoption Network News), Pam Wilson (Johannesburg Child Welfare Society) during 2000, do point to this emerging trend.

Many of the characteristics of adoptive parents are also seen to be circumscribed by the eligibility criteria that adoption practitioners have traditionally used in selecting "suitable" adoptive parents. For example, the fact that 81% of this study's adoptive parents had been married or living with a partner for an average of close to 16 years could be seen as a direct result of the recommendations made in the Guide to Adoption Practice in South Africa (1996). These state that "Although the law makes provision for adoption by persons other than married couples, an agency seeking adoptive homes for children in its care should work on the principle that the object of adoption is to give the child a home with a father and mother" and "Generally no marriage of shorter duration than five years should be considered sufficient to consider a couple for adoption" (p. 57).

Other eligibility recommendations by the Guide to Adoption Practice in South Africa (1996) include an investigation into the prospective adopters' income, education levels, and occupations. To this end, "The income should be high enough to ensure financial stability and security for the family....."; "An over-ambitiousness [in the level of achievement expected from an adopted child] could place an unduly heavy burden on the child"; and "Information as to [the couple's] adaptation to their employment and their attitudes towards their occupation, employers and employing bodies should give valuable insight into their personalities." (pp 64-65). These recommended criteria are reflected in the current study's adoptive parents: they are financially secure as evidenced by their high income levels and the earning potential of their partner's employment categories; few partners are unemployed; and they are well educated (although this may not necessarily be a good thing given the above reasons for exploring prospective parents' education levels).

Additionally, "The housing of the applicants should be such as to provide reasonable space and such living conditions as will conduce to the well-being and health of their family" (the Guide to Adoption Practice in South Africa, 1996). With an average of 5.35 rooms (excluding bathrooms and kitchens) and an average of just over 1 other person over the age of 18 years living with them, the adoptive parents in this study seem to conform to these recommendations.

A final suggestion made in the Guide to Adoption Practice in South Africa (1996), is that "The home should provide opportunity for the religious instruction and spiritual development of the child." The fact that more than 90% of adoptive parents indicated a distinct religious affiliation and that more than 50% attended religious ceremonies once per week or more, is an indication that they "conform" to this recommendation.

Finally, the fact that close to 86% of adoptive parents in this study were English-speaking may also be an indication of the previously mentioned, historical focus of adoption practice for "white" South Africans. This tend is changing (Harber, 1999b), but the current study's findings do not reflect this with only 14% of the sample of adoptive parents probably from the previously classified "coloured" and "black" population groups.

Given that South African adoption practice has been informed by policy and practice in the United States of America and England (Brink, 1998; Harber, 1999b), it is not surprising then that South African adoptive parents are much like those found not only in this country but also abroad. Evidently then, adoptive parents in the present study are representative of the adoptive parent population.

Contrary to research on adoption, foster care has received much wider attention - particularly in South Africa. The current study did not include any measure of foster parent's motivations. However, given that potential foster families need to demonstrate an enjoyment in caring for children; a commitment to fostering; and patience, tolerance, understanding and flexibility (Scholtz, 1997), one may presume that the current study's foster carers are similarly motivated. The child-centeredness of the current sample's attitudes towards caring for an AIDS orphan may also be used as evidence of their motivations.

The relatively small amount of research in southern Africa did point to a strong sense of family duty and obligation amongst their samples of foster carers. The fact that 38% of the current study's foster parents were caring for children related to either themselves or their partners, may lead one to presume that family duty and obligation may also be a relevant motivation amongst them.

The following Table 27 demonstrates the similar and dissimilar characteristics of the current study's foster parents and those from the synthesis of foster carer demographics from Southern Africa and abroad as described in Chapter 2.

Table 27: Foster carer Demographics: Comparisons Between Studies from Abroad and Southern Africa, and the Current Study's Foster Carers.

Abroad and southern African	Present Study
Abroad: On average 45 years old	
S. Africa: Mostly 50-60 years old	Mean age: 51.64 years
S. Africa: Grandmothers	*More than 50% were > 50 years old*
Mother younger than father	Mother younger than father
Abroad: Most likely to be married	
S.Africa: More likely alone	Only 43% married or living with partners
Average of 3 biological children	2.2 children < 16 years old
Caring for 2 foster children	Caring for 1.8 foster children
Mothers mostly unemployed	65% mothers unemployed
Fathers in "blue collar" occupations	Fathers mostly clerks, sales, & skilled service workers
Abroad: Home consists of 3+ bedrooms	
South Africa: fewer rooms	Home consists of 3.3 rooms
On average grew up with 4+ siblings	On average grew up with 6+ siblings
Mostly had unhappy childhood experiences	84% had happy / very happy childhood experiences

This Table demonstrates that the current study's group of foster carers are in most respects much like those from the southern African studies explored in Chapter 2 and in many respects much like those from abroad. Clearly this group of foster carers may be considered representative of the foster carer population.

However, although the adoptive and foster parents in the current study's sample appear to be representative of their respective populations, there are striking differences between them. If one refers back to Table 6 on pp 73-75, these differences are evident in virtually all the demographics explored by the current study and explored and expanded upon in Chapter 5. They will not be repeated here.

In terms of informing various recommendations that will be made later, the evidence of these groups' representativeness to their respective populations is vitally important. This, together with the fact that on the whole, the current sample is caring for 71 biological children younger than 16 years old as well as 56 biologically related children, and 223 non-biological children in need of alternative parenting. Clearly, together they represent a group of carers who are arguable well-informed as to the special challenges of, and experienced in caring for children in need. Recommendations based on this sample's data are therefore likely to be highly relevant and reliable.

Creating a Profile of Willing Carers For Either an HIV-Negative or –Postive Orphan

Explored in the opening chapters was the evidence that South Africa is facing the prospect of a large number of orphaned children now and in the future as a result of the HIV/AIDS epidemic. Also that traditional types of alternative parenting in their present forms are not going to be able to provide other options of parental care for these children. Additional hindrances to persons likely to take on the care of these children were also identified and revolve around the probability that the great majority of them will fall into the group of children classified in adoption and foster care discourse as "hard to place". Specifically, most of these orphaned children will exhibit emotional and behavioural problems that will accompany them into their alternative caring situations. Many of them will also be older and have siblings, with a small proportion being abandoned infants. The fact that some will also be HIV-positive and/or that they are known to originate from HIV-infected households, coupled with the pervasive stigma attached to HIV/AIDS in this country, will also often hinder their placement into alternative families.

Given these hindrances, the fact that 69% of the current sample's respondents indicated that they would be willing to care for an HIV/AIDS orphan must be cause for a great deal more optimism than appears in much of the literature to date. The fact that this sample is made up of adoptive and foster carers alone must also be cause for a more optimistic view of these traditional forms of care.

Additionally, it is interesting to note that McKerrow & Verbeek (1995:26) also found that 62% of their sample of 1100 households in eight Kwa-Zulu Natal communities were willing to care for, what these authors term, "children in distress". This was the only direct measure of willingness known to the researcher at the time of writing. These children were mostly either orphaned or displaced reflecting the expected status of most children affected by HIV/AIDS in this country. However, this same study found that the general willingness within the different communities was affected by the HIV status of the child. To the extent that children from HIV-infected households were more willingly accommodated if they were member of the carer's family rather than if they were friend's children or strangers.

In order to create a profile of those persons most likely to care for an HIV/AIDS orphan, the reported willingness of the current study's sample was explored in relation to their specific demographic characteristics. This examination also involved the HIV-status of the orphan. Expectations as well as whether they were confirmed or not, and the reasons for these expectations have already been explored in chapter 5 and will not be repeated here.

The rationale for creating such a "profile" was informed by a report on a recruitment drive specifically for foster families to accommodate adolescents in need of alternative family placements. This was undertaken by the Hennepin County Community Services Department (Moore, Grandpre & Scoll, 1988). By identifying the characteristics of those households that were licensed (i.e. existing foster carers), the staff hoped to be able to target a similar, potential population with its recruitment efforts. For example, it was found that foster parents of teenagers were predominantly suburban, white, married, had their own homes, had higher education than the general population, and fell between the ages of 25 and 34. This information was used to develop a specifically targeted recruitment drive to increase the pool of foster parents who were more likely to care for this group of children.

In similar vein, the presented "profiles" may be of use to those who are given the task of recruiting foster parents for HIV/AIDS orphans. Given the limited resources available to

social and child welfare agencies in this country, it would seem necessary to be very specific in any recruitment process in order to gain maximum advantage from such campaigns.

This profile, taken from an analysis of the relevant data, is therefore presented in Table 28.

Table 28: A Profile of Prospective Carers For Either an HIV-Negative or -Positive Orphan

Those more likely to care for an HIV-negative Orphan	Those more likely to care for an HIV-positive Orphan
Existing adoptive parents and existing foster parents	Existing foster parents
Mothers around 42 years old *Fathers around 44 years old*	Mothers around 44 years old *Fathers around 46 years old*
English-, Xhosa-, and/or Afrikaans-speaking persons	Xhosa- and Afrikaans-speaking persons
Persons with an average of 1.45 persons older than 18 years living with them	Persons with an average of 1.6 persons older than 18 years living with them
Persons with homes averaging 4.5 rooms (excluding bathrooms and kitchens)	Persons with homes averaging 4 rooms (excluding bathrooms and kitchens)
With household income of between R5001 and R8000 p.m.	With household income of between R2001 and R5000 p.m.
Achieved Std. 8 but more likely to have matriculated	Achieved Std. 7 and less likely to have matriculated
Have a university degree	*Had no after school qualifications*
Mothers unemployed	Mothers unemployed
Have a specific religious affiliation	Have a specific religious affiliation
Attend religious ceremonies once *per week or more often*	Attend religious ceremonies once *per week or more often*
Had an average of 4.3 siblings	Had an average of 5.46 siblings
Had experienced happy to very happy *childhoods*	Had experienced happy to very happy *childhoods*
Had friends who were caring or who had cared for an AIDS orphan	Had friends who were caring or who had cared for an AIDS orphan

From the above table, given the task to recruit parents for an HIV-positive orphan for example, one would probably focus on existing foster carers, and Xhosa and Afrikaans-speaking persons. Existing adoptive parents and English-speaking persons would

seemingly not produce positive results. As evidenced by indicators of socio-economic status, the drive would most likely target lower income and education groups of persons as more likely to be willing to care for such a child. This type of specific information to inform focused recruitment drives would reasonably be expected to produce maximised, positive results.

Creating A Profile of an HIV/AIDS Orphan Most Likely to Be Willingly Cared For

Also, in order to create a profile of AIDS orphan most likely to be willingly cared for, a variety of different characteristics of a hypothetically orphaned child were explored. This profile, as with the potential parenting profile above, reflects a synthesis of the results of the data exploring child characteristics. Expectations with regard to child characteristics have already been explored in chapter 5 and will not be repeated here. The implications of the created child profile are such that, those children most likely to slip through the extended family and/or formal alternative family caring arrangement nets, can be identified. According to Richter (2001: 33) "Children who slip through these safety nets become highly vulnerable and exposed, and include street and working children, as well as child-headed households". To these, and evidenced from the present study, may be added male children, those older than 6 years, those with surviving relatives and/or siblings, and HIV-negative children not related to prospective carers. A profile of HIV/AIDS orphans more likely to be willingly cared for is thus presented in Table 29 below.

Table 29: A Profile of an AIDS Orphan More Likely to Be Willingly Cared For

HIV-Negative Orphan	HIV-Positive Orphan
Female or male with preference *for female child*	Female child
Up to the age of 6 years	*Up to the age of 6 years*
Of the same culture/ethnicity as prospective parent	*Of either same or different culture/* ethnicity as prospective parent
From the same or poorer social class as prospective parent	From a poorer social class than prospective parent
Have no relatives or siblings	Have no relatives or siblings
Be a member of prospective parent's family	Be a member of prospective parent's family and/or a friend or neighbour's child, and/or a stranger
Commitment of prospective parent to caring irrespective of ups and downs	Mixed commitment among prospective parent to care irrespective of ups and downs
Most likely to be cared for for *child's and/or parent's life-time*	

There are striking similarities in some of the above findings and those from Pakati's (1984) study on adoption in an African community. Her sample of adoptive parents had distinct preferences for a child up to the age of 5 years old. Sixty-one percent also stated a preference for a female child. There was no reference to HIV/AIDS in this study - understandably since it was undertaken at a time when HIV/AIDS had not even begun to impact on this country. However, age and gender preferences are mirrored in the current study and are likely to have existed even before the HIV/AIDS epidemic. However, the current data do point to the possible marginalisation of male children, particularly if they are HIV-positive, and children over the age of 6 years.

Interestingly, with regard to the orphaned child's culture/ethnicity and his/her relationship to a prospective carer, HIV-positive orphans have some advantage over their HIV-negative peers. The present data indicates that respondents had a distinct preference to willing care for an HIV-negative orphan if he/she was of the same culture/ethnicity as the respondents. Not surprisingly, respondents were also more willing to care for an HIV-negative orphan if he/she was a member of their families.

Contrary to this, respondents were willing to care for an HIV-positive orphan irrespective of his/her cultural/ethnic background. They were also equally willing to care for this child should he/she be from their own families, a friend's or neighbour's child, and/or a stranger. These stated preferences suggest a wider range of potential carers for HIV-positive orphans as opposed to HIV-negative orphans.

McKerrow & Verbeek's (1995) previously mentioned study offers a different picture. Although these authors made reference only to the fact that children came from an HIV-infected household and not whether the orphans themselves were either HIV-negative or -positive, their findings suggest a far greater willingness to care for AIDS orphans if they are from the prospective carers' own families. This would appear to confirm the findings of the current study but only with respect to an HIV-negative orphan and not an HIV-positive one. One possible explanation may be that, given an HIV-positive orphan's expected short life-span, the importance of cultural/ethnic similarity is of far less concern to prospective parents and probably overshadowed by a desire to give a dying child a secure and loving environment in which to spend his/her last days. On the other hand, cultural/ethnic similarity is important when a child is expected to remain with the prospective parents for the remainder of his/her life.

Much of the literature on orphaning as a result of the HIV/AIDS epidemic, has reported a predominant desire amongst all role players to keep orphaned siblings together (Halkett, 1999; McKerrow, 1996a, 1996b; McKerrow & Verbeek, 1995; Smart,2000). The data from the present study seems to suggest that this may not be as difficult as one may assume. Close to half the respondents in this study indicated a willingness to simultaneously care for an orphan's siblings. In spite of this, though, respondents also reported a greater willingness to care for an orphan, irrespective of his/her HIV status, if he/she had no relatives or siblings.

Much like McKerrow & Verbeek's (1995) study, the present study made an attempt to assess how long alternative parents would be willing to care for an AIDS orphan. Congruent with these authors' findings, the present study's respondents indicated that they would be willing to care for the child for the rest of the child's life.

Having constructed a profile of potential alternative parents more willing to care for an AIDS orphan, as well as a profile of those orphans more likely to be accommodated in alternative parenting arrangements, a deeper analysis of the data reveals that there are significant differences amongst adoptive and foster parents, as well as differences depending on the HIV status of the orphaned child. It may also have been instructive to

explore differences along cultural/ethnic lines, but these issues in the present study appear to be confounded by the fact that the great majority of adoptive parents are also from the previously classified "white" ethnic group and foster carers from the previously classified "coloured" or "black" ethnic groups. Meaningful analysis of the data along cultural divides would therefore be meaningless.

To this end, many of the differences between adoptive and foster parents could arguably revolve around the nature of, and these groups' differing expectations inherent in, each of the types of alternative parenting. These considerations have already been examined in chapter 2 and are summarised here. For example, adoption traditionally has centered around the incorporation of an infant into an existing, childless family. Caring for an adopted child would involve a life-time commitment much like is expected of biological parenting. Once the adoption has been legally finalised, in the vast majority of cases there is no further intervention of either the placement agency nor the child's biological family.

On the other hand, foster care centers around the care of older children (probably beyond infancy) who are in need of care due to biological parenting break-down. As has been mentioned earlier, the arrangement is expected to be short-term and should terminate once the child's biological parent/s are able to resume parenting of their child. However, recognition is given to the fact that many foster care arrangements tend to be long-term, if not also life-time commitments. At all times, the placement agency is expected to be involved in continuing assessment and various interventions both with the foster family and the child's biological family. Further, the child's biological family is at all times a "presence" in the caring arrangement.

Given the expectation of life-time commitment, adoptive parents in the current study were more likely to willingly care for an HIV-negative orphan than they were to care for an HIV-positive orphan. This preference is likely to be informed by the short life-span that an HIV-positive orphan is likely to have. Foster carers, more familiar with short-term caring, did not show such distinct preferences and were equally willing to care for either an HIV-negative or an HIV-positive orphan.

Congruent with the traditional placing of infant children with adoptive parents, the current sample's adoptive parents were more likely to express a willingness to care for an orphaned HIV-negative child between the ages of 0 and 1 year old than any of the other age groups of children. Foster carers had similar preferences but were significantly more willing than adoptive parents to care for children older than 1 year old.

As mentioned earlier, this may be as a result of these parents' familiarity with, and expectations to, caring for children beyond infancy.

Different results emerge when the hypothetical child is HIV-positive. In this instance, although adoptive parents still showed a slight preference for an infant, they were as willing as foster parents to care for the older groups of children. Given the short life span of these children, perhaps what is being witnessed here is a change in adoptive parents' motivations to those closer to foster carers' motivations: being more centered around altruism and a desire to help needy children in the shorter term.

Not surprisingly, adoptive parents were unanimous in their preference for the child to have no siblings or relatives irrespective of the child's HIV status. Again this is an indication of the expectations of adopted parents informed by the traditional non-disclosed nature of adoption. Surprisingly, however, one would expect foster carers to be more accommodating of relatives and siblings, but in this study a great majority also indicated a preference for the orphaned child, irrespective of its HIV status, to have no siblings or relatives.

Having noted this preference, should the orphan have siblings and relatives, both adoptive and foster parents were equally willing for the child to either remain in contact with them or not. This is surprising in that, given the same reasons as above, one would expect foster parents to be more willing for the child to remain in contact with relatives and siblings. Additionally, one would expect adoptive parents to state a preference for the child not to have contact with relatives or siblings. In fact, adoptive parents were far more willing than foster parents for an HIV-positive child to remain in contact with his/her siblings and relatives.

Given that adoptive and foster parents care mostly for non-biological children, it was surprising to note that the current study's data pointed to a strong preference amongst both adoptive and foster parents for the orphaned child, irrespective of his/her HIV status, to be a member of their own families. Only if the child was HIV-positive did this situation appear to change with both adoptive and foster parents indicating a willingness to care for non-biological children.

Also, inherent in foster care is the notion that the placement of children with foster parents is a reversible arrangement. By this, it is meant that foster carers are probably more familiar with the notion of break-down and the removal of the child to another foster care placements should they no longer wish to care for the foster child. On the

other hand, one would expect adoptive parents would be more firmly committed - again as a result of the inherent nature of adoption. The current study revealed that although both adoptive and foster parents indicated that they would be committed to the care of the child, foster parents were in fact more likely to avail themselves of the opportunity relinquish their care of the child should they wish to do so. In fact this option was stronger for an HIV-positive child than an HIV-negative one.

Similarly, both adoptive and foster parents were prepared to provide life-time care to the orphaned child. For many of the same reasons as above, this was a somewhat surprising finding amongst foster carers. However, significantly more foster parents than adoptive parents were prepared to offer care to the child only until he/she was self-supporting.

Taking Responsibility For, and Assistance In Caring for Orphaned Children

The current study supports the notion that immediate and extended family members should be and are the most important alternative caretakers for orphaned children irrespective of the HIV status of the orphaned child (McKerrow, 1996a; McKerrow & Verbeek, 1995). Surprisingly, though, the next preferred group of persons whom this study's respondents felt should care for orphaned children was friends of the orphaned children's families. In both McKerrow (1996a) and McKerrow & Verbeek (1995), friends were low on their respective sample's lists of preferred caretakers. The Government seemed to feature dominantly in these studies as with the current study. Orphanages (institutionalisation) was the least preferred option of care for orphaned children in the current study as well as McKerrow & Verbeek (1995), but one of the preferred options of care in McKerrow's (1996a) Zambian study.

The current findings lend support for the call to keep orphaned children with their families and within their communities as a priority (Halkett, 1999; McKerrow, 1996b; Smart, 2000;). Support should be given to families and communities hosting orphaned children and perhaps this is where State aid is not only expected but also necessary.

In an attempt to determine what additional assistance alternative parents would value should they care for an AIDS orphan, the current study asked respondents to mark any or all of three options: free schooling for the child, free medical care for the child, and monetary assistance. Confining these options to only three may have had the effect of masking many more suggestions for appropriate assistance. However, the results indicate that free schooling and medical care are more important than purely financial

assistance irrespective of the child's HIV status. Particularly for HIV-positive orphans, respondents felt that free medical care for the child was the most important source of assistance they would prefer. Contrary to these findings, McKerrow & Verbeek's (1995) and McKerrow's (1996a) data point to a greater need amongst their respective samples for financial and material assistance.

Clearly assistance is required and whether it be with schooling, medical care or financial, the State appears to be the group expected and most likely to be able to provide it.

6.1. THE THEORY OF PLANNED BEHAVIOUR

For the purposes of the present study, the data from an exploration of the TPB as a possible appropriate and useful model to investigate behaviour relating to caring for AIDS orphans, may be explored along two dimensions. Firstly, and traditionally, the usefulness of the model to the present study can be investigated. This would encompass exploration of its predictive ability, the link between the different components of the theory, and various methodological and statistical concerns. However, as the TPB has not been used to explore alternative parenting decisions, comparisons to existing research would necessarily be excluded. Much of the discussion will therefore revolve around the TPB as it relates to the current study only.

Secondly, the analysis of individual items in the TPB battery can be used to compliment much of what has already been discussed. Particular attitudes towards caring for an orphaned child, influences of others' in deciding to care for such a child, and perceptions regarding facilitators and/or hindrances to caring for an orphaned child can be explored.

The TPB and Decisions To Care For An HIV-Negative Orphan

As a model to predict intentions to perform specific behaviours, the current study's results appear to confirm the TPB's predictive ability. Intentions to care for an HIV-negative orphan was significantly predicted by the three proposed determinants of intentions: attitude towards the behaviour, subjective norm, and perceived behavioural control.

However, of concern in the current study was the fact that the relative contribution of each of the determinants was not clearly defined. For intentions to care for an HIV-negative orphan, for example, beta weight analyses revealed that only perceived behavioural control contributed to intentions to care for such a child. Neither attitudes

nor subjective norm contributed to intentions. Although the correlations between the direct measures of these determinants and the measure of intentions were significant suggesting a strong relationship between them, these correlations did not corroborate the evidence from the multiple regression.

One explanation may have been a high degree of multicollinearity present between these independent variables. Evidence suggests that this was not the case. However, factor analysis of the items measuring the three direct measures suggests that the items were unable to discriminate between attitudes and subjective norm. Lack of discriminant validity between these two variables' items is a likely explanation for their insignificant contribution to the regression.

Although on the face of it, the items appear to be sufficiently different to suggest that they were in fact measuring different constructs, a possible explanation suggested by Armitage & Connor (1999) may be, quite simply, that the respective items did not measure what they were intended to. That is to say, attitudes towards caring for an HIV-negative child and the influences of important others' on decision-making processes.

Another concern in the present study was the relatively low correlations found between the belief-based measures of each of the constructs and their respective direct measures. Although there appeared to be a sufficient relationship between the belief-based measure of attitudes and its direct measure as well as between the belief-based measure of subjective norm and its direct measure (Ajzen, 1980), this was not the case for the perceived behavioural control measures. From these findings one may presume that behavioural beliefs and normative beliefs determine attitudes and subjective norms respectively. On the other hand, with regard to control beliefs, the current study found no evidence to support this formulation.

Possible explanations for this latter finding may be, as suggested by Fishbein (1993) and Hankins et at. (2000), that the belief X expectancy, multiplicative operationalisation of control beliefs is only a representation of the processes involved and is not necessarily a useful measure of it. A suggestion has been to provide a simple measure based on self-reported beliefs rather than a multiplicative composite (Eagly & Chaiken, 1993 in Hankins et al., 2000). Self-reports of respondents' own beliefs would not require an expectancy component as expectancies would be high.

Ajzen (1991: 197) provides another explanation to account for ".....the generally moderate correlations between belief-based indices and other, more global measures of

each variable". He suggests that global measures may provoke a more automatic response from participants as opposed to a more reasoned response that belief-based items would require. The different response processes, automatic or reasoned, may induce different responses and thus contribute to the poor correlation results.

However, useful additional information can be gained from an exploration of the correlations between the individual belief-based items and the respective determinants of intentions. Much of this information can be used to explain the specific determinants of the each of the predictors of intentions.

For example, if one refers to Table 17 on p 123, clearly those items that correlated positively and significantly with the direct measure of attitude towards caring for an orphaned child, were those that demonstrate a strong child-centredness. These beliefs bear repeating here: respondents felt that caring for an HIV-negative orphan would

* provide the child with a loving and stable home,
* provide the child with a sense of belonging,
* provide the child with a chance for a normal life, and
* would allow the respondents to help a needy child

These beliefs appear to be strongly indicative of respondent's motivations and are interestingly close to those investigated by both adoption and foster care practitioners as necessary for the successful placement of children in either of these groups' care (A Guide to Adoption Practice in South Africa, 1996 and Scholtz, 1997). Clearly, the motivations of prospective parents are a useful aspect of these carers to determine as, according to the TPB, they have a direct influence on attitudes towards caring which, in turn, is supposed to predict intentions (and behaviour) to care.

Also, Table 18 on p. 123 depicts the correlations between respondent's beliefs concerning the approval/disapproval of partners, friends and/or family of their willingness to care for an orphaned child and the direct more generalised measure of "subjective norm". Interestingly, respondents believed that their husbands/partners would be highly influential in their decisions to care for an orphan. This may point to the need for recruiters of alternative parents to assess *equally* the willingness to care for an orphan of *both* partners in a relationship, should there be two.

Of further interest is that, although respondents' friends were more likely to be caring or to have cared for an AIDS orphan, their caring experience did not influence the current sample's willingness. In fact the negative correlation (albeit small) points to the exact

opposite. The fact that only partners appeared to have any influence over respondents' decisions and beliefs is indicative of the nature and magnitude of a decision to care for an AIDS orphan. Arguably, the consequences of this type of decision will affect (adult) members of a family most and is therefore likely to need both partners' deliberation and agreement/disagreement with a final commitment.

Finally, Table 19 on p. 123 demonstrates that the current study's respondents report only potential facilitators to their sense of control over their decision to care for an orphan. Needing time and energy to care for the child appears to be a clear facilitator as does having contact with other families in similar situations. Having the support of family and friends did not influence these respondents' perceptions of control over their decisions. However, caution should be shown in using this information as possible explanations for perceptions of control. Even though perceived behavioural control was the only significant contributor to intentions, the correlation between the sum of the belief-based items and the direct measure was not significant suggesting a tenuous relationship between the belief-based items and the direct measure.

The TPB and Decisions To Care For An HIV-Positive Orphan

As with intentions to care for an HIV-negative orphan the present study's results for this sub-sample confirm the TPB's ability to predict intentions to care for an HIV-positive orphan. Intentions to willingly care for such a child was significantly predicted by the three proposed determinants of intentions: attitude towards the behaviour, subjective norm, and perceived behavioural control.

However, also of concern in the analysis of intentions to care for an HIV-positive orphan, was the fact that the relative contribution of each of the determinants were even less clearly defined than in the model predicting intentions to care for an HIV-negative orphan. In this instance, beta weight analyses revealed that none of the determinants contributed significantly to intentions to care for an HIV-positive orphan. Here too, although the correlations between the direct measures of these determinants and the measure of intentions were significant suggesting a strong relationship between them, these correlations did not corroborate the evidence from the multiple regression.

As with the previously described model, in the present model, high levels of multicollinearity were also not evident. Factor analysis of the items measuring the three direct measures also suggests that the items were not able to discriminate between attitudes and subjective norm. However, as all the items measuring perceived

behavioural control loaded onto a separate factor, this level of explanation does not account for the equally insignificant contribution of perceived behavioural control to the regression and other explanations need to be sought.

On the face of it, the items also appear to be sufficiently different to suggest that they were in fact measuring different constructs, the explanation offered by Armitage & Connor (1999) that the respective items did not measure what they were intended to, seems plausible here too.

The same concerns are expressed in this model as in the previously described model over the low correlations found between the belief-based measures of each of the constructs and their respective direct measures. In fact, for this model the correlation between the belief-based measures of attitude and its direct measure as well as the that between the belief-based measures of perceived behavioural control and its direct measure indicate almost no relationship between them. On the basis of these findings, one may presume that behavioural beliefs and control beliefs do not determine attitudes and perceived behavioural control respectively.

The possible explanations for these contrary findings have already been explored for the model to predict intentions to care for an HIV-negative orphan and will not be repeated here other than to suggest that they are equally relevant.

Additional, possibly useful information from an exploration of the correlations between the individual belief-based items and their respective direct measures follows.

None of the child-centred attitude beliefs survived the exclusion of some items in the attempt to increase the reliability of the items in the measure. In fact, it is doubtful whether any meaningful discussion can follow since the correlation between the belief-based X expectancy items and the direct measure of attitude was extremely low. However, some comments seem appropriate. Firstly, the fact that rejection by friends and family appears to refute the reported pervasive stigma that is thought to surround HIV/AIDS. Secondly, the expectation of incurring financial hardship corresponds to the reported need for medical care assistance and financial aid from the State. This was a significant belief. Thirdly, the expected emotional toll that caring for an HIV-positive child is expected to take, appears to be unfounded. Finally, the more positive this sample's attitude towards caring for an HIV-positive orphan, the less they anticipated placing themselves and their families at risk of cross-infection.

As with caring for an HIV-negative orphan, these respondents felt their decisions to care for an orphan were significantly influenced by their partners. Again pointing to the need to involve both partners equally in any decision-making processes given the magnitude of a decision to care for an HIV-positive orphan. Contrary to the findings with regard to caring for an HIV-negative orphan, these respondents' families were also instrumental in their decisions to care for an HIV-positive orphan.

The fact that the correlation between these belief based X expectancy items and the direct measure of perceived behavioural control was extremely low, makes any discussion around these items redundant. In fact, none of the facilitators that would be presumed to affect respondents' perceptions of control over their behaviour proved to be significantly correlated with the direct measure and will not be discussed further.

In conclusion, it appears that, on the whole, the TPB is a useful predictor of intentions to either willingly care for an HIV-negative or an HIV-positive orphan. This provides further validation of the theory's reported extensive predictive ability across a variety of behaviours. However, further analyses of the various components of the theory as well as their interrelationships reveal contradictory and disappointing results. As no other research has been conducted using the TPB to predict and explain alternative parenting decisions, these contradictions and disappointments are difficult to rationalise. Whether the TPB is in fact not a useful model to use in exploring this type of behaviour or whether, in the present study, there are major methodological flaws that may have compromised the quality of the information, is impossible to assess. However, until comparative indications become available, the additional explanatory information directly relevant to the current research has hopefully salvaged the effort that went into the construction and analysis of the TPB.

6.2. LIMITATIONS OF THE STUDY

One of the foremost limitations of the current study was the small sample size as a result of the poor response rate. Although the sample respondents appear to be representative of adoptive and foster parents on the whole, a better response rate and a larger number of respondents would have added substantial weight to the conclusions drawn from the results. The reason for the disappointing response rate may well be as a result of the complexity and length of the questionnaire alluded to earlier. Not only would this have excluded those respondents who may have had little or no education,

but also those who quite simply did not have the time to devote to completing the questionnaire.

The results indicate that the questionnaires were in fact completed by a relatively well educated group of persons lending weight to the above suggestion. Due consideration must be given to the possibility that the results may have been biased towards better educated persons' perspectives and that the viewpoints of less educated persons may have been inadvertently excluded. The over-representation of adoptive parents in the final sample may also have produced a similar bias, masking the perspectives of foster parents. However, analysis of the data along adoptive and foster parent divisions was an attempt to circumvent this possible bias.

Although it is difficult to suggest why the TPB produced disappointingly inconsistent results, it does represent another limitation of the present study. Possible explanations for these inconsistencies, and suggestions to obviate them have already been made and will not be repeated here other than to add that caution must be shown when making any inferences from these results.

6.3. RECOMMENDATIONS

- In the current study, existing adoptive and foster parents have indicated that they would be willing to care for an AIDS orphan. Two spin-offs are relevant here. Firstly, adoption and foster care as models of alternative parental care for orphans may not be as inadequate as originally presumed. To this end, adoption and foster care need to be promoted as viable options for these children. Secondly, existing adoptive and foster parents may be the springboard from which practitioners could begin their efforts at recruitment.
- However, the present study did uncover significant differences between adoptive and foster parents. These differences appear to be situated in the different motivations and reasons inherent in each form of parenting as well as having been entrenched to a large degree by adoption and foster care practice and policy. For this reason, it seems appropriate to recommend that alternative family care for orphans should be re-conceptualised and re-organised around more appropriate assumptions and guidelines, perhaps incorporating elements from both adoption and foster care. As only two examples, there would be a need to move away from the assumption that adoption involves infants only; and to move away from the assumption that foster care is a relatively short-term caring arrangement.

- The finding that there was a strong preference for children from respondents' biological families points to the need to promote adoption and foster care amongst those groups of persons for whom these services have historically been unavailable.
- Given that there is no such distinct familial preference for HIV-positive orphans, recruitment outside of biological family, and thus possibly cultural/ethnic boundaries, should be considered a viable option for these children.
- Support for families caring for orphans is a definite requirement. From the current study, assistance in the form of schooling and medical care seems to be most relevant. However, as mentioned, other equally relevant and important required assistance may not have surfaced in the current investigation.
- The role of husband/partners in decision-making processes as evidenced in the current study, points to the need for an equal and close examination of both partner's attitudes and beliefs towards caring for an orphaned child.
- Given the strong child-centred motivations reported by the current sample's respondents, an assessment of these motivations may be an important aspect in assessing prospective parents' suitability for alternative parenting, as they are already.
- Although not explicitly investigated in the current research, prospective parents should be advised of and/or counselled on the particular needs of special needs children.
- Given the predominant religiosity of the current sample, it may be relevant to harness the support from religious-based organisations particularly in terms of recruiting prospective alternative parents. However, due consideration is given to the possibility that the current sample may have shown this high degree of religiosity as a result of the particular selection criteria used in assessing their "suitability" to care for children in need.
- Recruitment drives should take cognisance of the current study's findings with regard to the characteristics of those who indicated a willingness to care for either an HIV-negative or-positive orphan. Person- or group-directed recruitment drives have obvious distinct advantages over generalised recruitment efforts.
- Protection for those children for whom care appears to be less likely, based on the current study's findings, may have to be carefully formulated and child-directed.

6.3. CONCLUSION

The current study has provided some insight into the possibility of adoption and foster care as being viable alternative parenting options for children orphaned by the HIV/AIDS pandemic in this country. Valuable information has been gained with regard to those

who are most likely to care for either an HIV-negative or HIV-positive orphan. This may have significant implications for recruitment of alternative families for these children. An assessment of those children most likely to be willingly cared for provides insight into the relative ease or difficulty that may be experienced in finding alternative family placements for certain children. Exploring factors contributing to decisions to care for HIV/AIDS orphans has expanded knowledge around the relative processes of attitudes towards caring for an orphan, of the influence of others' in decision-making, and of facilitators/ hindrances in perceptions of control over these decisions.

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APPENDIX A, page 1

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS (N=175)

	Form "A"	Form "B"
Mean Age		
Respondents	[illegible]	47.41 years
	N = 69; SD = 12.07	N = 91; SD = 11.04
[illegible]	44.05 [illegible]	45.77 years
	N = 42; SD = 9.17	N = 56; SD 9.82
Married or With Partners	[illegible]	[illegible]
	N = 42	N = 56
Length of Relationship	15 years	17.84 years
	N = 42; SD = 7.65	N = 56; SD = 8.91
Household Density		
Mean No. > 18 [illegible]	[illegible]	[illegible]
	N = 68; SD = 1.42	N = 87; SD = 1.39
Mean No. [illegible]	[illegible]	[illegible]
	N = 69; SD = 2.14	N = 88; SD = 2.41
Mean No. Employed	[illegible]	1.29 persons
	N = 65; SD = .83	N = 90; SD = .89
Household Income Bracket		
Mean	R2001-5000 p.m.	R2001-5000 p.m.
Mode	R1001-2000 p.m.	>R10000 p.m.
	N = 65	N = 90
[illegible]	[illegible]	[illegible] p.m.
[illegible]	[illegible]	>R10000 p.m.
	N = 30	N = 34
[illegible]	[illegible] p.m.	[illegible] p.m.
[illegible]	[illegible]	R1001-R2000 p.m.
	N = 27	N = 45
[illegible]	[illegible] p.m.	R5001-R8000 p.m.
	N = 33	N = 38
Xhosa-speaking: Mean	[illegible]	[illegible]
	N = 14	N = 17
Afrikaans-speaking: Mean	R501 to R2000 p.m.	R1001-R2000 p.m.
	N = 9	N = 28
Home Language		
English	[illegible]	44.09%
	N = 38	N = 41
English: adoptive parents	88.57%	82.86%
	N = 31	N = 29
English: foster parents	[illegible]	[illegible]
	N = 7	N = 10
Xhosa	[illegible]	22.58%
	N = 21	N = 21
Xhosa: adoptive parents	8.57%	[illegible]
	N = 3	N = 1
Xhosa: foster parents	[illegible]	[illegible]
	N = 18	N = 19
Afrikaans	[illegible]	[illegible]
	N = 13	N = 31
Afrikaans: adoptive parents	[illegible]	[illegible]
	N = 1	N = 5
Afrikaans: foster parents	[illegible]	[illegible]
	N = 12	N = 23

APPENDIX A, page 2

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS (N=175)

	From "A"	Form "B"
Mean Education Level		
Respondents	Std 8	Std 7
	N = 69	N = 90
Partners	Std 8	Std 8
	N = 48	N = 59
Matriculation		
Respondents	45.45%	45.56%
	N = 35	N = 41
Partners	59.26%	[illegible]
	N = 32	N = 34
No After School Qualifications		
Respondents	[illegible]	60%
	N = 44	N = 54
Partners	50%	[illegible]
	N = 27	N = 29
Some After School Qualification		
Respondents	19.48%	36.67%
	N = 15	N = 24
Partners	[illegible]	[illegible]
	N = 18	N = 10
University Degree		
Respondents	23.38%	[illegible]
	N = 18	N = 12
Partners	15.57%	33.90%
	N =9	N = 20
Employment Category		
Respondents: Mode	Unemployed 44.44%	Unemployed 55.43%
	N = 33	N = 51
Partners: Mode	Clerk, sales, skilled service worker	Clerk, sales, skilled service worker
Religious Affiliation		
Christian	81.01%	91.21%
	N = 64	N = 83
Muslim	8.80%	3.30%
	N = 7	N = 3
Jewish	2.53%	2.20%
	N = 2	N = 2
Other or None	7.60%	3.30%
	N = 6	N = 3
Frequency of Religious Ceremony Attendance	1p.w. or more 67.09%	1p.w. or more 75.82%
	N = 53	N = 69
Mean No. of Siblings	4.40 siblings	[illegible]
	N = 75; SD 3.15	N = 83; SD 3.96
Quality of Own Childhood		
Very or [illegible]	[illegible]	81.32%
	N = 66	N = 74

APPENDIX A, page 3

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS (N=175)

	Form "A"	Form "B"
Mean No. of Children < 16 years old	2.2 children	2.19 children
Relationship of Children to Respondents		
Biological children	28%	27%
	N = 22	N = 24
Mean age	9.6 years	9.68 years
Number	30	41
Related foster children	20.51%	23.60%
	N = 16	N = 21
Mean age	10.3 years	9.85 years
Number	23	33
Non-related foster children	32.05%	38.20%
	N = 25	N = 34
Mean age	8.2 years	7.94 years
Number	51	67
Adopted Children	44.87%	39.33%
	N = 35	N = 35
Mean age	5.6 years	5.23 years
Number	53	52
Caring Experience		
Presently caring: Respondent	5.08%	12.00%
	N = 3	N = 6
Cared in the Past: Responder	5.08%	6.00%
	N = 3	N = 3
Presently Caring: Family	3.39%	12.00%
	N = 2	N = 6
Cared in the Past: Family	–	10.00%
	N = 0	N = 5
Presently Caring: Friends	16.95%	28.00%
	N = 10	N = 14
Cared in the Past: Friends	20.34%	24.00%
	N = 12	N = 12

APPENDIX B

5th February 2001

Dear Parent

I am a researcher at the University of Cape Town. I am conducting research on the care of HIV/AIDS orphans. I am hoping that my research will, in some way, help us to understand the decisions that people make when agreeing to care for these orphans.

I would be very grateful if you would spend about 30 minutes completing the questions in the enclosed Questionnaire Booklet. It is confidential and your name does not need to be filled in anywhere. Please give your honest answers to all the questions. Once you have finished, seal it in the enclosed, stamped and addressed envelope and drop it into the nearest post office box.

As a token of my appreciation for your time and effort, I will be giving away 10 grocery vouchers to the value of R100 each. If you would like to enter this lucky draw, make sure you have answered all the questions, then write your address in the space provided at the bottom of the Questionnaire Booklet cover. The draw will take place during March and the grocery vouchers will be sent to the first 10 lucky winners drawn.

Thank you for your assistance

Yours sincerely

Loraine Townsend (Mrs)
Research

Assoc. Professor Andrew Dawes
Supervisor

QUESTIONNAIRE BOOKLET - A

I agree to answer all the questions on the

following pages.

I understand that my answers

are confidential.

Signature .....

Date .....

* * * *

If you would like to stand a chance of winning a R100 grocery voucher, write your address in the space below.

.....

.....

.....

18. How many children (16 years or younger) live with you **now** and what is their relationship to you (biological child, step-child, fostered child, and/or, legally adopted child)? (Tick applicable blocks)

Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child

19. I am already caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

20. In the past I have cared for a child whose mother had died of AIDS (Tick applicable block) Yes No

21. Other members of my family are caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

22. In the past other members of my family have cared for a child whose mother had died of AIDS (Tick applicable block) Yes No

23. Some of my friends are caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

24. In the past, some of my friends have cared for a child whose mother has died of AIDS (Tick applicable block) Yes No

25. How many children lived **with you** when you were growing up (including step-, adopted, and/or natural brothers and sisters, relatives and non-relatives) ....

26. How would you describe **your own** childhood? (Tick applicable block)

Very Happy	Mostly happy	Neither happy nor unhappy	Mostly unhappy	Very unhappy

Here are some statements that are about an orphaned child who is

HIV negative and DOES NOT have AIDS.

Read each statement carefully and place a cross in the option that BEST describes YOUR response to the statement

FOR EXAMPLE:

For me to care for this child would be

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	neither a good nor bad thing to do	a somewhat bad thing to do	a very bad thing to do

If you think caring for this child would be a VERY GOOD thing to do, place a cross in number 1
If you think caring for this child would be a SOMEWHAT GOOD thing to do, place a cross in number 2
If you think caring for this child would be neither a GOOD nor BAD thing to do, place a cross in number 3
If you think caring for this child would be a SOMEWHAT bad thing to do, place a cross in number 4
If you think caring for this child would be a VERY BAD thing to do, place a cross in number 5

MAKE ONLY ONE CROSS FOR EACH STATEMENT

The following statements are about how other people important to you would feel about your caring for an orphan who is HIV negative and does NOT have AIDS

1 People I respect would THINK that I should care for this child

1	2	3	4	5
strongly agree	agree slightly	don't know	disagree slightly	strongly disagree

2 If I were to care for this child, people I respect would

1	2	3	4	5
strongly approve	approve slightly	don't know	disapprove slightly	strongly disapprove

3 People I respect would WANT me to care for this child

1	2	3	4	5
strongly agree	agree slightly	don't know	disagree slightly	strongly disagree

4 With most things in life I do what my husband/partner wants me to do (only answer this statement if you have a husband/partner)

1	2	3	4	5
always	sometimes	not sure	seldom	never

5 With most things in life I do what my friends want me to do

1	2	3	4	5
always	sometimes	not sure	seldom	never

6 With most things in life I do what other members of my family want me to do

1	2	3	4	5
always	sometimes	not sure	seldom	never

17 If this child is related to me or my family, it would make it

1	2	3	4	5	
much easier	somewhat easier	would make no difference	somewhat more difficult	much more difficult	to care for this child

18 If this child is NOT related to me or my family, it would make it

1	2	3	4	5	
much easier	somewhat easier	would make no difference	somewhat more difficult	much more difficult	to care for this child

The following statements are about your beliefs about caring for an orphan who is HIV negative and does NOT have AIDS

19 I would be able to provide this child with a loving and stable home

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

20 I would be able to provide this child with a sense of belonging and security

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

21 I would be able to provide this child with a chance for a normal life

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

22 I would help a needy child

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

23 To care for this child would be a financial burden

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

24 The rest of my family would resent sharing the family income and home with this child

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

25 I would be concerned about this child's unknown medical and family background

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

26 This child could grow up wondering about his/her unknown medical and family background

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

27 This child would find it difficult adjust to a new environment and a different family life

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

38 To have my family resent sharing the family income and home with this child would be

1	2	3	4	5
a very good thing	a somewhat good thing	neither a good nor bad thing	a somewhat bad thing	a very bad thing

39 To be concerned about this child's unknown family and medical background would be

1	2	3	4	5
a very good thing	a somewhat good thing	neither a good nor bad thing	a somewhat bad thing	a very bad thing

40 A child who grows up not knowing about his/her medical or family background would be

1	2	3	4	5
a very good thing	a somewhat good thing	neither a good nor bad thing	a somewhat bad thing	a very bad thing

41 For this child to adjust to a new environment and a different family life would be

1	2	3	4	5
a very good thing	a somewhat good thing	neither a good nor bad thing	a somewhat bad thing	a very bad thing

In the following statement I want to know about your attitude towards caring for an orphan who is HIV negative and does NOT have AIDS

42 For me to care for this child would be: (Please circle one number in each of the three sections for this statement)

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	don't know	a somewhat bad thing to do	a very bad thing to do

1	2	3	4	5
a wise thing to do	a somewhat wise thing to do	don't know	a somewhat foolish thing to do	a foolish thing to do

1	2	3	4	5
an enjoyable thing to do	a somewhat enjoyable thing to do	don't know	a somewhat unenjoyable thing to do	an unenjoyable thing to do

QUESTIONNAIRE 3.

This part of the questionnaire deals with YOUR views about orphaned children.

On the following pages, there are a number of statements that will need your responses. Instructions on how to complete the questionnaire are provided as you go through it. An orphaned child is described in the box below.

Please read this carefully before going on to the questionnaire.

The child in this part of the questionnaire has been orphaned because his or her mother has died of AIDS. It is unknown whether the child has other family members who would be willing, or even able to care for him or her. The child appears to have no-one to look after him / her and nowhere to go.

IMPORTANT INFORMATION:

In the questionnaire, you will see that I ask a number of questions about **caring for** an orphaned child.

Caring for an orphaned child would mean taking the child into your own home and treating him or her as you would your own children; providing him or her with food, shelter and clothing; schooling and medical care; and love, support, and guidance.

Your answers are confidential and your name does not appear anywhere on the questionnaire.

PLEASE TURN OVER AND CONTINUE ON THE FOLLOWING PAGES

would be willing to care for the child if

the child is a member of my own family or extended family e.g. my aunt's child	YES	NO
the child is a neighbour or friend's child	YES	NO
the child is Black African and from the same clan as me i.e. has the same surname as me, but is not related to me	YES	NO
the child is not a member of my family nor a friend's or neighbour's child	YES	NO

would be willing to care for the child

only if there is a childcare agency or another family to care for the child should I no longer wish to care for him/her myself	YES	NO

would be willing to care for the child

until the child is self-supporting, after which my responsibility to the child ends	YES	NO
as with my own children, for the rest of my and/or the child's life	YES	NO

Please remember to fill in your address on the cover of this booklet if you would like a chance to win a grocery voucher to the value of R100

THANK YOU FOR YOUR TIME AND EFFORT

APPENDIX C

5th February 2001

Dear Parent

I am a researcher at the University of Cape Town. I am conducting research on the care of HIV/AIDS orphans. I am hoping that my research will, in some way, help us to understand the decisions that people make when agreeing to care for these orphans.

I would be very grateful if you would spend about 30 minutes completing the questions in the enclosed Questionnaire Booklet. It is confidential and your name does not need to be filled in anywhere. Please give your honest answers to all the questions. Once you have finished, seal it in the enclosed, stamped and addressed envelope and drop it into the nearest post office box.

As a token of my appreciation for your time and effort, I will be giving away 10 grocery vouchers to the value of R100 each. If you would like to enter this lucky draw, make sure you have answered all the questions, then write your address in the space provided at the bottom of the Questionnaire Booklet cover. The draw will take place during March and the grocery vouchers will be sent to the first 10 lucky winners drawn.

Thank you for your assistance.

Yours sincerely

Loraine Townsend (Mrs)
Research

Assoc. Professor Andrew Dawes
Supervisor

QUESTIONNAIRE BOOKLET - B

I agree to answer all the questions on the

following pages.

I understand that my answers

are confidential.

Signature .....

Date .....

* * * *

If you would like to stand a chance of winning a R100 grocery voucher, write your address in the space below.

.....

.....

.....

18. How many children (16 years or younger) live with you **now** and what is their relationship to you (biological child, step-child, fostered child, and/or, legally adopted child)? (Tick applicable blocks)

Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child
Age of child	Biological	Step-child	Foster child related to me or my husband / partner	Foster child not related to me or my husband / partner	Legally adopted child

19. I am already caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

20. In the past I have cared for a child whose mother had died of AIDS (Tick applicable block) Yes No

21. Other members of my family are caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

22. In the past other members of my family have cared for a child whose mother had died of AIDS (Tick applicable block) Yes No

23. Some of my friends are caring for a child whose mother has died of AIDS (Tick applicable block) Yes No

24. In the past, some of my friends have cared for a child whose mother has died of AIDS (Tick applicable block) Yes No

25. How many children lived **with you** when you were growing up (including step-, adopted, and/or natural brothers and sisters, relatives and non-relatives) ....

26. How would you describe **your own** childhood? (Tick applicable block)

Very Happy	Mostly happy	Neither happy nor unhappy	Mostly unhappy	Very unhappy

Here are some statements about an orphaned child who is

HIV positive and DOES have AIDS

Read each statement carefully and place a cross in the option that BEST describes YOUR response to the statement

FOR EXAMPLE:

For me to care for this child would be

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	neither a good nor bad thing to do	a somewhat bad thing to do	a very bad thing to do

If you think caring for this child would be a VERY GOOD thing to do, place a cross in number 1
If you think caring for this child would be a SOMEWHAT GOOD thing to do, place a cross in number 2
If you think caring for this child would be neither GOOD nor BAD thing to do, place a cross in number 3
If you think caring for this child would be a SOMEWHAT bad thing to do, place a cross in number 4
If you think caring for this child would be a VERY BAD thing to do, place a cross in number 5

MAKE ONLY ONE CROSS FOR EACH STATEMENT

The following statements are about how other people important to you would feel about your caring for an orphan who is HIV positive and DOES have AIDS

1 People I respect would THINK that I should care for this child

1	2	3	4	5
strongly agree	agree slightly	don't know	disagree slightly	strongly disagree

2 If I were to care for this child, people I respect would

1	2	3	4	5
strongly approve	approve slightly	don't know	disapprove slightly	strongly disapprove

3 People I respect would WANT me to care for this child

1	2	3	4	5
strongly agree	agree slightly	don't know	disagree slightly	strongly disagree

4 With most things in life, I do what my husband/partner wants me to do (only answer this statement if you have a husband/partner)

1	2	3	4	5
always	sometimes	not sure	seldom	never

5 With most things in life, I do what my friends want me to do

1	2	3	4	5
always	sometimes	not sure	seldom	never

6 With most things in life, I do what other members of my family want me to do

1	2	3	4	5
always	sometimes	not sure	seldom	never

17 If this child is related to me, this would make it

1	2	3	4	5	
much easier	somewhat easier	would make no difference	somewhat more difficult	much more difficult	to care for this child

18 If this child is NOT related to me, this could make it

1	2	3	4	5	
much easier	somewhat easier	would make no difference	somewhat more difficult	much more difficult	to care for this child

19 If I can cope with the child's illness and death, this could make it

1	2	3	4	5	
much easier	somewhat easier	would make no difference	somewhat more difficult	much more difficult	to care for this child

The following statements are about your beliefs about caring for an orphan who is HIV positive and DOES have AIDS

20 I would be able to provide this child with unconditional love and care

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

21 I would be able to help this child come to terms with his/her illness and eventual death

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

22 I would be doing a good deed

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

23 My friends and family will reject me and my family if I care for this child

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

24 To care for this child would be a financial burden

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

25 This child would find it difficult to adjust to a new environment and a different family life

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

26 I will put myself and the rest of my family at risk for also contracting HIV/AIDS if I care for this child

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

27 To care for this child will put an emotional strain on me and my family

1	2	3	4	5
strongly agree	agree slightly	not sure	disagree slightly	strongly disagree

38 To place a financial burden on my family would be

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	neither a good nor bad thing to do	a somewhat bad thing to do	a very bad thing to do

39 To place myself and my family at risk of contracting HIV/AIDS would be

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	neither a good nor bad thing to do	a somewhat bad thing to do	a very bad thing to do

40 To cope with the child's illness and death would be

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	neither a good nor bad thing to do	a somewhat bad thing to do	a very bad thing to do

41 For this child to adjust to a new environment and a different family life would be

1	2	3	4	5
a very good thing	a somewhat good thing	neither a good nor bad thing	a somewhat bad thing	a very bad thing

The following statement are about your attitude towards caring for an orphan who is HIV positive and DOES have AIDS

42 For me to care for this child would be: (Please circle one number in each of the three sections for this question)

1	2	3	4	5
a very good thing to do	a somewhat good thing to do	don't know	a somewhat bad thing to do	a very bad thing to do

1	2	3	4	5
a wise thing to do	a somewhat wise thing to do	don't know	a somewhat foolish thing to do	a foolish thing to do

1	2	3	4	5
an enjoyable thing to do	a somewhat enjoyable thing to do	don't know	a somewhat unenjoyable thing to do	an unenjoyable thing to do

QUESTIONNAIRE 3.

This part of the questionnaire deals with YOUR views about orphaned children.

On the following pages, there are a number of statements that will need your responses. Instructions on how to complete the questionnaire are provided as you go through it. An orphaned child is described in the box below.

Please read this carefully before going on to the questionnaire.

The child in this part of the questionnaire has been orphaned because his or her mother has died of AIDS. It is unknown whether the child has other family members who would be willing, or even able to care for him or her. The child appears to have no-one to look after him / her and nowhere to go.

IMPORTANT INFORMATION:

In the questionnaire, you will see that I ask a number of questions about **caring for** an orphaned child.

Caring for an orphaned child would mean taking the child into your own home and treating him or her as you would your own children; providing him or her with food, shelter and clothing; schooling and medical care; and love, support, and guidance.

Your answers are confidential and your name does not appear anywhere on the questionnaire.

PLEASE TURN OVER AND CONTINUE ON THE FOLLOWING PAGES

vould be willing to care for the child if

the child has no known relatives or brothers and sisters	YES	NO
the child has relatives and/or brothers and sisters with whom the child would need to stay in contact	YES	NO
the child has relatives and/or brothers and sisters with whom the child need not stay in contact	YES	NO
at the same time I was asked to care for one or more of the child's brothers and/or sisters.	YES	NO

/ould be willing to care for the child if

the child is a member of my own family or extended *family e.g. my aunt's child*	YES	NO
the child is a neighbour or friend's child	YES	NO
the child is Black African and from the same clan as me i.e. has the same surname as me, but is not related to me	YES	NO
the child is not a member of my family nor a friend's or *neighbour's child*	YES	NO

/ould be willing to care for the child

only if there is a childcare agency or another family to care for the child should I no longer wish to care for him/her myself	YES	NO

Please remember to fill in your lucky draw ticket for a chance to win a grocery voucher to the value of R100

THANK YOU FOR YOUR TIME AND EFFORT

APPENDIX D: Pilot Study

A child has been orphaned or abandoned because his or her mother has died of AIDS or is very ill and is going to die of AIDS. It is unknown whether the child has other family members who would be willing, or even able to care for him / her. The child, and in some cases brothers and siters, seem to have no-one to look after them and nowhere to go.

In each of the questions below, please consider that you have decided you **would be willing to care for** this child and answer them with this in mind. By caring I mean taking the child into your own home and treating him or her as you do, or would do your own child/ren; providing food, shelter and clothing; schooling and medical care; and love, support and guidance.

QUESTIONNAIRE

1) If the child is tested to be **HIV negative** and seems healthy, what do you think would be the most important **advantages** of caring for the child - both for yourself and the child?

.....

.....

.....

.....

2) If the child is tested to be **HIV negative** and seems healthy, what do you think would be the most important **disadvantages** of caring for the child - both for yourself and the child?

.....

.....

.....

.....

3) If the child is tested to be **HIV positive** and may become ill and die in the near future, what do you think would be the most important **advantages** of caring for the child - both for yourself and the child?

.....

.....

.....

.....

4) If the child iss tested to be **HIV positive** and may become ill and die in the near future, what do you think would be the most important **disadvantages** of caring for the child - both for yourself and the child?

.....

.....

.....

.....

5) If the child is tested to be **HIV negative** and seems healthy, what things do you think would make it **easy** for you to care for the child?

.....

.....

.....

.....

6) If the child is tested to be **HIV negative** and seems healthy, what things do you think would make it **difficult** for you to care for the child?

.....

.....

.....

.....

7) If the child is tested to be **HIV positive** and may become ill and die in the near future, what things do you think would make it **easy** for you to care for the child?

.....

.....

.....

.....

8) If the child is tested to be **HIV positive** and may become ill and die in the near future, what things do you think would make it **difficult** for you to care for the child?

.....

.....

.....

.....

9) If the child is tested to be **HIV negative** and seems healthy, what people important to you would **approve** of your caring for the child

.....

.....

.....

.....

10) If the child is tested to be **HIV negative** and seems healthy, what people important to you would **disapprove** of your caring for the child

.....

.....

.....

.....

11) If the child is tested to be **HIV positive** and may become ill and die in the near future, what people important to you would **approve** of your caring for the child

.....

.....

.....

.....

12) If the child is tested to be **HIV positive** and may become ill and die in the near future, what people important to you would **disapprove** of your caring for the child

.....

.....

.....

13) If you are already caring for a child / children that are not your own, what do you **like** most about caring for the child / children?

.....

.....

.....

14) If you are already caring for a child / children that are not your own, what do you **dislike** most about caring for the child / children?

.....

.....

.....

.....

What is your age? .....

What is your occupation? .....

How many children do you have? .....

How many of these children are not your own? .....

APPENDIX E, page 1

COMPARISON BETWEEN RESPONDENTS WHO INDICATED A WILLINGNESS &/OR UNWILLINGNESS TO CARE FOR EITHER AN HIV-NEGATIVE OR HIV-POSITIVE ORPHAN

	HIV-negative Orphan		HIV-positive Orphan	
	YES	**NO**	**YES**	**NO**
Willingness to Care	76.25%	23.75%	62.20%	37.80%
	N = 61	N = 19	N = 51	N = 31
Adoptive Parents	88.57%	11.43%	47.06%	52.94%
	N = 31	N = 4	N = 16	N = 18
Foster Parents	70.27%	29.73%	77.27%	22.73%
	N = 26	N = 11	N = 34	N = 10
Mean Age				
Respondents	46.26 years	50.32 years	46.88 years	44.60 years
	N = 58; SD = 12.27	N = 16; SD = 11.87	N = 49; SD = 9.77	N = 30; SD = 10.81
Partners	43.78 years	51.50 years	46.03 years	43.50 years
	N = 36; SD = 10.25	N = 10; SD = 14.07	N = 30; SD 8.63	N = 22; SD 10.38
Married or With Partners	62.07%	62.50%	61.22%	73.33%
	N = 36	N = 10	N = 30	N = 22
Length of Relationship	17.33 years	15.30 years	19.39 years	16.08 years
	N = 36; SD = 11.61	N = 10; SD = 5.77	N = 30; SD = 9.44	N = 22; SD = 8.63
Household Density				
Mean No. > 18 years old	1.45 persons	1.53 persons	1.7 persons	1.23 persons
	N = 58; SD = 1.42	N = 15; SD = 1.36	N = 47; SD = 1.44	N = 30; SD = 1.43
Mean No. Rooms	4.54 rooms	3.67 rooms	4.02 rooms	4.75 rooms
	N = 59; SD = 2.36	N = 15; SD = 1.45	N = 50; SD = 2.26	N =30 ; SD = 2.62
Mean No. Employed	1.46 persons	1.36 persons	1.33 persons	1.23 persons
	N = 56; SD = .83	N = 14; SD = .84	N = 49; SD = 1.01	N =30 ; SD = .63
Household Income Bracket				
Mean	R5001-8000 p.m.	R1001-2000 p.m.	R2001-5000 p.m.	R5001-8000 p.m.
Mode	>R10000 p.m.	1001-2000 p.m. an	>R10000 p.m.	>R10000 p.m.
	N = 49	>R10000 p.m.	N = 46	N = 28
		N = 12		
Home Language				
English	80.49%	18.42%	55.26%	44.74%
	N = 33	N = 7	N = 21	N = 17
Xhosa	70.83%	28.57%	80%	20%
	N = 17	N = 6	N = 12	N = 3
Afrikaans	73.33%	23.08%	64%	36%
	N = 11	N = 3	N = 18	N = 10

APPENDIX E, page 2

COMPARISON BETWEEN RESPONDENTS WHO INDICATED A WILLINGNESS &/OR UNWILLINGNESS TO CARE FOR EITHER AN HIV-NEGATIVE OR HIV-POSITIVE ORPHAN

	HIV-negative Orphan		HIV-positive Orphan	
	YES	NO	YES	NO
Mean Education Level				
Respondents	Std 8	Std 7	Std 7	Std 8
	N = 58	N = 16	N = 50	N = 19
Partners	Std 8	Std 8	Std 7	Std 9
	N = 43	N = 9	N = 32	N = 23
Matriculation				
Respondents	52%	25%	42.00%	67.86%
	N = 30	N = 4	N = 21	N = 19
Partners	58%	66.67%	46.88%	73.91%
	N = 25	N = 6	N = 15	N = 17
No After School Qualifications				
Respondents	53.45%	62.50%	62%	43%
	N = 31	N = 10	N = 31	N = 12
Partners	47%	66.67%	56%	35%
	N = 20	N = 6	N = 18	N = 8
Some After School Qualification				
Respondents	18.96%	25.00%	32%	25%
	N = 11	N = 4	N = 16	N = 7
Partners	34.88%	22.22%	15.63%	21.74%
	N = 15	N = 2	N = 5	N = 5
University Degree				
Respondents	27.59%	12.50%	6%	32%
	N = 16	N = 2	N = 3	N = 9
Partners	18.60%	11.11%	28.13%	43.48%
	N = 8	N = 1	N = 9	N = 10
Employment Category				
Respondents: Mode	Unemployed	Unemployed	Unemployed	Unemployed
	37.50%	62.50%	56%	47%
	N = 21	N = 10	N = 28	N = 14
Partners: Mode	Semi-skilled Service & Manual	Semi-skilled Service & Manual	Professional & Semi-Professional	Semi-skilled Service & Manual
Religious Affiliation				
Christian, Muslim or Jewish	92%	93.75%	96%	93%
	N = 51	N = 15	N = 49	N = 27

APPENDIX E, 3

COMPARISON BETWEEN RESPONDENTS WHO INDICATED A WILLINGNESS &/OR UNWILLINGNESS TO CARE FOR EITHER AN HIV-NEGATIVE OR HIV-POSITIVE ORPHAN

	HIV-negative Orphan		HIV-positive Orphan	
	YES	NO	YES	NO
Frequency of Religious Ceremony Attendance	1p.w. or more 64.27% N = 36	1p.w. or more 73.33% N = 11	1p.w. or more 80.38% N = 41	1p.w. or more 68.97% N = 20
Mean No. of Siblings	4.33 siblings N = 56; SD = 3.18	4.62 siblings N = 13; SD = 3.10	5.46 siblings N = 46; SD = 4.72	3.93 siblings N = 28
Quality of Own Childhood				
Very or mostly happy	83.92% N = 47	86.67% N = 13	84% N = 43	77% N = 23
Mean No. of Children < 16 years old	2.2 children	2.19 children	2.65 children	1.55 children
Relationship of Children to Respondents				
Biological children	27.00% N = 15	31.25% N = 5	27.00% N = 15	21.43% N = 6
Related foster children	23.00% N = 13	18.75% N = 3	27.00% N = 15	10.71% N = 3
Non-related foster children	31.00% N = 17	50.00% N = 8	43.75% N = 21	25.00% N = 7
Adopted Children	55.00% N = 31	25.00% N = 4	33.33% N = 16	64.29% N = 18
Caring Experience				
Presently caring: Respondent	5.08% N = 3	-- N = 0	12% N = 6	3.33% N = 1
Cared in the Past: Respondent	5.08% N = 3	5.26% N = 1	6% N = 3	3.33% N = 1
Presently Caring: Family	3.39% N = 2	-- N = 0	12.00% N = 6	3.33% N = 1
Cared in the Past: Family	-- N = 0	-- N = 0	10.00% N = 5	-- N = 0
Presently Caring: Friends	16.95% N = 10	10.53% N = 2	28% N = 14	10.00% N = 3
Cared in the Past: Friends	20.34% N = 12	5.26% N = 1	24% N = 12	10.00% N = 3

APPENDIX F , page 1

CHILD CHARACTERISTICS

	HIV-Negative Orphan %	N	HIV-Positive Orphan %	N	Significant differences Between HIV-negative and HIV-positive orphans
GENDER					
Female	91.80	56	91.84	45	
Male	83.61	51	69.38	34	
AGE					
0 - 1 years	75.00	45	65.00	32	
i) Respondents' Mean Age	(43.79 years)		(47.52 years)		
ii) Adoptive Parents	90.00	27	73.33	11	
iii) Foster Parents	65.38	17	57.58	19	
1 - 6 years	60.00	36	69.39	34	
i) Respondents' Mean Age	(49.97 years)		(50.38 years)		
ii) Adoptive Parents	53.33	16	66.67	10	
iii) Foster Parents	61.54	16	66.67	22	
6 - 10 years	26.67	16	48.98	24	$X^2=5.78$; $p<.05$
i) Respondents' Mean Age	(53.07 years)		(48.92 years)		
ii) Adoptive Parents	13.33	4	53.33	8	$X^2=8.18$; $p<.01$
iii) Foster Parents	34.62	9	45.45	15	
10 - 16 years	21.67	13	32.65	16	
i) Respondents' Mean Age	(57.92 years)		(48.06 years)		
ii) Adoptive Parents	7.00	2	40.00	6	$X^2=7.60$; $p<.01$
iii) Foster Parents	37.77	8	33.33	11	
CULTURE / RACE					
Same	91.53	54	78.00	39	$X^2=3.95$; $p<.05$
i) English-speaking	100.00	32	85.00	17	$X^2=5.09$; $p<.05$
ii) Xhosa-speaking	81.25	13	83.33	10	
iii) Afrikans-speaking	81.82	9	66.67	12	
Different	61.02	36	78.00	39	
i) English-speaking	65.68	21	95.00	19	$X^2=5.98$; $p<.05$
ii) Xhosa-speaking	56.25	9	75.00	9	
iii) Afrikans-speaking	18.18	2	61.11	11	
SOCIAL CLASS					
Poorer	94.83	55	98.00	49	
Same	87.72	50	80.00	40	
Better	77.19	44	66.00	33	
PRESENCE / CONTACT WITH RELATIVE / SIBLINGS					
None	93.33	56	94.00	47	
i) Adoptive Parents	100.00	31	93.33	14	
ii) Foster Parents	88.46	23	94.12	32	
In Contact	64.41	38	68.00	34	
i) Adoptive Parents	64.52	20	86.67	15	
ii) Foster Parents	68.00	17	61.76	21	
No Contact	59.32	35	64.00	32	
i) Adoptive Parents	64.52	20	73.33	11	
ii) Foster Parents	60.00	15	58.82	20	
Simultaneous Care of Sib	37.29	22	48.00	24	
i) Adoptive Parents	29.03	9	33.33	5	
ii) Foster Parents	52.00	13	70.59	24	

APPENDIX F, page 2

CHILD CHARACTERISTICS

	An HIV-Negative Orphan		An HIV-Positive Orphan		Significant differences Between HIV-negative and HIV-positive orphans
	%	N	%	N	
RELATIONSHIP TO CHILD					
Family	81.03	47	80.00	40	
i) Adoptive Parents	90.00	27	93.75	15	
ii) Foster Parents	72.00	18	70.59	24	
iii) English-speaking	93.55	29	95.25	20	
v) Afrikaans-speaking	[illegible]	[illegible]	[illegible]	[illegible]	
Friend's/Neighbour's	36.21	21	70.00	35	$X^2=12.28$; $p<.01$
i) Adoptive Parents	20.00	6	11.00	13	$X^2=18.22$; $p<.01$
ii) Foster Parents	48.00	12	58.82	20	
iii) English-speaking	19.35	6	90.00	18	
iv) Xhosa-speaking	52.94	9	66.67	8	
v) Afrikaans-speaking	60.00	6	50.00	9	
Stranger	23.73	14	84.00	42	$X^2=39.36$; $p<.01$
i) Adoptive Parents	13.33	4	93.33	14	$X^2=26.67$; $p<.01$
ii) Foster Parents	23.08	6	82.35	28	$X^2=21.08$; $p<.01$
iii) English-speaking	16.13	5	95.00	19	$X^2=30.35$; $p<.01$
iv) Xhosa-speaking	29.41	5	91.67	11	$X^2=11.02$; $p<.01$
v) Afrikaans-speaking	36.36	4	66.67	12	
ALTERNATIVE CARE OPTIONS	37.29	22	51.02	25	
i) Adoptive Parents	26.00	8	20.00	3	
ii) Foster Parents	48.00	12	60.61	20	
DURATION OF CARE					
Child Self-Supporting	32.20	19			
i) Adoptive Parents	12.90	4			
ii) Foster Parents	60.00	15			
Child's / Own Life	93.33	56			
i) Adoptive Parents	96.77	30			
ii) Foster Parents	88.46	23			