GUARDIANSHIP IN THE TIME OF HIV/AIDS – REALITIES, PERCEPTIONS AND PROJECTIONS.
(A mental health viewpoint).

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EXECUTIVE SUMMARY

INTRODUCTION

There is growing concern both nationally and internationally regarding "Africa's Orphaned Generations" (UNICEF, 2004). The HIV/AIDS pandemic will leave millions of children without their parents or primary caregivers. In South Africa alone, it has been estimated that in 2002 there were around 800 000 children under 18 who had lost a mother and that, without significant behaviour change and interventions, by 2015 three million children would be maternal and 4.7 million paternal orphans. The total number of children under 18 who would have lost one or both parents has been projected to peak at around 5.7 million (Johnson and Dorrington, 2001). Hence around a third of all children in South Africa would have lost one or both parents.

The impacts of this state of affairs on both the children concerned and society is enormous. However an area that has received relatively little attention is the potential mental health impacts. While some research on this has started in African countries (for example in Uganda, Tanzania, Zimbabwe, Zambia, Congo and South Africa), thus far the information is inadequate to lead to clear policies and interventions. Moreover, because the peak of orphanhood in most countries is still some years off, studying current mental health impacts may not reflect the cumulative problems that may arise when a much larger number of children are left without parents.

Nonetheless, from the studies that have been conducted and many years of tested science and theory of child development, it is clear that without stable homes and families, the emotional health of many children is likely to be severely compromised and interventions to assist with this are urgently needed.

More research is also required. For example research to establish psychological impacts more clearly and to develop and evaluate counseling models or medical interventions are essential. However, from a public health perspective a key questions is how mental health problems can be *prevented* rather than only examining more curative interventions. Plainly, helping people stay HIV negative and keeping parents who are positive alive for as long as possible are "good mental health interventions". The next preventive level down from this though, is to ensure that orphaned or vulnerable children are placed in locations that are conducive to good emotional and cognitive development. In most cases this would be guardianship within stable and caring homes and families – be this nuclear, extended, single parent or other family form.

But will families firstly be willing and secondly able to incorporate children into their homes and families? This research focuses substantially on this critical issue. (While it is acknowledged that incorporation into a family is not per se going to prevent mental health problems from developing and in some cases may make things worse if they

exploit and abuse a child who has been brought in, nonetheless families offer the greatest opportunities for growth, development and psychological well-being).

METHODOLOGY

The research focused on three main areas 1) Current household configurations with respect to children in the household – especially non-biological children 2) Views of current caretakers with respect to a (hypothetical) situation where they were no longer able to take care of their children/children in their care and 3) Perspectives of adults regarding taking in and caring for children of different "relational proximity" to them. Respondents were presented with various "incentives" and asked whether these would make a difference to their decision of whether to take in a child or not.

One thousand four hundred (1400) adults in 10 areas (representing rural "tribal", rural farming areas, urban suburb/township and urban informal settlement areas) were interviewed. Interviews were conducted in three provinces where the prevalence of HIV/AIDS has been found to be high i.e. Gauteng, Free State and Kwa-Zulu/Natal.

Selection of sites was conducted using the Geographic Information Systems (GIS) mapping process and households were randomly selected within these areas. The vast majority of respondents were African (98.5%) while 63.3% were women and 36.7% men. Depending on their relation to children, respondents were interviewed in one or more role/category. Interviews took place in English, Sotho or Zulu depending on the preference of the interviewee.

Ethical consent to conduct the research was obtained and respondents were required to give their informed consent to be interviewed. Moreover respondents were each provided with the details of a psychological counselor in their area, in case the questions provoked emotional responses that they found difficult to deal with. The questionnaire was designed specifically for this study.

RESULTS

An important feature of most of the respondents in this study, with important implications for the placement of orphaned children, is the extremely poor economic situation they are in. Almost 40% were unemployed (looking for work), 15% were pensioners whilst under 20% were in full time employment. In urban areas and rural 'tribal" areas (full time) employment was only a little over 10%. For 95% of respondents there was either not enough money for basic goods in their home or only money for food and clothes, but nothing available for other expenses that may accrue.

Seventy five percent (75%) of respondents had children living with and dependent on them. Of these 30% had dependents that were not their biological children. The majority of these were children staying with grandparents (67%), while 30% were staying with another family member.

The two main reasons why children were not staying with their biological parents were the death of a parent (29%) and financial need due to the parent being unemployed (27%). Where the death of the parent was the reason, 30% reported that the reason for this was HIV/AIDS. TB accounted for a further 10% while 7% reported unspecified reasons such as a "long illness".

Relative to the sample, pensioners had disproportionately high numbers of non-biological children staying with them while unemployed people had low proportions.

When respondents with children in their care were asked what may happen if they were no longer able to look after the children, 64% identified someone who would look after the child/children. However 16% merely said that "life would be very difficult for them", 6% did not know what might happen, 3% said the government would look after them and 2% said the child would become mentally unwell or that they would become a criminal or street child.

There was a strong "match" between the person that the caregiver identified as the person who the child would go to and the person whom they would want the child to go to.
Married men/men living with a partner were far more likely to say that their partner would look after the child (58%) than vice versa (30%). For most respondents adoption was not considered to be a feasible option for their children, however people with more education were more likely to accept this possibility than people with no or little education.

A substantial number of people in various "proximal relations" to the child believed that they would take in and care for children if the primary caregiver was no longer able to.

	Grand Parents N = 305	*Fathers* N = 294	*Other adults in household* N = 325	*Siblings* N = 849	*Best friends* N = 1391
I will raise them myself	59%	65.6%	35.4%	49.2%	17.25%
Family will care for them	20.2%	21.3%	35.3%	31.5%	42.6%
Life will be difficult	9.2%	6.8%	13.8%	7.3%	11.1%
Government will take care of them	2.3%	0.7%	2.1%	2%	8.2%
Will become mentally disturbed	1.3%	3.1%	3.1%	1.8%	1.2%
Will become street child/criminal	1%		1.2%	1.3%	2.1%
Don't' know	4.6%	0.7%	4%	3.1%	12.3%

Moreover 62% of respondents said that they would look after children who may be orphaned by AIDS if there was no family member to look after them.

Fathers and grandparents, as the two groups identified as most likely to take in children, were asked what additional stressors looking after/taking in children would have on them. For the majority, the first stress identified was financial. For fathers this was followed by anxieties about raising a child and stressors on the child living without a mother. Most fathers (67%) and grandparents (87%) said they would need financial assistance of some kind if they were to take on (additional) child responsibilities.

While there were some differences between the various groups interviewed with regard to what incentives would make a difference to their decision on whether to take in a child/child or not a clear pattern emerged across groups. For a relatively small group of people receiving a grant of R170 (the current child-care support grant) would make a difference. However, for each group a (hypothetical) amount of R600 shifted views significantly - with many more people reporting that they would be likely to take in a child. Moreover the numbers of people who would be positively influenced to take in a child rose significantly between R600 and R1000. Incentives made most difference to poorer people - with higher incentives making most difference the poorer the person is.

Importantly, it was not merely monetary gain but also having the child's full education paid for (including fees, uniforms, books etc) or having a trained and caring person come to visit from time to time to assist with problems the person may be having with the child, which acted as strong incentives. In fact there was very "strong agreement" for most people regarding the value of receiving R1000 relative to getting education paid for. Moreover having a person assist "swayed" people's views to taking in a child far more than R170 and in a number of instances more than R600.

For some respondents the age of the child and whether they were HIV positive would make a difference to their decision on whether to take in a child or not.

	Fathers	Grandparents	Adults in household	Aunts/ uncles	Best friend	"Stranger"
HIV status	15%	17%	27%	20%	28%	29%
Age of child	26%	30%	41%	35%	48%	46%

Men, in particular, reported that they would be reluctant to care for younger children.

MAIN IMPLICATIONS OF FINDINGS AND RECOMMENDATIONS

- Over the coming decades the placement of orphaned children in stable and caring families and homes will be an extremely important mental health intervention for a potentially very large population of children.
- Current guardianship options of foster care, residential care and adoption appear to be inadequate to meet the needs arising as a result of the HIV/AIDS pandemic.
- The extended family is already bearing much of the responsibility of children following AIDS deaths. However strains on these families, particularly (though not limited to) financial stress, are stretching these resources. It appears that without assistance, traditional means of caring for children are likely to reach a "breaking point" for many families.
- There is a good "fit" between whom the caregivers think will look after their children and potential caregivers themselves. However, there are a group of children who are unlikely to be caught into any family "net" if their parents are unable to look after them.
- There is a very strong willingness from fathers, grandparents, aunts/uncles, other adults living in households, friends and even "strangers" to take children in if their primary caregiver is no longer able to. However this "willingness" may be tempered by the numbers of children involved and, particularly, financial constraints.
- For most people a grant of R170 will not make a significant difference to their decision on whether to take in a child or not. However R600 will make a lot more difference and R1000 a substantial difference. Other assistance in the form of having education paid for or having a person assist are also regarded as strong incentives.
- Fathers have a potentially very important role to play in bringing up their children - especially if the mother cannot. Fathers see themselves as taking this role to a far greater degree than is perceived by the mothers of these children.
- The likelihood of extended family and other potential caretakers taking in and caring for children may be substantially assisted if financial and/or other incentives are provided to them.
- Despite adoption being uncommon in Africa, and most caregivers not wanting this option, a large number of adults expressed a willingness to take in children of "strangers".
- For some people the age and the HIV status of the child would make a difference. This is likely to make the placement of positive children and younger children more difficult than negative children/children where status is unknown and children over 5 years old.

Recommendations

- Guardianship options need to be thoroughly re-assessed to accommodate the needs of the HIV/AIDS pandemic.
- Placement of children in families, even within extended families, needs to be accompanied by programmes that monitor potential exploitation and abuse and, where appropriate, action taken against offenders.
- Extended families need to be assisted in the process of taking care of an increasing number of children in need. This includes continuity planning for the children while they are still in their families of origin.
- Some children will not be accommodated within extended families. As this number is likely to grow to substantial numbers, special social programmes are required. This may include interventions such as public education and providing incentives which encourage people who are not family members to incorporate children.
- Where children remain in child-headed households, communities must be mobilised to provide emotional as well as physical assistance to them.
- Fathers can play a very important role with respect to maternal orphans. Services, and possibly grants, which facilitate active paternal responsibility must be developed.
- Financial grants and services such as having education paid for and having a person assist from time to time should be provided as these would "sway" people of various relationships to the child/children to take them into their homes and families. It would also allow then to cope with the additional burden more easily. While this will be a costly process, it is likely to be a highly cost-effective intervention.
- Grants will have to be of sufficient value as to act as "incentives" or they will not assist in having children placed in families.
- If grants and services cannot be provided to all people taking in children, the poorest should be targeted for grants.
- In order to effectively place children who are living with HIV/AIDS, special support systems will have to be put in place for these families. For example having a trained person visit to assist with problems they may be having would be important.

CHAPTER I

GUARDIANSHIP AND MENTAL HEALTH IN THE ERA OF AIDS

INTRODUCTION

What is to happen to the millions of children of parents/caretakers who die a premature death in Sub-Saharan Africa? In particular what will happen to the mental health and emotional well being of these children? These vexing questions currently arise in the context of an amalgamation of three critical realities i.e. HIV/AIDS, poverty and shifting patterns of migration/urbanization.

Talking about "the mental health of orphans" as if they were an homogenous group is empirically wrong. Clearly, the mental health status and development of children who are orphaned is subject to genetic, biological, social and psychological factors - as far as these things are separable - in the same way as every other child is subject to such internal and external forces. What these factors are and how they merge within a human agent is what is important. Certainly, living "orphanhood" is very different things to different people in terms of the environment they are placed, the meaning attributed to their status (by themselves and others), the nurturance and stability they receive and so on. There is thus no standard or category into which the "mental health or orphans" can be put and interventions need to heed the differences.

Where orphaned children spend their developing years and how they are treated and supported *is* important to psychological outcomes. It is reductionist to assert the formula "good environment, good psychological outcome; poor environment poor psychological outcome" however, there are external conditions *which facilitate or inhibit* good emotional health and the absence of psychopathology. For this reason the question of what will happen to the mental well being of children orphaned by HIV/AIDS is inexorably tied to the more general question of what will *structurally* happen to them.

This research is particularly concerned with this issue. While, as mentioned, mental disorder and emotional well being are not subjects which easily lend themselves to simple cause and effect explanations, there are certain established basic conditions which promote human emotional well-being. Pertinently, for a child, *being part of a caring, stable and non-abusive environment which provides sustenance and support is a critical advantage for good emotional development.*

From a "public mental health" perspective then, placing orphans in healthy environments becomes vital – perhaps having priority even over counseling to children who have been emotionally scarred by inadequate or no family support or structure.

Death of parents before their children are of an age to live independent lives is not new. Disease, war, natural disasters, homicides, accidents and death from other natural and unnatural causes have typified human history and have left many children without one or both parents. The mental health consequences of such circumstances have received some attention, prominently in relation to survivors of the holocaust and more recently other situations of extreme violence (Dawes and Donald, 1994). The idea of "inevitable damage" has been thoroughly discredited, however the "supports" that people received, pre, at and post the events seems to make a profound difference (See mental health and orphans). Different societies and cultural groupings have had, or have during times of crisis developed, ways of coping with children who have lost parents – including, for example, integration within extended families, adoption, fostering and orphanages.. Currently the question facing many sub-Saharan countries is how best to place and deal with the millions of children left parentless within the context of the abovementioned triage of AIDS, poverty and urbanization/migration.

Who are orphans and why the concern?

"AIDS orphans" as an independent category deserving special social and economic attention has largely been debunked (Skinner et al, 2004)). The stigma of such separation from other needy children, the similar needs of children who have lost parents to other

causes and concern around the "vulnerability" of many children living in adverse circumstances (such those living with a chronically ill parent, abused children, disabled children and street children) has resulted in the use of the more correct concept of "Orphans and vulnerable children" (OVC). However this particular research does not cover all OVC but focuses specifically on concerns around the placement of children where "something terrible has happened to the parent/caregiver and they are no longer able to look after the child".

At what age a child becomes a young adult, and hence is no longer included in child statistics, or requiring special child oriented assistance, is debatable and confusing. and varies across different contexts and cultures. There are divergent constructions of children's rights, duties, needs and what constitutes emotional vulnerability (Dawes and Donald, 1994). Age categories are historical and cultural constructs and any universal attempt to make cut-offs is for convenience only. For example in one culture or historical time it would be appropriate for a person of 17 to have children and/or be heading a household, in other cultures and times this would be seen as socially and psychologically calamitous. The question then arises, who should be included as children when it comes to caring for children following the death of a parent/caregiver?

Ideally "childhood", and hence orphanhood, should be defined within local communities in each case and comparisons across situations would then not need to be age dependent, however this is impractical and an "age proxy" for childhood becomes imperative. An orphan is defined by UNAIDS as a child under 15 years of age who has lost their mother ("maternal orphan") or both parents ("double orphan") (UNICEF/UNAIDS, 1999). According to Skinner, Tsheko, Mtero-Munyati et al (2004) it is becoming more generally accepted that the loss of a father would also warrant classification of a child as an orphan. In South Africa an orphan is defined in the draft Children Bill as "a child (under 18 years old) who has no surviving parent caring for him or her after one of them has died or abandoned him/her". Within the AIDS context specifically the Department of Social Development defines an orphan as "a child under the age of 18 years whose primary caregiver has died" (Department of Social Development, undated [assumed 2002]).

UNICEF reports that there are currently more than 34 million orphans in sub-Saharan Africa – 11 million of them orphaned by AIDS (UNICEF, 2003). They estimate that around 12% of all children in the region are orphans with as many as 20% orphaned in some countries. However, they assert that the real "crisis" is only just unfolding. They predict that as to-days young adults die in growing numbers, they will leave even larger numbers of children behind. By 2010 HIV/AIDS alone will leave around 20 million children under the age of 15 without one or both parents. In South Africa in 2002 it was estimated that there were around 800 000 children under 18 who have lost a mother and that by 2015 three million children would be maternal and 4.7 million paternal orphans (though this could change significantly with interventions such as anti-retroviral treatment). The total number of children who would have lost one or both parents was calculated as 4.7 million (Johnson and Dorrington, 2001). According to the Medical Research Council around one third of children under the age of 18 will have lost one or both parents by 2015 if there are no changes in sexual behaviour and no significant health interventions (Bradshaw, Johnson & Schneider, 2002). Even when HIV prevalence is stabilized or decreases it is anticipated that orphan numbers will continue to grow, reflecting the time lag between HIV infection and death (UNICEF, 2003).

Due to the nature of the spread of HIV, if one parent is infected there is a high probability that the other parent will also be infected. Children thus risk losing both their parents within a fairly short time. UNICEF estimates that the number of "double orphans" in sub-Saharan Africa will almost triple between 1990 and 2010 (UNICEF, 2003).

According to UNICEF current age distribution is fairly consistent across countries. Around 2% of orphans are less then 1; 15% between 0 and 4 years old; 35% between 5-9 and 50% between 10-14 years old (UNICEF, 2003). This is fundamental to "placement programmes" as clearly the needs and requirements of children of different ages are vastly different.

The extended family – its securities and limitations

In Africa, the extended family is the traditional social security system where the members are responsible for the protection of the vulnerable, care of the poor and sick and the transmission of traditional social values and education (Foster et al 1997). It is widely accepted that most orphans would be cared for in extended families (Barnett and Whiteside) and the empirical evidence emanating from various African countries is currently clear - by far the majority of orphaned children are indeed living with extended family (Malinga 2002, Urassa et al 1997; Foster 1997 et al, Foster 2000, Ayieko, 1997, UNICEF 2003, Ansell and Young 2004, Ntozi 1997). However hopes that traditional African cultural norms, including the extended family and "ubuntu" would be sufficient to absorb the full social, economic and psychological impacts arising from the AIDS epidemic seem to be unrealistic (UNICEF). There are many reasons for this - not least of which are poverty and migration/urbanization. Even without HIV/AIDS, many people in sub Saharan Africa only just cope. Many people live below the poverty line and in social conditions of miserable housing, inadequate nutrition and poor health care and education. Any additional pressure on the family, such as an extra mouth to feed, one less income, or a family death, substantially strains the family resources (financially, socially and emotionally(Foster, 2002). With HIV/AIDS such pressures may be inflicted on a family many times over.

It is unrealistic to believe that without any additional assistance, poor families will be able to absorb all the effects of HIV/AIDS (including incorporating AIDS orphans) without reaching a "breaking point" which has consequences both within and outside of that family (UNICEF). The accumulated effects impact on whole communities, further weakening whatever social support structures may previously have been available to individual families and children. As Foster (2000) puts it "AIDS wears down extended families' resources over a period of several years, at the same time as the number of orphans is increasing. The extended family is not a social sponge with the infinite capacity to soak up orphans" (pg 55). Moreover, conditions in rural areas have become dire for millions of people resulting in large movements to cities and towns. This has

resulted in massive social shifts in life-style, in kinship relations, in people's ability to carry out cultural traditional rituals and roles and in family cohesion and stability[1].

Furthermore the extended families into which the children are placed are often physically or culturally far from the place from which the child originates (for example from urban to rural or vice versa), sometimes resulting in further trauma for the child (Ansell and Young, 2004). Migrations to extended family have also been found to not always be permanent. Reasons for this are predominantly that the child feels ill treated in their new family or changes in the circumstances (economic, death or other) of the guardian. The long-term stability of the relationship is often not considered when family placements are made soon after the death of the parent (Ansell and Young, 2004). Moreover with the HIV epidemic, placements with extended family members may be serially interrupted by the death of new and subsequent guardians.

Other difficulties which have been found within extended families are that the caregiver may be too old or too young to properly care for the orphaned children (Sengendo and Nambi, 1997). Hunter (1990) noted that this led to poor discipline and inadequate socialization. Guardians' within the extended families are themselves having to cope with the alarming rate of loss of their own supports, to HIV, further eroding personal resources to absorb and care for another young family or community member in the family. Bledsoe reported that adopted or fostered children were also often given worse treatment than the biological children in the family (in Sengendo and Nambi, 1997).

Extended families are also sometimes not able to incorporate all the siblings into a single family. According to Malinga (2002) separation of siblings adds to the psychological

[1] This is not to say that due to the AIDS "crisis" traditional and cultural practices should be discarded with regard to orphaned children; on the contrary it is essential that such practices are respected and built upon wherever possible. However, new innovations are required which are linked with what people know, feel comfortable with and with practices which give them meaning. Moreover, "culture" is not static and in fact the ways in which societies choose to deal with parentless children over the coming decades, will be central to the norms of the evolving "culture".

trauma. Following the death of a parent children rely heavily on each other and the grief is compounded if the children are forced to live in different households.

Orphanhood and mental health

Research into the mental health impacts on AIDS orphans has been limited. Moreover, as stated previously "AIDS orphans" are by no means a homogenous group and, for example, whether a person is integrated into their extended families, whether he or she is part of a child-headed household or whether he or she lives on the street is likely to have bearing on his or her well-being. A further crucial issue is whether measuring the psychological functioning of orphans in the current context helps to answer the question of what the likely impacts will be at the height of the crisis, in say ten years time.

The impacts may not merely be differences in number or degree, but in kind. For example, following the death of one of her children a grandmother may be able to take in, care for and provide emotional support to the children of this child; but what if three of more of her children were to die - with perhaps three of more children each who need to be cared for? While the grandmother may have the financial and emotional resources to deal with three children, with 9 or more she may not have adequate resources *for any of them*. Hence measuring the psychological functioning of the three children may bare little resemblance to the same three children being brought up in a situation of a family of ten children! Furthermore, what would occur if the grandparent herself were to die; finding caring homes will obviously be much more difficult the larger the number of children involved. It has been argued elsewhere that the full emotional impacts of the HIV/AIDS pandemic are likely to be "more than the sum of the parts" (Freeman 2004); seemingly the emotional impacts of orphanhood in the future too are likely to differ substantially from what can possibly be measured through looking at functioning of orphaned children today.

Nonetheless it is important to briefly review some of the existing theory and research concerning mental health and orphanhood. There are three important situations that may be anticipated as being crucial points, i.e. living with the ill parent, death and mourning and living as a parentless child.

The following sections are of necessity generalized. It has been previously emphasized that "AIDS orphans" differ in many ways and clearly situational, personal, cultural, and very importantly age differences will play a huge role in how children deal with their situations. There are also "degrees" of mental health/illness which receive little consideration in most current research in the area. "Distress", levels of "unhappiness" and even some anxiety and depressive symptoms are common to most people's lives and are surely appropriate in people living under conditions such as parental illness, death and new guardianship. These conditions may also be transient. Such circumstances should be differentiated from mental disorder which is much more severe and long lasting. While in the following sections there is an attempt to take some of these considerations into account, it is recognized that there are gaps, statements that may not apply universally and issues which are covered only very superficially.

Living with a person with HIV/AIDS

The psychological stressors for children who later become AIDS orphans usually begins a long time before the death of the parent(s). Given that AIDS is a chronic and deteriorating condition, children are likely to have experienced disrupted routines, unscheduled absences of their parent, and have seen, or even have nursed, their parent through distressing physical, behavioural, cognitive and emotional changes, often including severe debilitation (Geballe & Gruendel, 1998, Andiman In Wild, 2001). Moreover, as a result of their illness, parents would often not have had either the physical or the emotional resources required by the child - and thus may have found it very difficult to provide their children with a "secure base" during their period of illness. This could be exacerbated by the stigma attached to HIV/AIDS and the parent's feelings of guilt and anxiety about "abandoning" their children when they die (Wild, 2001).

Pequegnat and Szapoeznik (2000) remark that parents and children form an interdependent and interactive social unit such that when a parent becomes infected with HIV, the entire family is affected. Depending on the developmental phase of the child, vastly different feelings and reactions may be provoked by illness and specifically AIDS related illness. Lewis (1995), writing within the context of the United States, points to some of these responses. He suggests that a preschool child who has a parent or parents who are HIV positive may be cared for in a context of parental depression, unpredictability and erratic behaviour. The parent may at times become excessively protective, while at other times be absent for the child. As a result the child may develop an insecure or anxious attachment to the caregivers and a limited sense of self-worth. The child may withdraw and become apathetic and exhibit symptoms such as refusal to eat, temper tantrums and even failure to thrive. The child may also have difficulties forming and sustaining attachments with peers and adults.

With regard to a school age child, Lewis talks of the child potentially showing symptoms of depression and possibly oppositional and disruptive behaviours as a result of their disruptions at home and personal insecurities. In adolescence, he suggests that the child may develop strongly ambivalent feelings towards the dying and/or the surviving parent, manifesting in severe behavioural and psychological problems - including acts of destruction and assault and thoughts of suicide. He suggests that "the child or adolescent's fear of the outcome for the ill family member – as well as anxiety on his or her own behalf – may lead to counterphobic risk taking that includes, in adolescence, high risk sexual encounters and drug abuse". Parents who are ill may also have less control, especially over adolescent children at a time when clear parental guidelines and familial boundaries are essential for the adolescent to negotiate safe entry and assumption of broader social roles outside of the family

Hudis (1995) found that parents reported decreasing control over their children's behaviour as their illness deteriorated, partly because they were less able to supervise and partly because they were afraid that discipline would threaten their relationships with

their child. Having a dying parent may also mean having to drop out of school with consequent changes in peer relations and support. Moreover the "girl child" may be particularly vulnerable as they are most likely to shoulder care-giving responsibilities (Malinga, 2000).

There have been very few studies on psychological effects suffered by children in developing countries. However, again in the USA, Collins-Jones (in Wild 2001) found that as a group, children who had multiple families members diagnosed with HIV had clinically raised levels of psychological distress. Pivnick and Villeges (2000) found that children of HIV positive women suffered from heightened feelings of anxiety and depression, had difficulties eating and presented with somatic complaints such as migraines, stomach aches and headaches. Forehand et al. (1999) found that children of HIV positive mothers had poorer psychological adjustment than a control group. However another study by Landman (2001) found no such differences. The reason for this was seen to be related to factors such as family supports, the mother's health and the age of the children.

One African study, in Zambia, found that 82% of people caring for children noted changes in behaviour during parental illness. Children became worried, sad or too tired to help in the home and stopped playing in order to stay nearby. Compared with control children, these children were likely to become solitary, appear miserable or distressed and be fearful of new situations (Poulter quoted in Foster – responding to Makame, 2002). In Uganda, when their parents became sick, most children were reported to have feelings of hopelessness or anger and were scared that their parents would die (Sengendo and Nambi, 1997).

Death and mourning

Following the death of a parent most children will experience trauma and grief (Malinga 2002). A young child may experience and understand the death of someone they know and love as an abandonment which he or she may see being a result of his or her own misbehaviour. This experience evokes guilt which intertwines with feelings of anger,

sadness and loss (Lewis, 1995). However, according to Lewis, children often do not feel the full impact of death because they do not fully comprehend the finality of death. On the other hand if children are not given adequate opportunities to "work through" the death they could grow up with unresolved negative emotions which are expressed through anger and depression (Sengendo and Nambi, 1997). According to West et al (in Rotheram-Borus, 2001) with the death of only one parent, young children report increases in depression, anxiety conduct problems, academic difficulties, somatic complaints and suicidal acts. In reviewing over 500 articles over 10 years Rotheram-Borus et al report that clinicians found that parental death has substantial negative impact on adolescence. For adolescents the experience of loss at a time when he or she should be experiencing the difficult process of becoming independent from that parent presents unique difficulties (Demb, 1989). High-risk behaviour, depression and suicidal thoughts may result.

However expression of grief is culturally determined (Groce, 1995). In some cultures children are not permitted to grieve overtly as they are perceived to be too immature to understand such matters. Marcus reports that in Kwa-Zulu/Natal children are excluded from conversations about imminent or recent death as culturally such discussion is for elder people only (Marcus 1999). Whilst within most conventional western psychological theory such "unresolved grief" would be said to result in likely negative psychological consequences for the child; whether this is indeed true within the cultural context mentioned, has not been established.

In addition, clinical reports suggest that the process of grieving may be particularly difficult for children whose parents have died of AIDS (Wild 2001). There are usually a complicated set of material and psychosocial stressors which often accompany these deaths such as economic deprivation and disrupted schooling, Multiple losses, lack of adequate care and control and stigma, secrecy and social isolation (Wild 2001).

Being an orphaned child

The third layer that is spread onto the emotional experiences of having lived with an ill parent and having to deal with the death, is having to survive without the parent/caregiver. In reality these three levels cannot be easily separated and the degree to which the first two have been worked through will no doubt impact on how well a child is able to deal with their life following the loss of their parent/caregiver. Also, where the child has been placed, the levels of disruption to their living and social circumstances, whether they are able to continue with their education and previous life experiences will have a major influence on their psychological coping ability.

Studies examining mental health amongst orphans in developing countries are very limited and even more so with respect to AIDS orphans specifically. Sengendo and Nambi (1997) found that in Uganda orphans had a significantly higher depression and lower optimism about the future than a controlled group of non-orphans. Makame et al in Tanzania found that orphans had significantly higher "internalizing" problems than non-orphans (Makame, Ani & Grantham-McGregor, 2002). Thirty four percent reported that they had contemplated suicide in the past year. In a sample of 2 786 AIDS orphans in Tanzania there were 128 incidents of attempted suicide (nearly 5%) (Conroy cited in Bray, 2002). It is unknown what the incidence of suicide attempts in the general population is, however within a group of comparable non-AIDS orphans there were no suicide attempts.

In Mozambique, Manuel similarly found significantly higher depression amongst orphans than in non-orphans (Manuel, in Cluver & Gardner, 2003). They also found that orphans were more likely to be bullied and less likely to have a trusted adult or friends. In an unpublished study in the Cape Town area in South Africa Cluver and Gardner found that children orphaned by AIDS were more likely to see themselves as having no friends and having difficulties concentrating than matched controls. They also reported significantly higher levels of somatic symptoms and were more likely to have nightmares than their

counterparts. Seventy three percent of the orphans were shown to suffer from Post Traumatic Stress Disorder. The orphaned children did not exhibit more conduct or behavioural problems than non-orphans.

Using more qualitative methods, orphaned children have shown similar trends. Using focus groups, Foster, in Zimbabwe found that children reported anxiety, fear stigmatization from friends and community, depression and stress (Foster 1997). In Congo, examinations by clinical psychologists found that 20.1% of orphans presented with "psychological problems" (Makaya reported by Cluver & Gardner, 2003). Of these 34% had affective symptoms, 27% had problems with adapting and 37% had posttraumatic stress.

Do children need families for good emotional development?

Children thrive best where there is a caring, loving, holding, stimulating and stabilizing environment where they are taught values, culturally accepted norms and mores and are given life skills to deal effectively with the world into which they are born. These principles seem to be important in all childhood development stages. In conclusion of her extensively researched book "Resilience and Vulnerability" Suniya Luther states that "...investigators have consistently pointed to the critical importance of strong connections with at least one supportive adult: in many instances a primary caregiver, who is amongst the earliest, most proximal, and most enduring of socializing influences" (pg 432). Similarly Straker, Moosa, Becker and Nkwale (1992) in a thorough case study of youth during the violence in South Africa during the late 1980s concluded that the relationships developed over years within families largely determined how well the youth were able to emotionally deal with the crisis situation they were in and, more importantly, how they were likely to cope with their futures. The World Health Organization (WHO) have also emphasized the importance of early attachment, bonding and the need for a caring and stable home situation (WHO 1998).

However it is well recognized that being part of a family is not in itself a protective factor for psychological health, and certainly malfunctioning or abusive families may seriously damage children emotionally. Nonetheless families offer more opportunities for emotional sustenance and support and the passing on of social values than usually occur outside of them. *Whether such a family is nuclear, extended, has single or same-sex parents or takes some other form, and whether the caregivers are the biological parents of the child or not, all appear less important than that the above conditions for support and sustenance are present.* Within the framework of this research therefore "family" is used in a very broad sense, as indicating the child's primary unit of homecare and caregiver.

The need for the "supportive adult" or "primary caregiver" referred to by Luther (above) is most obvious the younger the child. Clearly infants are fully dependent on a caregiver for physical health and development but, research shows, are similarly dependent for emotional sustenance. Moreover, the links between emotional nourishment and physical thriving have been demonstrated (Ainsworth, 1978, Bowlby, 1988, Stern, 1998, Richter 2001). As the child grows, language, cognitive, moral as well as emotional development all occur within close relationships with adults ((Stern, 1985, Marschark, 1993, Richter, 2001).

Arguably, the older the child gets, the less need they have for adult caring and support, but this is not necessarily or always true:. Without being "universalist" about development, in many cultures one of the older child's, or adolescent's key developmental processes includes individuation and growing autonomy from adults. This requires adult modeling and supports within which these processes occur. Whether such adults are a necessary or merely a facilitative mechanism is equivocal, however the caring, loving, holding, stimulating and stabilizing environment certainly *assists* at this phase as it does in earlier developmental stages.

Who will be the 'adult' for children who have lost their primary caregiver?

The critical question in relation to children who have lost their primary caregiver then, is who will act as the "adult" in support of their development. Three categories will be discussed i.e. children who are integrated into homes or families which are headed by adults; children who are taken into institutional care and children who are part of child-headed households.

The first group is seemingly unproblematic as the relevant adult substitutes should fulfill the role of 'adult' for the children concerned. However it needs to be repeated that adults will not always be good providers of the physical or emotional needs of children, and indeed non-biological children integrated into such families may be exploited (Ansell and Young, 2004). Furthermore, where the adult is the father (or other male) who takes over the parenting role when a mother dies, often a lot of learning is required as male socialization often does not teach men to provide the nurturing and caring required by the child (Maybe add reference- from CYDF's fatherhood study?). While, for most children, it is mothers and related women who are the mainstay of support for affected children, it appears that surviving fathers are now taking more responsibility (Case et al in Richter, Manegold and Pather, 2004). If it is a grandparent who takes over the responsibility it may be that they are too old, or may feel too old to effectively take care of the child/children (Richter, Manegold and Pather, 2004). The numbers of children involved may act against good caring relationships and so on. Nonetheless an adult who can provide the necessary physical environmental support is available.

Secondly, children who are taken into institutional care. According to Save the Children, residential care should always only be utilized as a 'last resort" (Dunn et al, 2003). According to their many years of experience working with children from institutions, they assert that residential care can "threaten normal developmental processes and is a negative experience for many children....Children will often be deprived of the life skills that they would learn growing up in a family and may find it difficult to cope with life outside the institution' (pg 9). They assert further that in many countries children spend

their childhood without love, attachment or individual attention from adults. It would be wrong to assert that all children in residential care are deprived of the emotional support and sustenance of an "adult" as some institutions provide good quality care, even providing "house parents" who are available to the children for extended periods. Nonetheless there are serious limitations regarding the intensity of care and attention that most residential facilities can provide and the environment is often not conducive to good emotional development.

According to the South African Department of Social development " Every young person should be provided with the opportunity to grow up in their own family and where this is proved to be not in the interest of the child or not possible, to have a time-limited plan which works towards life-long relationships in a family or community setting" (Department of Social Development, undated, assumed 2002). According to Richter et al , though institutions have been rejected as an option in Zimbabwe and Uganda, increasing numbers of orphanages are being established in South Africa (Richter, Manegold and Pather, 2004). Orphanages are usually far more expensive than home care. A South African study showed that institutional care costs around 10 times that of home care (Desmond & Gow, 2001

Thirdly, children who are part of child-headed households. Two critical issues arise, that is (a)who, if anyone, sees to the emotional needs of the child who takes the lead responsibility for the household and (b) can this person adequately take care of the needs of the younger household members?. To complicate matters, psychological issues are frequently made more complex by severe poverty and inadequate access to many social services (Nelson Mandela Children's Fund, 2001). Sengendo and Nambi (1997) found that compared with other orphans, children from child-headed households were less likely to be angry at the death of the parent and were more depressed than children living with both parents.

The Farm Orphan Support Trust of Zimbabwe identified a number of challenges confronted by child-headed households (2002). These include food security, educational

opportunities, material needs, psychosocial support, skills and knowledge, protection from abuse and exploitation, poor housing conditions, and poor access to health. In addition households had nowhere to turn for emotional and social support. The children showed signs of trauma and stress, loss of social energy and lack of hope for the future. It was further noted that children from child-headed households were at high risk of HIV infection due to the need to support themselves and their lack of physical protection. The report also points out that because older siblings carry responsibility for child-headed households and carry the burden of providing emotional support to younger siblings, they are at psychological risk themselves.

An adolescent head of household may be forced to forego expected and age appropriate psychological struggles and social and material enjoyments (often linked to hormonal and biological changes). They may, together with the added burden of responsibility of taking care of others, find themselves seriously depressed, suffering from anxiety disorder or other problems of adjustment and even be suicidal. In addition, a lack of maturity, struggles with their own biological and emotional vicissitudes, inadequate parental role modeling and the need to keep control of other family members (who may be emotionally acting out as a result of their own caring needs not being fully met or may just be ordinary children with needs), may result in child heads becoming extremely authoritarian. Conversely they may provide inadequate discipline and structure. Both these alternatives are not optimal for good development of the other children - and also not for the interacting household unit.

Moreover, depending on their age, for the other children there may be a lack of acceptance of the authority of the "head" and issues of sibling rivalry may abound. Members of the family may specifically endeavour to make life difficult for the head through flouting discipline and asserting their independence. The emotional needs of children for love, structure and so on, which given the circumstances of the household may be even stronger than would be expected in "normal" family circumstances, may not be easily met by the child head - leading to further demand and possibly rebellion by the other children. There is as yet little evidence of children within child-headed households

acting out emotionally any more than other children, though from a theoretical perspective this might be anticipated.

The presence of an "adult" and/or "family" for emotional well-being and development is clearly advantageous but not sufficient for good emotional health. Reference has been made to good parenting and parenting which may damage a child and to children who may cope better in adverse circumstances than others; but where even the most basic needs of a child such are not being met, such as food and shelter, the parental importance may be lessoned. According to Luther "no child can live well, love well, or work well if his or her physical survival is in jeopardy" (Luther, 2003).

Living with AIDS-related Stigma

Stigma associated with HIV/AIDS may exacerbate psychological functioning through each of the above stages. While some attention has been given to impacts of stigma on the lives of young people and adults living with HIV, little attention has been given to "knock-on" social and psychological consequences of such stigma. . Many people living with HIV/AIDS survive with the prospect of possible emotional and social ostracisation or physical expulsion from family and other support should they disclose their status. They also face concerns of losing supports for their children.. The negative effect of these concerns on parental well-being and the possible reduction of "emotional energy" available for continued support of their children are not immediately visible, but may insidiously erode the parent child relationship over time.

Parents may remain silent through the various phases of their condition, believing that they are protecting their children from the trauma of the possibility that they too may be HIV positive, or stand to lose a parent or family support. Children, on the other hand, are often finely attuned to the well-being of their parents and may sense shifts in the emotional support system of their family fairly early on. Parental fear, anxiety and innuendo contribute to a confusing, destabilizing emotional environment within which the child may shift from its defined child roles to a parent support role. Parents or family

carers who choose to "hide" their afflicted family members or delay accepting treatment which would identify their condition, may inadvertently draw the children into shouldering the impact of these choices on their own lives. Denial and non-disclosure can reduce access to support for the parent as well as for their children.

Parents' reluctance to share their condition with their children may deny an opportunity to prepare emotionally for the impending death of the parent. When parents do die children may become stigmatised by family and community, They may be seen as different, bringing - by contagion- further bad luck, death to the family, loss of resources, or loss of community standing (Nyblade, Pande, Mathur et al, 2003). The alienation these children experience may be overt, such as being excluded from community supports and left to their own devises or being explicated by their community or more covert such as subtle emotional withholding from children who come to stay with the extended family.

CONCLUSION - PROVIDING EMOTIONAL STABILITY AND SUSTENANCE

The idea that every child who is orphaned by AIDS (or any other reason) will become psychologically or behaviourally "un-well' or develop psychopathology either immediately or over time is false. On the other hand that some orphaned children will experience severe psychological difficulties, and that, proportionately this is likely to be higher than matched non-orphans, is true. Nonetheless in examining the literature on psychological impacts of orphanhood some readers may be surprised that the 'damage" is not even more prevalent and severe - after all the levels of stress that these children have been through is extreme, for many their economic and social situation is devastating and, for most, they are not living without their primary care-giver and emotional provider!

Dealing with adversity is a product of a complex web of biological, social and psychological factors linked to the past and present - as well as to the person's future prospects. The resilience developed prior to the additional burden of AIDS is critical. As important though, *are the protective and supportive networks which surround (or have surrounded) the child through their periods of living with a dying parent, bereavement and ongoing orphanhood.* A number of writers who have studied mental health issues

linked to orphanhood have remarked on the ongoing support that so many children have received and specifically on the fact that numerous children have been placed in supportive family environments, particularly within extended family arrangements. Without these arrangements the mental health situation may well be far worse!

Telingator puts it this way "Children who experience the death of a parent are at a higher risk of ongoing psychological turmoil if they lack ongoing support from caretakers and other social networks than those children who are fortunate enough to have consistency and predictability in their lives before, during and after the chronic illness strikes a member of their family" (Telingator, 2000 pg 296).

Over the past few years international agencies, including UNICEF, UNAIDS and USAID, non-governmental organisations and governments have realized the urgency of addressing the problem of orphans and vulnerable children within the context of HIV/AIDS. Policy guidelines and models of intervention have been drawn up and a number of programmes have been implemented (Strebel, 2004). Most interventions have stressed the need to keep children as part of the extended family and of mobilizing the community around projects (Strebel, 2004). As part of their intervention strategy some projects have undertaken needs assessments before entering communities and have designed programmes accordingly. But what do ordinary community members, most of whom have not yet been directly affected by the challenges of parentless children, feel about the possibility of having to care for a child whose caretaker has died? What do family members (grandparents and aunts and uncles), friends and even strangers feel about incorporating a child or children into their own family? Have they already done so? Does "relational proximity" play a role? Would family members be able to take in all the orphaned family children - or only some? Are there financial considerations which would make a difference to a person's decision of whether to take in a child or not? Do people feel that free education make a difference, or perhaps having a knowledgeable person assist with the child? Does the HIV status of the child make a difference regarding incorporation? As the AIDS epidemic grows and more and more children are left without

their caregivers, these questions become more and more important. The aim of this research is to find answers, as far as this is possible, to such issues.

CHAPTER 2

METHODOLOGY

RESEARCH DESIGN

How people are likely to behave is often best answered by observing, measuring and extrapolating from actual behaviour rather than from questioning people regarding their future behaviour (Backstrom and Hurch-Cesar, 1981). Thus it may be argued that the issue of who will take orphans into their families and under what conditions is best answered by measurement of actual behaviour, i.e. what have people currently done in this regard. However, where the existing situation hardly resembles the envisaged future scenario, as is probable with regard to current orphanhood (see Chapter 1), measured behaviours may not be predictive. Moreover, it is important to use research to understand people's perceived opinions and attitudes in order to intervene and, where possible, shape future behaviour. From such research it is also possible to set up randomized case controlled studies in which various interventions may be introduced and tested. However, given the crisis of AIDS orphans and the need to initiate planning immediately, policy directions can currently be guided by information from self-predicted behaviour. The following research design facilitates this.

This research *does* assess how people are currently behaving with regard to taking orphans into their families, however it goes further by requesting community members to project themselves into a hypothetical situation which they may find themselves in the future and asks them to predict how they are likely to act. Participants are also presented with a range of alternatives or "incentives" and asked to assert how they think various scenarios may influence their behaviour. These incentives range from financial ones, to assistance with education and practical/emotional assistance.

SUBJECTS

One thousand four hundred adults (persons 18 and older) from 3 provinces (Free State, Kwa-Zulu/Natal and Gauteng) were interviewed. These provinces were firstly selected to ensure a mix of urban and rural areas and secondly because they have been identified as having high levels of HIV infection. In the Nelson Mandela/HSRC study on HIV prevalence, the Free State (14.9%) and Gauteng (14.7%) were found to have the highest rates of HIV (Shisana & Simbayi, 2002). In the Department of Health antenatal sero-prevalence survey, Kwa-Zulu/Natal (KZN) was recorded as having the highest rates of HIV infection (37.5%) (Makubalo et al, 2004). These three provinces (and Mpumalanga) may be regarded as the major crisis areas for the placement of orphaned children.

Subjects were selected from four identifiable and separable "groups" rather than being proportionately representative of the national population. These were urban suburban/township -(400 subjects), urban informal settlement (400 subjects), rural 'tribal' (300 subjects) and rural farming areas (300 subjects). Differences in urbanization status, housing, kinship arrangements, traditional hierarchical relations and physical space were hypothesised to be highly relevant to the research questions and deemed to be possibly more critical than national representivity. The research was conducted in historically predominantly "black' areas and hence most respondents were black (98.5%). However six coloured, four white and one Asian person were interviewed. In the Free State and KZN 500 subjects were interviewed while in Gauteng, due to its primarily urban demography there were 400 respondents.
Study areas within the identified provinces and within the 4 categories were independently selected using a GIS mapping process to represent the four Groups[2].

[2] **Free State:** Mangaung (urban suburban); Botshabelo (urban informal); De Brug (rural farming); Qwa-Qwa (urban tribal)
Gauteng: Diepsloot (urban informal); Orlando East (Urban suburban)
KZN: Edendale (urban suburban); Cato Manor (Urban informal); Impendle (rural tribal); Mooi River (Rural farming)

Eight hundred and eighty four (884) women (63.3%) and 513 men (36.7%) were interviewed[3] .

Depending on their relation to children, respondents were interviewed in one or more role/category.

- Parent/grandparent/caregiver – if they had a child living with them and dependent on them – 1049 respondents.
- Grandparents where grandchild/ren were living with their biological parent – 305 respondents
- Fathers of children living with biological mother (whether father was also part of the household or not) – 294 respondents.
- Adults in a household where there is a child/are children but where the child/ren is/are not dependent on them – 325 respondents.
- Adults who have siblings with children under 18 years of age – 849 respondents
- Adults with regard to the children of their "best friend" – 1391 respondents
- Adults with regard to children unknown to them – 1400 respondents.

PROCEDURE

Ethical clearance was obtained from the Human Sciences Research Council Ethics Committee.

Fieldworkers, previously trained in community based survey research, were trained in Pretoria, Bloemfontein and Pietermaritzburg specifically on the use of the interview schedule developed. As certain issues were considered to possibly be sensitive to certain respondents, interviewers were also trained on how to respond should the interviewees have negative emotional responses to any of the questions. Provincial health authorities provided lists of mental health services available within the proximity of the interview

[3] The gender of 3 subjects was unknown

areas and these were given to each of the interviewees in case they wished to seek assistance following the interview.

In urban areas fieldworkers were placed at strategic corners of the identified field sites. Interview routes were then plotted using a detailed map of the area. Interviewers began at the sixth house from their starting point and conducted interviews in every fifth house after that. This procedure was followed until the requisite number of interviews had been conducted. In rural "tribal" areas, clusters of homesteads were identified from detailed maps. From a random starting point, every fifth cluster within an expanding circular distance was identified. Each adult in the cluster was interviewed. In rural farming areas a random starting point within the chosen geographical area was also identified. Every fifth farm along the road (and from there along a preplanned road route) was identified. Each adult farmworker on the farm was interviewed after getting permission from the farm owner. The local police were informed about the research in all these areas . In rural tribal areas the local traditional chief was approached for permission to conduct the research. Consent to conduct the research was granted in all instances (See Appendix 2 for Consent form).

Each adult in the household was explained the purpose of the research (sometimes individually and sometimes to more than one person at a time) and requested to sign a consent form if they were willing to participate. Even where the purpose of the interview was explained as a group, interviews were conducted with each individual in private. In situations where the environment did not allow for complete privacy, as much confidentiality as was possible in the circumstances was strived for. Where members of a household were not present at the time when the interviewee came to the house, an appointment was made with other members of the household for a convenient time to conduct the interview. A number of interviews were conducted in the evenings and over week-ends. While some households were returned to more than twice, due to time and financial resource constraints it was often not possible to return after a third visit.

Every adult within the identified household was interviewed. Numbers per household ranged from 1 (13.2% of households) to 10 or more (0.4% of households). The majority of households had two (28.4%), followed by three (25%), and four (16.8%) adults. Every person over the age of 18 in the household was included in the study to ensure a proportionate range of relations to children in and outside of that household, for example mothers, fathers and grandparents. This selection process was aimed to pick up potential attitudinal differences within households as well as between households with regard to orphaned children.

INTERVIEW SCHEDULE

An interview schedule was designed for the purposes of the study. Key stakeholders, for example the Department of Social Development, requested that certain questions relevant to their policy development be included. The interview schedule was translated by a professional translation company into South Sotho and Zulu and checked for local idiom and accuracy by local study supervisors.

In addition to collecting demographic information of the adult respondents, the questionnaire elicits information on the children living in households, particularly with reference to children who are not the biological children of the adults living there.

Parents and caregivers with children under 18 living with them and dependent on them, are requested through the questionnaire to project themselves into a hypothetical situation whereby they are no longer able to look after the children in their care. They are asked what they think would happen to the children and what they would like to see happen to them in such an eventuality.

The questionnaire is then divided into sections designed specifically for different respondents depending on their relation to children. Hence certain sections are only answered by some individuals, for example grandparents, while other sections are answered by all interviewees, for example questions around taking in children unknown to them.

In all sections respondents are requested to respond on a five-point scale to various "incentives" offered. Each incentive was graded in terms of desirability: 1) Would make no difference whatsoever to their decision on whether to take in a child or not 2) Would make them give some thought to the matter 3) Would make them seriously consider the matter which they otherwise would not have considered at all 4) Would influence them towards making a positive decision and 5) Would definitely make a difference.

(See Appendix 1 for full questionnaire).

CHAPTER 3

RESULTS

DEMOGRAPHIC INFORMATION

Age of respondents

	18-25	26-35	36-45	46-55	56-65	Over 65
Female	22.2%	26.8%	17.8%	13.9%	9.3%	10.1%
Male	25.3%	24.6%	19.7%	13.1%	8.2%	9.2%
Total	23.3%	25.9%	18.6%	13.7%	8.9%	9.7%

Table 1

Around half the respondents (49.2%) were between 18 and 35 years old while just under 10% of respondents were over 65 years old. Gender was not significantly different by age, nor by the geographic situation they lived in (i.e. rural/urban situations). However women tended to be living in poorer economic circumstances than men (Chi-square= 14.0 $P < .01$).

The age distribution of respondents is well correlated with the country age distribution as found in the 2001 census. [Census 2001 – 18-25 (27%); 26-35 (26%); 36-45 (21%); 46-55 (13%); 56-65 (8.3%); over 65 (7%)]

Gender

Sixty three point three percent (63.7%) of respondents were women and 36.7% men. This overrepresentation of women relative to the 2001 census data (i.e. 52.2% women and 47.8% men) results primarily from men being less available to be interviewed than women. Even though interviewers returned to households up to three times, men in the household were often out. Slightly more men in rural areas were interviewed relative to women in urban areas but this was not substantial (34% as opposed to 38.5%) and does

not reflect a major impact of migrant labour. This sample did not include hostels and other residential facilities where men may be over represented.

Marital status

	Single	Married/living with partner	Divorced	Widowed	Other
Female	49.4%	42.2%	3.1%	0%	5.3%
Male	50.1%	44.2%	3.3%	.4%	1.9%
Total	49.6%	42.8%	3.1%	.1%	4.1%

Table 2

The vast majority of the respondents were either single or married/living with a partner.

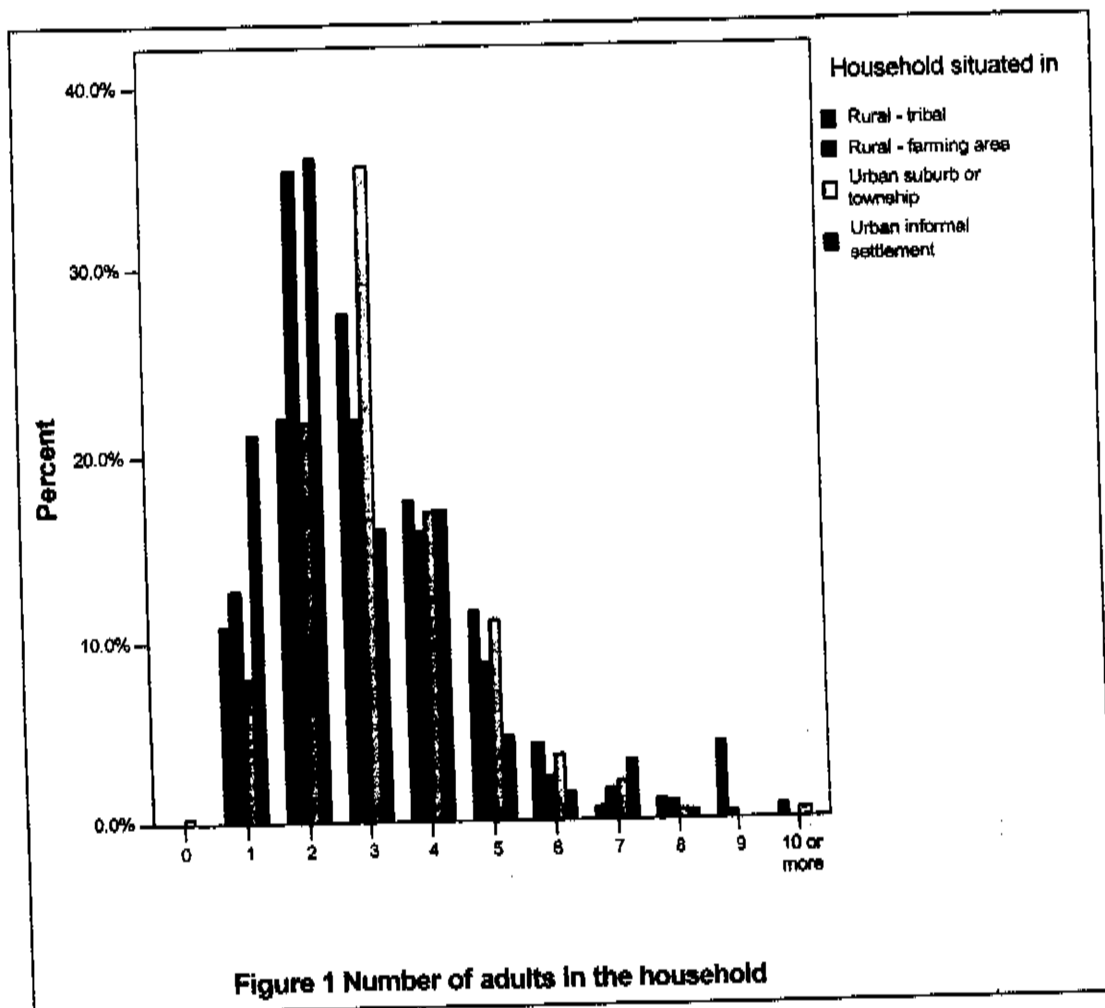

Figure 1 Number of adults in the household

The majority of households consisted of 2 (28% of households) or 3 (25% of households) adults. In 16.8% of households there were 4 adults and in 13.4% only one. In just under 16% of households there were 5 or more adults.

Education level

No schooling	Primary education	Secondary education	Post matric qualification
11.6%	27.1%	54. 3%	5.9%

Table 3

The majority of respondents had some schooling (88.4%), though 27.1% of these had not reached secondary schooling level. Less than 6% had a post matric qualification. Gender was not statistically significant with respect to education.

Employment status

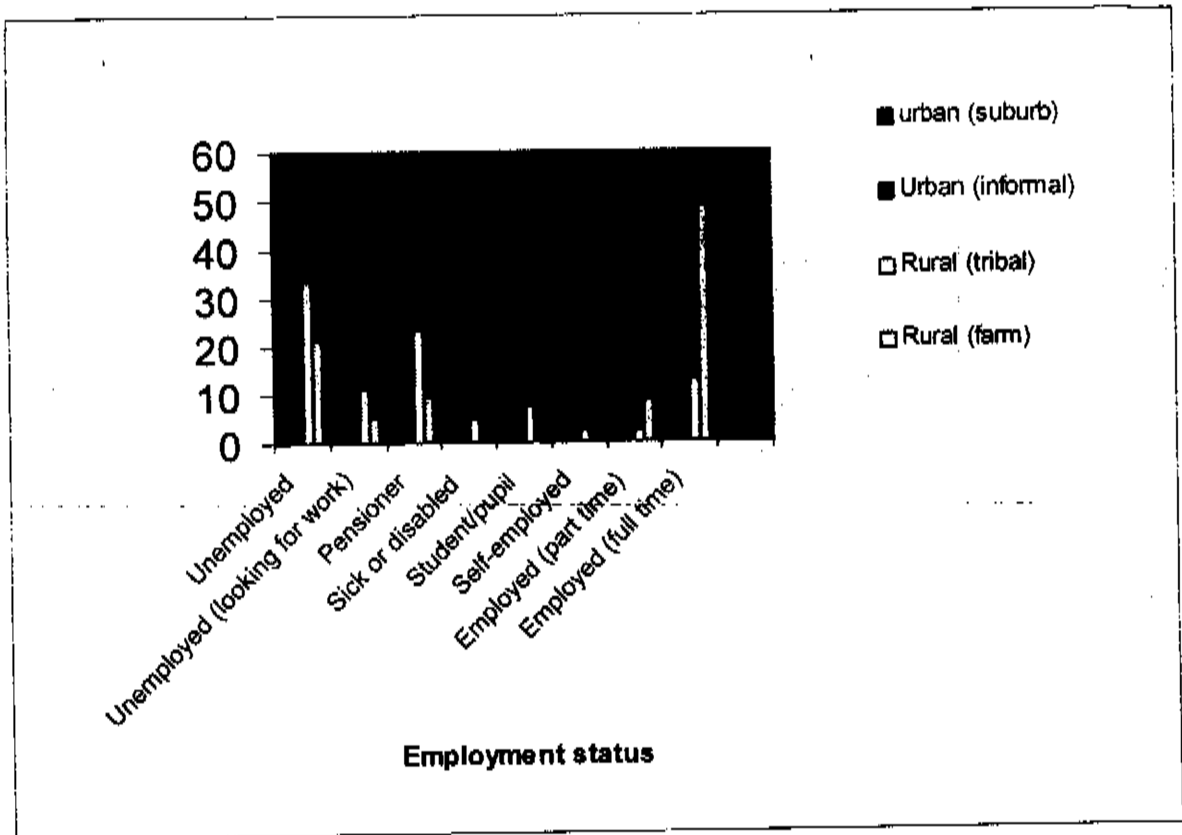

Figure 2

Over 40% of respondents were unemployed (with 4% of these not looking for employment). Just under 20% were employed fulltime and an additional 6.8% part time. In urban areas as well as rural "tribal' areas a little over 10% of the respondents were employed full time, while in rural farm areas this number was over 50%. Fourteen point four percent of interviewees received an old age pension.

Children

Of the 1 400 people interviewed, 1105 (78.9%) had their own children (some of whom where staying with them and some not) while 1049 (74.6%) had children living with them.

Number of biological children

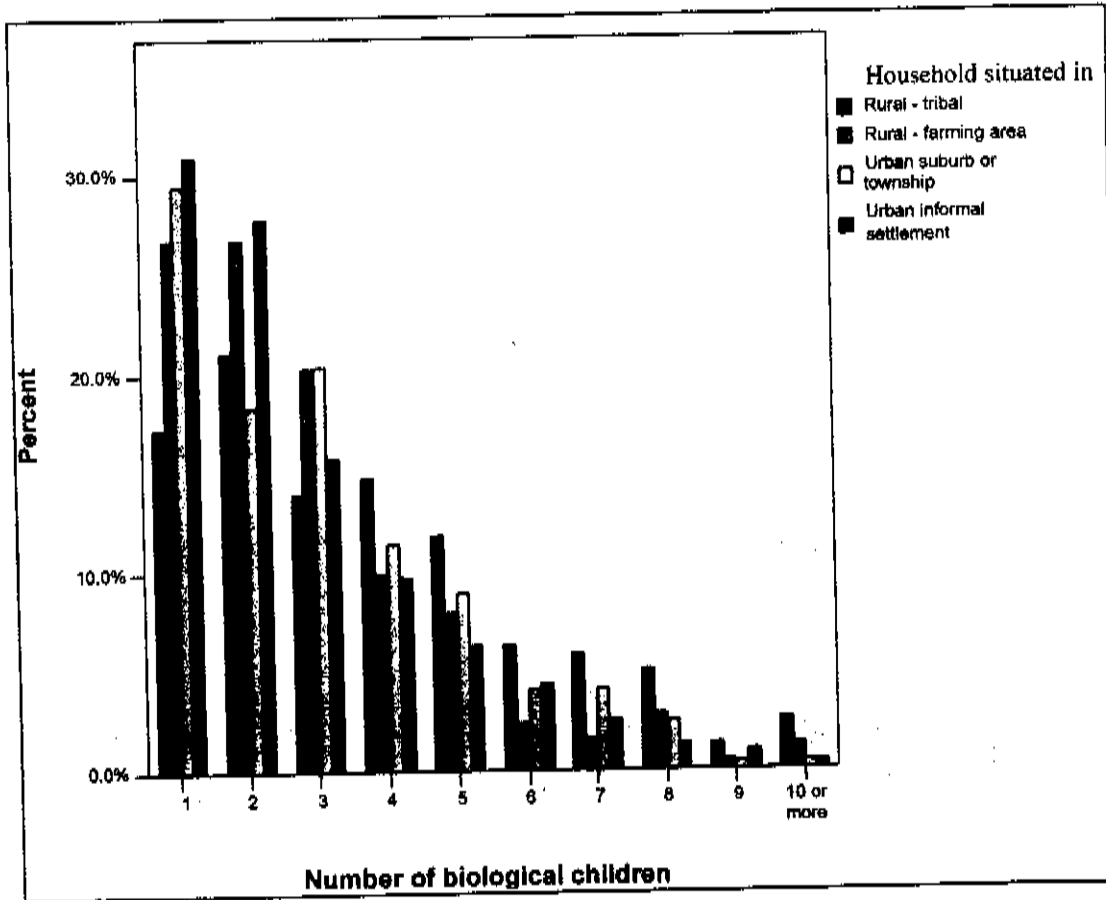

Figure 3

Over half of respondents (55.1%) had either one or two children while just under 21% had five or more children.

Non (direct) biological children living in households

Thirty percent of adults had children who were not their biological children living with and dependent on them. Of these 67% were grandchildren, 19% were children of siblings, 10.5% were children of another family member and 1.5% were children of a friend. In

1.6% of cases the biological parent was unknown to the respondent or the child had been formally adopted[4].

The number of grandchildren being raised by grandparents ranged from 48 people (35%) who had only 1 grandchild staying and dependent on them to 1 grandparent who had 13. Eight percent had 5 or more grandchildren staying with them.

Proportionately more grandparents in rural areas had grandchildren staying with them than grandparents in urban areas.

[4] Numbers of people who have grandchildren, children of siblings and other non-biological children dependent on them is more than the number who have "non-biological" children as some respondents had children in more than one category dependent on them.

The main reasons why adults had a non-biological child living with them were:-

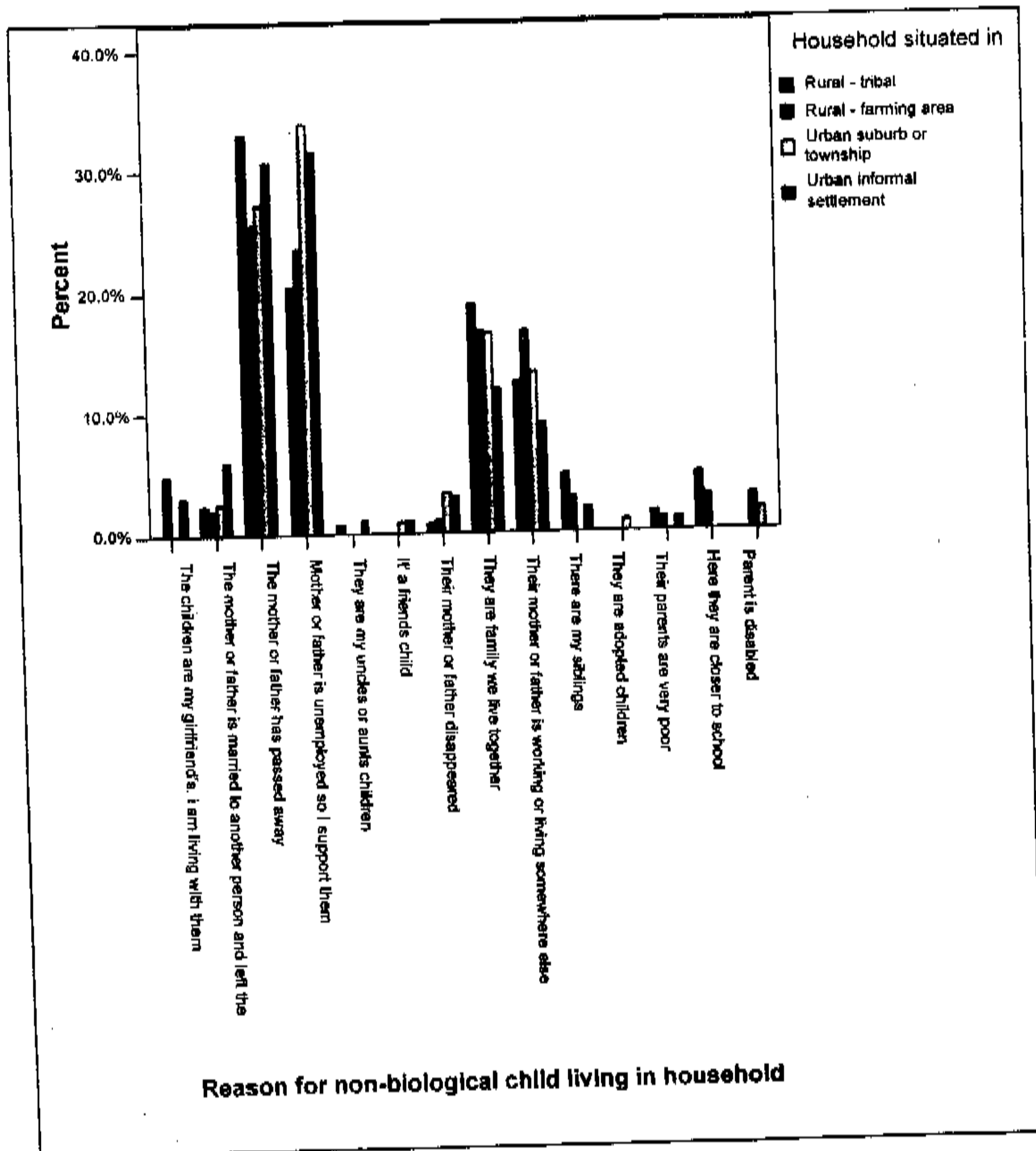

Figure 4

The two main reasons across all household areas why children were staying with non-biological parents were that the mother/father had passed away (29,3%) and that the mother/father was unemployed so the children needed to be supported (27.3%). The other substantial reasons why children were staying with the non-biological parent were that

the mother/father was working or living elsewhere (13.1%) and that the children were living with them simply "because they are family – we live together" (16.2%).

Where the reason for the child staying with the non-biological caregiver was the death of the biological parent, the main reasons given for the deaths were: -

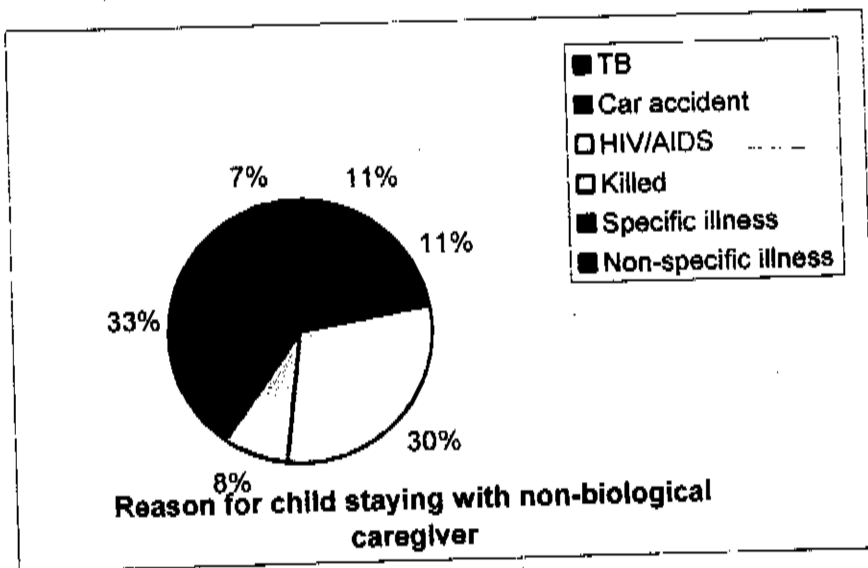

Figure 5

Thirty two point nine percent of deaths of parents of children under 18 were attributed to specific natural causes such as heart failure or stroke. A further 19.4% of people died of non-natural causes (11.4% car accidents and 8% homicide). HIV/AIDS was reported to be the cause of death of 29.5% of the parents while TB accounted for a further 10.8% of deaths. Non-specific reasons such as "he/she was sick" or "it was a long illness" were given for a further 7.1% of parental deaths. There were significant different in the causes of death by where the household was situated.

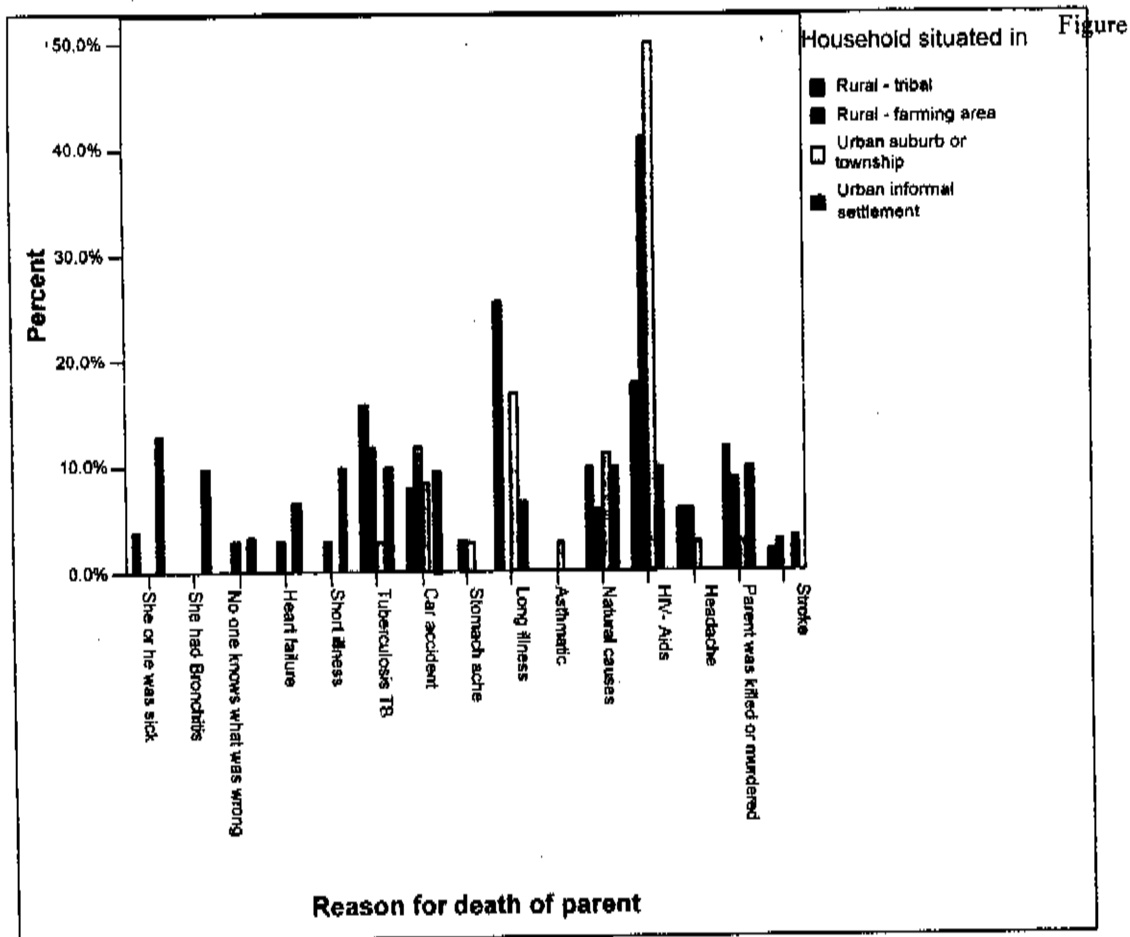

Figure 6

People in urban suburban and rural farm situations attributed HIV/AIDS as the cause of death to a far greater extent than people in rural farm and urban informal settlement areas. However tuberculosis and "a long illness" were given as the reason for death by significantly more people in rural tribal areas.

Employment status

Three "employment" groupings dominate in terms of who has taken in non-biological children. These are pensioners - 28.7%, unemployed people (looking for work) – 23% and people employed full time – 21%. This is substantially higher than the numbers of pensioners in the study (14.4%) but substantially lower than the number of unemployed (36.6%), but substantially higher than the numbers of pensioners (14.4%). The

percentage of employed people in the sample is similar to the numbers of employed people who have taken in non-biological children (19.5%).

People who have had their own children were significantly more likely to have taken in non-biological children than people who did not have their own children (Chi-square =26.3 P= 0.01)

RESPONSES OF ADULTS (PARENTS/GRANDPARENTS/CAREGIVERS) WITH CHILDREN UNDER 18 LIVING WITH THEM AND DEPENDENT ON THEM REGARDING PLACEMENT OF CHILDREN

Of the sample of 1400 adults interviewed, 1049 had children living with and dependent on them. In response to a question of what would happen to these children if "something terrible were to happen to you" 76% of respondents answered in terms of who would look after them. Whilst the vast majority (64% of respondents) identified some family member whom they thought would look after the child/ren, 33 people (3.2%) said that the government would have to look after them. One hundred and sixty seven (15.9%) of respondents answered that "life would be very difficult for them/they would suffer a lot", 60 (5.7%) simply answered that they did not know what would happen to the children, 17 (1.6%) said that they would become mentally or emotionally disturbed and 6 people thought that their children would become criminals or street children.

When asked specifically who they thought would look after the child/ren 30% thought it would be the other parent, 24.6% a grandparent, 6% an uncle or aunt, 8.1% another sibling, 19% a family member other than any of the above. Thus 87.7% of respondents thought that some member of the family would care for them. Two point seven percent (2.7%) of respondents did not know what would happen to the children and thirty people (3%) thought the government would take responsibility. In most cases people's choice of where they would want the child to be placed mirrored very closely where they thought they would go.

	Who do you think will look after the children	Who would you want to look after the children
Other parent	30%	28.7%
Grandparent	24.6%	26.9%
Uncle or aunt	6.0%	6.8%
Another sibling	8.1%	8.4%
Other family member	19%	19.7%
Government	2.9%	1.9%
Don't know	6.2%	4.6%
Other	2.5%	2.2%

Table 4

Significantly more men said that their wife/partner would look after the child/children (46%) than women who thought that the father/partner would look after them (22%) (Chi-square = 53.9 P<. 001).

Seventy percent of respondents had previously thought about the question of what may happen to their children should they no longer be available to look after them. Significantly more women had contemplated this scenario than men (Chi-square = 7.24 P< 0.01). Moreover older people were significantly more likely to have thought about what may happen to the children dependent on them if something were to happen to them than younger adults (Chi-square = 14.7 P< 0.05)

Respondents were asked to hypothesize a situation where it would not be possible for a member of the family to take over the care of the children and to consider adoption to either another South African family or by a family outside of South Africa. Responses were:

	Happy about this	*Would not object*	*Extremely unhappy*
Adoption in South Africa	19.3%	9.5%	71.1%
Adoption outside of South Africa	11.4%	5.9%	82.7%

Table 5

People who had secondary schooling or a post matric qualification were significantly more likely to accept the adoption of the child than people with little or no schooling whatsoever (Chi square = 23.7 $P < 0.01$).

RESPONSES OF GRANDPARENTS, FATHERS, ADULTS IN HOUSEHOLDS WHO DO NOT HAVE DEPENDENT CHILDREN, ADULT SIBLINGS OF PARENTS, FRIENDS AND "STRANGERS" REGARDING PLACEMENT OF CHILDREN.

Adults within households were asked various questions regarding the placement of children who were related to them at different "proximal" levels. The scenario was put to that if "something terrible" were to happen to the primary caretaker and they were no longer able to look after the child/ren, what was likely to occur. Open-ended responses were coded into the main response categories detailed here.

What would happen to the children?

	Grand Parents N = 305	*Fathers* N = 294	*Other adults in household* N = 325	*Siblings* N = 849	*Best friends* N = 1391
I will raise them myself	59%	65.6%	35.4%	49.2%	17.25%
Family will care for them	20.2%	21.3%	35.3%	31.5%	42.6%
Life will be difficult	9.2%	6.8%	13.8%	7.3%	11.1%
Government will take care of them	2.3%	0.7%	2.1%	2%	8.2%
Will become mentally disturbed	1.3%	3.1%	3.1%	1.8%	1.2%
Will become street child/criminal	1%		1.2%	1.3%	2.1%
Don't' know	4.6%	0.7%	4%	3.1%	12.3%

Table 6

Each respondent was also posed the question "...there is the possibility in South Africa that a number of mothers and fathers of children may die as a result of the HIV/AIDS

epidemic. If there was a child who lost their parents and had no-where to go to, do you think that you would take such a child in – even if you did not know the parent?"

Sixty two percent of respondents said that they would take a child/children into their family while 38% said they would not. This was significantly related to gender with women far more likely to say that they would take in such children than men (Chi-Square = 21.45 P< .000).

Grandparents

Grandparents who responded by saying that their grandchildren would come to them were then asked whether they would be prepared to take in *all* their grandchildren if necessary. Eighty one percent said that they would take in all while 19% said they would take in some but not all.

Of the grandparents that would not take in all the grandchildren (N = 71) 11% would be able to take in 1 child; 35% would take in 2; 25% 3: 11% 4, 7% 5 and 4% 6 children. Four respondents said they could take in more than six children.

Of the grandparents that said that grandchildren would come to them, most felt that this would put additional stressors on their lives. The graph below describes the types of stress expected.

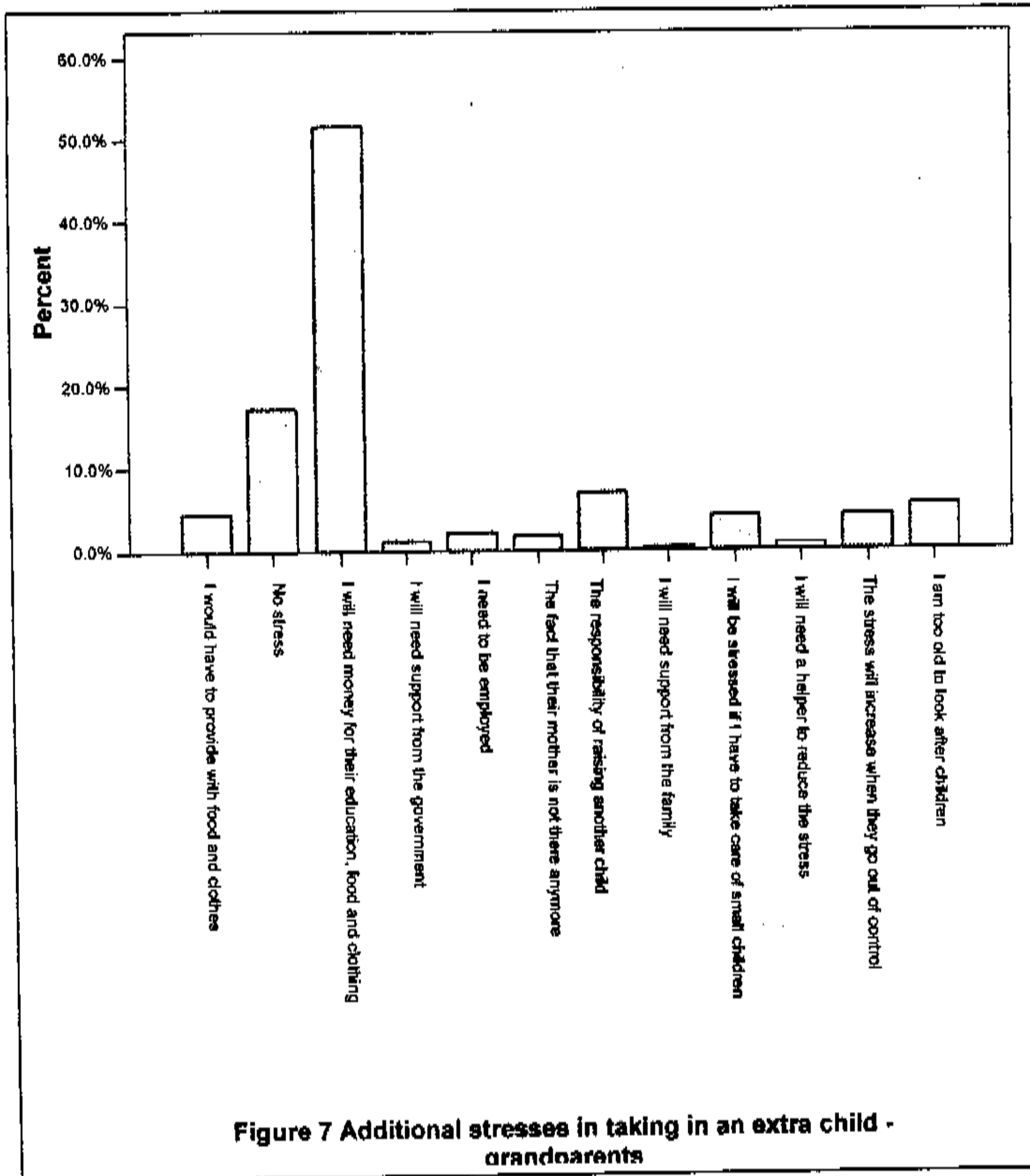

Figure 7 Additional stresses in taking in an extra child - grandparents

Figure 7

When asked what assistance they would need to cope with these stressors 54.7% said that they would need financial assistance while a further 22.2% said that they would need assistance from government. An additional 7% of respondents made reference to other forms of financial need (e.g. will need to be employed, will need a raise). Four point seven percent (4.7%) said that they needed a helper while six percent said that they needed the help of their families. Only 4.3% said that they would not need any additional assistance.

When given various options or "incentives" which may make a difference to grandparents taking in their grandchildren, around half the grandparents (51.7%) felt that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child. Twenty one percent of grandparents thought that R170 would definitely make a difference. However there was a significant difference between being given this amount and an amount of R600 per month (Chi-square=235, p< .001). There were also significant differences (p< .001) between getting a grant of R170 and getting R1000 as well as between R170 and having the child's full education paid for, and for having a caring and trained person to assist from time to time with problems they may be having with bringing up the child.

The percentage of grandparents where it would "definitely make a difference" rose from 21% with the R170 proposal to 37.9% if they were to receive R600 per month and to 67.4% if a grant of R1000 was available (Chi-square=183, P<. 001). There were also statistically significant differences between R600 and having education paid for (Chi-square=37, P<. 005) and between R600 and having a caring and trained person assist (Chi-square=53, P<.001).

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa=. 408) as well as between having education paid for and having a caring and trained person to assist (Kappa = .408). In other words, for grandparents getting a grant of R1000 would act as a relatively equal incentive to either having education paid for or having a caring and trained person assist. Agreement between having education paid for and having a caring and trained person to assist was low (Kappa = .154).

The "incentive" to take in a child is determined to some extent by education level. While this makes no difference with regard to the grant of R170 or R600, it makes a significant difference when the grant is R1000 (Chi-square= 49 P<0.05). However, a person's socio-economic status makes a significant difference with regard to any of the (hypothetical)

incentives offered i.e. R170, R600, R1000, education paid for and visits from a caring person. The lower the socio-economic status a person is from, the more difference the incentive makes for the grandparent; while the higher the grant the more relevant socio-economic status becomes.

Employment status is also statistically relevant (Chi-square=87, P<001). For unemployed grandparents the grant of R170 makes more difference than for employed people or pensioners.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	51.7%	13%	3%	11.3%	21%
Grant of R600	17.9%	12.6%	9.6%	21.9%	37.9%
Grant of R1000	5.6%	2.3%	2%	22.6%	67.4%
Education paid	8%	1.7%	.7%	15%	74.7%
Caring person visiting	27.2%	2.7%	4.3%	14.6%	51.2%

Table 7

For most grandparents the age of the child would not make a difference to their decision of whether to take in and care for their grandchild (70.3%). However age was more important to grandfathers – making a difference for 39% - than for grandmothers (26%%). Grandfathers were particularly reluctant to take in and care for younger children.

Whether a child was HIV positive or not would make little difference to the decision of most grandparents on whether to take in a grandchild or not. Eighty three percent said HIV status would make no difference. However there is a correlation for grandparents between the age of the child and the HIV status would make a difference. (Chi-square = 8.1 P< 0.005). The older the HIV positive child, the more reluctant the grandparent would be to take then in and care for them.

Fathers

Seventy one percent of fathers said that they would look after their child if something were to happen to the child's mother and she was no longer able to look after the child.

Thirty two point six percent (32.6%) of fathers reported that there would be no additional stressors in caring for their children without their mother, however only 12.8% said that they would not need any assistance. Almost 34% said that there would be financial stressors, 10.7% reported stress related to the mother not being there and 4.7% were concerned about the responsibility of raising a child. Five point six percent of fathers expressed concern about having to raise small children.

Sixty seven percent of fathers said that there would need to be a change in their financial situation e.g. financial assistance, government assistance, being employed or needing an increase at work if they were to take care of their children. In addition 9.8% said they would need their families assistance and 10.7% would need a helper.

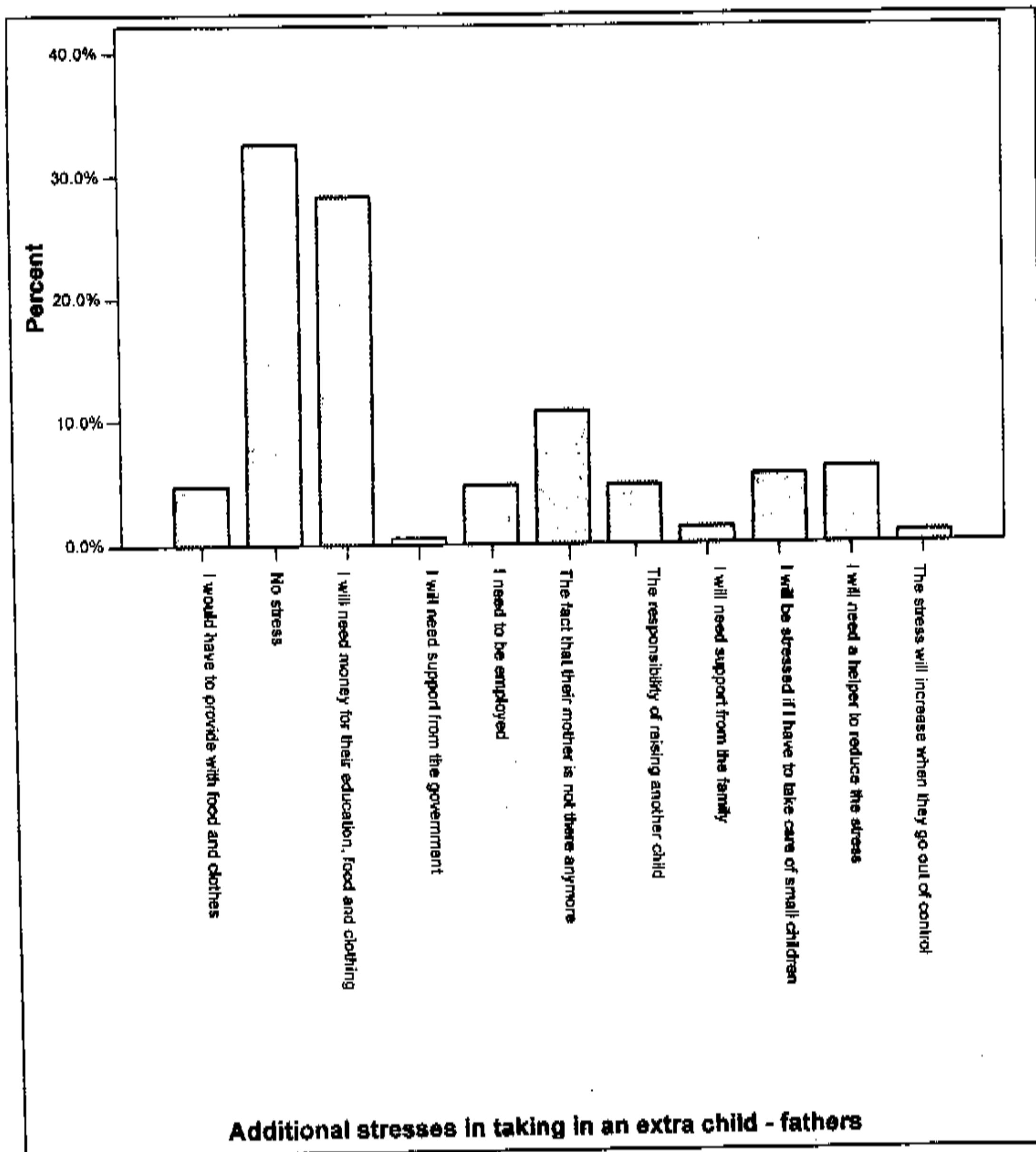

Figure 8

When given various options or "incentives" which may make a difference to fathers taking in their children, 61% said that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child. Under 15% thought that R170 would definitely make a difference. However there were statistically significant differences between being given this amount and an amount

of R600 per month, R1000, having education paid for and having a caring person assist (P< .001 in all cases).

The percentage of fathers where it would "definitely make a difference" rose from under 15% with the R170 proposal to 29.3% if they were to receive R600 per month and to 64% if a grant of R1000 was available. There were also statistically significant differences between R600 and having education paid and between R600 and having a caring and trained person to assist (P<.00 5 in each case).

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa=.451). Kappa agreement between R1000 and having a caring person assist was not very high (K= .220), however there was strong Kappa agreement between having education paid for and having a trained and caring person assist.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	61.1%	10.1%	4.4%	9.5%	14.9%
Grant of R600	22.9%	12.8%	12.8%	22.2%	29.3%
Grant of R1000	10.4%	4%	3%	18.5%	64%
Education paid	11.5%	2%	1.7%	11.4%	73.4%
Caring person visiting	28.7%	3.7%	3.0%	11.5%	53.0%

Table 8

For most fathers the age of the child nor the HIV status of the child would make a difference to looking after them (74% and 84% respectively).

For fathers the only statistically significant "incentive" to take in a child linked to education status is getting in a trained and caring person. However socio-economic status does make a significant difference with regard to any of the (hypothetical) financial incentives offered i.e. R170, R600, R1000 and for getting visits from a caring person. The lower the socio-economic status a person is from, the more difference each incentive make to their decision to take in and look after a child. For fathers employment status does not make a statistical difference.

Adults in the household where there is a child/are children but where the child/ren are not dependent on them.

Eighty five percent of respondents said that they would consider taking the child/children to be part of their family/household if the person/people on whom they were currently dependent were no longer able to look after them.

When given various options or "incentives" which may make a difference to taking in the children, 58.2% felt that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child while 13.4% thought that R170 would definitely make a difference. However there were significant differences between being given this amount and an amount of R600, R1000, having education paid for and having a caring person assist.

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa=517) as well as between having education paid for and having a caring and trained person to assist (Kappa = .450). Therefore getting a grant of R1000 would act as a relatively equal incentive to either having education paid for or having a caring and trained person assist.

The "incentive" to take in a child was not related to education level for adults in the household who are not the grandparents/siblings. However, a person's socio-economic status makes a significant difference with regard to any of the (hypothetical) incentives offered i.e. R170, R600, R1000, education paid for and visits from a caring person. The higher the grant the more relevant socio-economic status becomes.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	58.2%	10.7%	5.5%	12.2%	13.4%
Grant of R600	24%	15.2%	10.3%	22.5%	28%
Grant of R1000	10.4%	3.1%	4.6%	22.9%	59%
Education paid	15.8%	2.7%	3.6%	16.7%	61.1%
Caring person visiting	37.6%	3.2%	4.5%	19.1%	35.7%

Table 9

For over 40% of non parents/grandparents in the household the age of the child would make a difference. However different people appeared to prefer different ages - 30% preferred children 6-10 years of age; 26% preferred 0-5; 25% preferred 11-15 and 19% preferred children over 16. However, for men age was more of a factor than for women (Chi-square = 7.78 $p<.005$) with men preferring not to have take in younger children.

For 27.4% of respondents in this category the HIV status of the child would make a difference. This was statistically significant (Chi-square = 16.8 P< 005). For people who

have very few financial resources the HIV status appears to make less difference than for people with some resources.

Adults with siblings who have children under 18 years of age.

The vast majority of siblings (91.1%) said they would consider taking their siblings children to be part of their own families.

When given various options or "incentives" which may make a difference to taking in the children, 60.6% felt that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child while 13% thought that R170 would definitely make a difference. However there were significant differences between being given this amount and an amount of R600, R1000, having education paid for and having a caring person assist.

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa=471) as well as between having education paid for and having a caring and trained person to assist (Kappa = .508). Getting a grant of R1000 would act as a relatively equal incentive to either having education paid for or having a caring and trained person assist.

The "incentive" to take in a child was significantly related to employment status (Chi-square = 9.27 P< 005). However R170 would make no difference even to the unemployed. When this was raised to R600 (Chi-square = 124.4 P<,0001) and R1000 (Chi-square = 96.2 P < .001) then the largest difference would be for the unemployed. Similarly with socio-economic status, R170 did not make a significant difference but R600 and R1000 did. The largest difference was for people who currently do not have enough money for basic things like food and clothes.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	60.6%	9.8%	6.5%	10.1%	13%
Grant of R600	22.1%	10.2%	12.4%	25.1%	30.1%
Grant of R1000	10.3%	1.9%	4%	18.8%	65%
Education paid	12.9%	1.4%	3.5%	14.6%	67.6%
Caring person visiting	31%	3.7%	3.5%	14%	47.8%

Table 10

The age of the child would make a significant difference to whether siblings took in children (Chi-square = 9.27 P<005). These differences were particularly relevant to adults in the 18-25 year age group and people over 65s.

For 27.4% of respondents in this category the HIV status of the child would make a difference. This was statistically significant (Chi-square = 16.8 P< 005). For people who have very few financial resources the HIV status appears to make less difference than for people with some resources.

Close friends of adults who have children under 18 years of age

Sixty three percent of adults said that they would take in and care for the child/ren of their best friend if he/she was no longer able to look after them.

When the various options or "incentives" which may make a difference to taking in the children were presented, 64.3% felt that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child while 9.6% thought that R170 would definitely make a difference. However, as with grandparents, fathers, adults in the household and siblings there were significant differences between being given this amount and amounts of R600, R1000, having education paid for and having a caring person assist. The percentage of friends where it would "definitely make a difference" rose from under 9.5% with the R170 proposal to 22.7% if they were to receive R600 per month and to 49.1% if a grant of R1000 was available.

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa= .605) as well as between having education paid for and having a caring and trained person to assist (Kappa = .643). There were also strong Kappa agreements between a grant of R600 and R1000 (Kappa = .429) and between R1000 and having a carer assist.

No "incentive" to take in a child was significantly related to education level. However, people's socio-economic and employment status was statistically significant with respect to getting a grant of R600 and R1000 ($P<.001$). Such grants would make most difference to people who were socio-economically worst off and for the unemployed.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	64.8%	10.8%	6.4%	8.6%	9.4%
Grant of R600	32.8%	11.6%	12.6%	20.3%	22.7%
Grant of R1000	23.9%	2.2%	6.8%	18%	49.1%
Education paid	25.9%	2.2%	5.5%	14.3%	52.1%
Caring person visiting	37.4%	3%	5.3%	11.6%	42.6%

Table 11

With gender aggregated the age of the child would not make a significant difference to whether friends took in children; however for men the age of the child was much more important than for women (Chi-square = 12.6 $P < 0.001$). Men were least likely to take in children between 0 and five years old.

For 29.7% of respondents in this category the HIV status of the child would make a difference.

The age of the respondent did not make a statistically significant difference with regard to receiving a grant of R170, however as the grant is increased age becomes more significant (For R1000 Chi-square = 39.05 $P < .005$). For more people over 65 years of age, the grant would make little or no difference than for younger age groups. While 24% of 18-25 year olds and 21% of 26-35 year olds said that getting a grant of R1000 would

make no difference to their decision to take in their close friend's children, nearly 40% of over 65s said it would make no difference.

Adults who did not know the parents of children

When put in the context of deaths resulting from HIV/AIDS sixty two percent of adults said that they would be prepared to take in children who had lost their parents and had no-where to go.

When the various options or "incentives" which may make a difference to taking in the children were presented, 68.6% felt that receiving R170 (the current level of the child care grant) would make no difference whatsoever to their decision to take in and care for a child while 9.4% thought that R170 would definitely make a difference. However, there were significant differences between being given this amount and amounts of R600, R1000, having education paid for and having a caring person assist. The percentage of "strangers" where it would "definitely make a difference" rose from under 9.4 with the R170 proposal to 21.3% if they were to receive R600 per month and to 45.7% if a grant of R1000 was available.

Using Cohen's Kappa "strong agreement" was found between the incentives of receiving a grant of R1000 and having the child's education paid for (Kappa= .651) as well as between having education paid for and having a caring and trained person to assist (Kappa = .676). There were also strong Kappa agreements between a grant of R600 and R1000 (Kappa = .429) and between R1000 and having a carer assist (Kappa = 467).

Respondent's socio-economic and employment status was not statistically significant with respect to getting a grant of R170 but is with respect to R600 and R1000 ($P < .01$). Such grants would make most difference to people who were socio-economically worst off and for the unemployed.

	Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
Grant of R170	68.6%	10.7%	4.8%	6.6%	9.4%
Grant of R600	37.2%	10.6%	12.6%	18.4%	21.3%
Grant of R1000	28.4%	2.3%	5.5%	18.1%	45.7%
Education paid	32.1%	2.8%	4.7%	12.6%	47.8%
Caring person visiting	39.6%	4.3%	3.9%	10.3%	41.9%

Table 12

With gender aggregated the age of the child would not make a significant difference to whether friends took in children; however for men the age of the child was much more important than for women (Chi-square = 12.6 $P < 0.001$). Men were least likely to take in children between 0 and five years old.

For 27.7% of respondents in this category the HIV status of the child would make a difference.

Respondents who said they would take in the child of a friend were more likely to agree to take in a "stranger" than other groups Kappa = .473.

Costs of residential care for "AIDS orphans"

For the purposes of broad comparisons with potential grants or other services, the costs of residential care at three facilities which provide services for children orphaned by AIDS were ascertained. These were not randomly selected facilities and therefore the costs may not be representative of all residential facilities. Nonetheless these non-profit, non-government facilities were considered to be "mid-level" facilities, that is neither extremely deprived nor lavish and provide humane rather than exceptional levels of care. Costs include all living expenses as well as education and medication for those who require it.

Facility I - R2500 per month
Facility II - R3000 per month
Facility III - R3000 – R4000 per month depending on needs of the child.

CHAPTER 4

DISCUSSION

A striking feature of this research is how many people, in principle at least, are open and willing to become involved with and caring for children who's parent(s) is/are unable to look after and care for them. Equally apparent though is the dire economic and social circumstances in which so many people in South Africa live - including potential new caregivers for children. It is possible, and in a number of instances probable, that the attitudinal and "in principle" willingness to assist may be compromised by the economic and social difficulties that come with providing a home for a child. A critical question then is *what assistance may facilitate an effective integration of an orphaned or vulnerable child into a family?*

The extended family is clearly the most likely as well as the most logical option for placement of orphaned or otherwise vulnerable children in Africa. However, as discussed in Chapter 1, there are a number of limitations on the capacity of extended family taking in orphaned children. These include poverty, urbanization, strains on the family emotionally and economically (resulting inter alia from taking in a new member of the family, deaths and other stressors), age of grandparents and most importantly, the projected numbers of orphaned and vulnerable children which may stretch extended family resources beyond breaking point. Yet the option of institutional care is regarded by government, most social service organizations and most community members as a last resort. It is not only seen as not in the best interest of most children but an economically unsustainable option. The second critical question then, linked closely with the first, is *how far does the "extended family" stretch in terms of a placement net for orphaned and vulnerable children?*

A third related question is *to what extent, and under what circumstances will families who are not related to orphaned children, take children into their care?*

Before addressing these issues it is important to firstly discuss the characteristics of the sample interviewed; secondly examine who is currently looking after and caring for "non-biological" children and thirdly assess the views and attitudes of parents/people who are currently caring for children with respect to a scenario in which they were no longer fit or able to look after the children in their care.

Sample characteristics

HIV/AIDS affects all races and all socio-economic groups. However, given the demographics of the country the vast majority of orphaned and otherwise vulnerable children will be black (African). They will also come from geographical areas previously designated for black people (urban townships/previous "homeland" areas), settlements populated primarily by black people which have arisen since apartheid restrictions on movement were lifted (informal settlements) and be living on commercial farmlands. While a nationally representative sample would have yielded other interesting and important information, the sample and the provinces selected (see Chapter 1) represents the groups where the largest number of children are likely to require placement in the coming decades.

The age of the respondents sampled was very similar to the national age distribution while females were over represented in the sample (see subjects). The majority of respondents were single (50%). However the numbers of "widowed" people was disproportionately low (0.1%) and it seems likely that some respondents who may have been widowed classified themselves as single.

The number of adults in the household ranged from 1 to over 10. The highest number of households had 2 (28%) or 3 (25%) adults residing. Despite expectations that the extended family system would be more entrenched in rural areas, in this sample the number of adults in households in rural areas was not higher than in urban areas. Informal settlements had the greatest number of single adult households, however in over 10% of rural households there was also only one adult over 18.

Twelve percent of respondents had never been to school, 27% had primary school education, 54% had some secondary school education while 6% had a post-matric qualification. Over a third of respondents (37%) were unemployed (looking for employment) while in urban areas and rural tribal areas only just over 10% of respondents were fully employed. Employment levels were substantially higher in rural farming areas, with nearly 50% employment. However the conditions of poverty under which most people live was reflected by the fact that 57.3% of interviewees said they did not have enough money even for basic goods like food and clothing. A further 35.8% had some money for food and clothes but were short of money for other important needs.

It is clear from the high numbers of people who live on or below the breadline, that having to take in and care for an additional child or additional children would be likely to place enormous extra economic stress on the family. This could, in turn, generate serious emotional discord for the whole family - and especially for the child/children taken in who could be perceived to be the cause of the financial pressure.

The numbers of children (per parent) ranged from 27% of respondents who had 1 child, through 24% who had 2 and 17% who had 3 children, to 1% who had 10 or more children. Hence in the event of the death of a parent it could be one child who would need to be cared for but it could be more than 10. Thus in many instances for each AIDS related death a range of families may be affected or may need to be brought in to assist.

CHILDREN IN HOUSEHOLDS WITHOUT THEIR BIOLOGICAL PARENTS

A considerable number of children (30%) were not living with their biological parents. The highest reported reason for this was because the mother/father had died (29.3%). *This means that around 10% of children in the households sampled were not staying with their biological parents because of the death of their parent.* Other primary reasons were unemployment of the parent (and hence the child needing support) and that the mother/father was working or living somewhere else. There were not significant

differences in the reasons why children were not staying with their biological parent between rural and urban areas. From this sample it does not appear that the practice of sending children to rural areas while the parent works in an urban area is widespread.

The reason why most children appear to be living away from their biological parent seems most often to be out of necessity rather than choice. While 16% of adults did report that they were living with these children simply because they were family, death and unemployment were by far the predominant reasons why children were not living with the biological parent. The majority of children who were not staying with biological parents were staying with grandparents (67%), while a further 19% were children of siblings (i.e. aunts and uncles of the child) and 10.5% were children of another family member. Thus almost 97% of children who were not staying with their biological parents were staying with some family member. Formal adoption was a low 1%.

In terms of employment status, the greatest number of children not living with biological parents were looked after by old age pensioners (28.7%). This was despite the fact that pensioners made up only 14.4% of the sample. Though unemployed people were responsible for caring for the next highest number of non-biological children (23%), this was substantially lower than the number of unemployed people in the sample (36.6%). Employed people who were looking after non-biological children was proportionate to their sample number.

It appears then that in the current situation financial as well as cultural/traditional considerations are critical to the placement of children. The extended family, particularly grandparents and siblings of parents, are clearly playing a very important role in assisting to bring up non-biological children. Notwithstanding, financial considerations play an important role. This is particularly important if policy makers assume that extended families will continue to play a central part in child guardianship in the future. It would appear that if financial resources become overstretched, traditional/cultural norms may be severely challenged.

If a person had not had children of their own they were significantly less likely to take in and look after the children of others. This is largely related to age. Younger people (many of whom had not yet had children) are probably less likely to want to care for a child because they were not ready to settle down and take on such responsibilities; as they may wish to have their own children first and perhaps because they do not feel confident enough to look after children. However it is also likely that individuals who have themselves had children feel greater empathy for the plight of children who do not have a parent to care for them.

Reason for death of parent

The death of a parent is the major reason why children are not being looked after by their biological parents. In 29.5% of cases, the cause of death was directly reported as HIV/AIDS. However an additional 10.8% of deaths were reported to be as a result of TB and a further 7.1% to non-specific reasons such as "he/she was sick" or "due to a long illness". It appears likely that a proportion of these deaths are also AIDS related. According to the Medical Research Council, in the general population HIV/AIDS is the cause of death in 30% of people and contributes 40% to premature mortality. They estimate that in 2000 in the 15-49 age group around 40% of adult deaths were a result of HIV/AIDS (MRC, 2001). It appears that the numbers of parental deaths in this study is close to this figure. (This reinforces the projections of the number of children who will become orphaned due to HIV/AIDS discussed in Chapter I).

Given that AIDS is usually not reported as the cause of death on death certificates as well as the stigma associated with HIV/AIDS, it is somewhat surprising that as many as 29% of respondents gave AIDS as the cause of death. It is possible that in some areas especially, stigma associated with AIDS deaths may be decreasing. In urban suburban areas HIV/AIDS was given as the cause of death in half the cases, however in urban informal settlements only around 10% or respondents gave AIDS as the reason for death. In different rural situations too, there were major differences in reported AIDS deaths. In farming areas more than 40% of deaths were attributed to AIDS while in "tribal" areas

this was under 20%. It is unlikely that this variance is due to real differences in cause of death as, for example, studies on prevalence of HIV have indicated high levels of positive people in informal settlements and in rural areas (Shisana & Simbayi, 2002). It is probable that stigma and/or misinformation in these areas may be the reason for the underreporting.

VIEWS FROM PRIMARY CAREGIVERS IN THE (HYPOTHETICAL) SITUATION WHERE THEY WERE UNABLE TO TAKE CARE OF CHILDREN IN THEIR CARE

Part of this study aimed to establish what carers (parents, grandparents looking after a child, other primary caregivers) thought may happen to their child/children, and what they would want to occur, if something were to happen to them and they were no longer able to take this responsibility. This could then be compared with what others outside this family perceived may occur.

Seventy percent of respondents (70%) had, prior to the interview, considered what might happen to their children if something terrible were to happen to them and they were unable to look after the children. Consideration of what might happen to children is an important first step toward "succession planning" and making arrangements for the child to be looked after.

Women, as the primary caretaker of children in most cases, were significantly more likely to have thought about this issue than men. Moreover, older people with dependent children were more likely to have considered this question than younger parents.

For men it appears that they worry less about their possible absence and what may happen to their children because they are often not the primary caretakers of the child. They therefore believe that the mother will simply continue their parental role . Moreover it is likely that the less nurturing role that men play, and are socially expected to play in

relation to their children, and the consequent more distanced relationship they may have with the children, may permit them to worry less about what may happen to the child.

Younger parents/caregivers tend to be less focused on issues of death and other more "serious" issues such as what may happen to their children during the "life generating" stage of human development. It is also likely that older people have had more real life experiences and illnesses in which they have been forced to confront their mortality than younger adults and this may have prompted thoughts regarding the future of their children or children in their care.

With an illness such as HIV/AIDS the slow process of deterioration of health and the long period between testing positive and becoming ill (if the person has been tested early in the infection), may allow an infected person sufficient time to consider the future of their children and to take appropriate action. Nonetheless the fact that as many as 70% of people who have children dependent on them, have thought about the issue is encouraging. Notwithstanding, there is a large gap between thinking about permanency placement and negotiation of a planned transfer of a child to a new family. This finding would thus need to be built upon rather than regarded as an endpoint. Moreover, it appears that younger people and men may need to be supported to think about questions around what may happen to the children in their care if they were no longer able to take the responsibility for them. With the increased number of younger people who have dependents dying, this becomes particularly important.

When faced with the question of what they think will happen to their children or children in their care if they were unable to look after them, most respondents answered in terms of who would look after the children (76%). Almost all interviewees who did not respond to this question from a guardianship perspective foresaw highly difficult futures for their children - some suggesting that their children would end up as street children or as criminals. This re-emphasizes the importance of placing a child within a new community based home and family.

While in percentage terms parents/carers who believe that their children would "go off the tracks", that life would become extremely difficult for them or simply did not know what may happen to them may be relatively low, in real numbers this would, in time, become substantial[5].

When asked directly who would look after the children (rather than what might happen to them) 6.2% of respondents said they didn't know and 3% thought that the government would take care of the child. The remainder identified a caregiver. It is important that as many as 1 in 10 caregivers could not identify anyone whom they thought there child may go to if they were no longer able to look after them. If indeed this number of children were not "placed", as above, by 2015 this would be a very substantial number.

Only 2.5% said that the new caregiver would not be a family member. Importantly 8.1% said that one of the child's siblings would look after them. Unfortunately the study did not establish the age of the sibling who the parent/caregiver thought other children would go to. It is possible that the siblings being referred to were over 18 years of age, however this figure does suggest that a number of parents/caregivers believed that children would be brought up as part of child-headed households.

For most respondents the person that they thought the child would go to was the same as the person who they would have wanted the child to go to. This includes parents who would want their children to be brought up by their siblings.

From the combination of the questions of what would happen to the children and who would look after them, it is evident that a number of parents/caregivers feel that even if the child/children were to be placed (even with a family member) that life was likely to become a lot more difficult for them.

[5] If, for example this sample was representative of the population, by 2015 this group could number around 1.4 million. As this sample does not claim to be national representative, this figure should be regarded merely as a broad estimate.

Given gender social roles, it was perhaps not surprising that significantly more men than women stated that the person they thought would look after the child, as well as whom they wanted to look after the child if they were unable to, was the other parent/partner. While the percentage of men and women in the sample who were married/living with a partner was almost identical, 46% of men (who had their own children) thought that their partner would look after the child/children while only 22% of women thought that their husband/partner would look after the child. The study did not ask who would look after the child if both the respondent and their partner were unable to. It can be surmised, however, that the numbers of other carers identified would probably rise proportionately - that is grandparents followed by other family members would primarily be expected to be the new caregiver.

Adoption

Of the 1049 respondents who had children, only 3 said that their children are likely to be put up for adoption if something terrible were to happen to them. Not even one parent said that adoption would be their favoured alternative for their child. Moreover, in terms of current status, of the almost 2 500 children of the adults in this study only 4 had been adopted. It is thus apparent that for most South Africans (at least those living in the circumstances described in Chapter 1) adoption is not a commonly considered or a preferred option. Nonetheless respondents in this study were asked to consider adoption in a situation where it was not possible for a member of the family to take over the care of the child/children. They were also asked to consider adoption by a family in South Africa as well as adoption outside of South Africa.

The majority of parents/caregivers were "extremely unhappy" about the prospect of adoption both inside South Africa (71.1%) and outside of South Africa (82.7%). However 19.3% would be happy and 9.5% would not object to adoption within South Africa. Eleven point four percent would be happy to have their child adopted outside of South Africa and 5.9% would not object to this. Respondents more in favour of adoption in the circumstances described were individuals who had had secondary schooling or a

post-matric qualification. People with little or no schooling tended to be very unhappy about any adoption. It is likely that people with higher education have been more exposed to and influenced by adoption practices and hence they had become more sympathetic to it. Because the extended family has always been such a strong support structure in African societies, it has not been necessary for most people to even consider a "non-family" placement of a child. However, given the results of this study the adoption of orphaned children is one possibility that may need to be explored further to deal with the growing numbers who will require homes and families over the forthcoming decade.

If adoption is going to become a more utilized alternative to deal with the "orphan crisis", it is clear that for most people attitudes will have to undergo a rather dramatic shift – though people with more education are likely to be more open to this alternative.

TAKING IN ORPHANED OR OTHERWISE VULNERABLE CHILDREN

Where parents/caregivers think their children will go to if they are unable to look after them themselves and what they want in this regard is one side of an important equation. However perhaps more important are the views and attitudes of those who will have to take the children into their homes and families. In this section, these views and attitudes, and how they may be changed or influenced, are discussed.

The majority of fathers and grandparents (both 71%) said that if anything were to happen to the primary caregiver, the child/children would come to them. In addition, half of the adults living in the household, 20% of siblings (i.e. aunts and uncles of the children) and 12.5% of best friends said they thought they would take the caretaking role if the primary caregiver was unable to.

It is clear that there is a strong willingness amongst all the groups to take in and care for children, and amongst some groups especially, an apparent presumption that they would. This clearly reflects that traditional and cultural patterns are still dominant with respect to the extended family and the spirit of "ubuntu". However there were still a number of

adults in each group interviewed who stated that they did not know what would happen to the children, that life would become very difficult for them and that some would become mentally disturbed or street children/criminals (See Chapter 3). Moreover, good intention may not translate into actual behaviour and, given constraints previously discussed, it is important to know what would assist or influence the decision of individuals to take in and look after children.

Fathers

It is important that in response to the question of what may happen to their children if their mother was unable to look after them, 65% of fathers stated that they would look after their children. This increased to 71% when asked directly who they anticipated would look after the children. It is unsure whether the response that the child would come to them would be realized in practice as the currently few men look after children in Africa (Richter 2004b). However, the evident good will and apparent intention is important in itself and certainly provides the potential for a process of high levels of involvement of fathers in looking after and caring for children. The finding by Case et al that surviving fathers are now taking more responsibility for children (Case et al in Richter, Manegold and Pather, 2004) may indeed reflect changing attitudes such as those reflected in this study.

In order to assess how this good intention may be translated into similar behaviour, fathers were firstly asked to identify what additional stressors they thought they would be under if they were to take care of the child and secondly what assistance they thought they would need in order to take this responsibility.

In terms of additional stressors, 34% identified financial stressors as their first concern. Other concerns were stressors on the child in living without a mother (10.7%) and anxieties regarding their responsibilities in raising a child (9.8%). Some fathers were particularly concerned about raising young children (5.6%).

Only 12.8% of fathers felt that they would be able to take on the responsibilities of looking after the child/children without the mother and without any assistance being provided for them to do this. Financial assistance was the highest priority (45%) identified with an additional 10% of fathers saying they would need a job if they were to take the responsibility. Almost 10% of fathers said that they would need assistance from their families and 10.7% said they would need the assistance of someone such as a helper as their first identified need. Nine point four percent said they would need (non-specified) government assistance.

To assess what level of financial assistance may make a difference to their decision on taking in and caring for the child and to look at the potential impact of other assistance that could potentially be provided, respondents were given various financial, educational and caregiving assistance options

For only a relatively small percentage of fathers (15%) receiving a grant of R170 would make a definite difference to their decision on taking responsibility for the child. However there were statistically significant differences when the amounts were raised to R600 and R1000. There were also statistically significant differences between being given R600 and R1000.

Having education paid for and receiving assistance from a trained person were also highly valued by the fathers – more so than either R170 or R600. Having education paid for would act as very similar encouragement or incentive for fathers as receiving a grant of R1000. Moreover there was "high agreement" between the incentives of having education paid for and having a caring person assist.

The incentive to receive a grant of each amount stated and/or getting a trained and caring person to assist is significantly related to the socio-economic status of the father. The poorer the father is, the more difference the incentive will make. This is important because if, due to financial constraints, it would not be possible to provide support to all

fathers, the biggest difference would in fact be made through incentives to poorest people.

The idea of proving assistance to fathers to look after their own children would not be regarded as an appealing option to many policy makers, who may argue that fathers have a legal and moral obligation to these children. It may also be argued that this would be discrimination against mothers if they too did not receive a grant if fathers were no longer available to look after and support the child. However the findings from this study suggest that some fathers (especially very poor fathers) who may otherwise abandon their child, either for others to look after or simply without carers, would be encouraged to look after the child if assistance was available. The fact that educational or caring assistance is considered by fathers as valued alternatives to financial assistance may provide more acceptable help options.

While for some fathers the age of the child would be an important factor regarding whether they would care for them or not, this was not true for the majority (74%). For those fathers where age would make a difference, young children (0-5) were of most concern to them. This is an anticipated finding as most men in African society have very little to do with the nurturing and caregiving roles of infants and young children (Edwards, 2001; Richter et al, 2004b).

For most fathers (84%) the HIV status of the child would make no difference to their decision of whether to look after and care for the child or not. However taking this figure from a negative perspective, as many as 16% of fathers would discriminate against their own children if the child was HIV positive[6]. This may also mean that due to the positive status of certain children, and the fact that HIV status of the child was not mentioned in prior questions, that the number of fathers who expressed the belief that they would take in their child would be slightly less than recorded above.

[6] It is possible that for these fathers it is not as much stigma and rejection as the added stress and responsibility of bringing up an HIV positive child and possibly having to see the child die that is at issue, nonetheless given that stigma is known to be high in communities, this must explain a significant proportion of this view.

Grandparents

Where children are not living with their biological parents, as part of extended family tradition and culture, the majority live with grandparents. This expectation was borne out by the number of non-biological children staying with grandparents in this study (See Chapter 3). Also from this study it is evident that after the other parent, the majority of parents/caregivers said that the person their children would most likely go to if they were no longer able to take care of them, would be a grandparent.

Seventy one percent of grandparents felt that if their child was no longer able to look after their child (i.e. their grandchild), they would look after them. However, results show that a number of grandparents (19%) voiced concern that they would not be able to take in all their grandchildren. Of those who said they would take in some but not all, certain grandparents said they could take in as many as 6 while others felt they could take in only 1. It must also be noted that almost 30% of grandparents did not say that the children would come to them. Some grandparents said that they were too old to look after children (5%) while others felt that stresses involved in bringing up children may be too much for them. Clearly then, while grandparents are without doubt an extremely important resource for placing children, by no means all children could be placed with them.

Like fathers, for grandparents financial constraints appear to the biggest obstacle to taking in and looking after children in need (58% identified finances as the first constraint to looking after children without the mother). And, like fathers, the financial incentives suggested would make a minor difference when the amount provided is R170, but make progressively more difference as the amount is increased through R600 to R1000.

For grandparents, having full education paid for and having a trained and caring person assist from time to time with any problems they may be having with bringing up the child, were also regarding as highly desirable incentives. In fact both these options were rated similarly to receiving an amount of R1000. These incentives would therefore make

more difference to grandparents than receiving either R170 or R600 and similar to receiving R1000.

Socio-economic status is significant for grandparents in terms of each of the possible incentives. For poorer grandparents each incentive (i.e. R170, R600, R1000, education, carer) is more desirable than for financially better off grandparents. Moreover, the higher the financial incentive the more difference socio-economic status makes. Hence while an amount of R1000 would make a significant difference to both a poorer and a better off person, it would make most different to a person from a low socio-economic background. As with fathers this suggests that the most effective utilization of resources would be with people from lowest socio-economic groups.

Reinforcing the above is the finding that unemployed grandparents find an incentive of R170 to be more likely to sway their decision than either employed grandparents or even pensioners.

For a large number of grandfathers (62.7%) the age of the child would make a substantial difference to their decision on whether to take a child in or not. Many grandfathers would not want to take in and care for a young child, but would be happy with an older one. For grandmothers age is not an issue.

Like fathers there is some discrimination by grandparents against children who are HIV positive (17%). However unlike fathers, for grandparents there is also a correlation between HIV status and the age of the child. For grandparents a younger child who is HIV positive is more likely to be taken in and cared for than an older positive child. It appears that the "innocence" and dire need for caring and protection of a younger child may be more apparent to the grandparents. Perhaps they also feel that they themselves would be less stigmatised and blamed if they had a younger HIV positive child.

Adults living in households where there are children (but where they were not the primary caregiver), siblings of individuals who have children and friends with children under 18.

Though each of these groups was addressed separately in the study, there was high overlap in many of the responses. These groupings are also less likely to be considered as homes for children than fathers or grandparents (by both the parents/caregivers of the child and by themselves as respondents to this study). They are therefore discussed jointly in this section.

As with fathers and grandparents there is a strong perception amongst members of all the groupings that they would themselves take over the caretaking roles (51% of adults in the household, 20% of siblings and 12% of best friends). Moreover high percentages of respondents in all groups would consider taking responsibility for children if the primary caregiver was unable to (85% of adults in the household, 91% of siblings and 63% of friends). Whether many would in reality take on the responsibility would, it seems, depend on what assistance was made available to them.

In all three groups the grant of R170 was likely to make a major difference to only a fairly small proportion of people. However, in all three groups there was statistically significant differences between receiving this amount, R600 and R1000 per month. The three groups also followed the same pattern in having strong agreement regarding receiving a grant of R1000 and having the child's education paid for and between R1000 and having a trained and caring person assist from time to time.

Socio-economic status was an important variable in all three groups. While for adults in a household not responsible for the child socio-economic status was relevant for any of the three financial incentives, for siblings and friends this was important only for grants of R600 and R1000. In all cases however an incentive was more important the poorer the person is, and the larger the incentive the more difference it makes to poorer people.

For 41% of adults in a household not responsible for the child, 35% of adults whose siblings have children and 48% of friends, the age of the child would make a difference as to whether they would take responsibility for children or not. In each case this was largely attributable to the men in the sample who were reluctant to take in children in the 0-5 category. It is noteworthy that while a number of biological fathers were reluctant to take in young children rather than older ones (See Chapter 3), for men with more distanced relationships to the child, the age of the child was substantially more of an issue

The HIV status of the child was more important to people in each of these categories than for either fathers or grandparents. For household members not responsible for the children, the HIV status would make a difference to taking responsibility for the child in 24.7% of people, for adults who have siblings 18 years and younger in 20.6% and in friends it would make a difference for 29.7% of people.

Adults who do not know the child

Unlike all the previous groupings where questions related to any situation whereby the primary caregiver was no longer able to look after the child, in this section respondents were asked specifically whether they would assist children who were orphaned as a result of AIDS and where there was no family member to look after them.

Sixty two percent of respondents said that they would consider taking in one of more children. This was very similar to the number of "best friends" who said they would consider taking a known child. Moreover the profile of incentives which would make a difference to "strangers" taking in children was extremely similar to that of "best friend". This may mean that people tend to treat children who are not their blood relatives (or where they are not staying in the same home), in more or less the same way. However it is also possible that the introduction of HIV/AIDS with regard to "strangers" may have altered some peoples' reactions. Nonetheless there do appear to be a substantial number of people who may take unknown children into their homes, especially if they were provided with some support to do this.

It is possible that in this group, and indeed in others, that taking in the child is secondary to the incentive. That is, in order to get any income, people may be prepared to take in a child. This money could then be utilised for expenses unrelated to the upkeep of the child. While this may be true in some cases, what mitigates against this as a likely explanation is the "strong agreement" between the financial option of R1000 and getting a child's education paid for and between R1000 and having a trained and caring person come to assist. This strongly suggests that most respondents have the welfare of the child in mind rather than exploitable income.

COMPARING THE VIEWS OF CURRENT AND POTENTIAL CAREGIVERS

In most instances there is a reasonable "fit" between where most parents/caregivers think that their child would go if something were to happen to them and they were no longer able to look after the child/children, and the people to whom they say they would go. However, as most parents identified only one caregiver, there were many people, and a wider range of people, willing to "receive" children than identified by the parents. This is highly encouraging for the placement of orphaned children. However there may be substantial gaps between this apparent will and actual behaviour. Moreover, higher numbers of people willing to accept children than identified by parents does not imply that all children would be placed in a new home as there are likely to be a number of "overlaps" for specific children and zero "takers" for others.

The highest number of respondents identified the other parent as the most likely carer. This was dominated by fathers who believed that the mother of the child would be responsible. Fifty eight percent of married fathers/fathers living with their partner believed that the child/children would be taken care of by their partner. On the other hand only 30% of married women/women living with a partner believed that the child would go to the father.

Due to the role that mothers traditionally have in looking after children, mothers were not asked who would be responsible for their children if the father could not take responsibility. However fathers were asked what would happen if the mother was unable to. Seventy one percent of fathers said that they themselves would look after the child. There is thus a fascinating discrepancy between what the mothers think may happen if they were unable to look after the child and what the fathers think. More than double the amount of fathers believe that the children would come to them than mothers who believe this will occur. The question of empirical correctness is not at issue here, it appears though that mothers have much less confidence in the likelihood of the father taking responsibility, and perhaps ability to take care of children, than the fathers themselves..

As suggested earlier, the responses from the fathers can be seen as a strong willingness to take responsibility for children – even if this is not translated into behaviour. In the following section, how fathers may be assisted in translating the willingness into behaviour will be discussed.

The next highest parental/caregiver expectation is that grandparents would take responsibility (30%). However 71% of grandparents felt that the child/children of their own child would come to them. As with fathers many more grandparents felt that the child/children would come to them than identified by the current parent/caregiver. This was also true of the siblings of the parent/caregiver. While only 8% of parents/caregivers thought that their sibling would take responsibility for the child/children, 63% of siblings (i.e. aunts and uncles of the children) thought that they would care for the child/children.

In addition 50% of adults living in a household, and 23% of "best friends" thought that children would come to them if the primary caregiver was no longer able to take care of the children. While a certain proportion of the household members may have been "other family members" the range and willingness of people who thought that the child/children would come to them seems to dramatically exceed the expectations of the parent/caregiver. No parent/caregiver thought that the child would go to their best friend

(though 2.5% said "an other"), yet 23% of best friends thought that they would come to them.

It cannot be established from this research whether those children where the parent/caregiver did not know what may happen to them, that the government would have to take responsibility or where they thought the children would land up on the street and/or become criminals would be "covered" by the large number of people who say they believe the child would come to them. It is highly possible given familial and poverty clustering that for a number of children identified by parents as having nowhere to go, there were no extended family members or friends willing or able to take them in.

ASSISTANCE TOWARDS TAKING RESPONSIBILITY FOR A CHILD/CHILDREN

It seems that for some respondents certain answers may have been given in terms of what they considered to be correct or desirable response rather than based on a thorough consideration of their true-life realities. It appears that the gap between what many respondents would desire in terms of taking in and caring for children and the reality was to some extent exposed when they were asked what assistance they would require and when possible incentives were presented. This is not implying that respondents were not fully authentic in their responses nor that the willingness to take in children is any less genuine than stated, however it is possible that for many people their good intentions could in reality be undermined by harsh veracities – especially poverty.

The two groups identified as most likely to look after children, fathers and grandparents, were asked specifically what additional stressors would be put on their lives and what assistance they thought they would require. Only 12% of fathers and less than 5% of grandparents felt that they could manage to look after the children without assistance. In particular both fathers and grandparents predominantly said they would need financial assistance (See section above-Comparing the views of current and potential caregivers). However other assistance such as a helper, or families who would help were also seen as important.

The question "if an incentive is to be given, what would make a real difference?" was fairly similar for all groups. For the vast majority of respondents receiving a grant of R170 would not make much of a difference to their decision to take in a child. However R600 and to a much greater degree, R1000 were significant. Incentives were especially important to poorer people. Highly noteworthy, however, is that having a child's education paid for was just as likely to act as an incentive to take in a child as an amount of R1000. Moreover for most groups having a caring and trained person to assist from time to time was also regarded as highly desirable – often on a par with either R1000 or having education paid for.

Clearly the prospect of taking responsibility for additional children is a major anxiety for most adults. Predominantly for this sample it is an anxiety about finances, however educating the child and how they will cope are also extremely important. While education and personal assistance were not mentioned nearly as often as finances were when asked about potential stressors that a child may bring, assisting at these levels is likely to have similar benefit to direct financial assistance.

HIV STATUS AND AGE OF THE CHILD

For a number of people the decision of whether to take in a child or not would be influenced by the HIV status of the child. It appears, however, that it would make less difference for closer relatives than for people not biologically related to the child. For the following percentage of people the HIV status *would* make a difference.

Fathers	Grandparents	Adults in household	Aunts/ uncles	Best friend	"Stranger"
15%	17%	27%	20%	28%	29%

Table 13

Is would thus appear that though HIV status would not be an issue for most respondents, it would be a problem for sufficient numbers to influence placements. HIV positive children will, it seems, be more difficult to accommodate into families than children who are negative or even those whose status is unknown.

While at an initial glance these findings appear to reflect pure and unadulterated discrimination against people who are HIV positive, the reality is that taking in a positive child and possibly having to deal with ongoing illness and their death, makes this decision a highly complex one. It is therefore not surprising that people who are not blood relatives are less likely to want to take infected children into their families.

For certain groups the age of the child would make more difference than for others. For the following respondents age *would* make a difference

Fathers	Grandparents	Adults in household	Aunts/ uncles	Best friend	"Stranger"
26%	30%	41%	35%	48%	46%

Table 14

As with HIV status it appears that for closer relatives the age of the child is less important than for people who are not blood related. However younger children may be more difficult to place than older children – especially placement with men. For example the majority of grandfathers would be reluctant to take in a younger child, but this would make far less difference for grandmothers.

CHAPTER 5

SUMMARY AND IMPLICATIONS OF MAIN FINDINGS

1. Placement of children whose parent(s) are no longer able to look after them in families and within communities is desirable for many reasons. Good mental health in childhood and prevention of mental disorder in adulthood is one important (if thus far neglected) reason. In fact, placement within a good caring family is in all likelihood **the best** mental health intervention possible for an orphaned or otherwise vulnerable child.

Nonetheless, placement must be done with caution. An abusive family or family member, or where a child is used merely to gain financial incentives, may lead to severe emotional problems for the child. Placement is therefore not an end in itself, but a means to good emotional well-being and this must be considered in each placement decision.

Implications: Given the massive crisis of orphaned children expected, a thorough strategy of guardianship within families must be developed and implemented. Alternatives to the current options of formal foster care, residential care and adoption need to be found. However a robust process of ensuring that children are neither taken in to be abused nor abused once they have been taken in must be put in place.

2. Thirty percent of children in this study were not living with their biological parents. In nearly a third of these cases the reason for this was the death of a parent/parents. Nearly a third of these deaths were attributed directly to HIV/AIDS (though in all likelihood at least 40% of these deaths were due to HIV/AIDS). Hence the extended family is currently looking after a significant proportion of children - with at least 10% already as a result of AIDS deaths.

Sixty seven percent of children not living with their biological parents were living with a grandparent, 19% with aunts/uncles and another 10.5% with other family members. Pensioners had a disproportionately high number of non-biological children dependent on them while unemployed people had a disproportionately low number. It appears that traditional/cultural structures are being coupled with economic imperatives in the placement of children.

Implications: The extended family is already bearing much of the brunt of children whose parents have died of AIDS. The numbers found in this study reinforce the projections of likely orphans (made elsewhere) and huge additional pressures on extended family seem inevitable. Ways of managing this "explosion" are essential (See also points 4, 5, 6 & 8 below).

3. Most primary caregivers had considered what might happen to their children/children in their care if they were unable to take care of them. While most people thought that their child/children would go to another family member, a substantial number of caregivers were worried that their children would have nowhere to go to, that things would get extremely difficult for them and some (albeit a fairly small number) saw no alternative but emotional disturbance, the streets or criminal activity for their children. Some respondents perceived that the only possibility for their child's survival would be if the government intervened on their behalf.

When asked directly who would look after the children in their care, most respondents (90%) identified particular family members (mostly the other parent and grandparents), though some respondents expected the government to take care of the children and others simply did not know where they would go to. A small number of respondents (2.5%) identified non-family members. Moreover 8.1% said that children would be looked after by their own siblings. While some of these siblings are, in all likelihood over 18, it appears that for some caregivers child-headed households were the perceived alternative if they were no longer

present to take care of the children. Importantly the person/family identified by the caregiver as the person whom they expected would take care of the child was in most cases also the preferred alternative of the caregiver.

Implications: Most caregivers would want their children/children in their care to go to a family member if they were unable to look after them, and believe they would. Thus the caregiver's wishes mainly coincide with what most experts and indeed government thinks is best for children. This coherence in caregiver wishes and policy needs to be built upon. However there is a group, fairly small in percentage terms, but which could become quite large in actual numbers, whose caregivers seem to have little idea of what may happen to them and who may indeed have no-where to go if their caregiver was no longer alive or able to look after them. Special provision needs to be made for this group of children. Moreover a number of child-headed households seems likely. While, again, this is perhaps a fairly small group in percentage terms it could become fairly large in actual number. This group too, needs special provisions to be made for them.

4. The role of fathers in caring for their children if the mother cannot is important. It is encouraging that around 70% of fathers believed that they would take the primary caregiving role if the mother was unable to. (Unfortunately the study did not establish how many households of fathers looking after children currently exist). However, the numbers of mothers who thought that the children's father would take care of them was far lower (30%), suggesting that fathers' willingness and/or perceptions of themselves as caregivers are divergent from their partner and may not translate into behaviour.

However, most fathers believe that they would need assistance to cope with a child/children without the mother (87%). While the majority of fathers identified financial assistance as the primary need, a number of fathers said that they would need help from other family members or would require a helper. When presented with alternatives which may assist in looking after their child, a small percentage

of fathers felt that a grant of R170 would make a difference, however far more believed that R600, R1000, having education paid for and having help from time to time would make a substantial difference.

Many fathers would find bringing up older children preferable to younger ones. Many man appear to feel out of their depth in dealing with young children.

Implications: While the nature of HIV is such that many children will become "double orphans", for a number of children there are or will be fathers who could potentially play the primary caregiving role. The apparent willingness of many fathers to do this needs to be translated into actual behaviour through targeted assistance programmes. While fathers can certainly access child care grants when their child is under 7 years of age, this would stop after 7. Moreover, fathers would not have access to foster care grants. In addition, from the fathers interviewed it is apparent that having full education paid for is valued equally to receiving R1000 - while having a caring and trained person assist is also highly valued. It can be concluded that providing grants and services will be important if fathers are to play major caregiving roles. In addition, mechanisms to assist fathers with younger children need to be found. Perhaps other family members or other support systems could be utilised in the short term with the longer term objective of the child going to the father.

5. In addition to the father there are a substantial number of other family members, other adults who know the child - and even some who do not - who would consider taking children into their homes and families. Indeed there are many adults who believe that they would take responsibility for various children if the primary care giver was no longer able to play this role. Whether all these people would carry out their perceived intentions cannot be established from this research. However, it is clear that significant additional stressors will be put onto individuals and families should they take on these child caring responsibilities. The numbers of children involved and financial

responsibilies particularly may take many families "beyond breaking point". Therefore the possibility of providing some assistance is critical.

Though the government is reluctant to invest more of its budget in social grants (Minister of Finance, medium term budget vote, 2004), results from this study clearly suggest that financial assistance would certainly "sway" them toward taking in children who no longer had a caretaker. While for most respondents grants of R170 per child per month would have minimal inducement value, grants of R600 and certainly R1000 would. While this may be a significant sum from government's point of view, alternate costs must be calculated. For example residential care is likely to cost at least two to four times more than R1000. Costs to society in terms of crime and violence which could arise if children are not safely entrenched in families would also be substantially more than this investment.

Implications: While integration of children into their extended family or other caring homes may be a major policy objective in relation or orphaned and vulnerable children, new primary caregivers have limits which the HIV/AIDS pandemic is likely to push beyond breaking point. This research suggests that if financial or other incentives are provided it would make a significant different to people's decision on whether to take in a child or not (However see no 6 below). Investing in grants or other incentives must be costed against not providing this.

6. While there were some small differences between groups regarding the efficacy of providing different incentives, the trend amongst all the groups was clear. A grant of R170 may make a difference to a small group of people, but if grants are going to be utilised to seriously assist the integration of orphaned and vulnerable children, then a higher amount than the current childcare grant will have to be paid. For a number of people in this study this amount too would not make much difference, though R1000 would. In addition, having the child's full education paid for (including school fees,

books, uniforms etc) as well as the incentive of having a trained and caring person come to assist from time to time with any problems they may be having with bringing up the child, were both highly valued. So much so that for most people these services were valued more than receiving a grant of R600 per month. In fact for most respondents having education paid for would act as an equivalent incentive to receiving a grant of R1000.

Moreover, the anxieties that new caregivers have around taking in children is clearly illustrated in how highly they would value having a caring and trained person assist them from time to time.

Implications: For a number of people the stressors and difficulties in taking in an orphaned or vulnerable child may be lessoned by provision of assistance. For most people a grant of R170 will not make much difference to whether they take in a child or not, R600 will make some difference, but R1000 will make a substantial difference. However, assistance need not be financial. Despite the policy of free education, the value people still ascribe to having a full education paid for is very high. It appears that ensuring that children have their full education paid for, would lead to a number of children being integrated into families who otherwise would not be. In addition, people want and need assistance with problems they may be having with bringing up the child. Services which provide this support are essential.

7. The poorer a person is, the more they said that they required assistance in order to care for an orphaned or otherwise vulnerable child. Moreover the higher thc grant, the more of an incentive it becomes, especially to poorer people.

Implications: Grants and other assistance act as the highest incentives to the poorest of the poor. If grants and other services cannot be provided to each and every person who takes responsibility for orphaned or vulnerable children, a means test should be implemented to ensure that the poorest are prioritised for these grants.

8. Adoptions are not common practice in African societies and very few adoptions had taken place in the research sample. Moreover even when respondents were presented with a scenario where there was no family member to look after their child, only a minority were either happy or would not object to their child being adopted in South Africa (29%) or outside of South Africa (17%). People with higher education levels were more likely to accept adoption than people with little or no education. However as many as 62% of respondents said that they would consider taking in a child unknown to themselves whose parent/parents had died as a result of AIDS. Again it is not possible to know whether all these people would in fact take in children or not, and certainly it appears that incentives/assistance would make a difference to their decision, however this is a potential resource that needs further exploration.

   - *Implications*: While children going to strangers rather than family may not be the *preferred alternative of carers and is not a common practice in South Africa, the fact that so many respondents said that they would consider taking children into their homes opens possible new avenues for good homes for some orphaned or vulnerable children. In particular, for children who cannot be integrated within extended families, the option of being included into families of "strangers" may be an alternative. As with integration into other families, a grant or services would act as incentives for this to occur. Moreover public education programmes may be needed to both encourage people to take in children and to reduce the stigma of doing this If families were properly screened and no alternative other than residential care, child-headed household or "the streets" was available, placement with strangers could indeed be a good alternative*

9. Placing of orphaned or vulnerable children will, to some extent, be determined by the HIV status of the child and by the age of the child. The further the

"relational proximity" from the child, the more difference both HIV status and age will make. However, even for some fathers and for some grandparents both HIV status and age of the child would influence decisions around caring for children. With regard to age it appears that the gender of the caregiver is a major factor with many men extremely reluctant to look after young children.

Implications: Children infected with HIV are, an all likelihood going to be more difficult to place than children not infected. Special assistance and education programmes may be needed to encourage people to take in children living with HIV/AIDS.

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APPENDIX 1

QUESTIONNAIRE – PLACEMENT OF ORPHANED AND OTHER VULNERABLE CHILDREN

HSRC

QUESTIONNAIRE NUMBER: | | | | |

Area Number:

Diepsloot	01
Orlando East	02
Qwaqwa	03
Mangaung	04
Bloemfontein plots	05

Botshabelo	06
Impendle	07
Edendale	08
Mooirivier	09
Cato Manor	10

INTRODUCTION

The Human Sciences Research Council is a government-funded institution, with offices in Pretoria, Cape Town, Durban, PE and Bloemfontein, that conducts research on a wide range of social, political and economic issues.

We would like to ask you and other members of your household about issues related to the placement of orphaned and other vulnerable children.

Household No: | | | |

Respondent No: | | |

1. Household situated in:

Rural ("tribal")	Rural (farming area)	Urban (suburb/township)	Urban (Informal settlement)
1	2	3	4

2. Gender:

Male	1
Female	2

3. Race:

African	White	Coloured	Indian/Asian
1	2	3	4

4. Number of adults (people over 18) in the household

0	1	2	3	4	5	6	7	8	9	10 or more

5. What is your marital status?

Single	Married	Divorced	Living with partner	Other
1	2	3	4	5

6. How old are you?

18 -25	26-35	36-45	46-55	56-65	Over 65
1	2	3	4	5	6

7. What is your highest educational qualification? (CIRCLE ONE ANSWER ONLY)

a	No schooling	01
b	Up to Std 1/Gr 3 / ABET 1	02
c	Std 2 - Std 3/ Gr 4 - Gr 5 / ABET 2	03
d	Std 4 - Std 5/ Gr 6 - Gr 7 / ABET 3	04
e	Std 6 - Std 7/ Gr 8 - Gr 9 / ABET 4	05
f	Std 8/ Gr 10 / N1	06
g	Std 9/ Gr 11 / N2	07
h	Std 10/Matric/ N3	08
i	Diploma(s) / Occupational certificate(s)	09
j	First degree(s)/ Higher diploma(s)	10
k	Honours / Master's degree(s)	11
l	Doctorate(s)	12

8. How would you describe your present employment situation? (*Interviewer - Read out aloud*)

A	Housewife, homemaker, not looking for work	01
B	Unemployed, not looking for work	02
C	Unemployed, looking for work	03
D	Housewife, homemaker, unemployed, looking for work	04
E	Work in informal sector, not looking for permanent work	05
F	Old age pensioner	06
G	Sick/disabled and unable to work	07
H	Student/pupil/learner	08
I	Self-employed - full time (40 hours or more per week)	09
J	Self-employed -- part time (less than 40 hours per week)	10
K	Employed part time (if none of the above) (less than 40 hours per week)	11
L	Employed full time (40 hours or more per week)	12
M	Other, specify:	13

9. If employed what is your occupation?

Interviewer: Please write down the response and circle the appropriate code.

A	Manager	01
b	Professional	02
C	Technical and associated professional	03
d	Clerical	04
E	Services	05
F	Skilled agriculture	06
g	Miner	07
h	Plant and machine operator	08
I	Elementary occupation (labourer etc)	09
J	Other	10

10. I am going to read a number of statements. Which one best describes your household situation?

a	Not enough money for basic things like food and clothes	1
b	Have money for food and clothes, but short on many other things	2
c	We have most of the important things, but few luxury goods	3
d	Some money for extra things such as going away for holidays and luxury goods	4
e	Don't know	5
f	No response	6

11. Do you have children?

Yes	1
No	2

12. How many (alive) children do you have?

1	2	3	4	5	6	7	8	9	10 or more

13. What are the ages of your children:

	0 – 5	6 - 10	11 - 15	16 – 18	19 and over
Number of children					

14. How many children (18 and under) are living with you and *dependent on you* at present? I am not just talking about your own children, but how many children are living with you right now?

1	2	3	4	5	6	7	8	9	10 or more

15. How many of these children are your own natural children (i.e. by birth)?

1	2	3	4	5	6	7	8	9	10 or more

16. Of the children that are not your natural children, can you tell me who the biological mother is?

Child of my own child (i.e. I am the grandmother/father)	Child of a brother or sister	Formally adopted	Child of another family member	Child of a friend	Child of a person unknown (not formally adopted)
Number of children:					
1	2	3	4	5	6

Skip to 19 if no non-biological children staying with them

17. Can you please tell me how it has come to be that this child/these children (non-biological children) are living with you? *Note verbatim*

____

____

____

____

____

If the person says that the reason is that the mother/father have died. Ask:

18. Can you tell me how the mother/father died?

____

____

____

____

19. Do you have any brothers and sisters?

Yes	1
No	2

20. How many?

1	2	3	4	5	6	7	8	9	10 or more

21. Do any of your brothers or sisters have children under 18?

Yes	1
No	2

22. Do you have any grandchildren?

If No skip to Question 26

Yes	1
No	2

23. How many grandchildren do you have?

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	More than 20

24. Ages of grandchildren:

	0 – 5	6 - 10	11 - 15	16 - 18	19 and over
Number of grandchildren					

25. Are any of these grandchildren staying with their own parents at the moment?

Yes	1
No	2

Ask parents/grandparents/caregivers with children under 18 living with them <u>and dependent on them</u>

26. If by chance something terrible were to happen to you and you were no longer able to look after your child(ren)/ child(ren) under your care,

a) What do think may happen to this/these child(ren)? *Record verbatim*

____

____

____

____

____

b) Who do you think might look after them? *(If not all children would go to same, record this as stated – i.e. multiple response)*

They would be looked after by:

Other parent	Grandparent	Uncle/aunt	Another sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

27. Have you ever previously thought about this question yourself?

Yes	1
No	2

28. If you had the choice of where your child/children in your care were to be placed, whom would you choose? *(If not all children would go to same, record this as stated – i.e. multiple response)*

Other parent	Grandaparent	Uncle/aunt	Another sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

29. If your child/children currently in your care could not go to a family member, how would you feel about them being adopted by another South African family? ***(Read out)***

Would be happy about this	Would not object to this	Would be extremely unhappy about this
1	2	3

30. If your child/children in your care could not go to a family member, how would you feel about them being adopted by a family outside of South Africa? *(Read out)*

Would be happy about this	Would not object to this	Would be extremely unhappy about this
1	2	3

Ask grandparents with grandchildren living with their own parent(s) (See 25)

31. **If by chance something terrible were to happen to your own child(ren) and they were unable to look after their children, that is they were unable to look after your grandchildren,**

a) **What do you think may happen to the grandchildren?**

____

____

____

____

____

b) **Who do you think would look after them?** *(If not all children would go to same, record this as stated – i.e. multiple response)*

They would be looked after by:

Respondent Him/herself	Other Grandaparent	Uncle/aunt	Other sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

32. **Have you ever previously thought about this question yourself?**

Yes	1
No	2

If respondent says that children would come to them ask questions 33-36. Otherwise skip to 37:-

33. **You have x number of grandchildren,** *(see response in Q. 23)* **would you be prepared/able to take all of them into your home if necessary?**

Yes	1
Some but not all	2

34. **If answer "some but not all". How many of your grandchildren do you think you would be able to take in?**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	More than 20

35. **What additional stresses do you think that taking in an extra child or children would have on you/your family/your household?** *List verbatim*

____

____

____

____

36. What kind of assistance do you think you would need in order to take in and take care of these grandchildren? *List verbatim*

____

____

____

____

____

37. Would it make a difference to your decision to you yourself taking in the grandchild/grandchildren if:-

a) you could obtain a grant of R170 for each child you took in (*Read out options*)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) you could obtain a grant of R600 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) you could obtain a grant of R1000 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) the full education of your grandchild was paid for (including school fees, books, uniforms etc)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) **a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

f) Would the age of the child(ren) make a difference to whether you would care for them or not?

Yes	1
No	2

g) What age group do you think you would be most likely to care for yourself? *Read out options*

0 – 5	6-10	11-15	16 and up

h) Would it make a difference to taking in the child/children if he/she were HIV positive?

Yes	1
No	2

Ask fathers of children living with their mothers (whether father is part of the household or not)

38. If by chance something terrible were to happen to your child(ren)'s mother and she was no longer able to look after your child(ren),

a) what do you think may happen to them?

____

____

____

____

____

b) who do you think would look after them?

(*If not all children would go to same, record this as stated*)

They would be looked after by:

Respondent Him/herself	Grandparent	Uncle/aunt	Other sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

If answer to previous question is 1 ask 39 and 40, otherwise skip to 41

39. What additional stresses do you think that bringing up such a child yourself would have on you/your family/your household? *List verbatim*

____

____

____

____

____

40. What kind of assistance do you think you would need to look after your children?

List verbatim

____

____

____

____

____

41. Would it make a difference to your decision to continue to keep and look after your children if:-

a) you could obtain a grant of R170 for each child you took in (*Read out options*)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) you could obtain a grant of R600 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) you could obtain a grant of R1000 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) the full education of your child was paid for (including school fees, books, uniforms etc)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) **a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

f) **Would the age of the child(ren) make a difference to whether you would care for them or not?**

Yes	1
No	2

g) **What age group do you think you would be most likely to care for yourself?** *Read options*

0 – 5	6-10	11-15	16 and up

h) **Would it make a difference to taking in the child/children if he/she were HIV positive?**

Yes	1
No	2

Ask adults in the household where there is a child/are children but where the child(ren) is/are not dependent on the respondent

42. **If by chance something terrible were to happen to the person/people in this household on whom the children are currently dependent,**

a) **What do think may happen to the children?**

____

____

____

____

____

b) **Who do you think would look after them?**

(*If not all children would go to same, record this as stated*)
They would be looked after by:

Respondent Him/herself	Grandparent	Uncle/aunt	Other sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

43. Would you consider taking the children in to be part of your own family/household?

Yes	1
No	2

44. Would it make a difference to your decision to take them in and look after them if:-

a) you could obtain a grant of R170 for each child you took in *(read out options)*

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) you could obtain a grant of R600 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) you could obtain a grant of R1000 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) the full education of the child/children was paid for (including school fees, books, uniforms etc)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference

f) Would the age of the child(ren) make a difference to whether you would care for them or not?

Yes	1
No	2

g) What age child do you think you would be most likely to care for yourself?

0 – 5	6-10	11-15	16 and up

h) Would it make a difference to taking in the child/children if he/she were HIV positive?

Yes	1

Ask adults with siblings who have children under 18 years of age (See 21)

45. If by chance something terrible were to happen to your brother/sister and he/she was no longer able to look after her/his/their child(ren),

a) What do think may happen to the children?

____

____

____

____

____

b) Who do you think would look after them?

(If not all children would go to same, record this as stated)

They would be looked after by:

Respondent Him/herself	Grandparent	Uncle/aunt	Other sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

46. Would you consider taking the children in to be part of your own family/household?

Yes	1
No	2

47. Would it make a difference to your decision to take them in and look after them if:-

a) you could obtain a grant of R170 for each child you took in *(read out options)*

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) you could obtain a grant of R600 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) you could obtain a grant of R1000 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) the full education of the child/children was paid for (including school fees, books, uniforms etc)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

f) Would the age of the child(ren) make a difference to whether you would care for them or not?

Yes	1
No	2

g) What age child do you think you would be most likely to care for yourself?

0 – 5	6-10	11-15	16 and up

h) Would it make a difference to taking in the child/children if he/she were HIV positive?

Yes	1
No	2

Ask all respondents

48. If by chance something terrible were to happen to your best friend and he/she was no longer able to look after his/her child(ren),

a) what do think may happen to them?

____

____

____

____

____

b) who do you think would look after them?

(If not all children would go to same, record this as stated)

They would be looked after by:

Respondent Him/herself	Grandaparent	Uncle/aunt	Other sibling	Other family member	Other: describe	Don't know
1	2	3	4	5	6	7

49. If there was no one else to look after the child/children would you consider taking in the child/children yourself?

Yes	1
No	2

50. Would it make a difference to your decision to take them in and look after them if:-

a) you could obtain a grant of R170 for each child you took in *(Read out options)*

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) you could obtain a grant of R600 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) you could obtain a grant of R1000 for each child you took in

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) the full education of the child/children was paid for (including school fees, books, uniforms etc)

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) **a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

f) **Would the age of the child(ren) make a difference to whether you would care for them or not?**

Yes	1
No	2

g) **What age group do you think you would be most likely to care for yourself?**

0 – 5	6-10	11-15	16 and up

h) **Would it make a difference to taking in the child/children if he/she were HIV positive?**

Yes	1
No	2

Ask all respondents

51. **As I'm sure you know, there is a possibility in South Africa that a number of mothers and fathers of children may die as a result of the HIV/AIDS epidemic. If there was a child who lost their parent and had no-where to go to, do you think that you would take such a child in – even if you did not know the parent.**

Yes	1
No	2

52. **Would it make a difference to your decision to take them in and look after them if:-**

a) **you could obtain a grant of R170 for each child you took in** *(read out options)*

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

b) **you could obtain a grant of R600 for each child you took in**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

c) **you could obtain a grant of R1000 for each child you took in**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

d) **the full education of child/children was paid for (including school fees, books, uniforms etc)**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

e) **a caring and trained person were to assist you from time to time with any problems you may be having with bringing up the child.**

Would make no difference whatsoever	Would make me give some thought to the matter	Would make me seriously consider the matter which I otherwise would not have considered at all	Would influence me towards making a positive decision	Would definitely make a positive difference
1	2	3	4	5

f) **Would the age of the child(ren) make a difference to whether you would care for them or not?**

Yes	1
No	2

g) **What age group do you think you would be most likely to care for yourself?**

0 – 5	6-10	11-15	16 and up

h) **Would it make a difference to taking in the child/children if he/she were HIV positive?**

Yes	1
No	2

Thank-you very much, that's all.
I really appreciate your assistance with this.

APPENDIX 2 – CONSENT FORM

RESEARCH REGARDING PLACEMENT OF CHILDREN WHO HAVE LOST OR WHO MAY IN THE FUTURE LOOSE A PARENT THROUGH DEATH OR ABANDONEMENT

INTRODUCTION AND CONSENT FORM

Hello, I am .... I am from the Human Sciences Research Council and our organisation is asking people from your community to answer a few questions which we hope will benefit a number of children in the future.

The Human Sciences Research Council is a national independent research organisation, and we are conducting research regarding children who have lost or who may in the future loose either one or both of their parents to death or abandonment. We are interested in finding out more about what happens to these children and what may happen to children in this situation in the future. From our understanding it is likely that there is going to be an increase in the number of children without one of both parents in the future and we are carrying out this research to help government and non-government organisations to plan effectively for the future of these children.

You and your household has been chosen for no particular reason other than that we are stopping at every xth house in this neighbourhood and asking all the adults in the household to respond to some questions. We are doing this in quite a number of different areas in the country and through combining all people's answers we hope we will be able to make good recommendations to the relevant authorities and organisations.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way whatsoever. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. There can therefore be no "come-backs" from the answers you give.

The interview will last around 30 minutes. I will be asking you some questions and request that you are as open and honest as possible in answering these questions. I will be asking some questions that you may not have thought about before and which also involve the future which we know you cannot be absolutely certain about. I ask that you try to think about what you would do. When it comes to answering questions about the future there are no right and wrong answers and we are **not** interested in what you think the best thing would be to do, but what you think would actually happen.

If I ask you any question which makes you feel sad or upset we can stop and talk about it a little. There are also some people from the local Department of Health/University who have said they are happy to talk more with you if you need any assistance later. If you need to speak with anyone after I have left here a professional person can be reached on the number given to you.

If possible, our organisation would like to come back to this community once we have completed our study to inform you of what the results are and discuss our findings and proposals around the research and what this means.

CONSENT

I hereby agree to participate in research regarding regarding children who have lost a parent. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

....

Signature of participant **Date:**......................

If you have any further questions about the research, you are welcome to contact the main investigator Prof. Melvyn Freeman at 012 –302-2453.