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CHALLENGING DOMINANT POLICY PARADIGMS OF CARE FOR CHILDREN ORPHANED BY AIDS: DYNAMIC PATTERNS OF CARE IN KWAZULU-NATAL, REPUBLIC OF SOUTH AFRICA

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Challenging Dominant Policy Paradigms of Care for Children Orphaned by AIDS: Dynamic Patterns of Care in KwaZulu-Natal, Republic of South Africa

Abstract

Although caring for children orphaned by AIDS is increasingly acknowledged as a priority area for HIV/AIDS and development programs, there is limited knowledge on caregivers. Rapidly growing numbers of children orphaned by AIDS warrants increased attention from researchers, policy makers, and program planners. This paper explores dominant theoretical and policy paradigms of care for children orphaned by AIDS. Then, drawing from an analysis of interviews with staff at non-governmental organizations and community based organizations, and focus groups with caregivers gathered during fieldwork conducted between July 10 and September 8, 2006 in KwaZulu-Natal Province, Republic of South Africa, this paper contrasts local understandings of childcare with theoretical and policy notions of care. Findings from this qualitative study suggest that childcare practices are more diverse and complex than those currently recognized within existing theoretical and policy formulations. Such findings lead to the conclusion that current policy approaches towards care for children orphaned by AIDS face a potentially detrimental disconnect with local realities of care. Re-formulating policies to take into account how local practices of childcare are shifting in dynamic ways in response to the pandemic will be essential for the formulation effective policies and programs.

Introduction

Much research has been conducted on the distribution of HIV and the behavioral characteristics associated with transmission, but less is known about the macro-level sequelae of the pandemic that extend beyond biomedical outcomes (Merli and Palloni 2006: 117; Whiteside 2006: 337). Such research is urgently needed, particularly around the issue of caring for an estimated 15.2 million children orphaned by AIDS (UNAIDS et al. 2007).[1] Within the limited body of literature on care structures, care experiences, and the impact of care on children, only a handful of studies explore care for children orphaned by AIDS in the Republic of South Africa (RSA) (Desmond, Gow et al. 2002; Brookes, Shisana et al. 2004; Madhavan 2004; Townsend and Dawes 2004; Donald and Clacherty 2005; Hartell and Chabilall 2005) despite that fact that RSA is situated at the epicenter of the global pandemic (UNAIDS and WHO 2006: 1) with 320,000 deaths from AIDS in 2005 (UNAIDS and WHO 2006) and an estimated 1,200,000 children under age 17 years already orphaned by AIDS (UNAIDS and WHO 2006). This study uses attachment theory as a theoretical framework to explore care for AIDS orphans in three communities located in the Durban vicinity of KwaZulu-Natal (KZN), the province with the highest prevalence of HIV/AIDS (UNAIDS and WHO 2005: 21) and orphans in RSA (Jacobs, Shung-King et al. 2005: 53). This study is not only essential for constructing effective programs for supporting those who care for children orphaned by AIDS, but addresses one of the general weaknesses of existing studies - the lack of rigorous and theoretically framed approaches towards research on care for AIDS orphans.

Studies on Care for Children Orphaned by AIDS

A review of existing literature reveals three general trends on care for children orphaned by AIDS. First, studies reveal gendered patterns of care. For example, a USAID study analyzing Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) household data from 1990 to 2000 in 14 countries in Africa and the Caribbean illustrates that a significantly larger proportion of children orphaned by AIDS live in female-headed households compared with non-orphans (2004: 20). These gendered care patterns hold true for RSA where approximately 75 percent of orphans live in female-headed households (ibid). A UNICEF (2003: 21) study drawing from DHS and MICS data from 1997 to 2000 also demonstrates gendered patterns of care in RSA; female-headed households care for an average of two orphans while male-headed households care for an average of one orphan. Second, literature reveals differential patterns of care across generations (Ansell and van Blerk 2004: 690). USAID's analysis of DHS and MICS data reveals that "a higher proportion of orphans live in households headed

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[1] This paper adheres to the UNAIDS definition of "orphan" as children who have lost one or both parents to AIDS below the age of 18 years.

by elderly persons (mostly grandparents)" (2004: 20). In RSA, grandparents play a significant role as carers, providing 42 percent of care for paternal or maternal orphans (op. cit.: 22). These aged patterns of care seem to be increasing in prominence. For example, an analysis of DHS and MICS data illustrates that in Namibia, the proportion of grandparents caring for orphans increased from 44 percent in 1992 to 61 percent in 2000 with similar patterns in Tanzania and Zimbabwe (UNAIDS et al. 2004: 10). Third, data exhibits geographical patterns of care. DHS and MICS data from Africa and the Caribbean reveal higher numbers of orphans and higher dependency ratios in rural areas; both of these trends suggest that rural areas bear a disproportionate burden for caring for orphans (USAID 2004: 12). Although geographical differences in care provision exist in RSA, these differences are small with two percent more orphans existing in rural areas than in urban areas (UNICEF 2003: 10).

A review of existing studies also shows that little is known about how patterns of orphan care may be changing in the context of the pandemic. Research on trends in orphan care across 40 sub-Saharan African countries shows that family, typically siblings or extended family members, care for orphans (Monasch and Boerma 2004). This pattern of familial care holds true in South Africa where "the majority of orphaned children live with relatives without intervention or incentives from the State" (Jacobs, Shung-King et al. 2005: 34). In addition, literature from elsewhere in the African region suggests that patterns of orphan care may be changing but there is disagreement over how families are coping with changing care challenges. For example, Foster's studies suggest that families experience substantial difficulties in coping with the pressures of orphan care (2000; 2002), while other studies suggest few unique difficulties arise within families due to orphan care (Ankrah 1993; Sarker, Neckermann et al. 2005). A review of literature also illustrates that little is known about the role of non-family caregivers.

The process of arranging orphan placement is also an underexplored aspect in the literature. Studies suggest that family caregivers are preferred to other caregivers (Rotheram-Borus, Leonard et al. 2002; Beard 2005) but little is known about what factors influence child placement. Norms placing children with family may be changing due to large numbers of orphans and a paucity of potential family carers (Nyambedha, Wandibba et al. 2003). Few studies show how selection takes place or whether or not those assigned to care for children are willing to take on this responsibility (Rotheram-Borus, Leonard et al. 2002; Freeman and Nkomo 2006). Furthermore, Young and Ansell's (2003) research suggests that family roles and obligations are shifting in important ways due to the pandemic. Combined, these studies indicate that it is important to assess how increasing numbers of orphans impact the "process of negotiation between different individuals and sections of the extended family" particularly with regard to who cares for orphans as well as the willingness and roles of potential caregivers (Ansell and van Blerk 2004: 689).

The limited evidence on care suggests that care provision entails serious impacts on caregivers and households. First, working-age adults heading households with orphans experience a higher dependency burden than adults in non-orphan households (USAID 2004: 5, 11). Second, households strategies to provide care for orphaned children - such as migration or relocation of family members to extended family households (Desmond, Michael et al. 2000; Young and Ansell 2003) - may be compromised by the physical health of potential caregivers and AIDS-related stigma which impacts the availability of social support networks that caregivers can draw from (International HIV/AIDS Alliance and HelpAge International 2003: 7). Third, provision of care may include serious financial costs. One study in Zimbabwe illustrates that two-thirds of those caring for AIDS orphans experienced financial difficulties linked to care (Howard, Phillips et al. 2006). Finally, care for children orphaned by AIDS entails a great deal of physical, mental, and emotional stress (ibid). This evidence suggests that dynamics of care may impact caregivers negatively.

In order to better understand how caregivers deal with challenges entailed in care, more needs to be known about caregivers' support networks. A review showed that several studies explore who caregivers turn to for support and the factors that impact these support networks. For example, Zachariah *et al.* (2006) explore sources of community support in Malawi. Oleke *et al.*'s (2005) study in Uganda examines how cultural and historical processes of economic marginalization constrict caregivers' support networks. Moreover, care may create social costs that in turn, impact the care experience. For example, a study in Sudan identifies stigma as a significant factor that increases care challenges by weakening social ties and leading to marginalization from others at a time when carers and orphans need support (International HIV/AIDS Alliance and HelpAge International 2003: 16-17).

In addition, more research needs to be conducted on how particular caregiver characteristics influence child outcomes. Existing studies suggest that caregivers characteristics impact child growth and development. A small pilot study in Pietermaritzburg, RSA compares the experiences of children in child-headed households versus adult-headed households. Findings indicate that children in child-headed households face challenges accessing social services, income, sources for resource generation, and face emotional and psychological adjustment issues (Donald and Clacherty 2005). However, orphans in child-headed households perform better than children in adult-headed households in terms of social networking and managing time and money (ibid). A longitudinal study on orphans and school enrollment in Malawi illustrates that children living with single parent carers and grandparent carers have lower rates of school enrollment than children living with other relatives (Sharma 2006). Other studies suggest that a variety of factors external to the care dyad, i.e. the caregiver-child relationship, influence care provision. One such example is Hamra *et al*.'s (2006) study which shows that caregivers with higher levels of expressed stigma provide lower levels of care. Overall, the previous overview of the literature shows that there are important limitations in our understanding of care structures, care experiences, and the impact of care on orphans in the context of the HIV/AIDS pandemic.

Policies on Care for Children Orphaned by AIDS

With only limited studies to draw from, a review of policy documents produced between 2001 and 2006 on care for AIDS orphans reveals that policy responses have drawn from a restricted theoretical and empirical evidence base about the orphan caregiving experience, and have derived core policy assumptions from attachment theory, a highly influential theory of care and child development prevalent in the field of developmental child psychology. However as Burman (1994) and Scheper-Hughes (1985) have argued, the assumptions underlying theories developed in the West might be historically or contextually bound, and thereby might have limited relevance for the family and orphan caregiving conditions in RSA.

Attachment theory posits that healthy child development depends on the existence of an attachment relationship defined as “a warm, intimate and continuous relationship” between the young child and mother or permanent mother-substitute (Bowlby 1974: xi). While Bowlby focuses primarily on the importance of attachment for children under three years of age, other scholars illustrate that attachment relationships play a vital role in the developmental outcomes of preschool and young school age children (Main and Cassidy 1988; Marvin 1997). Attachment relationships are developed through “the reciprocal behaviors of child and parent" which "are adapted to each other in an evolutionary sense" (Ainsworth, Blehar et al. 1978: 9). Theorists suggest that children who lack secure attachment relationships may face impaired cognitive development (op. cit.: 12) and dysfunctional emotional behavior in adult life (Bowlby 1953: 23).

Three assumptions lay the foundation for attachment theory. First, attachment theorists assume that biological parents serve as primary caregivers, and that this attachment reflects evolutionary processes and is critical for the child's development (Bowlby 1973: 13). Deriving from this assumption, children lacking a biological parent attachment figure are presumed vulnerable to psychological challenges. Second, attachment theorists assume that non-kin caregivers are less able to meet the developmental needs of the child because substitute caregivers lack the biological connection that underlie adequate provision of the child's developmental needs (Bowlby 1974: 306). For example, Bowlby suggests, "a substitute's mothering responses may well be less strong and less consistently elicited than those of a natural mother" (ibid). In the absence of parental care, attachment theorists prefer extended family caregivers, suggesting that children are likely to attach to "near and known relatives" who are "at hand to take the maternal role in an emergency" (Bowlby 1973: 84). Third, theorists minimize the structural and contextual determinants of care and child development. For example, key texts in the attachment literature focus on individuals in the care dyad, with little mention of structural determinants of care (Ainsworth, Blehar et al., 1978; Sroufe and Fleeson, 1986). Moreover, due to the supposed ethological origins of attachment behavior (Ainsworth, Blehar et al. 1978), theorists assert that attachment theory is universally applicable.

A review of policies guiding AIDS orphan care in RSA reveals that these theoretical assumptions underlie the policy response. First, policies reflect the assumption that parental care is the norm, and construct parental deaths as an inevitable disaster for child development caused primarily by the loss of the affective bond between biological parent and child. For example, UNICEF's *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS* (e.g. The Framework) states, "the loss of a parent often means that young children are left without consistent responsive care" (UNICEF 2004: 9). Crisis also presumably arises because parental deaths destabilize or destroy the 'normal' care environment vital for processes of child development, based on dyadic principles of parent and child relationships. For example, The Framework states, "HIV/AIDS undermines, then destroys, the *fundamental human attachments* essential to normal family life and child development" (emphasis added, op. cit.: 16). Without parents, policy makers assert that children will be deprived of "love, attention and affection" and lack "interpersonal and environmental stimulation" necessary for child development (op. cit.: 9). It is suggested that "without parents to educate and protect them", orphans will be at risk for abuse, impoverishment, and exploitation (op. cit.: 9).

In the absence of parental care, policy makers propose that extended families provide the next most optimal environment for the care and growth of children. For example, the South African Department of Social Development's *Policy Framework on Orphans and Other Vulnerable Children* (i.e. Policy Framework) suggests, "children should be placed within the environment where the family resides or be placed with the extended family" (Department of Social Development 2005: 35). These preferences for familial placement over non-kin placement are closely connected to assumptions regarding healthy child development. For example, UNICEF's *Children on the Brink* states, "to survive and thrive, children and adolescents need to grow up in a family and community environment that provides for their changing needs, thereby promoting their healthy and sound development" (UNAIDS et al. 2004: 13). Non-kin carers, such as neighbors and family friends are not included as optimal carers in this policy formulation.

Finally, by proposing a standard framework for orphan care, policy makers overlook local historical, social, economic, and political context. Throughout policy documents, no reference is made towards local understandings of 'family', 'care', and 'community'. In one exception, the UNAIDS Framework notes there is "no model or specific set of interventions that can be prescribed for all communities, countries and regions" (ibid). Yet, all other identified policy documents propose a "common framework for an appropriate response" (op. cit.: 11) towards care for orphans (UNAIDS et al. 2004: 13; UNICEF 2004: 14; Department of Social Development 2005). The findings of this policy analysis lays the groundwork for exploring the disjuncture between theoretical understandings of care and perceptions of care in communities confronted with rising numbers of orphans.

Methods

This research utilized mixed qualitative methods to develop insights into care practices in communities in KZN. Methods were approved by an ethical review committee at the University of Oxford. Designed to identify specific variables for further investigation, this study was guided by the following theoretical and analytical aims: (a) to obtain a qualitative understanding of perceptions of childcare in KZN and (b) to qualify and revise theoretical understandings of care based on evidence.

Two groups were identified for participation: (a) staff at non-governmental organizations (NGOs) and community based organizations (CBOs) working with or advocating for carers and children orphaned by AIDS and (b) those providing care for children orphaned by AIDS. Staff at NGOs/CBOs were identified utilizing purposive sampling techniques guided by a conceptual sampling frame stratified according to characteristics derived from the HIVAN/KZNCAN 2005 Directory, a comprehensive listing of 1,300 organizations involved in HIV/AIDS work in KZN. Informed consent was gained prior to the start of each interview. Recruitment procedures resulted in a 59 percent response rate. In total, 14 staff at nine organizations were interviewed in English using a semi-structured protocol via telephone or in person.

Caregivers were identified in urban, peri-urban, and rural communities and organizational contacts were enlisted in order to assist in: (a) facilitating community access and building trust with local leaders and (b) identifying potential research assistants/Zulu translators from the community. With research assistants/Zulu translators, lists of caregivers of AIDS orphans were constructed according to the following criteria: 1) participant (i.e., caregiver) is 18 years or older; 2) participant provides care for one or more children orphaned by AIDS (care defined as a child living in the same home as the participant with the participant providing the majority of care duties); 3) participant is not the child's biological parent; 4) child or children being cared for have lost one or more biological parents to AIDS; 5) child or children was not in the care of the remaining biological parent. Stratified random sampling techniques were used to contact potential respondents. In total, 84 caregivers from three communities participated in four focus groups guided by a semi-structured protocol.[2] Informed consent was gained prior to the start of each focus group.

Results

There were significant areas of agreement between respondent narratives and policies on care for AIDS orphans. Respondent narratives coincided with policies in several areas including: the government faces enormous fiscal and manpower challenges from rising numbers children orphaned by AIDS; and collaboration between government, civil society, and NGOs/CBOs is essential for meeting carers' and children's needs; there exist significant challenges in meeting caregivers' and children's needs due to the socio-economic impact of HIV/AIDS and stigma; and there exists a need to build the capacity of families to meet these challenges. The findings, however, pointed to significant discrepancies between policy and the respondent's conceptions and experiences of care. The subsequent discussion highlights three ways in which respondent narratives diverged from the foundational tenets of attachment theory as reflected in the policy documents discussed above.

Challenging Notions of a Crisis in Care and Child Development

First, even though respondents recognized that parental deaths caused dramatic societal changes which reshaped household structure around the old and young with serious economic, social, and emotional repercussions, respondents suggested that parental deaths did not necessarily cause a direct crisis in childcare. Both caregiver and NGO/CBO respondents argue parental deaths did not cause a direct crisis in childcare because extended family members historically played a significant role in caring for children and continued to do so in the context of the pandemic. For example, a NGO/CBO respondent stated, "even before the epidemic, it has been normal practice for a child to be left with a grandparent while the mother and father work in town" (Respondent A, NGO/CBO 4, July 25, 2006). Similarly, 50 percent of the caregivers in the peri-urban focus group confirmed that, "many of us already lived in the same house with the parents. When the

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[2] NGOs/CBOs, leaders, and community contacts who facilitated contact with caregivers in urban, peri-urban, and rural communities asked that caregivers' communities be kept anonymous to avoid harms that may arise out of stigma and discrimination.

parents passed, we continued to stay with the children because they were in our house" (Peri-Urban Focus Group, August 23, 2006). This primary data is supported by existing literature. For example, Madhavan argues that in RSA, children have historically been "fostered by a variety of kin and, sometimes, non-kin. Therefore, child fostering has always been and continues to be a crucial part of black family life" (2004: 1443). Similarly, data from Cock, Emdon et al.'s national study of urban South African childcare shows that "almost 40 percent of women left children with adult relatives, particularly grandmothers, and 10 percent left their children with older siblings" (1986: 81). These existing studies combined with fieldwork data suggest that because childcare has historically diverged from non-parental forms, parental deaths did not directly generate a crisis of care.

Moreover, whilst caregiver and NGO/CBO respondents agreed that parental deaths created serious challenges for child development, respondents challenged the theoretical assumption the parental deaths *directly* generated a child development crisis. Instead, respondents argued that because non-parental individuals typically functioned as primary caregivers, parental deaths indirectly caused a child development crisis. For example, a NGO/CBO respondent stated, "the network of support is becoming smaller both socially and economically because so many relatives die" (NGO/CBO 7, August 25, 2006). Another NGO/CBO respondent stated:

> HIV/AIDS has had a huge impact in the community. Now, we are missing an entire generation in the family. We have many households managed by children themselves and also older individuals. This places a huge strain on the family. (NGO/CBO 8, August 24, 2006)

Similarly, another NGO/CBO respondent said:

> The epidemic seems to be placing a heavy burden on grandmothers who are taking care of many children without support of parents. While this is to some extent traditional, they are increasingly having to take care of children without other financial and emotional support. (Respondent A, NGO/CBO 4, July 25, 2006)

These statements suggest that parental deaths an *indirect* cause of crisis by first, depriving caregivers of important sources of economic and social support and then through the challenges that arise from the lack of resources needed to meet children's developmental needs.

In addition, respondents' perceptions of crisis were much more complex than theoretical formulations which tend to characterize the crisis as affective in nature as seen by the data gathered when respondents were asked to name the top five care challenges (***Table 1***).

Table 1: Care Challenges Associated with Caring for Children Orphaned by AIDS

Type of Challenges Mentioned by Respondents	**NGO/CBO Respondents' Perceptions of Challenges Faced by Caregivers (number of times the issue was raised by each respondent)**	**Caregiver Respondents (number of times issue was raised by each group)**
Economic Challenges		
School fees/uniforms	9	11
Poverty	8	9
Food	5	9
Accessing documents for children to get financial support	4	5
Shelter	4	10
Unemployment	3	3
Clothing	3	7
Transport, particularly to go to clinics	2	4
Caregiver and child health	2	1
Clean water	0	3
Affective, Emotional, and Psychological Challenges		
Children and Caregiver Bereavement	3	1
Children's affective needs	1	1
Disappointment about the expectations they had about their lives at this stage (elderly caregivers)	1	0
Social Challenges		
Stigma	6	1
Tiredness/stress because of the energy involved in caring for children (elderly caregivers)	4	
Sexual abuse of children	2	1
Disciplining children	2	1
Caregiver's sense of isolation	1	0
Combining families	1	0

Notions of crisis were not only affective but also economic and social. Such data is further verified through respondent narratives. For example, a NGO/CBO respondent argued that affective needs were only one of many aspects of care provision:

> [Caregivers are] . . . concerned about physical well being. Some are concerned about education. Some of the grandmothers have spoken about their sense of the need to address emotional and social issues, but say that they struggle with this aspect. (Respondent A, NGO/CBO 4, July 25, 2006)

Table 1 also shows significant differences between NGO/CBO respondents' and caregivers' perceptions of care challenges. NGO/CBO respondents identified a broad range of challenges but caregivers tended to focus on the economic challenges associated with care. This data indicates caregivers tend to prioritize the child's physical needs over affective needs, likely because physical needs tend to be more pressing and obvious than affective needs. For example, a NGO/CBO respondent stated, caregivers are primarily "concerned with the most basic needs – primarily food, clothes, shelter which is not large enough for these growing families of children left behind, and some love *if there is time*" (emphasis added, Respondent B, NGO/CBO 3, August 22, 2006). Moreover, whilst at least two caregiver focus groups mentioned that children needed "love" (Urban Focus Group 1, August 15, 2006; Peri-Urban Focus Group, August 23, 2006), the majority of the discussion in all focus groups centered around the economic and social challenges associated with care. This illustrates that support towards caregivers must be designed in a holistic manner with attention towards not only affective dimensions of care, but towards the multiple dimensions of care.

Challenging the Simplistic Dichotomy of Kin versus Non-Kin and Better versus Worse Care

Respondents also challenged the notion that in the absence of parental care, extended family caregivers were best able to mitigate the crisis of care and child development. For example, NGO/CBO respondents strongly felt that kin caregivers provide differential care. NGO/CBO respondents compared the experiences of children placed with grandmothers versus aunts, arguing that grandmother caregivers were better able to meet children's developmental needs. These differences in the quality of grandmother versus aunt care provision relates to the difficulty aunts face when incorporating additional children into the family. For example, a NGO/CBO respondent described the difficulties aunts face as caregivers:

> It is difficult to take care of this additional family when you have your own. Maybe you have four children of your own and four more are coming to join your family; it is a huge challenge to combine these children and treat them as your own. (Respondent B, NGO/CBO 4, August 1, 2006)

In addition, another NGO/CBO respondent argued that grandmothers are better poised to meet children's emotional needs:

> The children being cared for by grannies are doing far better than the children being cared for by aunties. The grannies are nurturing and have special love for the children . . . The aunties don't have time and have their own issues maybe with husbands, other children. (Respondent C, NGO/CBO 4, August 1, 2006)

It is likely NGO/CBO respondents, rather than caregivers, raised this issue due to their macro-level perspective of the care experience in comparison to caregiver respondents. Moreover, grandmother caregivers may have felt uncomfortable raising this issue within the focus group setting since such opinions may have been viewed as a direct criticism of aunt caregivers participating in the discussion. This evidence suggests the need to reassess the simplistic theoretical assumption that kin carers are preferable to other types of caregivers.

Both caregiver and NGO/CBO narratives also called into question the assumption that non-kin caregivers are inferior care providers due to their lack of an ethological connection with the child. Instead, caregivers suggested that what matters for child development is not whether kin or non-kin care for children, but that the children remain in their community. Both kin and non-kin caregivers are able to meet this need. For example, two focus groups mentioned that institutional care is acceptable when "children have nowhere to go" (Peri-Urban Focus Group, August 23, 2006). Rural caregivers similarly argue, "many of us think that [a center for orphan care] is crucial, especially if children have no other forms of support" (Rural Focus Group, August 10, 2006). Caregivers argued that institutional care should be a lastresort, not because non-kin care for children in these settings, but because institutional care separates children from their community. Several NGO/CBO respondents elaborated further, arguing that a child's connection with their community is essential to child development in the Zulu cultural context. For example, a NGO/CBO respondent stated:

> In the Zulu culture, the home is the total identity of the child. By removing the child from the home, you are removing him from his roots. You cut him off. It is a very aggressive thing to do, to take a child out of his home even if there is no one left of the family. (NGO/CBO 9, August 14, 2006)

Similarly, another NGO/CBO respondent suggested:

> It is possible that it is loss of home that creates a situation where children are unaccepted. In the Zulu community, ancestry is very important. Often, your grandmothers, grandfathers, etc. are buried in the back yard. Thus, being close to your ancestors is important for belonging. (Respondent B, NGO/CBO 3, August 22, 2006)

The same respondent elaborated further, arguing that if children are separated from their community:

> They won't be accepted back in their community. The community will look at these children with distrust and ask why they left their community in the first place, if they did something wrong in the community. So while these orphanages may be able to provide these children with food, clothes, and educations, these orphanages do not enable children to integrate into their communities. (Respondent B, NGO/CBO 3, August 22, 2006)

These findings provide insights into local understandings of care and child development and challenge the assumption that non-kin caregivers are automatically less able to meet the children's needs.

Structural and Contextual Factors Impacting the Care Experience

Finally, respondents suggested that care for children orphaned by AIDS is shaped by structural constraints and local context. Such evidence challenges attachment theory which tends to take an analytical approach that focuses on the actions of individuals within the caregiver-child dyad and assumes that attachment is an ethological behavior that is universally applicable across all settings. Two major structural issues - unemployment and poverty - constrain care provision in RSA. In the context of high rates of unemployment at 40 percent (Kingdon and Knight 2004), all caregiver focus groups suggested that unemployment creates serious care challenges. For example, caregivers argued that due to unemployment more responsibility falls on to the caregiver for meeting the child's economic needs (Peri-urban Focus Group, August 23, 2006). Caregivers also suggested, "the reason for all the [care] challenges is because of money. People do not have jobs" (Urban Focus Group 2, August 16, 2006). NGO/CBO respondents verified this view (Respondent B, NGO/CBO 4, August 1, 2006; Respondent B, NGO/CBO 2, August 3, 2006). For example, one NGO/CBO respondent stated that unemployment "places a major strain [on caregivers] when trying to care for additional children. It is an additional burden economically to care for the child" (NGO/CBO 3, August 25, 2006). Increasing dependency burdens may restrict the caregiver's ability to access employment in an already limited labor market and leading to a cycle of impoverishment.

Poverty repeatedly emerged as a dominant theme in both NGO/CBO interviews and caregiver focus group discussions. Eight NGO/CBO respondents stated that poverty severely restricts the resources available for care. The following statements are particularly illustrative of how poverty impacts care. A NGO/CBO respondent argued that the pandemic creates "poverty which is way above these people's heads. There is not much to go around . . . People who are willing to assist are also in dire need" (Respondent B, NGO/CBO 1, August 2, 2006). Similarly, another NGO/CBO respondent said:

> The epidemic has changed the family because the people who remain with the children bear such a big burden on their shoulder. One has to not spend more on unnecessary things because people at home are orphans. Also the attitude has changed. People normally shared their

> salaries but now the needs have changed. (Respondent A, NGO/CBO 3, August 18, 2006)

Clearly, poverty creates a situation in which “caregivers don’t have the resources or means to take care of extra children” (NGO/CBO 6, August 14, 2006).

Poverty impacts care in various ways. Six NGO/CBO respondents suggested that poverty creates food insecurity, a particularly pressing issue in KZN where people are unable to supplement their diet through gardening or farming. For example, a NGO/CBO respondent stated that “25 percent [of children are] stunted due to lack of enough food . . . It is not just the issue of protein and malnutrition, that does occur but we just want to give them enough food” (Respondent A, NGO/CBO 2, August 4, 2006). In addition, six NGO/CBO respondents and all the respondents in the caregiver focus groups argued that shelter is a major issue. Respondents elaborated on the issue of shelter, arguing that poverty makes it difficult to expand shelter to accommodate additional children. For example, caregivers stated, “the problem with shelter is that it is too small because now, there are so many people living with many children under one roof. The homes are like a box of matches (Peri-Urban Focus Group, August 23, 2006). Similarly, a NGO/CBO respondent argued, “shelter is not large enough because of so many extended family [members] living together” (Respondent A, NGO/CBO 3, August 18, 2006). Other care challenges are unique to particular geographic locations. For example, four NGO/CBO respondents said that in rural areas, caregivers have difficulty meeting children’s health care needs, many who may be HIV positive. This is due to the high cost of transporting children to urban areas where clinics are more readily available. This discussion highlights how the unique context of unemployment and poverty combined with “the HIV/AIDS epidemic and its impact exacerbates the vulnerability of children” (Respondent A, NGO/CBO 1, July 27, 2006).

Evidence also illustrates that South Africa’s policy context directly impacts care for orphans, often in unexpected and negative ways. This suggests that international policies applied uniformly to local communities regardless of context may be highly problematic. For example, the South African Schools Act of 1998 requires that schools waive fees for all orphans under the School Fee Exemption and the No-Fee Schools Policies. Even though these policies play an important role in alleviating the economic challenges associated with care in KZN, these policies generate additional care challenges. For example, a NGO/CBO respondent argued that waiving school fees stigmatizes orphans:

> If [orphans] don't pay the school fees, there is such a lot of pressure, negativity, and comment which is another form of abuse for the child. We have just found it to be easier to try to raise the school fees and pay them (NGO/CBO 9, August 14, 2006)

In addition, seven NGO/CBO respondents suggested that school fees present a major obstacle for caregivers. Caregiver and NGO/CBO respondents stated that this is due to the serious administrative obstacles entailed in accessing fee exemptions (Respondent A NGO/CBO 1, July 27, 2006; Peri-Urban Focus Group, August 23, 2006). For example, caregivers stated:

> We have trouble getting the school fees waived because you have to go to the social worker to get a letter. If you get a child support grant, which is R190, the social worker refuses to give you the letter because they say that the child support grant should go towards school fees. However, this 190 is not enough to cover school fees. We must use this money to pay for other things for the children. (Peri-Urban Focus Group, August 23, 2006)

Moreover, five NGO/CBO respondents and urban caregivers argued that policies are limited in effectiveness because families must still pay for school uniforms which constitute a significant economic obstacle for many families. This discussion illustrates that policies on school fees have several unintended, and often negative impacts upon children. In addition, policies may not be fully effective in meeting their stated goals due to administrative obstacles or due to poverty which makes it difficult to send children to school even if fees are waived.

In addition, policies guiding allocation of child support grants and foster care grants often function to support carers but can also create several care challenges.[3] For

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[3] Implemented in 1998, the child support grant is the "pre-eminent social assistance programme for children" (Rosa *et al.*, 2005: 2). Accessed through an income based means test, this grant targets children under 14 years of age living in poverty by providing caregivers with R180 per month (Jacobs *et al*., 2005: 18, 33). 2005 estimates show that 71 percent of children in KZN are eligible for the grant with a 65 percent uptake rate (RSA Department of Social Development, 2005 cited in Jacobs *et al.*, 2005: 55). The foster care grant is designed to support children under age 18 years who face abuse and neglect. The grant provides foster parents with R560 a month (Jacobs *et al.*, 2005: 33). In practice this grant is used for poverty alleviation, a practice that is "likely to increase as the AIDS pandemic progresses unless a more adequate social security policy is put in place" (Jacobs *et al.*, 2005: 33).

example, nine NGO/CBO respondents suggested that non-parental caregivers face major obstacles accessing the documentation needed for grant applications. These difficulties often arise in the context of households headed by single mothers, which is common in the RSA context. When mothers die from AIDS, “it is very difficult for the caregivers to prove that the father has been absent and this has become serious issue for accessing grants” (Respondent B, NGO/CBO 1, August 2, 2006). However, the “implied or express consent of the [remaining] parent” is necessary if non-parental caregivers wish to access grants (Rosa *et al*., 2005: 12). Moreover, there is a general lack of identity documents (ID) in South Africa. For example, caregivers stated that:

> The children often do not have birth certificates so we cannot get the grant. Often, the mother passed away and the mother had no ID. The social welfare department tells us to go to hunt for the other parent and ask them for help but we do not know or cannot find the other parent. (Peri-Urban Focus Group, August 23, 2006)

Clearly, accessing identity documents presents significant obstacles to non-parental caregivers. Policies need address the access issues associated with the rising phenomenon of non-parental caregivers taking on the economic responsibilities of childcare.

In terms of foster care grants, two caregiver focus groups argued this grant entails a lengthy application process which prevents caregivers from accessing economic resources critical to care. For example, urban caregivers noted:

> The foster care grant is a very hard process . . .You have to see the social workers, you have to go to court with the children . . . [In contrast,] the child support grant is 180 Rand and now, they are saying it should take 3 months . . . I think they should apply the same procedure for the foster care grant; I don’t know why the foster care grant takes so long. To me, the foster care grant is one and the same thing as the child support grant. You should go to the social worker, go to court, and be able to get the money. (Urban Focus Group 2, August 16, 2006)

NGO/CBO respondents verify that grant applications involve long delays stating, “there is a huge backlog – sometimes as much as three years where people have applied and are still waiting to get the grant. You wonder what happens to a child whose parent has died last week – do they have to wait three to four years to get the grant?" (Respondent B, NGO/CBO 1, August 2, 2006). Three NGO/CBO respondents suggested that a re-examination of the foster care grant policies is needed in the context of the pandemic because, "it used to be for children who needed to be removed for safety. It is now being used to accommodate orphans" (Respondent A, NGO/CBO 1, July 27, 2006). These administrative delays exacerbate care challenges.

Caregiver and NGO/CBO respondents also strongly felt that the child support grant needs to be extended beyond 14 years of age (Respondent A, NGO/CBO 1, July 27, 2006; Respondent A, Children Rights Centre, August 4, 2006; Peri-urban Focus Group, August 23, 2006; Urban Focus Group 1, August 15, 2006). An extension of assistance past this age is particularly important in the context of the pandemic since "more than half of all orphans are age 12 or older" (UNAIDS *et al.*, 2004: 12). Caregivers stated that this age cut off seems arbitrary stating that, grants "are cut off at too young an age" and argue that "the government must upgrade the ages of children getting grants because they are still schooling until 17 or 18 years. The children should actually get the grant until they are 21 or 25 for further education" (Peri-Urban Focus Group, August 23, 2006).

Child support grants and foster care grants have several unintended consequences that negatively impact child development. For example, in the context of high unemployment and poverty, grants provide a vital source of income for many households. This issue was raised particularly by NGO/CBO respondents who suggested that this may create a situation in which child placement is driven by economic calculations rather than child welfare. For example, one respondent stated that "because people are so poor it affects who cares for children. Sometimes because people are so poor, they depend on . . . grants . . . [to] care for children" (NGO/CBO 5, August 7, 2006). In addition, eight NGO/CBO respondents said that these grants may generate family conflict. For example, one NGO/CBO respondent stated:

> When family members die, some family do not care about the children but do care about the certificates because this is a source of income. The family members negotiate who gets the [birth] certificate. Poverty has created a situation where people tend to be greedy in a way because they know they will get something, that they can apply

> for the grant and get something. (Respondent A, NGO/CBO 3, August 18, 2006)

Similarly, another NGO/CBO respondent argued:

> The foster care grant is being used by people who are fighting to get a hold of the grant for dangerous reasons. These people are fighting to get hold, to grab these orphans whether they want them or not for money . . . There is such a danger here because of the pressure on the poorest families. (Respondent A, NGO/CBO 2, August 4, 2006)

While situations where individuals use "family to claim entitlement to [money]" are rare, and findings should not suggest that "everyone does this" (Respondent B, NGO/CBO 2, August 4, 2006), it is vital to identify ways in which policies may place children at risk.

Finally, old age pension policies create unique care challenges. While the old age pension functions as an important source of income for elderly caregivers, it is being used in new ways due to the pandemic and these new uses negatively impact both caregivers and children. Historically, the old age pension has been pooled between household members and served as a vital source of income (Case and Deaton, 1998). However, in the context of numerous deaths of working adults, the old age pension is being stretched in new ways. Respondents suggested that the pension is now unable to meet the needs of caregivers and children. For example, one NGO/CBO respondent stated:

> The old age pension is an important form of support, particularly now that families are made of the old and young. We had a case recently where there was an older person receiving the pension and this supported 18 people in the family; it was the only form of support. While I would not say that this is typical of all the cases, there are certainly many cases where the old age pension is supporting multiple family members. (NGO/CBO 8, August 24, 2006)

Similarly, another NGO/CBO respondent noted,

> Many of these grannies are receiving the pension grant and need to spend this money [on the children]. The grannies had to spend money

> on the family before, but did not spend the money like this. They spent money more to fill unemployment. Historically, unemployment is high so a grannie at home was the only one with an income and had to split this money to buy food. Now, the pension is used to address everything else and for more people. (Respondent A, NGO/CBO 3, August 18, 2006)

Both caregivers and NGO/CBO respondents suggested that the extension of the pension to cover a broad range of needs has negative consequences on caregivers and children. For example, a NGO/CBO respondent said:

> Caring for the ill adult and the children . . . is a huge burden if you are aged. There is not enough recognition of what the demands are on the elderly population. The old age pension is touted as being effectively dispersed but there is research coming about saying that while it benefits the family by being stretched for the household, there is not enough benefit being seen for the elderly. (Respondent B, NGO/CBO 2, August 4, 2006)

Similarly, caregivers argued:

> The old age pension is being abused. Now this pension is used to pay for rent, water, electricity. The money goes back to the municipality. We cannot even use it to care for the children. We use it to pay for all of these other things. (Peri-Urban Focus Group, August 23, 2006)

This primary data suggests that elderly caregivers may need additional forms of support, particularly if the old age pension is the only source of income within the household.

Discussion

This study challenges and qualifies notions of care as embodied in attachment theory and reflected within policies on care for children orphaned by AIDS by identifying three disjunctures between theoretical constructs of care and perceptions of care in KZN communities. First, respondent narratives challenge the assumption that parents function as primary carers and thus are essential to child development.

Since non-parental figures often provide care in KZN, parental deaths due to AIDS do not necessarily change existing childcare practices. Primary data also questions the theoretical linkage between parental death and child development, indicating instead, that the parental deaths are *indirectly* linked with a child development crisis. Parental deaths deprive caregivers of important forms of economic and social support which in turn, make it difficult for caregivers to meet children's needs. Moreover, primary data draws attention towards the multi-dimensional nature of the child development crisis in which pressing economic challenges often force caregivers to prioritize children's basic physical needs over affective needs. Second, narratives called into question the simplistic assumption that kin carers are inherently more able to meet children's needs. Respondents suggest that the type of kin caregiver influences quality of care. Moreover, the manner in which non-kin care provision takes place has a more important influence on children's developmental outcomes than the mere characteristic of being a non-kin caregiver. Lastly, respondent narratives identify the weakness of an analytical approach focused on individual caregivers, showing how structural variables shape a caregiver's ability to meet a child's developmental needs. Respondents also reveal how contextual variables unique to KZN shape care provision, indicating the need to nuance policies based on universal theories of care and child development.

These gaps between theoretical conceptions of care and respondent narratives on care expose the limitations of the emerging policy orthodoxy on care for children orphaned by AIDS. By exposing divergences between policy constructions of care based on dominant theoretical conceptualizations of child development and perceptions of care in communities confronted by rising numbers of orphans in KZN, this study illustrates that policies based on current theoretical formulations of care and family may lead to ineffective interventions or even worse, interventions which undermine local strategies of providing care for orphans. Formulating nuanced policies presents significant obstacles both in terms of capturing local level perspectives on care and the integration of these views into national and international level policies. In turn, this requires increased venues of communication and collaboration between local communities and government stakeholders. However, as this study suggests, findings more ways to bring local understandings of care and child development into the policy process will be essential for the design of policies and programs which meet local needs. While the aim of this study is not to dispute that parental deaths can have detrimental effects on children in situations where parental care is the norm (for example, see Rutter 1966; Brown, Harris et al. 1986) or the importance of attachment for child development which has been debated elsewhere (for example, see Rutter 1972; de Chateau 1980; for example, see Ali and Lowry 1981; Chess and Thomas 1982; Lamb, Thompson et al. 1985; Belsky and Cassidy 1994), this discussion challenges the validity of applying attachment theory uncritically to specific local contexts where childcare practices vary from the assumptions underlying attachment theory. Such theoretical constructions need to be re-formulated capture the dynamic nature of childcare in KZN which is being redefined in response to the pandemic.

This study is limited in several ways. First, this study focused solely on communities within the Durban area due to budget and time limitations and thus, findings are context specific and cannot extrapolated to other communities without further research. Second, this study would have benefited from additional in-depth interviews with caregivers. These interviews would have offered an opportunity to explore the lived experience of caregiving in more depth.

Despite these study limitations, there are several policy implications that follow from this study. First, in communities where care diverges from parental care, this paper calls into question the purported linkage between parental deaths and a crisis of care and child development. Such evidence points towards the need to nuance policies based on attachment theory since childcare may take diverse forms and understandings of children's developmental needs may diverge from those formulated within the policy realm. Second, evidence from this study also suggested that the dichotomies of kin versus non-kin and better versus worse care oversimplified the relationship between care and child development. By challenging the plausibility of the link between kin caregivers and better care as well as the link between non-kin caregivers and worse care, the evidence suggests that policies should not idealize the benefits of placing children with kin caregivers or discount the role of non-kin caregivers in meeting the developmental needs of orphans. Such simplistic policy formulations may marginalize the potentially important and positive role that non-kin individuals play in care for orphans as the impact of the pandemic increases. Third, attachment theorists focus on how individual caregivers impact child development and largely ignore the unique historical, economic, and policy contexts that shape childcare and child development. This theoretical approach may lead to inadequate policy formulations since an individual-centered approach results in policies that place the onus of responsibility for care and child development upon individual caregivers whilst ignoring the important and serious structural limitations that constrain caregivers' efforts to provide for orphans. In addition, this sort of approach leads to policies that are devoid of context. However, communities confronted by increasing numbers of orphans are highly variable. Universal solutions are unlikely to meet the unique needs of these communities in a sustainable manner.

By questioning current theoretical formulations of care, this study reveals several productive areas for further research. First, while this paper offers an important critique of attachment theory, further research may offer substantial refinements that would greatly strengthen their applicability to communities impacted by HIV/AIDS. Second, as policy implementation proceeds, it would be fruitful to explore how local communities respond to policies shaped by dominant discourses of care. Third, future research should explore whether differences in the care experience are correllated with the caregiver's relationship to the child (related to the child through kinship, through marriage, or unrelated to the child). This should involve an exploration of how caregivers are linked into particular support networks and the nature of assistance that these networks offer. Finally, future research needs to explore how different care arrangements impact the health and wellbeing of caregivers and children.

This paper begins to uncover a more complex picture of care in the context of rising numbers of children orphaned by AIDS in KZN. Evidence points towards the need to refine theories of care and reformulate policies based on such theories in order to account for unique impacts of HIV/AIDS on care and family in different communities. Taking into account local variations in understandings of care substantially complicates the policy process, but meeting this challenge will be essential if policy makers wish to firstly, avoid undermining community strategies and secondly, implement effective strategies for addressing the development challenges associated with children orphaned by AIDS. As the HIV/AIDS pandemic continues to generate societal change, it will be critical to continually reexamine the assumptions underlying theoretical understandings of care and family. This requires recognizing the role of human agency in responding to the pandemic and the resilience of local communities to a situation that policy actors tend to view as a 'crisis'. Indeed, this research demonstrates that local actors possess knowledge that not only challenges dominant understandings of 'crisis' but also offers alternative formulations of policy problems and solutions that are more attentive to the local conditions that shape the reality of care.

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