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Exploring the effect of kin caregivers' family functioning on child survival in South Africa: An application of the Family Systems Theory

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Abstract

The survival of children who are raised in kinship care is largely influenced by the way their primary caregivers manage their family dynamics. Although research has focused on the effects of family structure and other extended kin effects on various child health outcomes, it remains largely unknown how kin caregivers' family functioning influences child survival, particularly in the South African context where the practice of kinship care is widely spread. An inductive thematic approach was employed, and data were collected from 24 kin caregivers who were providing care to under-five children. Analysis of the data resulted in the development of three superordinate themes, namely, (1) relationship with family members, (2) poor relationships and (3) family attachment and communication. Each superordinate theme was linked to subthemes that helped explain the phenomenon under study. Overall, the kin caregivers' family environments serve as both protective barriers and risk factors for child survival depending on the state of familial relationships, collaboration and involvement of other kin within the households of primary kin caregivers. This translates into the survival of children being greatly determined by the family environment in which they live and the quality of care that they receive in that family environment.

KEYWORDS
child survival, family functioning, family systems theory, kin caregiver, kinship care, South Africa

1 | INTRODUCTION

Family arrangements are diverse and complex, as they are continuously responding to societal, political and economic changes (Hall & Posel, 2019; Sooryamoorthy & Makhoba, 2016). South Africa is a country that is largely characterized by diverse family structures and household forms, a decline in marital unions, increasing cohabitation rates and an increase in households that headed by females (Hall et al., 2018). This is largely attributed to factors such as mortality, divorce, family disruptions, desertion of family life and other familial responsibilities, the processes of urbanization, modernisation, the HIV/AIDS pandemic and labour migration (Mokone, 2014). Culturally, children who had lost both parents through death would be placed under the guardianship of other extended kin (either through the involvement or non-involvement of Child Welfare authorities) who would assume all responsibilities pertaining to the rearing of the child

placed under their care (Mtshali, 2015). Although kinship care was not a customary practice that was solely for orphaned children in South Africa due to its emergence being partly because of cultural and historical factors, for example, apartheid system, unemployment and poverty, however, generally in sub-Saharan, including South Africa, the care of orphaned children by their relatives has become an abiding practice even in contemporary times. The extended family still bears the greatest burden in providing care to orphaned children despite the obligation of governments to provide alternative care for children without parental care.

Despite the existence of this widespread practice, there has been a noticeable rise in the past few decades of family arrangements that involve extended kin assuming the primary caregiver role and raising children who are non-orphaned (Ariyo et al., 2019; Cudjoe et al., 2019, 2020). Kinship care, which is the placement of children with relatives (in the absence of biological parents who are alive but are unable to provide parental care), is a phenomenon that is receiving global attention despite its existence in communities for years (Assim, 2013). Moreover, at a global level, non-orphaned kinship care is the biggest out of home care choice for children who cannot receive primary care from their parents (Selwyn & Nandy, 2014) and increasingly expanding at a high level in relation to traditional foster care (Dziro & Mhlanga, 2018; Kiraly et al., 2020; McCartan et al., 2018; Shelton, 2018; Skoglund & Thornblad, 2019). In South Africa, many non-orphaned children live in households where aunts, uncles or grandparents play the primary caregiver role. Recent literature has shown that of the estimated number of close to 20 million children who reside in South Africa, 20.9% of these children whose parents are alive do not live with these parents (Hall et al., 2017). In addition, close to 70% of children who have lost parents through death and those whose parents are still alive, and do not reside in the same household as their birth parents, live with their grandmothers, close to 20% reside with aunts, 6% with additional extended kin and only 1% reside with non-related adults (Mkhwanazi et al., 2018).

Goal 4 of Target 5 of the Millennium Development Goals (MDGs) for South Africa set for the year 2015 was to reduce under-five mortality rates to 20 deaths per 1000 live births (Maluleke & Chola, 2015). Although improvements have been made in reducing under-five mortality rates in several regions, under-five mortality remains a major problem (Acheampong et al., 2019; Ekholuenetale et al., 2020; Houle et al., 2013). Trends in under-five mortality indicate a marked decrease in South Africa and are lower than other parts of Africa. Current statistics show that under-five mortality in South Africa was 32.2 deaths per 1000 live births in 2020 (UNICEF et al., 2020). Several scholars have made considerable efforts to establish factors that explain under-five mortality in South Africa. Scholars have identified maternal individual, household and community-level characteristics as main contributors of under-five mortality. These include, among others, maternal education, maternal age, wealth status and place of residence (Argeseanu, 2004; Bija, 2019; Buwembo, 2010; Hlongwa, 2016; Hossain & Islam, 2009; Kyei, 2011; Motsima et al., 2020; Rademeyer, 2019; Worku, 2009; Worku, 2011; Zewdie, 2014).

Family and household composition has been found to influence child mortality significantly (Houle et al., 2013). The developmental outcomes and overall wellbeing of a child that occurs over a short or long period of time are largely determined by the family environment in which they live. Specifically, it is determined by the quality of care that they receive in that family environment (Biemba et al., 2010). The diffusion of children to grandparents and other extended kin has been reported to negatively influence child outcomes (Roby, 2011). A study that examined the influence of kin on the survival of children in rural Ethiopia found that 15% of children placed under the care of relatives died before age five, while 14% died before the age of three (Sear et al., 2002). Another study in Gambia examined the effect of kin on child mortality. This study found that there were 179.9 under-five deaths per 1000 of under-five children living with maternal grandmothers in Gambia (Sear et al., 2002). Furthermore, it has been found that children living with relatives often experience a burden of illness and disease that is disproportionally high and often results in increased risks of mortality (Gao et al., 2016; Radel & Bramlett, 2014). Children who are raised by relatives tend to receive less attention and social protection support from welfare authorities, which results in their living circumstances remaining largely unmonitored (Bramlett et al., 2017; Lin, 2014).

Kin caregivers can experience increased pressure within their households, greatly affecting their ability to provide adequate care to the children (Kadungure, 2017). Their inability to provide adequate care is attributed greatly to the qualities of the kin caregiver, the relationship they have with other kin in the household and their quality as an appropriate caregiver (Goldberg & Short, 2012). According to Hunt (2003), some family environments and relationships of kin caregivers who assume parental responsibility for a child are often strained and have an increased likelihood of breaking down, following the placement of the child. This is because the need for family members to cooperate in providing care to children who are not biologically their own increases the likelihood of conflict among members of the family (Mace, 2013; Sear, 2008; Sheppard & Sear, 2016; Strassmann & Garrard, 2011). Similarly, older studies have provided the view that an addition to the family creates competition for resources. This then translates into conflict, poor altruistic behaviour, poor familial cooperation and increased competitive behaviour among kin, resulting into poor child health outcomes (Griffin et al., 2004; West et al., 2008). This is largely because households that have many people tend to have fewer resources (particularly resources related to childcare) (Mendoza, 2009). Moreover, children raised by relatives may become entwined in intra-familial conflicts. This can often lead into children placed under such care to experience psychological distress because of negative home dynamics (Nduna & Jewkes, 2012). Often, this is due to a lack of clarity over roles and responsibilities—such family instability may consequently have adverse effects on the children (Broad, 2007; Vandivere et al., 2012).

While there is substantial literature that has examined the effect of household dynamics and composition on child health outcomes, it remains largely unknown how kin caregivers' family functioning influences child survival, particularly in the South African context, where

the practice of kinship care is widespread. Reducing under-five deaths has been a central concern of the Convention on the Rights of Children Initiative (Mekonen & Tiruneh, 2014; Reinbold, 2019; September, 2014; Tait et al., 2020). Thus, it is vital to focus on children who are raised relatives, as these children are often placed in situations that are complex and where serious physical, mental, developmental and psychosocial problems develop (Bramlett & Blumberg, 2007; Szilagyi et al., 2015).

Given this background, the objective of this study was to explore the effect of kin caregivers' family functioning on child survival in South Africa, through the application of the Family Systems Theory. The research question in this study was how does family functioning within the kin caregiver's household influence under-five mortality? This study thus served to expand on current knowledge, and shed new light, on non-orphaned kinship care by examining one of the adverse outcomes—the mortality risk among these children.

1.1 | The Family Systems Theory

The Family Systems Theory was developed by Murray Bowen and focuses on general family functioning (Bowen, 1978). The central premise of the theory is that families operate as a complex, organized and interactive system that works together (Bowen, 1978). In addition, families constitute a multitude of parts that are dependent upon one another. When one part of the system malfunctions, all other parts will be affected (Bowen, 1978; Constantine, 1986). Furthermore, factors such as family interactions, general family functioning, degree of connectedness or separation, and adaptation to change are factors that determine the overall function and system of the family (Sabatelli et al., 1993). In this theory, families are considered to consist of the immediate individuals with whom the person resides (biological parents or nuclear family), the extended family or the community (Bowen, 1978). Hence, the theory helps provide insight on how subsystems (parents, children and siblings) and suprasytems (families in relation to their extended families or relatives) function as a family. It also provides insight on the complex nature of each part of the family (Bowen, 1978).

Additionally, the theory holds that when one member of the family modifies his or her behaviour or actions, this change may likely influence other family members (Bowen, 1978). It further provides insight on the challenges that individuals face within the family system. Additionally, the Family Systems Theory also provides us with comprehensive insight on factors that may influence a child's and family's quality of life. This in turn may either threaten or strengthen the wellbeing of the child or family members (Sabatelli et al., 1993).

1.1.1 | Application of the Family Systems Theory in the current study

The Family Systems Theory was applicable in the conceptualization of this study, as it provided insight on the familial characteristics that could influence a child's health outcomes. The theory was adapted to show how the family environment in which a child is raised can have a significant influence on their health. To gain an in-depth understanding of how under-five mortality could possibly occur, it was vital to observe the family context in which the child resides. Furthermore, the general functioning and degree of connectedness are important, as this played a crucial role in whether a child will have positive or negative health outcomes. Thus, the way the family functions may thus mediate or moderate the effects of various kin-caregivers on child survival. This theory, therefore, was useful in gaining an in-depth understanding of how under-five mortality could possibly occur. With respect to integrating the Family Systems Theory in this study, one study has shown that an important factor that is often overlooked in studies that focus on the association between child health and determinants of health is the family (Witt & DeLeire, 2009). The authors further argue that the family environment can have a major influence on the health outcomes of an individual, particularly those of a child (Witt & DeLeire, 2009).

1.1.2 | Rationale for adapting the Family Systems Theory in this study

Given that the Family Systems Theory posits that to gain an understanding of an individual's outcomes (such as that of a child), the family context in which that individual resides needs to be observed first. Furthermore, the theory provides insight on factors that may influence a child's and family's quality of life. This may either threaten or strengthen the wellbeing of the child or family members (Sabatelli et al., 1993). Given this background, the Family Systems Theory was adapted in this study, as it includes a component that focuses on the relationships between adults and children, their functioning within a particular household (in this case, the kin caregiver and the child placed under the care of the child) and indirectly stipulates how these relationships ultimately influence child health. Second, the characteristics of families are often deemed important determinants of health outcomes, as families represent the first point of contact between children and the larger world and thus provide an environment that can either foster or hinder childhood development or influence the health of children. Third, the family institution is generally recognized as the first point of support for children. Therefore, once there is dysfunction in the family, children inevitably become vulnerable.

2 | METHODS

2.1 | Design

This study adopted a qualitative descriptive design to provide a rich description of the phenomenon of family functioning on child survival based on the experiences of kin caregivers. This approach was employed given that it involves the use of in-depth interviews and involves the use of data to understand and explain the phenomenon

under study (Bradshaw, 2016). The rationale for employing this approach in this study is that its theoretical underpinning is typically directed towards discovering the who, what, where and why of events or experiences (Neergaard et al., 2009). Of note, qualitative description design moves beyond the literal description of the data and attempts to interpret the findings without moving too far from the literal description (Denzin & Lincoln, 2011). Within the qualitative description approach, the phenomenon under study is examined using a particular theoretical framework (Parse, 2001). Thus, the qualitative descriptive design grants researchers the opportunity to obtain rich descriptions about a phenomenon that little may be known about. In-depth interviews were used to collect data from both kin caregivers who had a child that died while under their care and kin caregivers who were still providing care to under-five children through the aid of an audio-recorder.

2.2 | Study setting

The study took place in two South African provinces, namely, the Eastern Cape and KwaZulu-Natal provinces. The two research sites were selected on the basis that they have the highest rates (>34%) of children who are raised by relatives (Hall et al., 2014). Second, it is highly common for children to live in the households of extended family members in the absence of their biological parents in South Africa, and this is often largely attributed to impoverishment, migratory practices due to work purposes and work and educational opportunities that may arise (Meintjies & Hall, 2011). Moreover, the South African foster care system is generally administrative and complex due to the legal orders and administrative work that need to be conducted to make sure that children placed in alternative care are highly monitored (Fortune, 2016). This system has led into social auxiliary workers often being capacitated to monitor children and to ensure that children are protected from any form of neglect and maltreatment (Fortune, 2016). As such, the health outcomes of the children in relation to the environment in which the children are taken care of remain unknown.

2.3 | Population

The population of interest was kin caregivers who experienced the death of a child who had not reached his/her 5th birthday while living in the household of the kin caregiver. An under-five child that died was a relative's child for whom the kin caregiver was responsible for. The comparative group in the qualitative analysis was kin caregivers who were responsible for the care of a relative's child who was still alive and lived with the kin caregiver. Kin caregivers who were of interest in this study were those who were providing primary care to children who have both biological parents alive, but the parents are not resident in the kin caregiver's household. Kin caregivers who were providing care to children who had lost both parents to death were excluded from the study.

2.4 | Sampling

Participants were sought through the assistance of the KwaZulu-Natal and Eastern Cape Department of Social Development (DSD) who assisted in providing a sample of the kin caregivers who have raised children under the age of 5 years (see Appendices A and B for letters of approval). Though the placement of most children who are placed under the care of relatives is recorded in the Child Welfare system, the process of placing children in out-of-home contexts reduces the time and resources of social workers to follow up on the health outcomes of children who are in this care context (Mkhwanazi et al., 2018). Instead, caregivers are encouraged to apply for foster care grants, which oftentimes results in social workers not periodically reviewing the placement (Mkhwanazi et al., 2018). Thus, this study was limited to kin carers, as it was believed that stakeholders that regulate kinship care may not have comprehensive knowledge about the primary kin caregivers' family functioning and family environment and its influence on child survival. With regards to recruitment of participants, information of individuals who were providing care to relatives' children was obtained from a database provided by the DSD, which provided identification of several kin caregivers. To access these participants, the researchers entered the homes of the respective kin caregivers through being accompanied by Social Workers who were usually assigned to do quarterly visits in these homes. The Social Workers then explained the intention of the researchers visits to these kin caregivers' homes and kin caregivers who consented would then participate in the study (in the absence of the Social Workers). In other instances, other participants were recruited through referrals made by Kin caregivers who had already participated in the study and would then connect the researchers to other participants.

A purposive sampling technique was adopted in the study. The purposive sampling technique was suitable, as it assisted in selecting participants who share similar characteristics and meet the selection criteria of the study. Kin caregivers who experienced a child death and those who had children still alive were recruited. Children were linked to kin caregivers on a household basis (i.e., children were matched with the kin caregiver they lived with using two pieces of information): (1) person responsible for care of child and (2) child resident in the resident head's household based on information obtained from the Department of Social Development. The focus was restricted only to children who have both biological parents alive but who resided with a relative kin caregiver (mother or father alive but not resident in kin caregiver's household). Lastly, children who had lost both parents to death were excluded from the study. The duration of kinship was not taken into consideration in this study given that this was beyond the scope of this study and would be examined in subsequent papers. The sample size of 24 participants was selected taking into consideration the feasibility of the study. Feasibility in this study was assessed using three criteria, namely, (1) the objective of the study; (2) the time allocated to conduct the in-depth interviews; (3) the costs and resources that would be available to conduct the interviews; and (4) generating a manageable amount of data for meaningful analysis.

Status	Eastern Cape	KwaZulu-Natal	Total
Kin caregivers who had a child that died under their care	6	6	12
Kin caregivers who are still providing care to a child that is alive	6	6	12
Total	12	12	24

TABLE 1 Sample size of kin caregivers for each respective province

2.5 | Data collection

The interviews were conducted during the period of February to April 2019. In-depth interviews were conducted with 24 kin caregivers. Twelve in-depth interviews were conducted in one rural community, and the remaining 12 interviews were conducted in one urban community in each respective province. Of the 24 participants who were selected in this study, 12 were kin caregivers who had an under-five child die while under their care (6 from the South African province of Eastern Cape and 6 from the South African province of KwaZulu-Natal). The remaining 12 respondents were kin carers who are still raising children who are under the age of 5 years (6 from the Eastern Cape province and 6 from the KwaZulu-Natal province) (see Table 1 for full details). The interviews were conducted during the period of February to April 2019. The interviews were conducted in the participants' native language. Twelve interviews were conducted in IsiZulu, and the remaining interviews were conducted in Xhosa. Interview guide questions were structured and were developed by the study team (KM, NDW and CO) to ensure that a basic line of questioning was followed. They were also used for prompting where necessary. A funnel approach to interviewing was used by first building rapport with the participants, which assisted in creating a safe space where participants could speak candidly about their experiences (Matsumoto et al., 2015).

The transcripts were then later translated into English. The interviews were audio-recorded and lasted between 60 to 90 min. Notes were taken during the interviews to capture the key narrative accounts of the participants and non-verbal cues. The sample of participants was selected on the basis that the participants are not homogenous and their family and living environments may differ. Additionally, the sample size would make certain that each proportion of the population of interest is attended to, thus making sure that the sample is representative. Lastly, the sample was derived by considering issues such as data saturation. Data saturation was assessed based on empirical evidence, which found that the first five to six interviews produce most of the new information, and little new information is gained as the sample size approaches 20 to 30 interviews (Bernard & Ryan, 2010; Guest et al., 2012; Guest et al., 2020).

Qualitative data analyses often require a smaller sample size in relation to quantitative analysis. A very large sample often results in data saturation. In other words, any additional participants simply result in similar perspectives being heard. This does not improve the explanations of the themes that emerge in the findings and does not provide any additional or useful perspectives or information. Further, given the in-depth nature of the interviews, the sample size was also selected taking into consideration the feasibility of the study. Feasibility was assessed as (1) time allotted to conduct this research, (2) the costs and resources available and (3) the objectives of the study. Additionally, the number of participants selected made it possible to engage with the participants intensively.

2.6 | Data analysis

Overall, prior to analysis, the audio recordings of the participants were transcribed verbatim. The in-depth interviews were analysed using a deductive thematic analysis. In the next phase, transcripts were checked against the recordings any errors and to ensure accuracy and quality as well as to identify significant responses or quotes from the participants' narratives. The transcribed data were then coded and recorded using NVIVO software to identify major and minor themes. The analysis was structured by identifying emergent themes, allowing subthemes to be formed and cohesive narratives to be constructed. Common themes were grouped together resulting in the production of a master list that contained superordinate and subordinate themes.

2.7 | Trustworthiness

To maintain trustworthiness, we ensured that the information provided by the participants was recorded and accurately captured, as it was described by the participants. We ensured rigour throughout the research process by making sure that the lived experiences of what is known about kinship care and kin caregivers did not influence the data collection and analysis of data, as we continually took account of any personal biases that arose and would potentially interfere with the research findings. This was done by remaining objective even in our interpretation of the findings.

2.8 | Ethical considerations

Ethical approval to conduct the study was granted by the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (Ethics number H18/10/38) and the Research Ethics Committee of the Department of Social Development. Potential participants were first provided with a participant information sheet that explained the nature and aim of the study. Participants who were recruited in this study were provided with an informed consent form which stipulated the aims of the study, guaranteed confidentiality.

The informed consent form also provided information on who would have access to the participants' information, indicated that the study was voluntary and provided information on the storage of data, recording of data and the dissemination of the findings. In addition, the participants were provided with the contact details of the authors if they had any enquiries or concerns pertaining to the study.

Verbal consent was then sought from participants who were willing to participate voluntarily and fully acknowledged that they understood the purpose of the research. Before participants could sign the informed consent, they were given the opportunity to ask any questions they may have had or to receive clarity on certain issues pertaining to the study. The participants were then requested to sign the informed consent form. Participants were further informed about the processes that would be undertaken to store the data (in a password-protected computer) and how results would be shared. Thereafter, the anonymity of the participants was respected, and the transcriptions contained ID numbers that represented each participant's responses. To minimize harm and distress and provide maximized protection to the participants, given that some had experienced a child death, a bereavement counsellor was sought to provide counselling services in the event of a re-occurrence of post-traumatic distress while recalling the death of a child. The trained professionals provided the participants with grief support services that allowed them to discuss the issues that arose during the interview and caused them to remember the traumatic event. The services also assisted in the avoidance of potential adverse psychological and emotional health outcomes.

3 | RESULTS

Overall, 11 under-five children (both alive and dead) were raised by grandmothers, 9 by aunts, 3 by their sisters and 1 by a cousin. The mean age of the kin caregivers was 50 years, and majority of the kin caregivers (13 participants) had a secondary school qualification. Six kin caregivers had some secondary school education, two have a primary school qualification and three have a tertiary qualification. In addition, 14 kin caregivers are unemployed, and the remaining 10 kin caregivers are employed. Moreover, 15 kin caregivers are or have been in a marital union, while 9 have never been in a marital union. In terms of the demographics of the under-five children, 14 children died while under the care of a kin caregiver, and 10 children are still alive. The mean age of children who are alive was 4 years old, and the mean age of children who died was 2 years old. Of note, 21 children presented with a health issue, while only 3 had no illness (see Table 2 for full reference).

The major findings obtained from the caregivers' narratives in this study were that the kin caregiver's family environment can serve both as a (1) protective barrier and a (2) risk factor for poor child health outcomes (mortality). The two factors that emerged as the key themes that explained the effect of the kin caregiver's family functioning on child survival were (1) family cohesion and (2) family attachment and communication. The main sub-theme under family cohesion was 'relationship with immediate family', and the main sub-theme under family attachment and communication was 'collaboration and involvement' (material, physical and emotional support).

There were differences in the experiences of the two comparator groups (children who died vs. those who are alive). The findings obtained from the narratives of the participants showed that kin caregivers whose children were still alive reported receiving support from their family members to take care of the children and indicated that it was a voluntary decision taken by the entire family. Of note, the participants reported that they had good family attachment and communication with their families and reported witnessing collaboration and involvement of their family members with respect to provision of childcare in the form of material, physical and emotional support with all members of the family playing a key role in taking care of the children placed under the main kin caregiver's care. Thus, the kin caregivers believed that the clearly defined roles and responsibilities, which were equally shared among all family members fostered healthy functioning among family members which contributed greatly to positive child health.

Conversely, kin caregivers whose children died while under their care reported that provision of care for the child placed under their care was not a decision undertaken by the entire family and indicated that their family environments and relationships with their families were strained due to the family environment being characterized by hostility and competition, translating into poor child health outcomes.

An overview of the superordinate themes and accompanying subthemes is shown in Table 3. This section is sorted into the narrative findings with illustrative quotes provided.

3.1 | Relationship with family members

3.1.1 | Positive relationships

Some of the participants reported that the relationship with the immediate family of the child influenced the child's overall wellbeing. The participants reported that their families (including themselves) had good relationships with the birth parents of the children under their care and had felt a sense of connectedness with them. This was irrespective of the fact that some had simply abandoned their children without providing an explanation for doing so. Others reported that they had even decided as a family to voluntarily take over and provide primary care to the children under their care. This, they believe, contributed positively to the child's wellbeing. An example of an excerpt is shown below:

> My daughter gave birth to her children when she was very young. She sat us down one day and told us that she does not have any physical and financial capabilities to care for her children and thus she is asking us to assist in this regard. We as a family made the decision that she should go to Johannesburg, study, and then find work once she has completed her studies so that

TABLE 2 Demographic profile of interviewed kin caregivers

Participant code	Relationship to child	Age	Level of education	Employment status	Marital status	Living status of child	Age of living/deceased child	Cause of death of child or current illness
Participant 1	Aunt	55 years old	Matric	Unemployed	Married	Alive	4 years old (two identical twins)	Mental illness
Participant 2	Grandmother	80 years old	Grade 7	Unemployed	Widowed	Died	4 years old	Physically and mentally handicapped accompanied with seizures
Participant 3	Grandmother	59 years old	Matric	Recently stopped working as a domestic worker	Widowed	Alive	3 years old	HIV positive
Participant 4	Grandmother	78 years old	Grade 10	Unemployed	Widowed	Alive	4 years old	Diarrhoea and vomiting
Participant 5	Aunt	49 years old	Matric	Employed	Single	Alive	4 years old	No illness
Participant 6	Cousin	42 years old	Matric	Unemployed	Single	Alive	4 years old (two fraternal twins)	Bronchiolitis and episodic seizures
Participant 7	Aunt	36 years old	Matric	Employed (casual work)	Single	Dead	3 years old	Asthma
Participant 8	Aunt	40 years old	Matric	Unemployed	Married	Dead	4 years old	Pneumonia
Participant 9	Grandmother	55 years old	Matric	Employed (casual work)	Married	Dead	3 years old	Cardiovascular illness
Participant 10	Sister	29 years old	Grade 11	Unemployed	Married	Dead	3-month-old	Pneumonia
Participant 11	Grandmother	78 years old	Grade 10	Unemployed	Widowed	Dead	2 years old	HIV/AIDS
Participant 12	Grandmother	60 years old	Matric	Employed	Married	Dead	3-month-old	Meningeal infection
Participant 13	Aunt	47 years old	Matric	Employed	Cohabiting	Alive	4 years old	Recurrent diarrhoea
Participant 14	Grandmother	44 years old	Grade 11	Employed	Finalizing process of divorce	Alive	2 years old and 4 years old (taking care of two children)	4-year-old suffers from asthma
Participant 15	Grandmother	51 years old	Grade 6	Unemployed	Single	Dead	4 years old	Epileptic seizures
Participant 16	Aunt	38 years old	Matric	Employed	Single	Alive	3 years old	No illness
Participant 17	Grandmother	56 years old	Grade 10	Self-employed	Single	Dead	3 years old	HIV/AIDS
Participant 18	Grandmother	81 years old	Grade 7	Unemployed	Married	Dead	4 years old	Epileptic seizures
Participant 19	Aunt	41 years old	National Diploma	Employed	Single	Dead	2 years old	Asthma
Participant 20	Sister	20 years old	Matric	Unemployed	Single	Dead	3 years old	Severe malnutrition

TABLE 2 (Continued)

Participant code	Relationship to child	Age	Level of education	Employment status	Marital status	Living status of child	Age of living/ deceased child	Cause of death of child or current illness
Participant 21	Grandmother	65 years old	Grade 9	Unemployed	Widowed	Dead	11 months old	Bronchiolitis
Participant 22	Aunt	35 years old	Degree	Employed	Married	Alive	4 years old	No illness
Participant 23	Aunt	44 years old	Matric	Unemployed	Married	Dead	2 years old	Pneumonia
Participant 24	Sister	25 years old	Matric	Unemployed	Single	Alive	4 years old	Recurrent diarrhoea

TABLE 3 Themes showing how family functioning influences child survival

Superordinate themes	Sub-themes
3.1. Relationship with family members	3.1.1. Positive relationships
	3.1.2. Poor relationships
3.2. Family attachment and communication	3.2.1. Collaboration and involvement (material, physical and emotional support)

she can assist with raising her children. (Participant 14, Grandmother, 44 years, rural KwaZulu-Natal)

Thus, these findings show that children who are raised in households in which the primary kin caregiver receives support (emotional, social and material) from other kin who are resident in the same household are more likely to present with positive health or developmental milestones.

3.1.2 | Poor relationships

Other participants reported that their families had poor relationships with the immediate parent(s) of the child, which somehow influenced the children's wellbeing. Given that most of the children were placed under the care of the participants involuntarily, this created conflict within some of the caregivers' homes and affected their relations with their families, as such changes were highly unexpected. For instance, Participant 11 recalls the day she took over the care of her grandson who died while under her care. She recalls that that day changed the nature of her relationship with her sister and brother. She argues that her siblings had always had issues with her children as they believed that Participant 11's children had not been brought up well. They also felt they had no sense of responsibility given that they had even abandoned their children and left them under Participant 11's care. When her grandson, who died from HIV, was abandoned into her care, this created even more tension between her and her siblings to the point that they cut all forms of communication with her and told her to 'deal' with her own issues. She narrates:

> My siblings, particularly my sister was not happy at all when she heard that I had additionally taken over the care of another grandchild. She asked 'why don't you take this child, including all the other children to a Social worker who will organise for them to be taken to alternative care homes? What are you going to do with this child?' I told her that I cannot do that to my grandchildren. She then said 'I see you have decided. We are not going to be responsible for these problems, particularly the health problems of this child that you are creating for yourself. You are on your own from now on. You will see how you deal with this issue. Unfortunately, my grandson passed away'. (Participant 11, Grandmother, 78 years, rural Eastern Cape)

Participant 11 further narrates how this affected her tremendously as she had no support from her siblings (who are her only family). This affected her ability to provide adequate and comprehensive care for the child given the additional responsibility she had of looking after six other children. These findings bring forth the argument that assuming the primary caregiving role while simultaneously focusing on other family responsibilities and trying to preserve familial relationships has an adverse impact on kin caregivers' ability to fulfil their primary caregiving tasks successfully. This subsequently affects child survival significantly.

A distinctive feature that emerged in one narrative showed how previous painful experiences can result in the development of generational grudges. Participant 19 recalls taking over the care of her cousin's child and bringing the child home where she lived together with her five siblings. She maintains that she was not working at the time. She recalls how two of her siblings' demeanour changed towards her following the child's placement with her. She argues that the child fell ill after a few months. However, the two siblings who were working would not assist her in giving her money to take the child to the

doctor given her serious condition. The lack of support that she witnessed in her home infuriated her to the point that she eventually confronted her siblings to find out why it was difficult for them to assist her with this child. She provided a narrative account of one of her sibling's responses to her:

> You seem to have forgotten that this child's grandmother treated us very badly when we were growing up. There were days we would go to bed hungry, go to school barefoot and even fall sick without her giving us anything to treat our condition. Now, you expect us to take responsibility for this child. This is your burden to bear not ours. (Aunt, 41 years old, urban KwaZulu-Natal)

She narrates that the constant hostility, fights and lack of support in the household led her to find it difficult to provide optimal care to the child which unfortunately led into the child's death. These findings show that conflict, poor altruistic behaviour and poor familial cooperation result into poor child health outcomes. Moreover, children who are raised by relatives who have poor relationships with other family members may be entwined in intra-familial conflicts, and such family instability may consequently have adverse effects on the child's health.

Similarly, Participant 2 narrated that the other members of the family were not happy at all when she assumed care for her grandson who was physically and mentally handicapped and died from an epileptic seizure as they felt that she is old. They maintained that she is supposed to be resting and taking care of her own health, not adding a burden to her life and that of her other family members. She said that one of the family members said angrily:

> Now we need to be responsible for the care of this child. What are we going to do with this child? (Participant 2, Grandmother, 80 years, rural Eastern Cape)

She further recalls how she had gone to the clinic for her routine check-up before the child died and had left the child with other older members of the family. When she came back, she was horrified at what she witnessed. She said:

> I found out that one of the children had twisted his ankle and no one knew because they had not been paying attention to the child. In the second instance, I left him once and when I came back, I found out that he had been rushed to hospital because he had fallen from the chair, and no one had been paying attention to him. The child honestly almost died that day. So, my family has never been good to this child. That is why I took care of him by myself when he was still alive. To protect him from them. (Participant 2, Grandmother, 80 years, rural Eastern Cape)

3.2 | Family attachment and communication

3.2.1 | Collaboration and involvement (material, physical and emotional support)

The narratives of the participants in this section highlighted how collaboration and involvement of various family members, in the form of material, physical and emotional support influenced the child's well-being. Several participants argued that the family environment in which they were providing care to the children was a conducive one as all the members of the family played a key role in taking care of the children and displaying increased receptiveness to the children's needs. To illustrate these outcomes, Participant 5 narrates how she was so overwhelmed with witnessing how the members of her family were so receptive to her 4-year-old niece whom she assumed full responsibility for. She argues that the members of her family displayed so much support for her and have portrayed nothing but love, care and protection towards the child. This has contributed immensely to the child's wellbeing because the child has assimilated very well in the family and generally presents with positive developmental outcomes. An excerpt of her narrative is shown below:

> My children are playing a very active role in this child's life. My eldest daughter, she is the one who prepares this child every morning for crèche when I go to work, she accompanies her and takes her to her school transport and helps her get inside the transport. My second daughter works together with my third daughter, and they help each other bathe her …. They also make sure that they take her to the doctor for frequent check-ups. (Participant 5, Aunt, 49-years-old, urban Eastern Cape)

Participant 13 also shared similar sentiments as Participant 5:

> Firstly, with my mother, she was in such a hurry for this child to arrive because I had told her that she is coming. I remember her calling her brother asking 'Brother, when is the child going to arrive? I am waiting eagerly for her …'. Secondly, I can say that my son has also taken after me. Being a boy as he is, he bathes this child, he feeds her, he puts her to sleep. He does everything for her. So, I can say my family has accepted this child …. (Participant 13, Aunt, 47-years-old, urban Eastern Cape)

Participant 2 also shared similar sentiments as Participant 5 and 13 explaining how the members of her family have shown so much involvement in helping her raise her grandson, by providing her with both physical and emotional support. She narrates:

> My sister's child (aunt to my grandson) has been so supportive, caring and loving towards this child. She

> was sent by my sister to come and live here with me and help me with taking care of the child. She is the one who takes the child to crèche, sometimes bathes him, prepares food for him, and even feeds him. She comes in handy when she sees that I am not fine. You know, diabetes has its days …. (Participant 2, Grandmother, 80 years old, rural Eastern Cape)

These findings indicate that the health of children who are raised in kinship care is largely influenced by the way their primary caregivers manage the dynamics of the family within which they reside.

Despite these narratives, in two of the narratives of the caregivers, some unanticipated findings were revealed. The narrative accounts of the two participants indicated that the members of their families blatantly refused to collaborate with them in providing care to the children under their care particularly through lack of physical and emotional support. This has resulted in insecure attachments and poor communication between the caregivers and their families. For instance, Participant 17 recalls the physical condition the child was in when the child first arrived before he died while under her care. She maintains that the members of her family displayed so much disgust and lack of support given the child's condition. He was bony, his ribs and outer limbs stuck out and his face and buttocks had so many sores. She recalls one of the family member's sayings:

> Sister, this child is going to die here in this house. What are you going to bury him with? (Participant 17, Grandmother, 56 years old, urban KwaZulu-Natal)

Instead of receiving her family's support and involvement in providing care to the child, her relationship with her family changed instead, and she lost all form of attachment to them. She maintained that they held that they would not be able to live like this given that they could also see that this child was not going to live. So they left her to face this situation on her own since she had taken the decision to take care of this child and not make means to find his parents and return him back to them.

Participant 17 concluded her narrative with a very distinctive statement:

> There is even a social worker that I once spoke to when I was sick and bedridden for 5 months, in the previous year (2018). I asked her that should I die, please find my grandson the best care possible because my own family does not want to take over the care of a sickly child, who needs constant attention and care. So that shows that they will not treat this child well. So, it is much better if he is under the care of a Social worker. Sadly, my grandson has passed on. In as much as I miss him, I believe that his death is a blessing in disguise and he is in a much safer and peaceful place now. (Participant 17, Grandmother, 56 years old, urban KwaZulu-Natal)

4 | DISCUSSION

The study's objective was to explore effects of kin caregivers' family functioning on the survival of children through an application of the family systems theory. The major results acquired from caregivers' narratives on family functioning were that the kin caregiver's family environment can serve both as a (1) protective mechanism and a (2) risk factor for poor child health outcomes (mortality). With respect to the kin caregiver's family environment serving as a protective mechanism to child survival, some of the participants reported that the good relationship with the immediate family of the child influenced the child's overall wellbeing positively. These findings are strongly aligned with the family systems theory, as the degree of connectedness that family members have influences the household dynamics and general functioning of a family significantly, and such interactions will thus yield positive outcomes for the children placed under the care of such family contexts. The family environment impacts individual health outcomes significantly (Witt & DeLeire, 2009). Thus, the way the family functions can have a mediating or moderating effect on health outcomes. Although the narratives of the participants are explained by the Family Systems Theory, their narratives are also strongly affirmed by studies, which revealed that factors such as family functioning as well as interactions and relationships that exist among family members within and outside the primary home significantly influence the physical and psychosocial functioning of children who suffer from illness (Moreira et al., 2014; Palermo & Chambers, 2005). Most importantly, this finding is strongly corroborated by a study that showed members of a family that live in an emotionally safe environment are more likely to have an increased urge to provide adequate care and protection to the children under their care. This is all the while ensuring that children have adequate access to resources, with the assistance of other fellow family members. A safe environment is said to be characterized by peace, harmony, respect, teamwork and resilience (Wakhweya et al., 2008).

In contrast, the narratives of other participants showed that they had good family attachment and communication with other members of the family. The participants highlighted how collaboration and involvement of various family members, in the form of material, physical and emotional support, influenced the child's wellbeing positively. A few participants argued that the family environment in which they were providing care to the children was a conducive one. This is because all the members of the family played a key role in taking care of the children placed under the main kin caregiver's care as well as displaying increased receptiveness to the children's needs. These findings are supported by the Family Systems Theory as the support that kin provide to each other in the household has a significant influence on child health. Children who are raised in households in which the primary kin caregiver receives support (emotional, social and material) from other kin who are resident in the same household are more likely to present with positive health or developmental milestones. Thus, the assistance, or lack thereof, that primary kin caregivers receive from other kin residing in the same household has a significant impact on the primary kin caregiver's ability to fulfil their caregiving role.

Children who are raised in households in which the members of the kin family work cooperatively in assisting the primary kin caregiver to provide care are more likely to have positive health outcomes. This is particularly in societies that are characterized by high rates of child mortality (Bezner Kerr et al., 2008; Douglass & McGadney-Douglass, 2008; Sear & Mace, 2008). Moreover, children who are raised in households in which the primary kin caregiver receives support (emotional, social and instrumental) from other kin who are resident in the same household are more likely to present with positive health or developmental milestones (Cole & Eamon, 2007). Thus, it can be deduced that families that have good communication and clearly defined roles and responsibilities, which are equally shared, are most likely to foster healthy functioning among the members of that family, including children.

Contrary to these findings, the narratives of other participants indicated that their family environments served as a risk factor that resulted in poor child health outcomes. Given that majority of children were left in the care of the participants involuntarily, this created conflict within some of the caregivers' homes and affected their relations with their families. The family systems theory supports these findings, as it shows that a lack of support from other kin resident in the household may affect the primary kin caregiver's ability to effectively perform or manage tasks related to providing care to the child, consequently affecting the child's wellbeing. These narrative findings are also strongly affirmed by a distinctive feature that emerged in one study, which indicated that the family environments and relationships of kin caregivers who assume parental responsibility for a child are often strained (Hunt, 2003). They also have an increased likelihood of breaking down, following the placement of the child with the primary kin caregiver (Hunt, 2003). Similarly, other older literature has shown that an addition to the family creates competition for resources, which then translates into conflict, poor altruistic behaviour, poor familial cooperation and increased competitive behaviour among kin, resulting into poor child health outcomes (Boyd, 1982; Frank, 1998; Griffin et al., 2004; Hamilton, 1967; West et al., 2008). Thus, it can be deduced from these findings that the need for other family members to cooperate in providing care to children who are not biologically their own increases the likelihood of conflict, which may have adverse effects on a child's health and wellbeing.

The study has a few strengths. It is the first in South Africa to explore the family environments of kin carers who are raising non-orphaned children who are below the age of 5, and how the kin carers' family environments have influenced child survival. Second, applying the Family Systems Theory in this study helped examine the social environment (in this case, the kinship care family context), as it helps to understand how such care contexts shape the lives of children profoundly, through an interplay of various family characteristics that ultimately affect kin caregivers, their family environments and the capability of kin cares to provide proper care to the children placed under their care.

The study is not without any limitations. Three of the participants were hesitant in providing detailed responses during the in-depth interviews, and thus, probes had to be used. This created difficulties as some of the responses that required further explanations were brief. This could have posed some problems, as they may have withheld very important information that could have provided insight into the study and provided informative recommendations to Child Welfare Authorities, healthcare professionals and government at large. Second, the study found that all the children raised by kin (those who were still alive) were also suffering from either an ongoing acute or chronic condition which required frequent medical attention. Another major limitation of this study was that only mortality was assessed, thus excluding morbidity. Examining morbidity among non-orphaned children who are still alive could have assisted in describing the progression and severity of a given health event within the context of kinship care and how this can ultimately influence child survival. However, this is an aspect of research that has been considered for future research.

5 | CONCLUSION

The main objective of this study was to explore the effect of kin caregivers' family functioning on child survival. The conclusion reached in this study was that the kin caregivers' family environments are greater risk factors that play a crucial role in compromising the ability of kin caregivers to provide adequate care. The outcomes that children experience throughout as they grow as well as their general health are greatly determined by the family environment in which they live and the quality of care that they receive in that family environment. In addition, focusing on intra-family relationships helps provide insight into the role that interactions within families help play in child development. This is mainly because extended families are effective in adequately allocating resources to aid in the health and development of children in the household.

The use of South Africa as a focal country of study has proved to be successful considering that family structures in South Africa are changing rapidly. The implication of this is that the practice of kinship care is rapidly emerging into a customary practice. Second, the aims and goals of kinship care as a family institution are rarely documented in the South African Constitution and in various other policies. This is because a large proportion of children are informally placed under the care of extended kin without the knowledge or intervention of child welfare authorities. This study will thus assist in providing policies such as the White Paper on Families and Social Welfare, National Family Policy, Draft National Policy Framework for Families and the National Development Plan to evaluate and redesign their policies to include strategies that promote cooperation between primary kin caregivers, their families and the child welfare system to collaborate in enhancing overall child wellbeing, safety and positive developmental outcomes.

These strategies may further assist in providing comprehensive insight on how household composition and the quality of relationships of the people residing in the same households' influence child health outcomes significantly. Knowledge of these factors may thus assist in determining the appropriate interventions that should be implemented to improve the survival of children who are raised in such care

contexts. Moreover, caregiving environments should be rigorously examined to gain a comprehensive overview of the familial relationships, the cooperation or lack thereof of family members in providing care to the child and the kinship carer relationship with that of other family members within the household. Examining the caregiving environment will enable child welfare authorities to determine if the members of the household meet the necessary health and safety standards that are necessary in creating a nurturing and protective caregiving environment for the child placed under such care.

Lastly, application of the Family Systems Theory in studying the effect of kin caregivers' family functioning on child survival has proved to be successful, as it has provided a comprehensive insight on how the family context, degree of connectedness and general functioning of a family plays a crucial role in influencing whether various family members will have positive or negative outcomes on the survival of children. The theory has further shown the way the family functions and the support and care, or lack thereof, that family members provide to each other and how it can ultimately influence the families' subsequent life course outcomes those of children raised in such a family institution. It is thus vital to observe the family environment to gain an understanding of a child's health outcomes. In addition, the way the family adjusts to having an additional family member can substantially influence the adjustment in particular the health of the child and the family. Thus, positive family functioning may moderate or mediate the relationship between caregiving, the caregiver's family functioning and child health outcomes.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable in this article, as no datasets were generated or analysed during the current study.

ETHICS STATEMENT

Ethical approval was sought from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand. The ethics number is H18/10/38.

CONFLICT OF INTEREST

The authors declare that they have no competing interest.

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APPENDIX A: KWAZULU-NATAL DEPARTMENT OF SOCIAL DEVELOPMENT APPROVAL LETTER

FAX : 033-264 2075
Telephone/Ucingo/Telefoon: 033 264 2078
Enquiries/Imibuzo/Navrae : Mr. VW Gumede
Email address : velaphi.gumede@kznsocdev.gov.za
Reference/ Inkomba/ Navrae: S6/2/1

HUMAN RESOURCE DEVELOPMENT
174 Mayors Walk Road
Private Bag X9144
Pietermaritzburg
3200

Ms K Mabetha
School of Social Sciences
Private Bag 3,
Wits
2050

Email: kmabetha@gmail.com

Dear Ms Mabetha

PERMISSION TO CONDUCT RESEARCH IN THE DEPARTMENT OF SOCIAL DEVELOPMENT

This matter has reference.

Kindly be informed that permission has been granted by the Head of Department for you to conduct research in the Department of Social Development to fulfill the requirement of your PhD in Demography and Population Studies.

The permission authorizes you to -

(a) Approach and distribute your survey questionnaires to foster care parents and children's that are willing to participate in your research at their consent deemed relevant to your research project and maintain high level of confidentiality; and
(b) Share your findings with the Department.

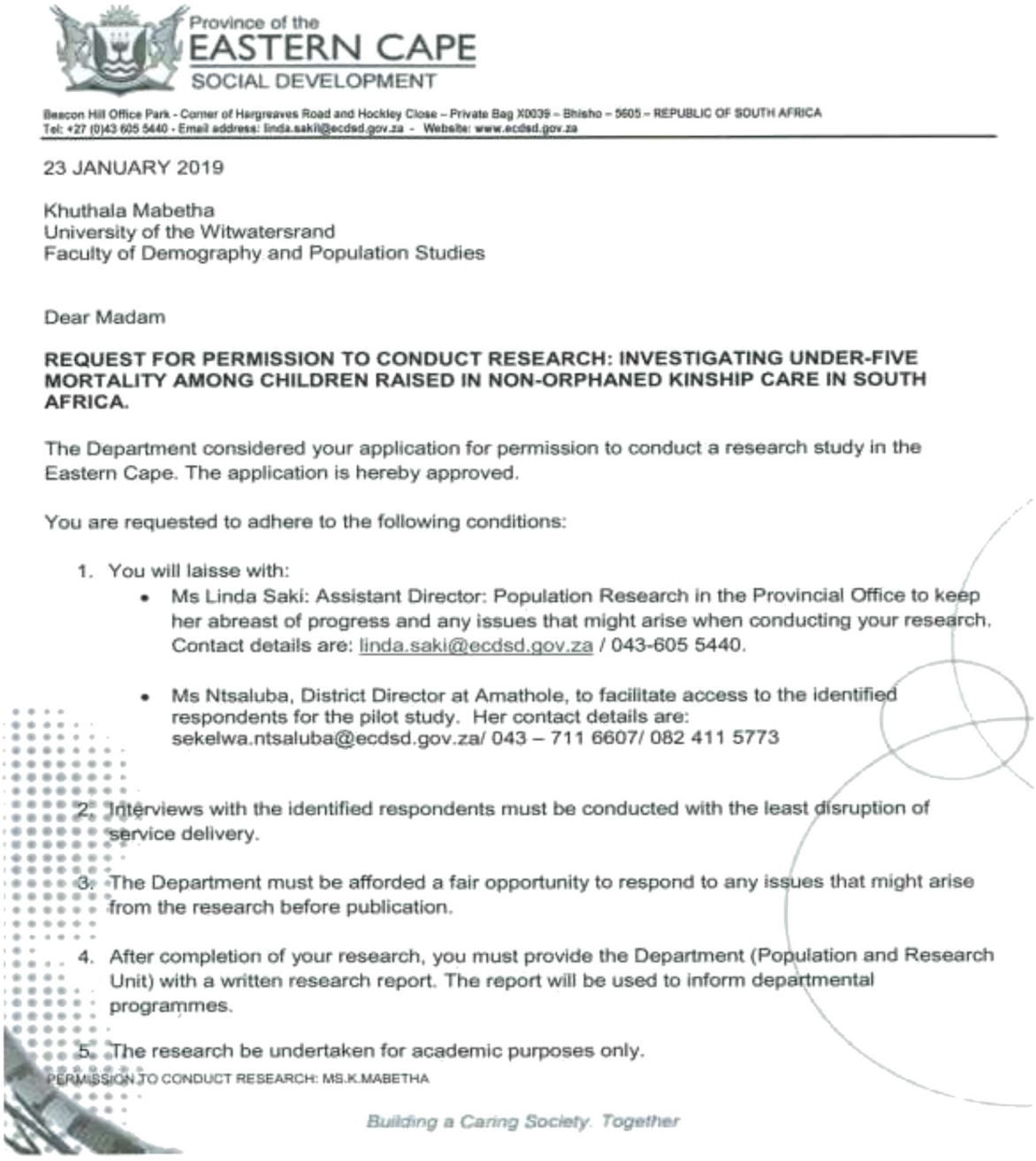
Wishing you success during your research project.

Yours Faithfully

MS NG KHANYILE
HEAD OF DEPARTMENT

DATE: 05/12/2018

APPENDIX B: EASTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT APPROVAL LETTER



Province of the
EASTERN CAPE
SOCIAL DEVELOPMENT

Beacon Hill Office Park - Corner of Hargreaves Road and Hockley Close – Private Bag X0039 – Bhisho – 5605 – REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)43 605 5440 - Email address: linda.saki@ecdsd.gov.za - Website: www.ecdsd.gov.za

23 JANUARY 2019

Khuthala Mabetha
University of the Witwatersrand
Faculty of Demography and Population Studies

Dear Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH: INVESTIGATING UNDER-FIVE MORTALITY AMONG CHILDREN RAISED IN NON-ORPHANED KINSHIP CARE IN SOUTH AFRICA.

The Department considered your application for permission to conduct a research study in the Eastern Cape. The application is hereby approved.

You are requested to adhere to the following conditions:

1. You will laisse with:
   - Ms Linda Saki: Assistant Director: Population Research in the Provincial Office to keep her abreast of progress and any issues that might arise when conducting your research. Contact details are: linda.saki@ecdsd.gov.za / 043-605 5440.
   - Ms Ntsaluba, District Director at Amathole, to facilitate access to the identified respondents for the pilot study. Her contact details are: sekelwa.ntsaluba@ecdsd.gov.za/ 043 – 711 6607/ 082 411 5773
2. Interviews with the identified respondents must be conducted with the least disruption of service delivery.
3. The Department must be afforded a fair opportunity to respond to any issues that might arise from the research before publication.
4. After completion of your research, you must provide the Department (Population and Research Unit) with a written research report. The report will be used to inform departmental programmes.
5. The research be undertaken for academic purposes only.

PERMISSION TO CONDUCT RESEARCH: MS.K.MABETHA

Building a Caring Society. Together

6. Strictly adhere to ethical standards to make sure no harm comes to participants in the study.

7. You avail yourself, should the need arise, to make a presentation of the findings and recommendations to the Department.

Please acknowledge and sign this document to indicate that you agree to and accept the conditions as stated above. Return the signed document via email to the Director: Population Policy Promotion
E-mail: linda.saki@ecdsd.gov.za

I wish you well with the research and look forward to the findings and recommendations.

Yours sincerely

MS N. BAART
HEAD OF DEPARTMENT
DATE: 05/02/2015

MS.K.MABETHA
PHD CANDIDATE: WITS UNIVERSITY
DATE:_____

PERMISSION TO CONDUCT RESEARCH: MS.K.MABETHA

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APPENDIX C: INTERVIEW GUIDE (KIN CAREGIVERS WHO STILL HAVE A CHILD ALIVE)

(For kin caregivers who still have a child alive)

Interviewee Information

Part 1: Demographic information

Relationship to child: …….
Age: …….
Sex: ……..
Level of education……...
Occupation…….
Marital status……
Date of
Interview……
… Duration of
Interview……
Place of
Interview…….
Age of child…….

Family environment/functioning of kin caregivers

1. Could you please share why the child was placed under your care? How long has the child been under your care?
2. Does the child have any contact with the biological parents? If no, why not?
3. What do your roles and responsibilities as a caregiver to the child entail? Did these roles adjust when you became the primary caregiver?
4. Is there anyone else who is assisting you in taking care of the child? If so, what is the relationship of the person to the child and in what ways does this person assist in taking care of the child? If not, how does solely providing care have an effect on both you and the child?
5. Can you walk me through a day in your family/household?
6. Could you please tell me about the quality of your relationship with the child, including that of the child with other members of the family?
7. How did the members of your family feel when the child first started living with you?
8. Were there any changes in the relationships within your family ever since you assumed care of the child? If so, please describe how the relationships within your family changed since taking on the care of the child?
9. Please describe any challenges that you have experienced as a family while the child has been under your care?

10. Have you ever experienced any problems or dysfunctions in your family since the child has been under your care? If so, what problems did you come across?
11. Please describe your family's living and financial situation.

APPENDIX D: INTERVIEW GUIDE (KIN CAREGIVERS WHO EXPERIENCED A CHILD DEATH)

(For kin caregivers who have experienced a child death)

Interviewee Information

Part 1: Demographic information

Relationship to deceased child: …….

Age: ……

Sex: ……..

Level of education……...
Occupation…….

Marital status……

Date of
Interview……
Duration of
Interview……

Place of Interview……...

Age of deceased at death…….

Family environment/functioning of kin caregivers

1. Could you please share why the deceased child was placed under your care? How long was the deceased child under your care?
2. Did the deceased child have any contact with the biological parents prior to his or her death? If not, why not?
3. What did your roles and responsibilities as a caregiver to the deceased child entail? Did these roles adjust when you became the primary caregiver?
4. Is there anyone else who assisted you in taking care of the deceased child? If so, what is the relationship of the person to the child and in what ways did this person assist in taking care of the deceased child? If not, how did solely providing care have an effect on both you and the deceased child?
5. Can you walk me through a day in your family/household?
6. Could you please tell me about the quality of your relationship with the deceased child, including that of the deceased child with other members of the family?
7. How did the members of your family feel when the deceased child first started living with you?
8. Were there any changes in the relationships within your family ever since you assumed care of the deceased child? If so, please describe how the relationships within your family changed since taking on the care of the deceased child?
9. Please describe any challenges that you experienced as a family while the deceased child was under your care?
10. Have you ever experienced any problems or dysfunctions in your family while the deceased child was under your care? If so, what problems did you come across?
11. Please describe your family's living and financial situation prior to the child's death.