CULTURE AS ANCHOR OR CULTURE AS IMPEDIMENT?
THE PLIGHT OF CHILD CARE WORKERS (CCWS) IN DEALING WITH HIV RELATED DEATHS IN A CHILDREN’S HOME

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ABSTRACT
This reflective article is based on the experiences of child care workers in a children’s home in South Africa, who, when faced with untimely and successive deaths of children from HIV/AIDS related illnesses, resorted to culturally informed emotional coping mechanisms. This is, therefore, not a research study but presents the authors’ reflections on the topic and seeks to highlight the need for further exploratory studies in the area of the positive role of cultural practices in HIV/AIDS interventions. The women whose experiences are the focus of the article, adopted culture specific coping mechanisms which they saw as a necessary strategy for managing their distress i.e. an anchor in the face of what they perceived as an “unnatural” occurrence. This, however, conflicted with their organisational identities as employees in an establishment for abandoned/orphaned children, referred to here as a ‘Home’, thus causing what could be perceived as an impediment to their organisational care-giving services. The authors document the nature of the conflict, highlighting how the care workers adopted ‘mothering roles’ based on African cultural parenting practices, resulting in the need to perform culturally prescribed rituals, and how this brought about challenges within the workplace. The need for integrating traditional methods of healing with Western approaches of counselling and psychotherapy is reflected on, especially in recognition of the symbolic nature of African healing practices. The article emphasizes the role of culture as an anchor rather than an impediment.

Keywords: Circumstantial AIDS care work, coping, cultural identity, occupational identity, other-mothering, symbolic African rituals.

INTRODUCTION

“In times of strife or adversity, the tendency is to revert to the familiar”

The provision of care for people living with HIV/AIDS poses a challenge for all concerned, including government and non-governmental authorities, health care professionals and communities. Essential to this challenge is the shared acknowledgement that adequate care for infected (and affected) individuals is not a choice, but a moral obligation that cannot be ignored as the right to health care is enshrined in the constitution (The Bill of Rights, 1996). Yet the reality of caring for people living with HIV and the difficulties faced by concerned parties often gets lost as focus is primarily on prevention, education and treatment measures. This becomes more of a challenge when those tasked with providing care are doing so by default, as opposed to being part of the formal or volunteer care-giving sector. Child care workers (CCWs), particularly those working in South
African children’s Homes often find themselves in this position as circumstances rather than choice see them being ‘surrogate mothers’ not only to orphaned and abandoned children, but to children infected with the HIV/AIDS virus. For many CCWs, AIDS care work is, therefore, circumstantial, and coping becomes a major challenge, if not a crucial aspect of their daily duties.

Researchers have documented that caring for people living with HIV/AIDS can be an emotionally and physically demanding task (Akintola, 2008). As a result, there has been rising concern over the mental and emotional health and well-being of AIDS care workers, which in turn, has led to increased interest in the area of stress, burnout, coping, as well as factors influencing attrition rates among HIV/AIDS health care workers (Alexander and Hegarty, 2000; Dageid and Duckert, 2008; Gueritault-Chalvin, Kalichman, Demi and Peterson, 2000; Maslanka, 1996; Ross, Greenfield and Bennett, 1999; UNAIDS, 2000). For example, in her research, Maslanka (1996) highlights the influence of the three components of the burnout syndrome such as emotional exhaustion, depersonalization and lack of personal accomplishment on dropout of most people who work in the areas of HIV/AIDS. On the other hand, Ross, Greenfield and Bennett (1999) cite the components of stress such as client problem and role ambiguity, emotional overload and organizational factors as predictors of dropout of volunteers from AIDS service provision. However, the idea of leaving employment does not seem a viable option for the CCWs discussed in this article, despite the fact that they seem to face on-going problems that may be associated with stress and burnout.

Most studies in HIV/AIDS service provision have largely focused on professionals, para-professionals, as well as volunteers in the home-based care sector (Akintola, 2006). The purpose of most of these studies has been mainly to understand the dynamics of being a caregiver and hence to find ways of alleviating some of the challenges, as well as to formulate appropriate policies and strategies for intervention. However, there are indications that certain aspects of the complex nature of AIDS care work remain largely unaddressed, such as for instance, the continuing stigma associated with AIDS care work (Akintola, 2008; Van der Heijden and Swartz, 2010). Important also is documenting different coping strategies that people use in order to deal with the demanding nature of their work, especially those mechanisms that do not necessarily adhere to the well documented models of coping, such as those advocated by Lazarus and Folkman (1984). In working within African communities, attempts to understand methods of coping need to be inclusive of the cultural context within which those adopted methods are applied. It should be noted that the African cultural practices tend to lose their significance and meaning unless if they are interpreted within the relevant cultural context (Mbanaga, 2004).

The stress and coping paradigm described by Lazarus and Folkman (1984) differentiates between problem-focused and emotional-focused coping, with the former being active, assertive, and confrontational, and the latter perceived as passive and avoidant. Coping strategies are defined as behavioural and psychological attempts to manage any stressful event, and these strategies, therefore,
indicate how people are likely to react to stressful situations (Lazarus and Folkman, 1984). An additional dimension to coping involves cognitive appraisal, which entails a process of evaluation indicating the person’s subjective interpretation of the event. This includes both primary and secondary appraisal of the situation in order to ascertain the potential for harm or benefit, which in turn influence decisions to either try to improve the possibility for benefits or prevent harm. Akintola (2008) reported that those who adopt the problem-focused coping strategies are likely to experience lower levels of psychological distress, whereas Carver, Schreiner and Weintraub (1989) were of the opinion that coping that involves focusing on and venting emotions as well as behavioural and mental disengagement tends to be maladaptive and less useful.

According to Dageid and Duckert (2010), the shortcoming of the Lazarus and Folkman’s model is that it is largely quantitatively oriented, and is preoccupied with predicting, controlling and managing health behaviour of individual participants through development and application of “universal” theories. The difficulty of applying such traditional individualistic models become pronounced when one has to deal with cultures that adhere to communal type of existence. Given the influence of culture on behaviour, coping with psychosocial stressors inevitably acquires a cultural dimension, and as Dageid and Duckert (2010) further argued, it is imperative to consider the context within which coping occurs in order to understand its meaning and relevance. This implies that there are differing coping mechanisms within cultures, and that attempts to view coping as homogeneous would tend not only to rob different communities of their heritage and knowledge systems, but would also obscure the richness of their diversity. Mbananga (2004) believes that the imposition of dominant views (cultural or otherwise) in understanding matters relating to health suppresses the differences between cultures and may thus result in stagnation. This is because these dominant views are usually couched in ‘universalist’ approaches and fail to acknowledge the benefits of indigenous knowledge systems that are culturally relevant and have served people through time (Swartz, 1998). It is therefore important to explore how coping mechanisms based on culture may be adapted and re-conceptualised in a bid to enhance their efficacy in the light of contemporary health challenges, such as in HIV/AIDS related issues.

The aim of this reflection article is to provide an account of the experiences of a group of CCWs working in a children’s home in South Africa. It documents observations that were made during site visits and experiences shared during group therapy sessions held with the women. This article, therefore, is not a report on a formal research endeavour, but rather it is a reflective account of CCWs experiences during an (informal) intervention.

Circumstances surrounding the need for this informal intervention will be elaborated on below. The main purpose is to highlight the influence of a cultural framework as an anchor and indicate how this can be enhanced for the benefit of the care workers. Further, it is important to investigate how the cultural survival skills may be formulated as culturally appropriate interventions. Kilonzo and Hogan (1999) have emphasized the importance and psychological efficacy of
culturally sensitive interventions in the face of the HIV pandemic. To contextualise the discussion, a brief background of the group and the circumstantial nature of their employment will be provided. This is followed by an in depth discussion of the CCWs experiences and the role of culture as a ‘coping mechanism’ against AIDS related deaths. In conclusion, reflections are made and comments are drawn from the ensuing discussion.

BACKGROUND

Setting and Context: The Home for abandoned and orphaned children that we are reporting on is situated in the city of Durban, KwaZulu-Natal Province, Republic of South Africa. This Home has different units for children, based on gender and age, with two additional specialized units, one for drug rehabilitation and the other for children who are HIV-positive. It is this specialized unit for HIV-positive children that the authors of this article had to visit in order to render some psychological service for the staff. Each unit has a surrogate mother or “auntie” who takes care of the children’s needs such as health, schooling etc. The relationship that the “auntie” enjoys with the children tends to somehow emulate that of an ordinary family. This is in keeping with African tradition of child care by the extended family (Allen Jr., 2004). In this unit, the “aunties” were also responsible for administering anti-retroviral medication to the children, as well as ensuring that those who were sickly were cared for appropriately. In the event of a death of a child, it was also the aunties who would report to the Home authorities and oftentimes ensure that the body is prepared for removal to the morgue.

The Home authorities had asked for professional intervention for workers who were reported to have difficulties in coping with the successive death of children in the HIV/AIDS unit. During that particular time, they had lost five children within weeks, and there were other sickly children who were at the advanced stage of AIDS infection. The authorities requested assistance especially with regards to helping workers in dealing with the normal grieving process, while preparing them to deal with the possible death of some of the remaining children. In essence, the authors were requested to assist workers in developing better coping mechanisms suited for the challenging nature of their work.

The Group of Child Care Workers: The group of CCWs comprised of seven women, with ages ranging between twenty-five and forty-five years. They all belong to the Zulu cultural group, and had children of their own, even though only one of them was married. Their educational level ranged between grade 1 and grade 12, and they had had minimal, but mainly informal training on HIV/AIDS issues. As mentioned earlier, these women had primarily been appointed to care for orphaned and abandoned children, (in line with the original definition of working in a children’s home or orphanage), and not necessarily to care for children with HIV/AIDS. They were, therefore, inadequately prepared for the nature of their work.

Before a structured intervention programme was developed, a meeting was arranged with the CCWs in order to determine their specific needs and expectations.
The aim was also to enable them space to share their concerns and offer them an outlet for the emotional burden that the authorities reported had become a significant concern requiring immediate intervention.

ISSUES OF CONCERN

The initial conceptualization of the proposed intervention was that of providing a support structure, possibly group therapeutic intervention to help them deal effectively with the death of the children under their care, while psychologically preparing for the impending loss of the others that were in the final stages of the disease. However, the issues that emerged in group discussions went beyond grief and bereavement to include aspects of culture and spirituality, which were seen as being in conflict with occupational requirements and expectations. In addition, several other issues were raised, including aspects of role ambiguity (i.e., the (detached) occupational role versus the ‘mothering’ role involving closeness and attachment to the children); the CCWs own cultural identity and that of the children under their care; the challenging nature of HIV/AIDS; dealing with death of children; the stigma associated with HIV/AIDS; and the HIV status of the CCWs themselves (an aspect the Home Authorities appeared to have overlooked); burnout and emotional overload, and of course, mechanisms of coping with work related stressors.

The cultural dynamics in coping form the core of this discussion as they seemed to overshadow other issues raised by the CCWs. It appeared that competency on cultural values seemed to be the cornerstone of how the care workers conducted their duties, even though at times there were apparent conflicts of interest between the care workers’ and management’s cultural values. In fact, the relationships that the CCWs established with the children at the Home seemed to be based on the African cultural notion of viewing every child as being a child of the community (Nsanemang, 1992). Meyiwa (2011) has argued that the mothering role is actually a communal practice involving generally all women within the homestead and community setting. This cultural practice is aimed at ensuring that children raised within a particular African community learn to respect every adult as their own parent, which in turn helps to instil good cultural values. Parents also assist in ensuring that children, wherever there may be, are at all times under the watchful eye of any adult person/s in the community (Nsanemang, 1992). It was thus evident that the CCWs cared for the children at the Home as though they were their own children, in accordance with cultural provisions. Culture, therefore, appears to have provided an anchor rather than an impediment in helping the CCWs deal with work related challenges. Evidently this was neither fully understood by the Home authorities nor was it appreciated as an effective coping mechanism.

It should be noted further that the CCWs adherence to cultural values is informed by the underlying principles of ubuntu or humaness, according to which every person is accorded utmost respect, based on the age old dictum that “a person is a person because of other people” which in isiZulu is known as umuntu ngumuntu ngabantu (Holdstock, 2000). This would have been the guiding principle
behind the CCWs understanding of what is expected of them as African cultural women.

CIRCUMSTANTIAL AIDS CARE WORK

Child care workers (or ‘surrogate mothers’) working in children’s homes which happen to have orphans that are infected with HIV/AIDS have relatively not been subjected to extensive research. Most studies in the area of HIV/AIDS care work has largely concentrated on either AIDS volunteers (Akintola, 2006; Akintola, 2008; Maslanka, 1996; Ross, Greenfield and Bennett, 1999), nurses who provide HIV/AIDS care (Gueritault-Chalvin, Kalichman, Demi and Peterson, 2000), people affected and infected with the virus (Cluver, Gardner and Opeario, 2009; Dageid and Duckert, 2008; Shambley-Ebron and Boyle, 2006), HIV/AIDS within the school context (Mbananga, 2004), as well as communities that are affected by the disease (Kidman and Heymann, 2009). The ‘surrogate mothers’, who obviously are women, find themselves having to deal with children infected with HIV/AIDS as part of their daily care-giving services when they were employed to take care of abandoned and orphaned children, and not specifically children with HIV. It may be argued that the nature of occupational activities for caregivers in children’s homes has changed, given the increase in the number of AIDS-related orphans (i.e. children abandoned by parents dying of HIV/AIDS-related illnesses and/or children abandoned because they are infected with HIV (Allen Jr., 2004). Many care workers, therefore, become AIDS care workers mainly by chance or default. This is understandable given the high unemployment rates and poverty, especially in the South African context (Statistics South Africa, 2006). As a result of this circumstantial AIDS care work, these care-givers are generally ill-prepared for the demands of this ‘occupation’. This becomes even more difficult when they have to deal with successive deaths of the children under their care.

COPING STRATEGIES: FALLING BACK ON THE FAMILIAR

People who work with abandoned and orphaned children in Homes require certain mechanisms to cope with the challenging nature of their work. In addition to the daily duties, it is not uncommon for CCWs to be faced with either gravely ill or dying children (Allen Jr., 2004). Thus care-giving work necessarily imposes relatively enormous emotional demands on CCWs (Akintola, 2008; Ross, Greenfield and Bennett, 1999; Maslanka, 1996). This is often aggravated by a lack of knowledge and inadequate training (Naidu, 2005). As a result, care-givers tend to resort to coping strategies that they are familiar with, even though they may not consciously do this nor are they likely to adopt cognitive appraisal strategies to assess the costs and benefits of such methods. In the context of this article, we identified the use of cultural practices and rituals as coping strategies for CCWs, which they adopted in the context of having to deal with HIV/AIDS related grief and bereavement. For these CCWs, the cultural cleansing methods associated with death that the CCWs were familiar with were not an option but a necessity, and this somehow proved to be beneficial to their plight. However, the CCWs were aware that these cultural cleansing methods were, in
We wish to highlight the nature of this conflict and then explore possibilities of how some of these strategies may be adapted to form part of cultural sensitive coping methods.

**PERCEPTIONS OF THE HOME: HOME OR HOME?**

The move to change ‘orphanages’ to Homes (Child Care Act of 1983, amended in 1999) was meant to alleviate the stigma associated with orphanages. However, this change seems to have inadvertently brought about a different problem where some people regard the term ‘home’ to literally mean a family homestead. Although generalizations may not be made to other children’s homes, at least for this particular group of CCWs, they seemed to have adopted a literal meaning of ‘home’, imbuing the children’s home with values and cultural transcriptions that are associated with a homestead. With the CCWs hailing from the Zulu cultural group and looking after predominantly Zulu speaking children, it became easier for them to want to raise the children according to cultural traditions, customs, and values that would be found in a typical Zulu home or homestead. It then followed naturally that the CCWs dealt with death and bereavement following Zulu traditional guidelines, and perhaps this is typical of how African people would respond to such challenges. Similarly, Shambley-Ebron and Boyle (2006) have noted that the manner in which African people respond to illness (and adversity) often corresponds with core African beliefs, values, and established lifeways. This often manifests in resorting to structured and familiar mechanisms of coping with adversity or painful emotional situations, which are usually drawn from cultural prescriptions and values, which, in turn fosters survival, cohesion and provides some meaning and relevance. This would, at times clash with the Home Authorities’ policies on how to deal with the child who dies while under the care of the Home and thus result in women feeling that their cultural identities, as well as that of the departed child, were undermined by the Home Authorities. This was further aggravated by culture-based concerns about the possible dire consequences of not adhering to appropriate cultural rites and rituals (e.g. encountering the wrath of ancestors).

**DEALING WITH DEATH**

**Occupational Identity and Role Ambiguity**

The CCWs expressed a difficulty in detaching themselves from their occupational activities, especially since they themselves were mothers. In essence, they saw themselves playing more of a ‘mothering’ role than just being child care workers, even though this seemed to present them with a dilemma. On the one hand, they wanted to treat the children as their own, in line with the notion of communal parenting (Meyiwa, 2011), rather than treat them in a detached manner as if the Home was a ‘hospital’. Yet, on the other hand, treating the orphaned children as their own would necessitate proper mourning rituals in the event of death. It should be noted that the health care workers see themselves as the only “family” available for the children. The role of ‘other mother’ and
‘community other mother’ has been identified by Shambley-Ebron and Boyle (2006) as typical of African women who have always been in positions of servitude, and had to care for and raise children of others. In an African setting, this is perhaps influenced by traditional polygamous families where the mothering role is shared among the wives (Meyiwa, 2011). However, over-identification with children sick and dying from an incurable disease brought about a sense of helplessness for the CCWs and naturally, they experienced difficulty in coming to terms with the death of children (Naidu, 2005). In fact, Kilonzo and Hogan (1999) argued that the death of children from AIDS is a phenomenon that remains elusive and confusing, perhaps because children are expected to outlive their elders. In instances where children died, CCWs often internalised a sense of failure for not having been able to care for the children and hence performing what few cultural rituals they could do was seen as the only hope. In view of the positive meaning that the CCWs seemed to derive from their reliance on culture, it would have been appropriate to assist them in ensuring that the rituals were performed. In fact, encouraging involvement in cultural mourning rituals may be perceived as a type of problem-focused coping strategy as it fosters engagement with activities sanctioned by family and community and thus help draw strength from the collective (Shambley-Ebron and Boyle, 2006).

**Funeral Arrangements and the Associated Rituals**

The CCWs raised concerns about funeral arrangements at the Home, which seemed to be in conflict with cultural prescriptions. They were particular about following proper rites and rituals in handling the dead body of a child as failure to do so would not be in keeping with their cultural identities which prescribe elaborate practices concerning the proper cultural manner of conduct on how to handle a dead body (Ngubane, 1977). They therefore also expected that appropriate pre- and post-burial rituals (on behalf of the deceased child) be performed, as well as personal cleansing rituals for themselves and the other surviving children at the Home. These cleansing rituals seem to have significant psychological implications and assist in avoiding issues related to complicated grief (Nwoye, 2005; Makhaba, Memela and Magojo, in press). The essential belief is that the rituals help both the living and the dead to ‘disengage’, with the dead becoming free to dwell in the world of the ancestors and the living being freed from the power of the deceased, and thus at liberty to engage in new networks of relationships (Kilonzo and Hogan, 1999). In the case of CCWs, this means that the knowledge that they had performed what was culturally expected would psychologically free them to continue with their duties to the surviving children without their grieving process being confounded by a sense of guilt.

There were several issues that emerged in relation to funeral arrangements which the CCWs appeared to grapple with. Firstly, they seemed to have relegated the duty of handling any dead body to the eldest CCW, as would be culturally expected. She would be expected to prepare the dead body and be present when it is taken to the mortuary. This may be perceived as the continuation of the “mothering” role ascribed mostly to older African women. Shambley-Ebron and Boyle (2006) explain that older women hold a position of honour
because of their status as elder women who have raised children and weathered the storms of adversity. Further, culturally, young and unmarried persons may not perform this task as this leads to pollution and misfortune, which would adversely affect their prospects of marriage and procreation (Ngubane, 1977; Makhaba, Memela and Magojo, in press). The eldest CCW therefore acted as the ‘family elder’ and had the additional task of taking care of the younger CCWs, and had no one to offer her emotional support. As mentioned above, Shambley-Ebron and Boyle (2006) have identified the folly of treating older women as strong and able to somehow ‘weather the storm’ of adversity, such that they are not permitted or expected to seek psychological help for themselves.

It was not clear if the CCWs reliance on cultural prescriptions in handling the deceased body could be attributed to their educational level or to the state of being overwhelmed by death. Unlike physicians and/or nurses who are trained to maintain emotional distance from the human body, perhaps viewing it mainly as a biological entity, the caregivers’ reaction tended to be emotional and embedded within their cultural context. They appeared to have collapsed their occupational identities with their cultural identities, and thus experienced difficulty in maintaining professional detachment often expected in contexts where death has to be dealt with on an ongoing basis. The CCWs’ behaviour seemed reminiscent of what Gueritault-Chalvin et al. (2000) regarded as over identification with patients, which unfortunately tends to have implications for caregiver’s emotional functioning. However, it seems that the CCWs appeared to find the idea of “over identification” with the children they cared for as culturally desirable rather than a source of emotional stress.

Other problems that emerged in relation to the reliance on culture as a coping strategy were CCWs’ insistence that the deceased child be given proper burial rites and rituals in line with deceased child’s respective surname, clan, and/or ethnic group. It should be noted that many abandoned children had to be given names and surnames upon admission to the Home. Yet the care workers believed that every child is a ‘cultural entity’ and, therefore, the necessary cultural rituals ought to be performed in spite of the obvious contradictions. To the CCWs, an adopted surname (with its embedded African cultural values) would provide more of a substantive identity to the child, than using a surname devoid of indigenous cultural prescriptions. It seemed that the CCWs believed in the importance of the surname in determining ethnic ancestry and hence cultural identity (Waters, 1989). For them, giving a child a surname would help facilitate the spiritual connection in the afterlife. This seemed to help them in dealing with loss. However, it often landed them at odds with the Home authorities who could not understand how cultural practices based on an adopted surname would make a difference or alleviate the grief and bereavement. This, of course may be due to the Home authorities’ lack of understanding of the symbolic nature of healing practices (including mourning rituals) among the AmaZulu of Southern Africa (Berglund, 1976), which may not be readily clear to an uninformed observer (Makhaba, Memela and Magojo, in press).
CULTURE: ANCHOR OR IMPEDIMENT?

The foregoing points raise some questions and concerns regarding the support that CCWs can be given by the Home authorities. Firstly, should this coping style be encouraged or discouraged, taking into account the conflicts that arise between their cultural needs as against organizational guidelines and rules? We argue that this coping style would seem to be an anchor for the CCWs and therefore it should be encouraged. We also feel that it is possible for arrangements to be made to ensure that the CCWs do not feel that their occupation poses a threat on their sound cultural standing.

Another issue of concern is whether it is worthwhile to conscientize CCWs about the importance of separating their occupational identities from their cultural identities in carrying out their duties (i.e. maintaining professional boundaries), as is normally the case among Western trained professionals. Again our view is that it would be of benefit to both the authorities and the CCWs to educate them about the importance of such a separation of identities. However, care should be taken not to suggest to the CCWs that their adoption of cultural values is somewhat problematic, since our view is that it has significant benefits for the CCWs, in terms of coping with grief.

In addition to the above, it is important to consider whether it would be practical to manage the unit of the Home specialized for HIV/AIDS infected children as some sort of ‘clinic’ or ‘hospital unit’, and to staff it with personnel who specialize in HIV/AIDS care, so as to overcome some of the problems already mentioned. In view of the problems related to the lack of resources, specifically financial resources, we feel that it would not be practical to do so in the near future.

Another issue that poses a challenge is that of the significance of the CCWs practice of ‘forcing’ orphaned children to ‘buy into’ cultural clan names and rituals. Again we argue that this practice should be emphasized rather than discouraged, especially in view of the benefits that cultural competency appears to provide for the CCWs. Clearly these cultural rites and ritual pose no harm on the lives of the children and they are mainly meant for the CCWs coping. Attempts can be made to accommodate these cultural practices despite the challenges of the working environment.

Over and above this, the issues raised above do not seem to clarify how the CCWs’ coping strategies may be conceptualised in the context of Lazarus and Folkman’s (1984) problem-focused and emotion-focus coping strategies. At face value, the CCWs activities are more problem-focused as they seem to assert themselves and plan a course of action to deal with death, while at the same time there is an element of emotional-focussed coping as they blame themselves and feel helpless for their inability to prevent the death of children. This helplessness would be compounded by their inability to perform appropriate rituals for deceased children and would possibly result in emotional and psychological disturbances. Possibly the solution to the problem would be to engage in negotiations to find ways of meeting the cultural needs of the CCWs while satisfying the requirements of the Home. This would also help to overcome the difficulty
that the CCWs seemed to experience in separating their occupational identities from their cultural identities.

It is our observation that reliance on cultural explanations appeared to provide the CCWs with solace, meaning and hope. When it comes to grief and mourning, it would seem that psychological models and theories of Western origin that would have been applied, tend to pay relatively less focus on social and/or communal factors and thus do not adequately deal with the inherent complexity of the African traditional mourning process (Kilonzo and Hogan, 1999). In fact, Kilonzo and Hogan further cast doubt on the efficacy of Western models of dealing with grief and mourning when they argue that:

It is doubtful if formal grief counselling, whichever model it uses, can replace the traditional sacred and dynamic mourning process. Counselling models tend to be based on western philosophical and theoretical assumptions about the personalized experience of emotional distress and the 'self' as a separate entity distinct from the 'self-in-communion'. As a result it is likely that the emotional impact on the individual may be addressed while the relational and communal dimensions of the loss are ignored. A more effective intervention is more likely to hinge on an intervention ritualized in the context of social relationships.

Kilonzo and Hogan's (1999) statement highlights the importance of adopting cultural or traditional methods, based on indigenous and traditional way of life, in coping with grief and loss. Their view appears to place value on the significance of traditional interventions in dealing with emotional distress since this includes the role of the community and social relationships, as against the grief counselling methods that are based on western philosophical underpinnings about what constitutes the 'self'. Interestingly, our initial encounter with the CCWs was aimed at adopting the grief counselling methods we are familiar with, in terms of psychological practice. We remain indebted to the CCWS for their wisdom and generosity in sharing their cultural expertise.

There seems to be consensus among scholars and researchers that each ritual in the traditional mourning process has significant psychological functions, and that some of these rituals are deeply ingrained in the culture, affirming fundamental norms and values of the community, conveying a sense of predictability, security, order and continuity (Bodibe, 1993; Kilonzo and Hogan, 1999; Makhaba, Memela and Magojo, in press; Ngubane, 1977; Shambley-Ebron and Boyle, 2006). This sense of predictability, security, order and continuity was exactly what the child care workers needed when faced with the inexplicable multiple deaths of children under their care.

The foregoing discussion suggests that the CCWs should ideally be offered an opportunity to merge their cultural identities with their occupational identities, especially in relation to dealing with death. Adaptive strategies of coping, such as those advocated by Lazarus and Folkman (1984) may be negotiated with the CCWs. However, literature has indicated that in the context of African people, abridged or abandoned cultural grief practices may result in unresolved, pathological and complicated bereavement (Kilonzo and Hogan, 1999), irrespective of
the relations with the deceased. To prevent this, the CCWs should ideally be permitted to express their cultural identities by performing the necessary rituals and rites as this would help them receive communal support and achieve a sense of closure. There is also an understanding of the importance of circumventing the track of misfortune that is associated with failure to carry out appropriate rituals as obligated by African customs and traditions (Ngubane, 1977; Memela and Magojo, in press).

One may also not overlook the emotional anxiety associated with the HIV status of some of the care-givers themselves, as well as their significant others, and how this would complicate their responses to death and dying. The familiarity of their cultural traditions and rituals thus provided them with an anchor during times of strife.

**IMPLICATIONS FOR PRACTICE**

Given the complexity associated with caring for people with HIV/AIDS, it seems prudent to advocate for more practical ways of providing psychological care for those involved. Sensitivity to the complexity of HIV/AIDS pandemic can never be over emphasized. Kilonzo and Hogan (1999) believe that innovative ways can be found to integrate elements of existing cultural mourning and coping practices to modern intervention strategies. They argue further that to respond effectively to this mental health challenge, perhaps maintaining the culturally prescribed mourning rituals, or even reintroducing them in some form, may have significant value. Similarly, Shambley-Ebron and Boyle (2006) argue for culturally appropriate interventions. Bujuwoye (2005) defines a ritual as “culturally organized, symbolically meaningful activity that provides standardized therapeutic experiences for reduction of anxiety and emotional distress”. This definition highlights the symbolic nature of the rituals and the inherent benefits that they would have for the CCWs in terms of helping them find meaning and closure. In addition, since rituals are a group activity, they would enhance social support and thus foster a sense of community (Helman, 1994), in line with the principles of ubuntu already explained. In this sense, rituals that address the needs of the people must reflect the complexity of the HIV/AIDS experience. To achieve this, there must be a willingness to allow for the meanings of the AIDS experience that go beyond what is visible and rational, that reside in the lives, hearts and imagination of the people (Kilonzo and Hogan, 1999).

The challenge is to find common ground by attempting to meet the expectations of the employers, while at the same time satisfying the cultural needs of CCWs. Rituals that indicate respect for the deceased as well as provide support to those affected can be useful. The CCWs would be empowered as they have the cultural expertise of how to conduct the relevant rituals. We make a few suggestions about some symbolic cultural practice. Our suggestions may not necessarily apply to every situation, but may help bridge the cultural divide in a manner that may not cause disruptions to the management of the Homes. It should be noted that these suggestions may be appropriate to AbeNguni people of sub-Saharan Africa. Variations may be found in other parts of the African continent.
• Allowing workers to burn incense (*impepho*) to introduce the spirit of a child to its ancestry.

• While the Home attends to the cremation of the deceased body, the CCWs and the surviving children may be allowed to hold a vigil (funeral wake), involving whatever cultural rituals the CCWs would deem fit (eg. keeping a candle alight). This may also help with what Nwoye (2005) refers to as fact memory, where attempts are made to reframe the circumstances surrounding the death in positive terms so that those left behind may finally accept the loss and find peace, a 'cognitive-restructuring' of sorts.

• Those who were involved in handling the deceased child’s body may be allowed to cleanse themselves by taking a bath in tambotie grass (*isiqunga*) or any other appropriate cleansing materials as understood by the CCWs.

• A day of remembrance may be held for those who have departed. If possible, community members who share similar cultural beliefs may be invited. This would also be in line with the involvement of the community in the grieving process that is essential in African culture.

• Negotiations can be made with the funeral home that the bathing of the deceased body be done in their premises and thus alleviating pressure and stress from the oldest of the ladies.

**CONCLUSION**

The complexity of the HIV/AIDS pandemic has resulted in numerous attempts to provide help and support to those tasked with providing care for the infected and affected individuals. Integral to this attempt is finding ways and means that would limit challenges that are experienced by care providers. The difficulty of working in the area of HIV/AIDS by default, resulting in having to deal with the disease not as a matter of choice, has been identified as providing further complications in this area. This has led the care workers under discussion to adopt culturally relevant emotional coping mechanisms. It may appear that these coping mechanisms may be in contradiction to the requirements of the organization that provides them with employment, and thus may be perceived to be an impediment to the manner in which they deal with grief. However, research indicates the value of culturally appropriate intervention strategies as they may serve to mitigate against grief and mourning complications that are associated with HIV/AIDS related deaths. Therefore finding ways to negotiate ways and means by which the AIDS care workers can perform their cultural rituals without disturbing the organizational processes would seem a more pragmatic approach to the challenge. Since incidents of untimely and successive loss of life in these settings may periodically occur, it would seem practical to incorporate the African cultural rituals into the mainstream processes at the Home. This, we believe, would provide the AIDS care workers with opportunities to integrate death and mourning into a world-view that is familiar and one that allows for coherence and a sense of closure.
REFERENCES


