Social Policy Implications for the Care and Welfare of Children Affected by HIV/AIDS in KwaZulu-Natal

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DECLARATION

I, Mary Christina Harber, declare that this is my own work. It has not been submitted before for any degree or examination in any other university.

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ABSTRACT

In the next few years South Africa with be faced with immense socio-economic problems created by the HIV/AIDS epidemic, not least of which will be the impact on children and their families. Evidence from other African countries shows that the presence of large numbers of AIDS orphans has major implications for the societies in which they live. Reports from these countries suggest that, even in the midst of high rates of HIV/AIDS, the African extended family system is remarkably persistent. However there is also evidence that HIV/AIDS affected children face an increased risk of poor health care, of dropping out of school, of abuse and exploitation. The majority of communities affected by HIV/AIDS in South Africa are already poor, yet HIV/AIDS will place a huge strain on available resources. As the epidemic develops, an increasing number of children are likely to fall through the extended family safety-net and pressure will rise on welfare organisations to provide alternative forms of care. The welfare sector must therefore urgently find innovative ways both to support traditional forms of child care, and to develop new models of care.

Welfare organisations are being faced with the challenges presented by HIV/AIDS at a time when national welfare policy is in a process of change. The White Paper for Social Welfare (Department of Welfare, 1997), promotes a major shift of approach to welfare provision. The new approach is based on the principle of 'developmental social welfare'. This is a broad concept incorporating ideas such as 'building human capacity', 'promoting self-reliance', creating 'appropriate' services through 'community development' and the promotion of income generating activities. Organisations are encouraged to move away from a concentration on rehabilitative services and institutional care and to develop a preventative approach which relies more on community-based services and 'community' care. This important shift in welfare policy is being introduced within the constraints of the government's macro-economic strategy GEAR (Growth Employment and Redistribution). GEAR aims to create jobs and to link growth to redistribution. This is to be achieved through a tight monetary policy in which reduction of the budget deficit and 'fiscal restraint' are major emphases.

Spending on welfare, along with the rest of the public sector is thus constrained within tight budgets.

This thesis looks at a changing welfare policy in relation to the development of strategies to support children affected by HIV/AIDS. It explores themes contained in the 'developmental social welfare' paradigm and considers the impact of the HIV/AIDS epidemic through an examination of the literature and through empirical research. It focuses on the implementation of macro policy change at an organisational level. The following broad questions formed the basis for this research.

1. Given the growing HIV/AIDS epidemic in KwaZulu-Natal, what is being done by welfare organisations, and by whom, to provide care and support for children affected by HIV/AIDS?

2. Are welfare organisations in KwaZulu-Natal devising 'developmental social welfare' approaches to respond to the challenge of HIV/AIDS? If so, how is this approach being developed to assist children affected by the epidemic? What issues are being encountered?

3. In view of the fact that the AIDS epidemic in South Africa is several years behind other sub-Saharan African countries, are there any lessons that can be learned from other African countries about alternative models of care for affected children which have been developed?

The research uses a case study approach within a qualitative research methodology. Research methods used were participant observation, interviews, questionnaires and collection of documentary sources. Three case studies are presented which look at different models of care and support for children affected by HIV/AIDS in the Pietermaritzburg district of KwaZulu-Natal. Each of the case studies focuses on themes contained in the 'developmental social welfare' approach. The first case study looks at a community-based project for the support of HIV/AIDS affected children. It focuses on concepts such as community development and community action and at

ideas of 'building human capacity' and 'self reliance'. The second case study considers the theme of 'appropriateness' through the development an 'appropriate' adoption service for African children. The third case study, considers the issue of maximising resources through a study of a 'cluster' foster care scheme for HIV positive children.

This study paints a picture both of potential disaster and of some possible ways forward. It highlights the achievements of the case study organisations. These include the promotion of awareness about the needs of vulnerable children through a community-based approach, as well as the development of new models of adoption for abandoned children and fostering for HIV positive children. However, it also highlights the difficulties which faced these organisations, in particular budgetary constraints and the context of poverty within which they were operating. Tensions were found between the slow progress of 'community development' and the immediate needs of poor children and their carers in a rapidly progressing HIV/AIDS epidemic. The study points to the important role played by state social grants and the need to protect these benefits. The study provides examples of the gendered nature of 'developmental social welfare' policies, specifically with regard to notions of 'self reliance' and community care. It proposes the need for a better analysis of the concepts contained within the 'developmental social welfare approach'. The need for a closer collaboration between the state and the non governmental sector is seen as critical to the development of a 'holistic' approach to the support of HIV/AIDS affected children.

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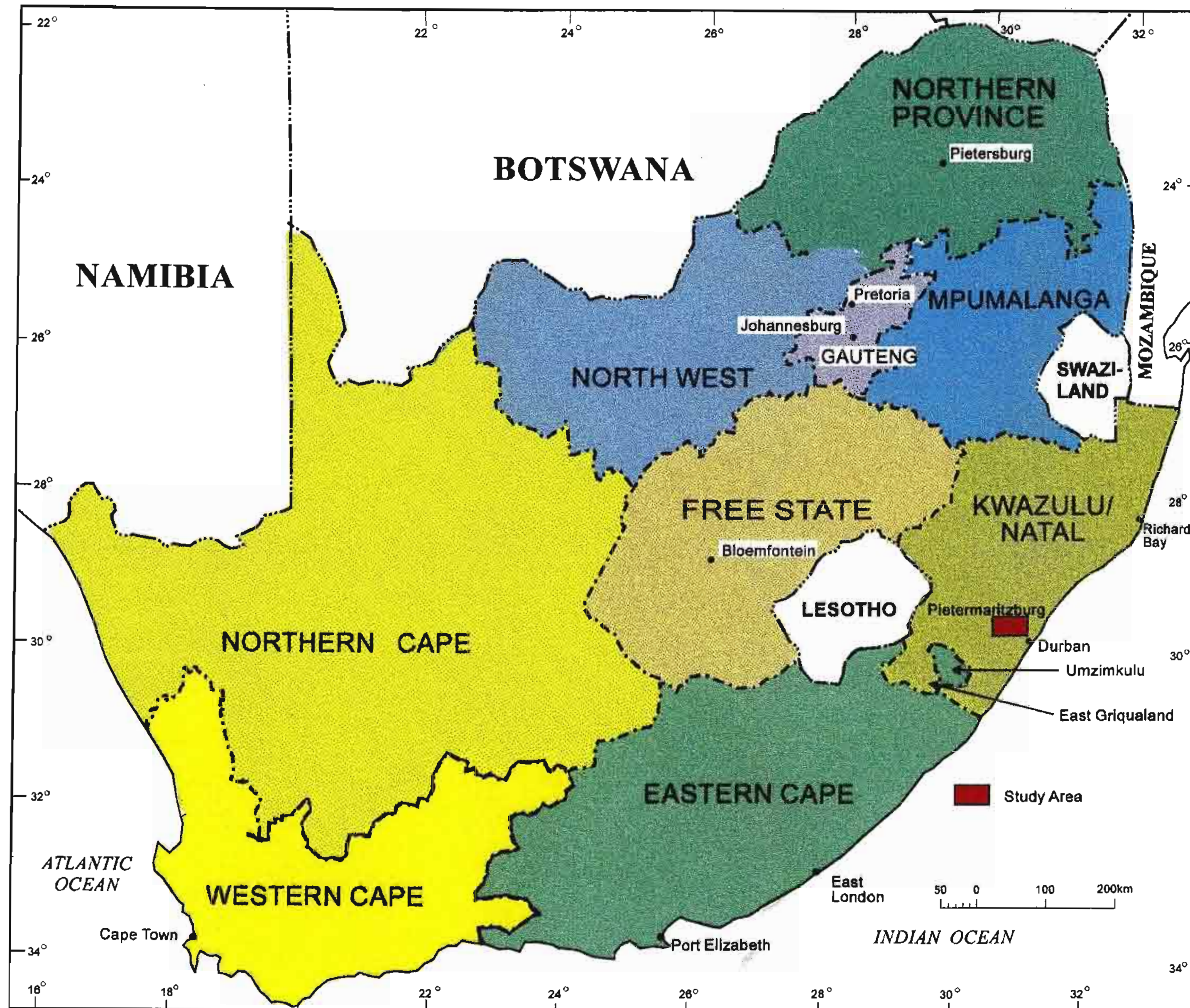

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Abbreviations and Glossary of Terms

ACP: Abandoned Children's Project

Adoption: A legal process through which a child becomes a permanent part of a new family, having the same rights as if s/he had been born to the adoptive parents.

AIDS: Acquired Immune Deficiency Syndrome. 'A list of major and minor illnesses which, alone, or in combination are most likely to indicate that a person has AIDS and not something else' (Berer& Sunanda:1993:14).

AGM: Annual General Meeting

ANC: African National Congress.

AOP: AIDS Orphans Project.

Carer/Caregiver: An individual who provides for the physical and emotional needs of another individual, who may be related or non-related, but who is dependent on the provision of care due to immaturity, advanced age, sickness, disability or other reason.

CBO: Community Based Organisation

CCC: Child Care Committee

CFWSP: Child and Family Welfare Society of Pietermaritzburg.

CINDI: Children in Distress. Refers to children who have been separated from their own parent(s). Also name adopted by consortium of welfare organisations concerned about children affected by HIV/AIDS in Pietermaritzburg.

Extended family: A network of individuals incorporating several generations who are related to each other by birth and marriage, and who are tied together through a variety of social and economic rights and obligations.

Foster care: Care provided either by a relative or a non-relative for a child who is unable to live with his own parent(s). Foster care may be an informal arrangement between family members, or formalised through procedures laid down by the state.

GDP: Gross Domestic Product

GEAR: Growth, Employment and Redistribution. Macro-economic strategy adopted by the South African government in 1996.

HIV: Human Immunodeficiency Virus. One of a group of viruses, known as 'retroviruses,' which causes AIDS.

Kinship care: Care provided by a relative.

Nuclear family: A man and woman who live with their children in a two-generational household.

NGO: Non governmental organisation.

Placement: The act of placing a child to live with a substitute carer.

'Race': A social construction which categorises individuals and groups of individuals based on ideas of superiority and inferiority. (Inverted commas in the text to signify that 'race' is a social construction, not a biological definition).

RDP: Reconstruction and Development Programme. Social and economic policy document developed by the ANC in the period leading up to the first democratic elections in 1994.

Substitute care: Care of any nature provided for a child who is unable to live with his/her own parent(s).

STDs: Sexually transmitted diseases.

Transracial placement: The practice of placing a child with substitute carers of a different 'race'.

UN: United Nations.

UNDP: United Nations Development Programme.

UNICEF: United Nations Children's Fund.

A note concerning terminology used in relation to 'race'

Under apartheid the entire population of South Africa was categorised into four 'racial' groups. African, coloured, Indian and white. These terms are still widely used today and many of the statistics kept by organisations continue to show a breakdown into these four categories. Although it has therefore been necessary to continue with the four categories, this should not be taken to suggest approval of terminology by the author. The term African has been used to refer the majority population in preference to 'black'. The latter term is used to refer to all those people or groups who are not classified as 'white'.

CHAPTER 1

INTRODUCTION TO THE STUDY

1. Overview of the Study

The South African AIDS epidemic shows no signs of abating. KwaZulu-Natal has consistently led the HIV prevalence rates and these continue to rise. In the next few years the numbers of children affected by HIV/AIDS in South Africa will place tremendous strains on traditional methods of child care, both that provided by extended families and that by welfare organisations. Experience from African countries with a high incidence of AIDS orphans suggests that the majority of such children are likely to continue to be nurtured within the extended family. Studies report the persistence of the extended family system in performing its traditional roles even in the midst of high rates of HIV/AIDS (Ankrah, 1994:26). Nevertheless, research also suggests that, even when they are cared for by relatives, orphans are at a greater risk of poor health care, abuse and exploitation than non-orphans.

Although the African extended family is still an important factor in South Africa, its functioning as a mutual support system has been severely strained by decades of migrant labour and the policies of apartheid. As the AIDS epidemic develops in South Africa it is likely that an increasing number of children will fall through the extended family safety-net. Increasing rates of HIV infection are already beginning to present enormous challenges, not least to an under-resourced and over-stretched welfare sector. This is especially evident in the field of child care, where organisations are increasingly concerned about the growing numbers of children orphaned by AIDS, or infected by the HIV virus. The welfare sector must now urgently find innovative ways to bolster extended families and to develop new models of care for those children who cannot be cared for by their families.

Welfare organisations are being faced with the challenges presented by HIV/AIDS at a time when national welfare policy has been reformulated. Government policy, as contained in the White Paper for Welfare (Department of Welfare, 1997), promotes a

major shift in approach in the provision of welfare services and programmes. It exhorts organisations to rethink their whole approach and to reorient services according to new values and concepts. The new welfare policy is based on the principles of 'developmental social welfare', which is an encompassing concept incorporating ideas such as 'building human capacity', 'self-reliance', 'appropriateness', 'community development' and 'community care'. This thesis explores these, and other relevant concepts of welfare policy, through an examination of the existing literature and through empirical research. The empirical research uses a qualitative methodology, and a case study approach, to consider the implementation of policy change at practice level. Three case studies are presented. Each of these looks at a different model of care and support for children affected by HIV/AIDS which has been developed in the Pietermaritzburg district of KwaZulu-Natal. These initiatives were developed in response to the changing welfare policy in South Africa. Each was also prompted by concerns about the growing numbers of children affected by HIV/AIDS.

2. Background to the Study: A Changing Welfare Policy in South Africa

The South African welfare system was developed on principles and theories emanating from Western, industrialised countries, and in particular Britain. These principles, however, became overlaid with the discriminatory policies of apartheid (Lund et al, 1996: 97). Welfare services and social security benefits were not made available to all, rather they formed part of a package of measures which were developed to benefit the white population, while the majority African population was left with few safety-nets. In the run up to the first democratic elections in 1994, the future of a welfare policy in the 'new' South Africa (in common with many other areas of social policy) became the subject of intense debate. These deliberations culminated in February 1997 in the publication of The White Paper for Social Welfare (Department of Welfare, 1997).

The White Paper for Social Welfare (hereafter referred to as The White Paper) recognises the need for radical change. The preamble calls on South Africans to:

> participate in the development of an equitable, people-centred, democratic and appropriate social welfare system

It continues:

> The goal of developmental social welfare is a humane, peaceful, just and caring society which will uphold welfare rights, facilitate the meeting of basic human needs, release people's creative energies, help them achieve their aspirations, build human capacity and self-reliance, and participate fully in all spheres of social, economic and political life.

The White Paper sets out its mission:

> To serve and build a self reliant nation in partnership with all stakeholders through an integrated social welfare system which maximises its existing potential, and which is equitable, sustainable, people centred and developmental (Department of Welfare, 1997:5).

There are several key ideas contained in these statements. Firstly, there is an emphasis on the promotion of services which are community-based and developmental. Sustainable services should be developed which 'build human capacity' and foster 'self-reliance'. Individuals and communities are not to be passive recipients of welfare, but rather will play an active role in the promotion of their own well-being. The practical translation of these aspects of welfare policy are addressed in the first case study, which looks at experiences of one organisation as it sought to develop a 'community development' project to support children affected by the AIDS epidemic.

A second key theme is the move towards a more 'accessible' and 'appropriate' welfare system. Rather than maintaining an over-reliance on approaches based on Western theory and practice, new approaches should be developed which reach the majority of the population and which are suited to the South African context. In other words, the welfare system must be 'indigenised'. The second case study takes this aspect of policy as its theme. It examines the experience of one adoption agency which sought to

develop a more 'appropriate' adoption service in readiness to respond to the challenges of the AIDS epidemic.

Thirdly, the White Paper emphasises the importance of 'maximising' the 'existing potential' of the welfare system. For reasons discussed below, the new welfare policy is to be implemented in a climate of financial restraint. There will be no major injection of government funds available. The third case study considers the development of a 'cluster' foster care project for HIV positive children. It looks at the theme of resource maximisation and considers the implications of promoting 'community care' in a context of poverty and fiscal restraint.

Before outlining the objectives of the study, it is necessary to consider the macro-economic climate within which a re-oriented welfare policy is to be implemented and the implications of the AIDS epidemic for welfare policy.

3. A Changing Macro-Economic Climate

When it was originally debated in the late 1980's and early 1990's, ideas for the transformation of South African welfare policy, which later were to become enshrined in the White Paper, were closely linked to ideas for the broader transformation of South Africa in the post apartheid era. These broader ideas became integrated in The Reconstruction and Development Programme (RDP).

The overall vision of the RDP was to:

> integrate growth, development, reconstruction and redistribution into a unified programme (RDP Base Document, 1.3.6. cited in Adelzadeh & Padayachee, 1994:3).

At the time of the 1994 elections the RDP was the central plank of the socio-economic policy of the African National Congress (ANC). It was based on Keynesian and social democratic, state interventionist principles, which held that state investment in

development can promote economic growth in order to facilitate both employment and the redistribution of wealth. The six key principles for implementation of the RDP were:

integration and sustainability
people driven
peace and security
nation building
meeting basic needs and building infrastructure, and
democratisation (Gulati et al, 1996:3).

By the time the RDP White Paper was published in September 1994, however, Adelzadeh & Padayachee (1994:5) had noted a significant shift. The emphasis was now on economics, and had changed towards a more centre-right, growth-driven economic policy. As these authors pointed out, commitments contained in earlier RDP documents to establish comprehensive social welfare provision, had been replaced by a new emphasis on 'fiscal discipline' and on 'improving efficiency' in welfare.

In 1996, following a collapse of confidence in the currency, the government announced its macro-economic strategy for Growth, Employment and Redistribution (GEAR). This strategy confirmed the government's changing commitment to a market-driven, neo-liberal, economic policy (F&T Weekly, 21-6-96). This approach, which restricts government borrowing and allows for no major increases in taxation, represents a distinct shift from the state interventionist principles underpining the RDP. GEAR partly has its origins in the global dominance of free-market ideas promoted by international financial institutions such as the World Bank and the International Monetary Fund and promulgated in Africa through lending policies associated with structural adjustment programmes. These, typically, involve reductions in public expenditure and taxation, privatisation and a move from the state to private provision in public services. However, the adoption of such policies by the South African government has not only been the result of global factors, but has also been influenced by local circumstances. The government tax base in South Africa is severely restricted

by low levels of employment and taxable income plus a historical culture of non-payment stemming from resistance to apartheid. Given the global pressures (for example a further run on the currency in mid 1998) and a lack of political will to adopt any radical alternative policies, the resulting budgetary restrictions therefore allow only for more limited public spending programmes, including welfare programmes.

Although the RDP continues to be an important part of government policy, its once critical importance has become diminished. The interventionist principles upon which the RDP was based appear to sit uneasily with the principles of the GEAR strategy. Many of the underlying principles of the RDP are mirrored in The White Paper for Social Welfare. Nevertheless the latter also acknowledges the ideological and economic realities of the GEAR strategy. Although the objective is for past disparities to be addressed and access to services made more equitable, changes to welfare programmes will have to be made within existing budgets (Department of Welfare, 1997:2). There is an emphasis on the development of programmes which make the best use of existing resources. This is especially critical for welfare services which have historically been very poorly funded. Only a small proportion of the welfare budget is allocated to welfare services, which includes services for the elderly and the disabled in addition to children and families. 85% of the national welfare budget, of 18 billion rand in the financial year 1997/98 (Singh, 1997), is allocated to social security benefits.

4. The Implications of the AIDS Epidemic for Welfare Policy

A major challenge to South Africa's new welfare policy comes from the AIDS epidemic. Figures from the eighth annual HIV Survey of women who attend antenatal clinics of the public health services in South Africa show that, by October 1997, 16.1% of women tested were HIV positive. This represents a 12.99% increase in prevalence of infection since 1996. KwaZulu-Natal remains the Province with the highest prevalence of HIV, with an infection rate of 26.9%, having increased from 19.9 in 1996 (Department of Health, 1998). At the time of writing, South Africa can best be described as experiencing an HIV epidemic. Given the long incubation period, many of those infected by HIV remain well and the full socio-economic impact of the AIDS

epidemic has yet to be experienced. Macro-economic analyses of the impact of AIDS in African countries indicate that growth in Gross Domestic Product (GDP) will decrease as a result of the epidemic. This has clear implications for the sustainability of social development initiatives (Moultrie, 1996:11). AIDS will present challenges to service delivery across a wide spectrum, including health, education, employment and housing, but not least it will place huge pressures on an already over-stretched welfare budget.

In 1994 a national strategy programme for HIV/AIDS, was adopted by the National AIDS Convention of South Africa (NACOSA). This included welfare as one of six main components where urgent action was needed (Health Systems Trust, 1997:189). The White Paper for Social Welfare (Department of Welfare, 1997:65) also recognises the need for action. It spells out the need for partnership between government and non governmental organisations to devise 'appropriate and innovative' welfare services for people affected by HIV/AIDS. It again underlines the principle of community-based care strategies as the 'preferred options for coping with the social consequences of HIV/AIDS'. Despite this recognition at the policy level there has been little sign of effective action. This lack of action was admitted by government in 1998 when an inter-ministerial project was established under the Deputy President's office as an attempt to promote a more co-ordinated approach (Mercury Correspondent, 19-3-1998). To date most resources appear to have been directed towards AIDS prevention and to health needs, but very little priority has been given to care and welfare. Moreover, despite rhetoric from politicians about the coming 'AIDS orphans problem', surprisingly little attention has been given to the development of services concerned with the welfare of children.

5. HIV/AIDS and Welfare Policy for Children in South Africa

Many of the people infected with HIV are parents of dependent children. It has been estimated that by the year 2004 around 450,000 children in KwaZulu-Natal (5% of the Province's total population) will have been orphaned by the disease (Whiteside et al, 1995:43). Additionally, a growing number of children will be infected by HIV, many of whom will need substitute care. In the past, the majority of orphaned children in South

Africa, as in the rest of Africa, have been cared for by their extended families. Evidence from African countries where HIV/AIDS is prevalent suggests that the extended family is remarkably resilient. Nevertheless, there is evidence of places where this safety-net has broken down and AIDS orphans have been left to fend for themselves (Foster, 1997). South African welfare policy promotes the care of children in 'the community', but does recognise that there may be a limit to the capacity of the extended family to absorb ever growing numbers of orphans without some means of support. A number of community-based options are suggested in the White Paper for the care of children who fall outside the extended family safety-net. These include 'family homes', whereby 'support is given to women of the community who live with and care for orphaned children' (Department of Welfare, 1997:65), as well as more traditional forms of foster care and adoption.

6. Objectives and Presentation of the Study

The Department of Health has acknowledged that a gap exists between the level of the epidemic and efforts made nationally to devise means of care and support for AIDS orphans and HIV positive children. Where developments have taken place, it is the non governmental (NGO) sector which has generally taken the lead (Health Systems Trust, 1997:194). The Department of Health has commended the development of regional initiatives by this sector which 'may be used as case studies upon which future policies may be based' (Jijana, 1996).

This study seeks to explore what happens to the implementation of macro policy change at an organisational level. It takes a case study approach to look at three different ways in which NGOs concerned with the support of children affected by HIV/AIDS have sought to respond. It describes what happens when organisations seek to implement different strands of policy change in a context of poverty and of growing needs and in a climate of fiscal restraint. Faced with the growing AIDS epidemic in KwaZulu-Natal a number of NGOs in the Pietermaritzburg area have formed a consortium to try to find innovative ways to provide support to AIDS affected and HIV infected children. Three of these initiatives (in two of the NGOs) were selected as case studies through which different aspects of policy change could be examined.

The purpose of this chapter has been to provide an overview of, and background to, the study. In chapter 2 a theoretical background to the case studies is presented. It draws on the relevant literature to consider theories and critiques of welfare. It includes a discussion of notions of developmental social welfare, community development and community care and their relevance to South African welfare policy. Chapter 3 then describes the research design and methodology utilised in this study. The following two chapters concern HIV/AIDS. They draw on literature both from South Africa and from other countries of sub-Saharan Africa. In chapter 4 the nature of HIV/ AIDS, the current state of the epidemic in South Africa and the socio-economic impact of HIV/AIDS are discussed, with particular reference to the effects on children. Chapter 5 then looks at the nature of family life in contemporary South Africa and the implications for welfare policy. It first considers the context of poverty and family disruption which are the legacy of apartheid policies, and then considers the new challenges to family life associated with the AIDS epidemic, focussing in particular on the implications for orphans and their carers. These chapters set the policy context for the case studies which follow.

Chapters 6, 7 and 8 present the empirical data from the three case studies. Although a number of strands of policy change are common to all three case studies, each focuses on one or two main areas which are outlined briefly below. (See Diagram on page 11)

Chapter 6 contains data from **Case Study 1. Developing a Community-Based Project to Support AIDS Affected Children: A Case Study of The Thandanani AIDS Orphans Project.** This looks at the work of a small NGO, the Thandanani Association, which began life as an organisation operating in the 'welfarist' tradition of providing direct care and support to children. Faced with predictions of growing numbers of AIDS orphans, this organisation embarked on the development of a new project designed to use a 'community development' approach to support HIV/AIDS affected children. The case study traces the progress of the project over a period of one year and looks at the issues it faced as it made the change from 'doing welfare' to 'doing community development'.

Chapter 7 presents data from **Case Study 2. Developing Appropriate Welfare Services for HIV/AIDS Affected Children: A Case Study of the 'Indigenisation' of Adoption Practice.** This looks at another important thread of welfare policy, namely the challenge to organisations to:

> devise appropriate and integrated strategies to address the alienation and the economic and social marginalisation of vast sectors of the population (Department of Welfare, 1997:preamble).

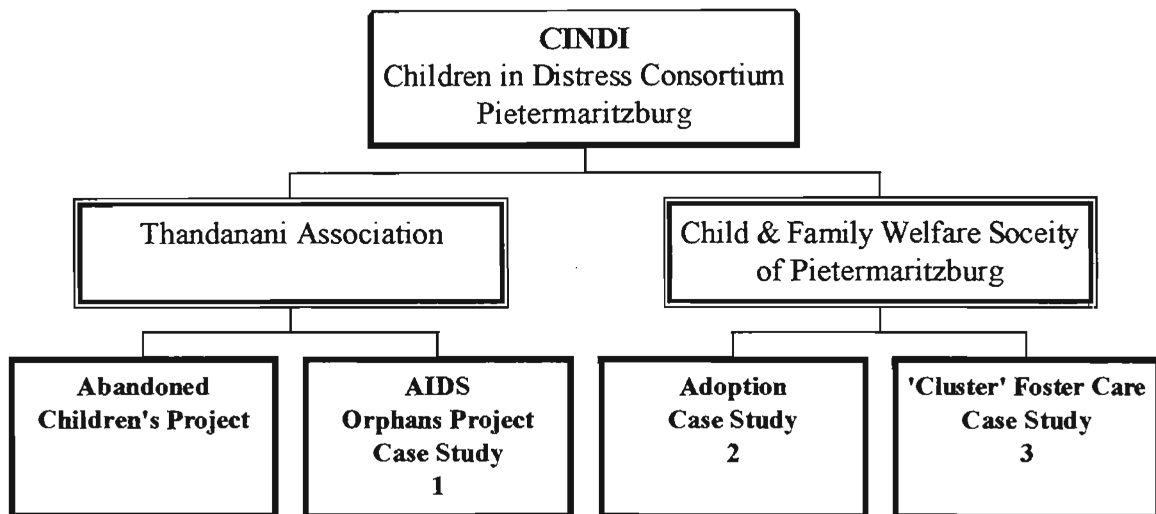
Adoption of children in South Africa has, in the main, been a service provided for white childless couples. Very few African children have been adopted by African families. HIV/AIDS places strains on all families where a member is infected, but it is the African population in South Africa which has been predominantly affected by the AIDS epidemic. As the epidemic progresses therefore it is very likely to lead to an increase in the numbers of African children in need of non-kin care. The second case study explores the 'appropriateness' of Western style adoption for African children. It considers the work undertaken by the adoption team of the Child and Family Welfare Society of Pietermaritzburg, and their efforts to devise a more 'indigenous' adoption service.

Chapter 8 presents data from **Case Study 3. Maximising Resources: A Case Study of a 'Cluster Foster Care' Project for HIV Positive Children.** This looks at the theme of resource maximisation through a case study of a separate initiative developed by the Child and Family Welfare Society of Pietermaritzburg, a special fostering project which aimed to provide 'community care' to children infected with the HIV virus. The concept of 'community care' is a major strand of welfare policy. When applied to the field of child care, this means finding ways to maintain children who cannot live with their parents within their communities of origin, rather than placing them in institutions or in geographically distant, or culturally different, environments. 'Community care' is often seen by planners as a good way to maximise resources as it is less costly than residential care. This case study considers the implications of the

promotion of 'community care' policies in a context of poverty and in conditions of financial stringency.

Finally, chapter 9 draws together the threads from the case studies and considers the lessons learned. It presents conclusions from the study and looks at some ways forward for welfare policy.

DIAGRAM



CHAPTER 2

CHANGING WELFARE POLICY:THEORETICAL PERSPECTIVES

1. Introduction

This chapter presents a review of relevant literature in order to explore some of the concepts and theories which have influenced the development of welfare internationally and in South Africa. The chapter begins by looking at theories of, and challenges to, state welfarism. It then looks at the influence which these theories have had on the development of welfare in South Africa. There follows an exploration of the concepts of social development, developmental social welfare, community development and community care and of some debates around these concepts. Particular attention is paid to critiques by feminist writers. The purpose of the chapter is to provide a theoretical background to the case studies which follow and to work towards the development of a framework for particular aspects of welfare policy.

2. The Concept of Welfare

Welfare has been defined in many different ways. George and Page (1995:1) describe welfare as a 'slippery and difficult concept', made more complex by its 'promiscuous' tendency to attach itself 'somewhat indiscriminately to other moral and political ideas'. These authors suggest that in essence 'welfare' simply means the well being of individuals and the satisfaction of an individual's needs (George & Page, 1995:1). Human needs can be defined in restrictive terms, relating to such basic, minimum material needs that will ensure an individual's survival, such as food, shelter and clothing. Alternatively a more comprehensive definition can be utilised to include a comprehensive range of social and cultural needs (Dube, 1988:55). Children have needs in common with adults, but their dependency on adults, particularly in the first few years brings additional, specific needs. As Dube (1988: 53) notes:

> Being born human is not a sufficient condition for becoming human; the latter requires a long process of socialization and education.

3. The Rise of the Welfare State and the Influence of Beveridge

People throughout history have devised structures designed to meet their needs, perhaps the most enduring and universal of these being the family unit. Individuals, with the support of their families, were in general responsible for their own welfare until the late nineteenth or early twentieth century. The idea that welfare could, or should be the responsibility of the state began to emerge in Europe between 1880 and the early 1940's. The first modern social insurance scheme was introduced by Bismarck into Germany in the 1880s. Other European countries soon followed, introducing social security programmes and extending state provision into such sectors as health, education, housing and personal social services (George & Page, 1995: 2-5).

Between the mid 1940's and the mid 1970's arguments by welfare theorists that the state should be the main provider of welfare continued to find favour amongst governments in many Western industrial nations. The economic theories of John Maynard Keynes, who believed in economic and social intervention through planning, were widely adopted and provided justification for the intervention of the state in the economy and society (George & Page, 1995:72; Midgley, 1995:46). In Britain, the economic theories of Keynes combined with Beveridge's beliefs in the desirability of collective goals in regard to welfare (George & Wilding, 1994:16). The ideas propounded by Keynes and Beveridge formed the basis of state welfare in Britain and influenced welfare policy for many decades. The Keynes-Beveridge approach was based on the idea of 'correcting' the tendencies of the market economy through state intervention in social policy (Luiz, 1994). A major assumption was that individuals with higher incomes or better opportunities had an obligation to assist those who were less fortunate. Redistribution of wealth would be achieved via taxation. The Beveridge model differed from earlier interventions, which focussed predominantly on poor relief, in its emphasis on 'universality', or the provision of benefits to all citizens.

These ideas had an important influence on social policy in many other countries, both in Europe and in less developed nations. Although few developing countries had the

resources to introduce, for example, a comprehensive social insurance programme, health care and education became major priorities for colonial, and later for independent governments (Midgley, 1995: 48-49). In South Africa a much diluted version of the Beveridge model of welfare was gradually introduced, for the benefit of the white population. As some of the assumptions upon which the Beveridge model was based have had an enduring impact on welfare policy in South Africa, it is important to look at these in more detail.

The Beveridge report was based on assumptions about the family, taking the nuclear family as the norm. The assumption was that a married man and woman would live with their children, the man would be the breadwinner, he would be in employment and his wife and children would be dependent on him (Lund et al, 1996:97). It was also assumed that the numbers of women not supported by men would be minimal and that they would thus require no special provisions (Dominelli, 1991:154). These assumptions formed the basis for entitlement to welfare benefits in Britain. However they went largely unrecognised, or at least unchallenged, until the 1970's and 1980's when a growing number of, mainly British, writers (Dale & Foster, 1986; Dalley, 1988; Dominelli, 1991; Wilson, 1977) began to provide a feminist critique of the Beveridge report and the effect of policies stemming from it.

The feminist critique highlights the patriarchal nature of the Beveridge report. Women, it is argued, are placed firmly in the home serving their husband's and children's needs doing work which the report sees as:

> vital, though unpaid, without which their husbands could not do their paid work and without which the nation could not continue (from Beveridge Report, quoted in Williams 1989:123).

Wilson (1997:148) is particularly critical of the Beveridge report which she describes as:

> one of the most crudely ideological documents of its kind ever written

Wilson contends that policies based on the assumptions contained in the Beveridge report about the nature of family life have caused suffering to women ever since.

Many of the assumptions about nuclear families contained in the Beveridge report were also built into the South African welfare system. A small number of writers have analysed the effect of Beveridge on welfare policies in South Africa (Sunde & Bozalek, 1995; Segar & White, 1992; Lund 1997). These authors point out the inappropriateness of basing welfare policy on the nuclear family in a country in which there are a number of forms of marriage, where many people live in three generational households, where families have been separated due to migrant labour and influx control policies, where a large number of rural women live in women headed households and where a significant proportion of children are raised separately from one or both parents (Sunde & Bozalek, 1995: 65; Richter, 1994: 37).

4. Challenges to State Welfarism: Theories of the New Right

During the 1970's and 1980's 'statist' ideas of welfare provision increasingly came under attack from theorists and politicians of the New Right. These critics of state welfare resurrected the 'laissez-faire' theories of nineteenth century Classical Liberals such as Adam Smith, who believed that:

> unfettered individualism would lead towards a state of economic equilibrium in which labour, land and capital were combined in the most effective way to satisfy consumer demand (George & Page, 1995: 2).

One of the most influential theorists of the New Right, Hayek, had been challenging the principles of the welfare state since the 1940's, but it was not until the emergence into power of right-wing politicians in a number of industrialised countries in the 1980's, that his ideas gained prominence. Hayek argued that societies are made up of individuals who function independently of each other and that maintenance of the market system is:

> the prime condition of the general welfare of its members (Hayek, cited in George & Wilding. 1994:17).

With the election of the Thatcher government in Britain in 1979 and President Reagan in the USA in 1981, came the political will to implement the neo-liberal agenda. As Culpitt (1992:2) has argued, the debate about welfare in these, and later many other, countries became:

> dominated by the 'logic' of economic rationality rather than ideas of 'social obligations'.

Although the welfare state has not been totally abolished, it has been radically altered in many countries in line with the prescriptions of New Right thinking. The view that markets should play the major role in the provision of social services, means that reduction in public expenditure, contracting out of state welfare services and creating for-profit social services become key elements of welfare policy. In Britain, for example, local government responsibility for social services was severely curtailed. The concept of a 'mixed economy of care', in which the state would act in partnership with private and voluntary organisations, plus the creation of internal markets, were introduced in areas of welfare which were too popular with the electorate for the government to privatise, such as the National Health Service. Where services could not be returned to the 'invigorating world of market forces' they were subjected to the influence of a new 'scientific' managerialism with its emphasis on efficiency and effectiveness. It has been argued that managerialism:

> was a key tool in the control of the local state and public services and in limiting the power of professionals, in particular lawyers, teachers, doctors and social workers (Hadley & Clough, 1996:13).

To explain why these ideas became so influential internationally it is necessary to look at the prevailing economic climate of the 1970's and early 1980's. During this period,

an economic recession, declining international growth rates, and oil price rises, meant that public expenditure was increasingly financed through public borrowing (George & Page 1995:9). Moreover, increased globalisation of economies reduced the power of national governments to influence events (Hadley & Clough,1996:14). The collapse of the communist economies and the general acknowledgement that these systems had suppressed individual liberties also weakened any attempts by the left to mount an effective critique. The global dominance of free-market ideas affected developing as well as developed countries. Many developing countries, had borrowed heavily in the 1970's when interest rates were low. They were then forced to cut back on social welfare programmes as interest rates soared and they were faced with a huge burden of debt. Many of these countries were forced to borrow from the International Monetary Fund and the World Bank which imposed severe conditions under Structural Adjustment Programmes compelling countries to make substantially reduced state welfare provisions (Midgley,1995: 65).

A central tenet of New Right thinking is the idea that the welfare state is a threat to individual liberty because individuals cease to be free to make choices about, and take responsibility for, their own welfare. Individuals should rather operate as if in a market place, making individual decisions about what will best meet their needs, with no faith in ideas of 'the common good'. If in Mrs Thatcher's words: 'there is no such thing as society' then, as Culpitt (1992:1) says, there can be no validity in:

> any social policy analysis which tries to assert a claim for access to public services based upon traditional community ties of authority and obligation.

Paradoxically, the desire for 'economic rationality' and public expenditure cuts led to the call from many governments for a growth in 'community care' which, both relies on the notion of social obligation and restricts choices for individuals, in particular for women.

5. The Contemporary Welfare Debate

During the 1990's writers of the left and centre-left began to mount a more concerted critique of New Right thinking and to advance new ideas about the role of the state in welfare (Taylor-Gooby 1991; Culpitt, 1992; George & Wilding, 1994; Hutton, 1995; Etzioni, 1996). Nevertheless, as Deakin asserts, there appears today to be no universal consensus about the future of welfare:

> One of the striking features of the current political debate about welfare is that the whole range of views expressed since the first tentative steps towards intervention by the modern State were taken in the mid-nineteenth century can still be heard today. It is as if prehistory were rewritten so that dinosaurs and space shuttles co-existed, with no certainty about which would be likeliest to become extinct and which survive (Deakin, 1994:4).

Many contemporary writers promote a community-based approach to welfare. For example, in contrast to the neo-liberals, 'communitarian' writers such as Etzioni (1996), do not oppose the welfare state in principle, but believe that the welfare state, particularly in industrialised countries, has exhausted its capacity to continue to provide an ever expanding number of functions and its ability to raise taxes to pay for them. Accordingly, the answer lies in calling on individuals and communities to fill the gap between needs and services.

There are differing views about whether or not the ideas of the New Right have lost their influence. For George and Page (1995:11) the fact that neo-liberal ideas have begun to influence the policy agenda in countries like Norway, Sweden and Denmark seems to suggest that the 'intellectual advantage' remains with the New Right. However Midgley sees signs of a shift internationally towards a growing recognition of the need for a more interventionist approach and in greater support for notions such as 'sustainable development' (Midgley, 1995:65). It has been argued that the welfare state is remarkably resilient (Taylor-Gooby, 1991). The British welfare state, for example,

has been resilient against concerted attacks by successive Conservative governments. Public support for social welfare provision in Britain remains strong, particularly in relation to the National Health Service and pensions. This was a factor leading to the return of the Labour government in May 1997. Support for welfare however tends to reflect the interests of the middle classes and is less evident in relation to social security benefits, especially for single parents and unemployed youth.

The question of cash benefits is perhaps the most contentious issue in the contemporary welfare debate. The availability, universality and value of welfare benefits varies widely from country to country. Social security systems were essentially established to respond to economic inequalities and not to solve them. They have thus been criticised as a drain on the economy and a hindrance to economic development. Only a few countries, for example Sweden, have integrated social and economic policies which seek to promote employment and economic growth through their social policies (Midgley, 1995:170). A number of other countries, including the USA and Britain, are currently seeking a 'middle way' for welfare which attempts to link welfare benefits with work opportunities. These strategies are based on the premise that cash benefits can promote dependency and lessen the individual's desire to seek employment. Arguments about welfare dependency are, however, frequently based on anecdotal examples and are tied up with political and moral beliefs and attitudes towards the 'undeserving poor'. This is particularly prevalent in relation to arguments about cash transfers for single, 'unsupported' women and their children. Evidence from the USA, where welfare recipients have come in for similarly harsh criticism, suggests that levels of chronic dependency may be much lower than is often assumed. Duncan (cited in Dominelli, 1991:133) found that only 4.4% of all Americans, or 20% of those on welfare were chronically dependent on the system. For, although 25% of Americans rely on assistance at some point in their lives, this was just a temporary state whilst overcoming a crisis.

6. Definitions of 'Community'

The term 'community' is central to many aspects of social welfare, however there is no one agreed definition of the word 'community'. Hillery in 1950 assembled 94 definitions from a variety of sources and concluded that apart, from an agreement that all definitions dealt with people, there was no agreement beyond this common basis. (cited in Van Royen & Bennett, 1995:17). According to a definition by the South African Council for Social Work, a community is:

> a collection of people living within a geographical area engaged in social interaction among themselves and having psychological ties with one another and the place in which they live (Government Gazette No. 15658 of 29 April 1994).

However, a distinction needs to be made between this, which has been termed a geographical community (and which includes everyone within a defined geographical area) and functional communities (which refers to specific groups within geographical boundaries). A third definition, communities of interest, refers to groups of people who share a common interest across geographical boundaries (Swill, cited in Van Royen & Bennett, 1995).

The concept of community has been described as one of the most contested in the sociological literature. (Allan, 1991:108) The idea of community is often linked with positive values, evoking a nostalgic picture of a society in which:

> neighbourliness, friendliness and concern for others are an integral part of life (Pereira, 1993:6).

Critics (Etzioni, 1996; Pereira, 1993) of this rosy picture of 'community' (albeit coming from a Western perspective) argue firstly that mutually supporting communities never actually existed, or if they did, they are incompatible with contemporary life. Secondly, that communities can be culturally oppressive, that is they can pressure members to

abide by a culture which they do not truly share. Thirdly that community of itself is not necessarily a positive concept, the stronger a community becomes, the greater the danger that it will turn hostile to outside groups and finally that communities are 'majoritarian' and can ignore or exclude marginal sections of the community, such as minority ethnic groups.

Feminist writers have highlighted the way that the concept of 'community' has been used to obscure the role of women and to oppress them. The feminist critique emerged during the 1960's and 1970's as part of an analysis which looked at the relationship between the state and the family in social policy. As much of this critique focuses on aspects of 'community' care, it is considered more fully in section 14.

7. The Origins of South African Social Welfare

McKendrick (1990a) provides an overview of the development of South African social welfare. He makes the point that:

> Although all social welfare systems seek to promote aspects of the human condition, each is individually sculpted by a unique interplay of historical, cultural, economic, geographical, religious and political forces (1990a: 5).

The foundations of formal institutions of social welfare in South Africa were laid in colonial times. The Dutch colonialists who established themselves in The Cape of Good Hope in the 1650's were Calvinists whose belief that they were the 'chosen people' gave 'religious sanction to their racial attitudes' (McKendrick, 1990a:7). Calvinism, combined with the rise of Capitalism and Darwinian ideas of the survival of the fittest, saw the poor as responsible for their own poverty. The poor thus became identified with the colonised and racial segregation and ideas of social supremacy took root (Mandela, 1993). As Patel (1992: 35) notes, ideas of:

> racial discrimination, the denigration of indigenous ways, paternalism in social services and the distorted nature of social welfare policies favouring whites

influenced South African welfare policies up until the advent of the first democratically elected government in 1994.

The discovery of minerals in the 1870's and gold in the 1880's brought a period of rapid industrialisation, which moved South Africa swiftly from its position as a predominantly rural economy (McKendrick, 1990a:9). Industrialisation required a large, predominantly male, labour force, so a system of migrant labour was established to meet the demands of capitalism. This led to a destruction of African family networks and reduced the ability of those networks to provide for the welfare of needy members. However this was largely ignored by a South African government whose policies were driven by:

> racial attitudes, white self interest and economic factors (McKendrick, 1990a:11).

8. The Development of State Welfare in South Africa

The effect of industrialisation on the white population was less easy to ignore. The belief that individuals were responsible for their own welfare continued to be influential, but this clashed with the desire to:

> create a stable, up to date white population that could stand competition from African, Indian or coloured groups (McKendrick, 1990a:11).

Welfare programmes aimed at alleviating poverty among poor whites began through the efforts of churches and voluntary organisations. The first two child welfare organisations, for example, were established in Cape Town in 1908 and Johannesburg

in 1909 (Patel, 1992:37). The state also began to adopt a welfare role providing assistance to needy communities and subsidies to private philanthropic organisations. The Children's Protection Act of 1913 provided state maintenance grants for children, however very few of these were given to African parents and none were given to rural Africans (Kruger, cited in Bhorat, 1995). The first Department of Welfare was formed in 1933, within the Department of Labour, (Bhorat, 1995).

According to McKendrick (1990b: 20-25), the South African welfare system was founded on four principles: racial division, a rejection of socialism, partnership between state and community and a movement from residential to community-based services. Other influences, as already noted, were colonialism, paternalism, Calvinism, and individualism. The introduction of the state into welfare provision in South Africa during the 1930's was not due to any shift in these underlying philosophies, but rather to political pragmatism, the need to maintain a high standard of living for the white population and thereby ensure political stability. The result was a unique mix of a welfarist tradition, implanted from Europe (and in particular from Britain) and a Classical Liberal tradition of free market individualism.

In 1937, following the Carnegie Commission of Enquiry into the 'poor white problem', a state welfare department was established (McKendrick, 1990a:12).This marked the beginning of organised state intervention in social welfare, and the professionalising of social work (Patel, 1992:37). The state began to take further responsibility for poor whites with the introduction of non-contributory welfare grants for the aged, disabled, widowed and orphaned (Mandela, 1993). Grants and services for Africans remained negligible. Despite this entry of the state into welfare, the principle was maintained that, even for whites, welfare should not be the sole responsibility of the state, but should be provided in partnership with churches and other community groups. State subsidies were thus given to voluntary welfare organisations which were to deliver and co-ordinate services (Patel, 1992: 38-39).

9. Apartheid and Welfare Policy

The period after the Second World War saw the rise of the Welfare State in many countries, particularly in the West. For about thirty years it came to be accepted in these countries that the state should be the main provider of welfare services, either directly through the provision of services or indirectly through the maintenance of full employment. In South Africa, however, a quite different ideology held sway during these years. The election of the national Party in 1948 marked the beginning of apartheid and of separate development of the 'races' in all aspects of life, including welfare. Between the 1950's and the early 1990's, 'race' became the primary factor in the allocation of resources (McKendrick, 1990a:17).

During this period, the rhetoric of South African Government was one of adherence to the philosophy of free market capitalism and a rejection of the Welfare State. However, while the rhetoric was that families should provide for their own needs, and that state services should only be provided in extremis, there was in fact considerable intervention by the South African state aimed at ensuring the welfare of the white population. In order to further its racist goals the government intervened in the workings of the 'free market' in order to provide support to the white population through such means as job and land reservation policies and housing subsidies (Sunde and Bozalek, 1995:67).

During the 1980's the ideas of the New Right fitted well with the ideology of the South African government. Plans to restrict public expenditure and privatise welfare were debated during this period, but this did not really mark a major change, since the idea of the welfare state had never really been embraced in South Africa (McKendrick, 1990b:22; Patel 1992:38). Moreover, whilst attempts were made to roll back the involvement of the state, the need to maintain a discriminatory socio-political system meant that the government was unable able to reduce expenditure on white welfare to any significant extent. As Patel (1992:43) has argued, state welfare expenditure for whites represented an important means of keeping the white population from becoming dissatisfied and thereby maintaining political stability.

Apartheid policies eventually led to a costly, inefficient and fragmented welfare sector, which by the early 1990's consisted of:

> seventeen departments of welfare, arranged in four clusters, co-ordinated by three other departments and one secretariat (Lund, 1992:4).

In a review of policy documents drawn up in the years immediately prior to the first democratic elections in 1994, Weekes (1994) identified the values which he believed should inform a revised social welfare policy in the 'new' South Africa. These were equity, equality, affordability, collectivism, participation, decentralisation and needs-based as opposed to problem-based services. Many of these values were subsequently incorporated into the White Paper for Social Welfare (Department of Welfare, 1997). Nevertheless it will take many years to develop a more equitable welfare structure in South Africa. In 1995, for example, Patel (1995:32) found that about 50% of the services and facilities of state-subsidised welfare organisations in Guateng Province were still accessible only to whites, who constitute 20% of the population.

10.Towards Developmental Social Welfare

'Developmental social welfare' has been adopted by the South African government to refer to the broad principles which its new welfare policy espouses. The term 'developmental social welfare' was first used by the United Nations to refer to one aspect of social development (Department of Welfare, 1997:68). Social development has been defined as a means of promoting an individual's welfare by:

> purposefully harmonizing social policies with measures designed to promote economic development (Midgley, 1995:1).

The objective of social development is:

> to bring about sustained improvement in the well being of the individual, family, community and society at large (Department of Welfare, 1997:71).

Social welfare is only one aspect of social development, others are education, health, housing, urban and rural development, and land reform (Department of Welfare, 1997:71).

Central to the concept of developmental social welfare is the belief that investing in 'human capital', for example through education or skills development, promotes economic development. Human Capital theorists argue for greater investments of this kind, and some have extended the arguments to investing in health care and welfare programmes (Midgley, 1995:159). Rather than assisting individuals through the provision of material goods or services, or through remedial interventions, social development:

> focuses on the community, or society, and on wider social processes and structures (Midgley, 1995:23).

Developmental social welfare is a wide concept which encompasses a range of other concepts and strategies. These include community development, community-based programmes, community action, developmental social work, community work, community organisation and community care. Each of these terms refers to a different approach within the developmental social welfare paradigm. Many of these approaches overlap and the boundaries between concepts are frequently blurred. This has led to a debate in the literature about the need to clarify the meaning of terms (see for example, Terblanche & Tshiwula, 1996:18). Some of these debates appear, however, to be driven by the concerns of different professional groups to protect their territories (Patel, 1996:1). It is therefore intended to focus here on those concepts which have particular relevance to the case studies which follow.

11. Community Development and Community Action

Midgley (1995: 54-55) provides an outline of the history of community development. The term community development was adopted at a conference of British colonial administrators in 1948 and the approach was actively promoted by the Colonial Office during the process of decolonisation. Community development emphasises the importance of self-help and self-determination. From the late 1930's, the growth of industrialisation and urbanisation brought new social problems to many developing countries. The initial response was to implement social policies imported from Europe. These policies were criticised by some as unproductive, since they consumed scarce resources. Critics argued that welfare needs would be better served by development programmes that would contribute to economic development and thereby benefit everybody.

In the 1960's and 1970's the idea of community development flourished. It was promoted by the United Nations as an important element of its strategy towards developing countries. The U.N. defined community development as:

> The processes by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress. This complex of processes is then made up of two essential elements: the participation of the people themselves in efforts to improve their level of living with as much reliance as possible on their own initiative; and the provision of technical and other services in ways which encourage initiative, self-help and mutual help and make these more effective (United Nations, 1963).

This definition emphasises the central role of the state working in partnership with local people. However, in many countries a significant proportion of community development programmes have been undertaken not by the state but by non-

governmental organisations. This is especially true of South Africa, where civil society organisations promoting community development proliferated under apartheid.

Criticism of community development as defined by the U.N. grew during the 1970's as development programmes failed to deliver the promised benefits. Major criticisms were that solutions were being imposed from above and that community development bureaucracies were remote from the people, large, corrupt and inefficient. In response to these criticisms a more radical concept, community action, was developed. Rather than relying on government or outside agencies the community action approach empowers people to become politicised, to take control of their own development initiatives (Midgley, 1995:118). This approach was inspired by the writings of Paulo Freire (1972) and his theory of 'conscientization', which argues that the poor and powerless need to be empowered through a raising of their political awareness. Numerous development projects in South Africa and internationally have been developed on these principles.

Recent definitions of community development, such as that by Korten below, stress the importance of sustainability in development and the realisation that unless people are fully involved in the process of development any change is likely to be short-lived.

> Development is a process by which the members of a society increase their personal capacities to mobilize and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations (Korten, cited in Louw, 1993).

Emphasis is also given to the importance of recognising that development will only be successful where there is, a 'fit' between development initiatives and their context. In other words:

> people will not be steered, influenced or 'taken with' unless the development initiative has positive meaning within their context (Kotze & Kotze, 1996:8).

Theories of community development stress that the process is as important, if not more important, than the product. So, if a community development initiative is to be successful, it must begin with identification of need at the community level, and actively involve members of that community in the whole enterprise (Louw, 1993). A further discussion of this aspect of community development is presented in relation to the first case study, in chapter 6.

12. From Institutional Care to Community Care

The idea of community care is linked to, but differs from, that of community development. Whilst both are community-based strategies, community development aims to improve socio-economic conditions in a community, through the involvement of community members in capacity building ventures. The concept of community care, by contrast, refers to community participation in the provision of care to vulnerable members through community-based rather than institutional services. Community care may involve an element of community development, but it is not contingent upon it. Historically the funding of welfare services in South Africa has been geared towards institutional rather than community care. Of the 13.4 billion rand which was allocated to the welfare budget in 1995/1996 only 1.7 billion was used for welfare services, and of this sum 40% went towards support of the elderly (Van der Berg, 1995). The majority of this money has historically been spent on institutional care, overwhelmingly for elderly whites (Ministry of Social Welfare and Population Development, 1995). In order to address this disparity in provision a policy of 'community care', not only for the elderly but also for children and the disabled, has been adopted. According to the South African Minister for Welfare and Population Development, Geraldine Fraser-Moleketi:

> We are moving away from institutional care to community care...
> 'community' is the buzzword. (quoted in F&T Weekly, 21June 1996)

13. Theories of and Debates around Community Care

The idea of community care began in Europe in reaction to the policy of separation and segregation of the poor and the mentally ill. Segregation began in the 19th Century and was still prevalent in European countries in the first part of the 20th Century (Pilgrim, 1993:168). Community care was developed further after the Second World War and by the 1970's the ideal of community care had become a central tenet of left and centre-left thinking on social policy in many European countries. The vision of these theorists was of a world where:

> clients stayed in their homes in the community rather than in institutions and the care they had was decided solely by their needs (Dobson, 1995:2).

Tinker (1981), writing about Britain, noted five factors which combined to move the focus of welfare policy towards community care. These were firstly, a general reaction against institutional care. Secondly, there were practical problems associated with institutions, such as recruiting and retaining staff. Thirdly, costs of residential care were rising. Fourthly, there was less need to keep 'disturbed' people away from society due, for example, to improvements in medication. Finally, there was a growth in the recognition that people have a right to live in society (cited in Scogings, 1992:30-31).

Theorists of the New Right have little regard for the concept of 'community', since they contend that individuals are free-standing agents who make choices on their own. Paradoxically, the policy of community care is attractive to these theorists. Community care fits well with their thinking as it is seen as a major means of reducing public expenditure. However, as feminist writers have pointed out, with this approach there is a subtle, but crucial, shift of emphasis. What began as an idea of de-institutionalisation or care 'in' the community, but still provided by the state, now becomes care 'by' the community, most often by unpaid female carers.

14. The Gendered Nature of 'Community' Care

It is clear that, if community care is predominantly conceived of as care 'by' the community, then it has to be provided by individuals within that community. As Walker says:

> in practice, community care is overwhelmingly care by kin, and especially female kin, not the community (Walker cited in Snaith, 1993:53).

Feminist analysis shows the way in which the ideology and practice of community care is based on, and reinforces, gender divisions (Finch & Groves, 1980 & 1983; Williams 1989; Dalley, 1988; Tester, 1996; Graham, 1993). Much of this critique has been by British writers where community care policies are well entrenched. These writers argue that many aspects of welfare policy have been based on an ideology of 'familism' (Dominelli, 1991; Dalley 1988). 'Familism' holds that the nuclear family is the norm, that the natural place for women is in the domestic sphere, that women will be dependent on a male provider and will provide for his needs, as well as for those of their children and other dependents. Policies of community care based on such assumptions therefore keep women in traditional caring roles.

The recognition that the private and personal sphere of life is also political, is a central idea of feminist analysis. If women are to have choices, and are to be able to gain independence through employment, then caring must be seen as more than simply a private and personal matter. Women are more likely than men to be under pressure to take on caring roles, and if necessary to give up employment, not just because of patriarchal ideas that caring is 'women's work', but also because of their disadvantaged position vis a vis the labour market where they are typically in part-time, low paid and low status employment (Tester, 1996: 137).

The link between women's poverty and caring for children has been established by writers such as Graham (1987:223) who concludes that:

> women are economically dependent not because they need care but because they give it.

In countries which have adopted community care policies, women are increasingly expected to take on responsibility not only for their children, but also for other vulnerable and dependent kin. Such policies are attractive to politicians because they control the costs of care borne by the state, however they do not take into account the opportunity costs for women in terms of income lost. Attempts to address this gap and to cost the earnings forgone by women through the adoption of caring roles have been undertaken, by Joshi in Britain (1987) and Lund in South Africa (1997).

The payment to carers of allowances to compensate for loss of earnings has been a matter of some debate among social policy theorists (see for example Baldwin, Parker and Walker, 1988). A number of writers have shown that, whilst important, money is not the only factor to consider when analysing the motivation of carers. Leat (1988), in a study of women providing care in their homes on behalf of British local authorities for non-related elderly and mentally ill or disabled adults, found that the allowances they received were 'both crucial and largely irrelevant'.

Leat explains this paradox as follows:

> the highly ambiguous role of money in caring seems to be the result of two relatively distinct sets of norms and values in which the norms, values and affective elements of caring meet the norms, values and rational calculative world of paid work (1988:141).

This kind of ambiguity can be found amongst foster carers and adoptive carers for children with special needs in Britain. Whilst these carers typically say they are not 'in it for the money', many are on a low income and often have to reduce their hours of employment in order to care for the child. They would not therefore be able to provide the care without the payment of an allowance.

Other factors which affect the provision of care by women include some form of official recognition (Guthrie, 1988), a sense of satisfaction (Baldwin & Twigg, 1991), notions of 'doing the right thing' and of duty and obligation. The latter is particularly important in relation to caring for kin. Finch & Mason (1993), for example, found in their research into children's care of parents in Britain, that these are clearly founded on a sense of obligation.

Feminist analysis of community care written in the early 1980's has been criticised for neglecting to recognise that not all women will be affected by such policies in the same way. Williams (1989) has highlighted the fact that women's experiences are mediated by factors other than just gender, such as age, 'race', disability and sexual preference. According to Tester:

> community care policy expectations about family care, based on the White British family and British values, are often inappropriate to minority ethnic communities from widely different cultures and with varying family patterns (1996:139).

15. Promoting Community Care: Issues for South Africa

Community care policies tend to be driven by economic imperatives, fiscal constraints, budgetary reductions, the push for 'cost effectiveness' and 'value for money'. Although developed for and from a very different context, much of the theory developed by British feminists would seem to be relevant for the South African context, particularly that which recognises the differences and inequalities between women. Analyses of the costs saved to society by unpaid carers are inconvenient to governments and policy makers looking for cheap welfare options. Although the full impact of HIV/AIDS has yet to be felt, the epidemic has already brought about a growth in the number of 'home-based care' schemes which depend on care of the sick by their (usually female) relatives.

The rhetoric of community care has been adopted by politicians and policy makers, despite a dearth of research into, or analysis of, the implications for the South African context. As Finch & Groves (1980:495) point out:

> if major policies are to be based on the assumption that communities or caring networks do indeed exist, then it is important to go beyond imagery and examine the evidence for the existence and the frequency of the particular quality of social relationship implied by the imagery.

The 'imagery' which is invoked in relation to ideas of community care in the South African context involves assumptions about 'the family' which is ready, able and willing to provide the care. As a number of commentators (Segar and White, 1992; Sunde and Bozalek, 1995) have observed, there is a need to 'deconstruct' the notion of 'the family' in South Africa if the effect of new policies on women is to be made transparent.

Notions of what constitutes 'the family' have historically underpinned welfare policy in South Africa and definitions based on stereotypical views of the nuclear family as the norm have been enshrined in laws relating to areas such as marriage, divorce, illegitimacy and adoption (Segar and White, 1992:62). This is regardless of the fact that there have always been a wide variety of family structures and of marriage forms in South Africa. As noted by Sunde and Bozalek:

> In South Africa the experience of families has been mediated by gender, race, class, language, age and ethnic power relations. A critical starting point is to recognise the political and historical significance of family life in South Africa, as well as to acknowledge the nature of different family structures in this country. The existence of large numbers of single parent families, extended families and other types of families that do not fit into the nuclear family form must be recognised (1995:73).

Whilst community care can certainly give individuals a better quality of life than they would have in an institution, 'community' care can equally be a convenient cover for

neglect by the state. In Britain, for example community care policies for the mentally ill led to an increase of mentally ill people living on the streets and a series of violent attacks and killings by former psychiatric patients. Such facts were apparently known to, but ignored by, the government for many years. The policy of sending seriously disturbed people to be cared for in the community has recently been reversed (Thomson & Sylvester, 1998). There is a danger that community care policies for the majority of the population in South Africa, might similarly become a cover for not improving the conditions of the vulnerable. The implementation in March 1996 of the Social Assistance Act is an example of a possible move in this direction. This act removes state pension grants for non-citizen permanent residents in South Africa. Many of these people are from neighbouring states, have resided in South Africa for many years and have no alternative form of income. Nevertheless, the Department of Welfare is quoted as responding to criticism about the policy as follows:

> These people will be accommodated by developmental social welfare programmes. Which means that people in need should be cared for in their own communities (Mail&Guardian, Aug 16-22 1996).

This begs the question who or what is the 'community' who will provide for the care of such individuals?

16. Meeting Basic Needs

Cash benefits are frequently criticised as treating symptoms rather than causes, of requiring on-going funding for problems that will not go away (Swarts, 1996). Welfare of this kind is seen by such critics as a less appropriate solution for South Africa, because it does not assist in the promotion of economic development, is passively dependent on the economy for funding, in short is unaffordable. Some economists have argued, however, that economic growth will not of itself abolish poverty, especially in less developed societies. These writers advocate that governments should adopt a 'basic needs approach', to addresss the problems of poverty directly rather than waiting for poverty to be reduced through increasing employment. The 'basic needs' approach

exhorts governments to target the poorest and most needy. Targeting programmes more carefully can, it is argued, ensure the most effective use of resources and rectify imbalances in delivery, for example between rural and urban areas (Midgley, 1995:132-134).

Despite its emphasis on developmental social welfare, South African welfare policy acknowledges the importance of maintaining an adequate social security system to meet basic needs, in order to protect people at vulnerable times. Social security benefits are acknowledged as contributing to:

> human resource development by enabling impoverished households to provide adequate care for their members, especially children and those who are vulnerable (Department of Welfare, 1995:4).

In comparison with other African countries South Africa has a relatively well-developed social security system. A large slice of government spending on welfare is allocated to cash grants. In 1995/1996 the South African welfare budget was 13.4 billion rand, of this 88% was allocated to cover social security pensions and grants (Van der Berg, 1995). The largest part (60%) of the social security budget goes towards pensions for the elderly, 25% to the disabled and only 15% to child and family care (Lund et al :1996:100). Benefits were historically distributed inequitably across 'racial' groups, but priority has been given to establishing equity.

Social grants which benefit children are currently in the process of change. The state maintenance grant which, was inequitably distributed across 'racial' groups is to be phased out over three years from 1998. The child support grant which replaces it will be targeted at the very poorest families. However, budget restrictions mean that this benefit will be payable only for children under 7 years, and at a much lower monthly rate than the old grant. Eligibility for the grant will be subject to a means test. Additional benefits for the support of children are the foster care grant, which is payable to approved foster carers, and a care dependency grant which enables parents of severely disabled children to care for them at home (Lund et al, 1996:108).

Debates about the potential for social security benefits to promote a culture of dependency rage in South Africa, as they do internationally. There is little evidence available from research in South Africa on which to base or refute allegations of dependency creation. There is research evidence, however which shows the crucial part which cash benefits play in meeting basic needs. It has been established, for example (Lund, 1993; Ardington & Lund, 1995), that state pensions play an important role in the alleviation of poverty among rural African families and that they are distributional in nature, benefiting several generations, not simply the elderly recipient.

17. Conclusion

This purpose of this chapter has been to provide a theoretical backdrop to the case studies which follow. It has considered a variety of theories of welfare and critiques of those theories. It has traced the development of social welfare in South Africa with a view to understanding the underlying ideas and forces which have shaped social policy. It has then explored concepts which are currently influential in the welfare debate, in particular the concept of developmental social welfare and the notions which this encompasses. The need for a more nuanced understanding of the term 'community' has been explored, especially in view of the potential of this term to obscure the implications for women of policies such as 'community' care.

The chapter which follows describes the research design and methodology used in this study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

1. Background to the Research

According to Ely et al.:

> the great majority of topics for study and research questions do not arise out of a vacuum or specious choice but, instead, mesh intimately with researchers' deepest professional and social commitments (1991:30).

This research arose out of a combination of personal and professional interests. My professional background is in social work with children and families, mainly in England, but I have also lived and worked in West Africa and have regularly visited many other African countries over the past twenty years. Prior to moving to Durban in July 1995 I had been employed in England first as a social worker and then as a social work manager, specialising in the field of adoption and fostering. My experience had been gained both in the state sector and in a large NGO. Between 1988 and 1995 I had managed a project which specialised in placing children with a range of 'special needs', such as older childen and children with disabilities, with adoptive and foster families. A number of these children were at a high risk of HIV infection and one of my responsibilities was to ensure that prospective foster and adoptive parents were appraised about issues relating to HIV/AIDS.

I arrived in South Africa only a year after the first democratic elections and at a particularly crucial time for the welfare sector. A draft document had just been produced by the Ministry of Social Welfare and Population Development entitled 'Towards a New Social Welfare Policy and Strategy for South Africa' (Department of Welfare, 1995). This document proposed some major changes for welfare services. In future the emphasis for service delivery would be on reaching out to previously

disadvantaged and under-served groups, rather than on providing a 'first world' service to a largely urban-based minority. Through a process of reading, attending workshops and discussion with welfare practitioners and academics I began to make myself familiar with the child and family welfare system in South Africa and of the implications of the proposed changes. Involvement in a research project which entailed gathering data from two child welfare societies helped to deepen my understanding of the operation of the child welfare system in South Africa.

During early 1996, prompted by concerns about the high rate of growth of HIV infection in South Africa, and particularly in KwaZulu-Natal, I became interested in researching the policy implications of this new challenge for the child care sector. The question of what was to being done to plan for the care of increasing numbers of AIDS orphans and HIV infected children appeared to be an area which was particularly under-researched.

Ely et al (1991:30) state that, unlike, 'positivistic research in which questions are posed from the start and do not change', researchers working in the qualitative paradigm (or what they term 'naturalistic' research) generally begin with 'broad' questions. These questions then change and become more focussed as the study progresses. The following broad questions formed the basis for this research.

1. Given the growing AIDS epidemic in KwaZulu-Natal, what is being done by welfare organisations, and by whom, to provide care and support for children affected by HIV/AIDS?

2. Are welfare organisations in KwaZulu-Natal devising 'developmental social welfare' approaches to respond to the challenge of AIDS? If so, how is this approach being developed to assist children affected by HIV/AIDS?

3. In view of the fact that the AIDS epidemic in South Africa is several years behind other sub-Saharan African countries, are there any lessons that can be learned from

other African countries about alternative models of care for affected children which have been developed?

2. Preliminary Research

In order to begin addressing the first two of the research questions, a limited survey of welfare provision for children affected by HIV/AIDS in KwaZulu-Natal was commenced. In view of cost and practicalities it was necessary to approach the question concerning other African countries using secondary sources.

The purpose of the preliminary survey in KwaZulu-Natal was to identify organisations which were specifically addressing issues of HIV/AIDS and children and to establish what strategies were being developed to meet predicted increases in the incidence of AIDS orphans and HIV positive children. Shortly after making contacts with relevant organisations I was asked to contribute to an analysis of HIV/AIDS programmes in KwaZulu-Natal which was being undertaken by the University of Natal's, Centre for Health and Social Studies (CHESS). It had become clear that the CHESS researchers and I were in danger of duplicating efforts. I was therefore allocated the role of surveying programmes for children affected by HIV/AIDS. Involvement in this study enabled me to undertake a much more extensive survey of provision for children affected by HIV/AIDS in KwaZulu-Natal than would otherwise have been feasible. I was given permission by CHESS to use information gathered in the survey to further my own research. Interviewees were also informed of my dual role and permission sought from them to use information provided for the purposes of my personal research.

Between April and June 1996 I conducted 29 semi-structured interviews of between one and two hours duration with 25 different organisations. These were mainly non-governmental organisations working in the fields of health or welfare, but included some state agencies. The full results of the survey are contained in a paper produced by CHESS (Lucas et al, 1997). For the purpose of this study the following findings are relevant.

1. The overall picture was one of organisations being largely unprepared for the predicted AIDS orphan crisis. HIV/AIDS organisations were concentrating mainly on AIDS education programmes, rather than on developing models of care and support for children.

2. A few organisations showed signs of developing innovative ways of responding to the impact of HIV/AIDS for children, but many were heavily burdened by statutory work such as child protection, or were overwhelmed by work with AIDS affected adults.

3. In general there was a continuing reliance on rehabilitative services and residential care, especially for HIV infected children.

Two organisations interviewed for the survey, both in Pietermartizburg, stood out as different. Both were developing new approaches to the care and support of children, prompted by concerns about rates of HIV infection. The first of these, the Thandanani Association, which was in the process of developing a community-based AIDS Orphans project (AOP). The second, the Child and Family Welfare Society of Pietermaritzburg (CFWSP), was promoting adoption within the African community and also developing a 'cluster' foster care project for HIV positive children. I therefore decided to focus on the work of these organisations for the purpose of the Master's study.

3. Understanding the Difference Between Quantitative and Qualitative Research

It was decided to undertake a more detailed study of the two organisations described above utilising a case study approach within a qualitative research methodology. Qualitative (also known as 'naturalistic', or 'interpretative') research, and quantitative, (or 'positivistic') research are based on two distinct ways of thinking about the world and of approaches to knowledge. These ways of seeing the world are often known as

'paradigms'. Mark, quoting Guba and Lincoln (1994) defines a paradigm as representing:

> a world view that defines for its holder, the nature of the 'world', the individual's place in it, and the range of possible relationships to that world (Mark, 1996:206).

As Fuller & Petch (1995:35) note, there is no 'absolute dichotomy of qualitative versus quantitative research', but rather a continuum between the two approaches. Nevertheless it is important to understand the underlying differences.

Quantitative, or positivistic, research is based on:

> an approach to the creation of knowledge which emphasises the model of the natural sciences: the scientist adopts the position of the objective researcher who collects 'facts' about the social world and then builds up an explanation of social life by arranging such facts in a chain of causality, in the hope that this will uncover general laws about how the society works (Finch, 1986:7).

Mark (1996 : 206-207) provides a summary of beliefs that underlie positivistic research. In this paradigm researchers hold that there is an 'objective' world that exists independently of each of us. Events in the world are determined by the operation of natural laws and mechanisms, which researchers can discover. Positivist researchers use theory to make a hypothesis which must be tested by objective study. The researcher sees him or her-self as completely independent from the phenomena being studied. The researcher can thus study phenomena without affecting them in any way. As long as researchers adhere to scientific procedures positivist researchers believe they can avoid bias and their research will be 'value-free'.

Qualitative researchers, by contrast, operate within a set of beliefs that:

> hold realities to be multiple and shifting, that take for granted a simultaneous mutual shaping of knower and known, and that see all inquiry, including the empirical, as being inevitably value-bound (Ely et al, 1991:2).

Qualitative research seeks to understand human behaviour through observing and interacting with people in order to try to understand the world as they understand it. As Mouton (1986) states:

> the aim of qualitative research is not to explain behaviour in terms of universally valid laws or generalizations, but rather to understand and interpret the meanings and intentions that underlie everyday human action (cited in Schurink & Schurink, 1988:30).

Qualitative researchers do not therefore seek to test a theory through formulating a hypothesis and examining their data. This does not mean they approach their subject 'devoid of theory' (Edwards & Talbot, 1994:8), but rather that this theory is not seen as fixed. 'Grounded theory' is the generally used label for theory which is generated from an analysis of data in qualitative research.

4. Reasons for Adopting a Qualitative Research Methodology

There were a number of reasons for chosing a qualitative research methodology for this study. Firstly, as a number of writers (Yin, 1984; Schurink & Schurink, 1988; Ely et al, 1991) suggest, qualitative methodology is particularly suited to research in the social sciences, such as social policy, social work and education where a 'holistic' or intensive description of a contemporary phenomenon is desired. Secondly, qualitative research is considered to be an appropriate methodology for researchers whose research questions lead them towards an 'inductive' or 'data driven' approach. In other words researchers who wish to:

> look at what is going on and try to make sense of that by testing out themes and patterns (Edwards & Talbot, 1994:7).

Thirdly, qualitative research is said to suit research in which:

> description and explanation (rather than prediction based on cause and effect) are sought, when it is not possible or feasible to manipulate the potential causes of behaviour, and when variables are not easily identified or are too embedded in the phenomenon to be extracted for study (Yin, 1984:7).

This study followed the progress of two organisations as they explored new territory by trying out innovative models of care for children. It sought to understand the day to day realities of the organisations, to look at issues from their perspective. It also sought to interpret the findings against a number of key themes.

5. Utilising a Case Study Approach within a Qualitative Framework

Qualitative case studies, have been defined by Yin (1984:21) as 'an intensive, holistic, description of a single instance' (1984:21). Case studies can use a combination of any number of research methods, both quantitative and qualitative. However, many writers (Edwards & Talbot, 1994; Merriam, 1988; Mark, 1996) suggest that the case study approach is particularly well suited to qualitative research, especially that which seeks to understand complex social phenomena and to examine the processes of change. Wilson (1979) describes the case study as a:

> process which tries to describe and analyze some entity in qualitative, complex and comprehensive terms not infrequently as it unfolds over a period of time (cited in Yin, 1984:11).

According to Merriam (1988:13-14) case studies allow research to retain the 'holistic and meaningful characteristics of real-life events' and are the strategy of choice:

> when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real- life context.

The presence of such factors led to the choice of a case study approach. Firstly, the study sought to address inter-relationships between contemporary phenomena set in a 'real-life' context. These were the transformation of social welfare and the responses of organisations to changing social policy, within the context of the AIDS epidemic. Secondly, the phenomena to be studied were undergoing a process of rapid change, and it was felt appropriate to study these changes over a period of time. Thirdly, the phenomena to be studied were totally outside of the control of the researcher.

6. Selecting 'Cases' for Study and Defining Boundaries

Yin (1984:44) notes that qualitative research often begins with a problem identified from practice from which broad questions are raised, but that it is the decision to focus the study on a particular instance which makes the inquiry a case study. Mark, following Stake (1994) argues that the:

> sole criterion for selecting cases for a case study should be the 'opportunity to learn'. This may mean, for example that the researcher should select the most atypical or most unusual case. The unusual case can help to challenge previously accepted generalizations...Often it is better to learn a lot from an atypical case than a little from a typical case (1996:221).

Yin has labelled this 'unique case selection' (1984:50). In a time of rapid transformation such as that currently facing the South African welfare system, it seems imperative to study the 'atypical' or the unusual case, as it is these which are breaking new ground.

Writers on case study research note that it is important to define the boundaries of a case study. The preliminary phase of this research had identified two organisations in

KwaZulu-Natal which were developing models of care to address the problem of HIV/AIDS and children. It was originally intended to define family placement work (incorporating adoption and fostering) within CFWSP as one 'case' and community-based support for AIDS orphans being developed by Thandanani as the other. However, as Merriam (1988:31) notes, definitions of what the 'case' is have 'plagued' many researchers, and that case studies about programmes and about organisational change can be particularly problematic. This problem of definition was faced as it became clear during the course of the research that the 'cluster' foster care scheme was progressively becoming sufficiently separated from adoption work, and raised sufficiently different issues, to be considered as a separate 'case'.

7. Advantages and Limitations of Qualitative Case Studies

There are a number of advantages to using a case study approach within a qualitative research framework. According to Yin (1984:33) case studies have been particularly useful for informing policy because:

> processes, problems and programs can be examined to bring about understanding that can affect and even improve practice.

Other advantages include:

> It allows in-depth focusing on shifting relationships.
> It captures complexities.
> It allows a focus on the local understandings and sense of participants in the case.
> It provides readable data that bring research to life and are true to the concerns and meanings under scrutiny (Edwards & Talbot, 1994:48).

Nevertheless, qualitative case study research presents certain limitations. These include:

> It can be an unwarranted intrusion into the lives of others.
> It is situation and time bound.
> It requires carefully collected, high quality data.
> Appropriate data collection takes time.
> The researcher can become so immersed in the case that data analysis becomes difficult (Edwards & Talbot, 1994:48).

Concerns about 'reliability', 'validity' and 'generalisability' are pertinent to all research, but criticisms about 'soft subjectivity' (Edwards & Talbot, 1994:46) are often raised in relation to qualitative research in general and case studies in particular. Reliability refers to the extent to which findings can be replicated (Yin, 1984:170). The issue of reliability is central to all qualitative research, since it is the researcher who is the primary instrument of data collection and analysis. This brings with it a potential for subjectivity or bias. A number of writers (Yin, 1984; Merriam, 1988; Mark, 1996) suggest that perhaps the most important way of enhancing reliability is the use of 'triangulation' which can be defined as a:

> process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation (Stake cited in Mark, 1996:220).

In other words qualitative researchers verify their findings by gathering data from a number of sources, or by collecting data through a number of different research methods. Triangulation can also be used to overcome concerns about validity, or 'the extent to which one's findings are congruent with reality' (Yin, 1984:183). Ways of establishing validity include checking interpretations with interviewees and other participants, staying on site over a period of time, involving participants at all stages of the research, and being clear about researcher biases and assumptions (Yin, 1984; Merriam, 1988; Ely et al, 1991). Finally, qualitative case studies, in common with all qualitative research, are limited in terms of generalisabilty. Findings from case studies are not automatically generalisable to other settings. Theories generated through this

type of research may or may not apply any more widely than the 'case' studied and must of necessity be more 'tentative' (Mark, 1996:213).

8. Establishing Feasibility and Negotiating Access

Many writers on research methods stress the importance of selecting a feasible research design and of establishing the practicability of the research project. In addition they caution against assuming that access to pursue research will be automatically forthcoming (Edwards and Talbot, 1994:12). Details of the process by which I established feasibility and negotiated access are therefore included here. My first contact with both the AIDS Orphans Project (AOP) and with Child and Family Welfare Society of Pietermaritzburg (CFWSP) was on 15th May 1996 when I conducted a two-hour, semi-structured interview with management representatives of both organisations as part of the preliminary survey. During the course of these interviews I was also provided with documentation about the work of the organisations. On June 15th 1996 I attended Thandanani's Annual General Meeting. This gave me the opportunity to meet other members of Thandanani's staff, as well as members of the management committee, and to get a fuller picture of the aims and objectives of the Association. Three weeks later I attended a two-day 'Summit' (July 6th and 7th 1996) which brought together welfare organisations in the Pietermaritzburg district which were concerned about the welfare of children affected by HIV/AIDS. Staff and management representatives of both case study organisations attended this event. This afforded me with further opportunity to discuss the different initiatives which both organisations were taking to respond to the challenges of the AIDS epidemic.

These initial contacts served a number of purposes. Firstly they enabled me to determine that the work of these organisations was appropriate to be selected as a 'cases' for the purpose of this research. Secondly, they enabled a natural process of building relationships and establishing of trust between myself and key individuals who would be involved in the research. Thirdly they helped to facilitate obtaining of

permission to undertake the research and thus avoid what can often be a lengthy process of negotiating access.

9. Research Methods Used

In the interests of triangulation a number of different research methods were used in this research. These included participant observation, interviewing, and document collection. In addition, written questionnaires were used to gather some background information. The methods used and the different emphasis given to a particular method varied in each of the case studies. The methods selected were determined by the nature of each 'case' and the opportunities which were available. In the discussion which follows:

Case study 1 refers to the Thandanani, AIDS Orphans Project (AOP)

Case study 2 refers to Adoption work in The Child and Family Welfare Society of Pietermaritzburg (CFWSP)

Case Study 3 refers to the 'Cluster' Foster Care scheme developed by CFWSP.
See diagram Appendix 2

10. Participant Observation

Participant observation was used only in relation to Case Study 1. This method was decided upon because, shortly after the July 6th -7th 1996 'Summit' held in Pietermaritzburg, the opportunity arose for me to become part of a group which had recently been established to provide support to AOP staff. Permission was sought and granted for me to use the support group for the purpose of this research, using participant observation to gather data. The support group consisted of people with an interest in the aims of AOP who could bring a variety of skills and knowledge to assist in the development of the project. Most of these individuals had a background in welfare or community development and worked for local non governmental

organisations. The group normally consisted of 6 or 7 people (including myself), although attendance fluctuated. Group members gave their time on a voluntary basis, which meant that they were not always able to attend due to work commitments. Apart from myself there was a core group of 3 members who attended meetings throughout the period of the case study, otherwise group membership was fluid. This led to some lack of consistency and a repetition of issues, but allowed for a wide variety of ideas to be expressed and experiences to be shared. Discussion generally centred around reports from AOP fieldworkers about progress and any issues and difficulties faced in implementing the project's aims. Meetings lasted between two and three hours. In addition to seven support group meetings I also attended two full-day workshops arranged by AOP. Dates of meetings and workshops attended are contained in appendix 1.

It had been decided to end data collection in June 1997, one year since I had attended Thandanani's AGM. This, by chance, proved to be a natural time to stop. Firstly, the organisation was about to enter a new phase in its development, having just employed a project co-ordinator and five new fieldworkers. Secondly, and linked to these developments, was a decision that the support group would cease to operate in its existing form.

Many writers (for example Ely et al, 1991; Jorgensen, 1989) note that participant observation covers a broad spectrum of types of participating, from full participant, living and working in the field, to a silent observer. Ely et al (1991:45) note that most researchers 'find a level somewhere between these extremes' and that the role adopted will depend on the opportunities each setting provides. They also note that the role of participant observer is one which is likely to develop and evolve over time, and that this will only become problematic if the researcher loses sight of his/her dual role as both 'insider' and 'outsider'. Over the course of the research I became aware that my role as participant observer did undergo a subtle change. Initially my contributions to the group were limited and my role was mainly that of silent observer. However my research notes reflect a shift of role as I became more confident about making contributions.

One concern about participant observation is that the very presence of the observer will change the phenomenon under study. Qualitative researchers believe that this is true of all research and that the important thing is to acknowledge that this is inevitable and to 'name it and note it' (Edwards and Talbot, 1994:42). In view of the fact that my background did not include working in community development my research notes show that for the most part my contributions to the group were confined to issues relating to management issues, particularly regarding the support of the fieldworkers. Although my contributions will inevitably have impacted on some of the decisions taken by the project, there were a couple of other members of the support group whose ideas had far greater impact on the shape of the project. It is thus significant to note that views and ideas which I noted as having expressed in my own recordings are rarely recorded in the official minutes of meetings.

Writers on participant observation (Ely et al, 1991; Jorgensen, 1989) recommend the keeping of detailed research notes and regular introspection as the two most important ways in which researchers can maintain their dual role of 'insider' and 'outsider'. Detailed, hand-written research notes were therefore kept of all the meetings attended. Although it was at times difficult to keep notes and to contribute to discussion at the same time, I was fortunate to have had prior experience of participating in, and keeping verbatim minutes of, lengthy meetings in my professional capacity. Hand-written notes made in the meetings were typed up either later the same day or at the very latest the following day. These notes were subsequently analysed alongside reports and official minutes of the meetings produced by AOP.

One criticism which is made of all qualitative research, and of participant observation in particular is that it is subjective and therefore not 'scientific'. Writers on participant observation, however, reject the idea that truth can be achieved 'in any absolute sense' (Jorgensen, 1989:27). They accept that, although participant observation seeks to present accurate and truthful findings, pure objectivity in observation is an 'impossible goal' because 'observation comes out of what the observer selects to see and choses to note' (Ely et al, 1991:53). These writers suggest that what researchers should strive for

instead is to be aware of their values and biases, and to work towards ensuring that these do not 'color unfairly' both what they observe and what they detail in writing (Ely et al, 1991:54; Jorgensen, 1989:27). It is therefore important to highlight some of the values, assumptions and biases which I brought to this research. (It should be noted that, although these issues are discussed in relation to participant observation, many of the issues raised also apply to other aspects of this study).

Firstly, as a white, female researcher I will have approached this research with ideas and prejudices borne of my 'race', gender and class. Secondly, as a social worker with many years experience in adoption and fostering, I hold that every child should have the opportunity of a family life, preferably within their own family, but where this is not possible within a substitute family. Linked to this is an assumption that children should, wherever possible, be placed in substitute families which as nearly as possible reflect their 'racial' and cultural and linguistic background. This is a highly controversial issue in many countries, but given the history of apartheid it is a particularly emotive topic in South Africa. It is therefore important to acknowledge my personal stance on this issue. Thirdly, as a relative new-comer to South Africa (though not to Africa) it is important to acknowledge that there may be gaps in knowledge and understanding, particularly in relation to cultural issues. Finally, while I have an awareness of some of the values and biases which I have brought to this study, there no doubt remain areas where I am 'blind' to my prejudices and to my gaps in knowledge.

Another area that needs to be acknowledged relates to language, since I am unable to speak Zulu. This placed certain limitations on the research. Although all of AOP's business is conducted in English, there were occasions when I was unable to understand, or to participate in, informal discussions which took place in Zulu outside of the support meetings. There may therefore have been some interesting details which I was unable to include in the analysis. I was also conscious that I may at times have misunderstood, or have been misunderstood by, individuals for whom English was not a first language. In recognition of this and in order to ensure that any such misunderstandings have been minimised, I have wherever possible shared my

observations and interpretations with participants as the study progressed. Additionally these have been checked against documentation and during interviews.

11. Using Interviewing in Research

Interviewing, both formal and informal in nature, was used to gather evidence in all three case studies. Edwards & Talbot (1994:86) state that interviews are an invaluable tool in qualitative case study research because they allow participant's voices to be heard and so produce the richness of data which is required. However, as these authors point out, interviews must be done well or they will produce little of value. For the more formal interviews written question areas were devised in advance of each interview. These were used to act as an 'aide memoir' to guide the discussion and to ensure that each question area was covered. The interviews themselves were semi-structured in nature. This type of interview format was chosen because it allowed flexibility to explore the observations, concerns and interpretations of interviewees. As interviews schedules were not standardised (each covered different topics) the amount of material was considered too great to be included as appendices. They have, however, been retained by the researcher. Dates of formal interviews are contained in appendix 1.

Some writers (Ely et al,1991; Yin, 1984) recommend the use of tape-recorders to record interviews, but other commentators suggest that methods of recording interviews comes down to a 'matter of personal preference' (Merriam, 1988:91). I decided to make detailed written notes of interviews rather than tape recording for three reasons. Firstly, I believe that persons occupying positions in public organisation are likely to be cautious about speaking frankly to researchers on tape. This is based on personal experience of being interviewed for the purposes of research. Secondly, because the data I was interested in gathering was concerned with policy matters rather than individual issues as in ethnographic research, it was not necessary to obtain a totally verbatim recording of interviewees. Thirdly, I felt comfortable in taking written notes because my professional experience had given me considerable practice of conducting interviews (albeit of a different nature) and taking detailed, accurate

written notes. All the interviews were conducted in English, although English was a second language for several of the interviewees. In order to avoid the potential for misunderstandings due to language, draft copies of the relevant sections of the study were shared with participants.

Four formal interviews were held during the course of Case Study 1. Each interview lasted between one and two hours and were with individuals who were key players in the development of AOP. (Dates contained in appendix 1.) The purpose of these interviews was fourfold. Firstly to clarify facts and information gathered through other methods and to check preliminary observations and interpretations, secondly to fill gaps in knowledge and understanding on the part of the researcher, thirdly to gain the perspectives of individuals working in different roles within the project, and fourthly to facilitate 'triangulation'.

Informal as well as formal interviews were used. Ely et al's description of informal interviewing sums up well the experience of this researcher:

> Qualitative research provides a great many opportunities to talk with people. Some interviews are done 'on the hoof' during participant observation when the time is available and the spirits are amenable,. These interviews are usually quite informal. They flow from a situation, perhaps at its tag end, and usually occur with less prior planning than formal interviews (1991:57).

Informal interviews were conducted with AOP staff and with support group members. These often took place at the beginning or the end of support group meetings, or when meetings were cancelled at the last minute and I had not been informed in time, or in telephone conversations in between meetings. Information gathered through these informal interviews was noted in writing, immediately afterwards.

In Case Studies 2 and 3 semi-structured interviews were undertaken with single participants, or more than one interviewee. A group interview was also conducted with

family placement social workers. Each interview lasted between one and three hours. The interviewees were selected either because they occupied a key role in relation to adoption and fostering work within CFWSP, or because they were key individuals from outside of CFWSP, who were working co-operatively with the adoption team. By obtaining evidence from a variety of sources it was hoped to achieve triangulation.

As has already been noted, the third case study 'grew out of' research undertaken in relation to adoption work. Indeed it was originally intended to focus on adoption and fostering as one entity, since when the research began, 'cluster' foster care was being developed under the auspices of the adoption team. In view of this, information on both 'cluster' fostering and on adoption were obtained in early interviews. In June 1997, however, the 'cluster' foster care scheme was placed on a more formalised footing and a project co-ordinator was appointed. Two interviews were thus held with the newly appointed co-ordinator, one in June, and a follow-up five months later when the project was more firmly established.

In order to gain a broader understanding about the nature of fostering in South Africa and to provide a comparative perspective, two further contacts were made. Firstly, information about the national picture was discussed with the National Council for Child and Family Welfare by telephone. Secondly, an interview was held with a senior manager of another Child and Family Welfare Society in KwaZulu-Natal. National and local statistics on foster care were obtained from these sources.

12. Questionnaires

Edwards & Talbot (1994:73) suggest that questionnaires are a useful research method when background information is needed. Two short questionnaires were used to gather background information about CFWSP's adoption and fostering work. This information was gathered as 'backdrop' to the interviews. As these questionnaires were completed by individuals who were participating in the study in other ways and who agreed to provide the material, the problem of non-returns, which can limit the

usefulness of questionnaires, was avoided. The questionnaires used are included as appendix 2.

13. Using Documentation

Organisations generally produce a range of documents, such as project proposals, reports, minutes of meetings and case records, which can provide a good source of evidence in case study research. Documents are useful for gathering many different kinds of data, both contemporary and historical. Caution needs to be taken, however not to simply accept the contents of documents at face value. Documents may reflect the perspective of the writer, or may stress certain issues over others because they were produced for a specific purpose, or a particular readership. The value of documents therefore lies in their potential for corroborating evidence gathered by other methods (Merriam, 1998:85).

A wide variety of documents were collected in relation to each of the case studies. In respect of the first case study I was afforded full access to documentation relating not only to the period of the study, but to the early development of the project. These included initial project discussion papers and proposals, documents relating to the research on which the project proposal was based, minutes of management committee meetings dating from the inception of the project in 1995 and reports of annual general meetings. These documents were useful in providing an understanding of the development of the project prior to the commencement of the research in May 1996. This information could then be crossed checked with information obtained through interviews. As the case study progressed documentation collected was predominantly in the form of reports and minutes of support groups and workshops. The latter were particularly useful for corroborating and comparing perceptions and observations of events as recorded in my own research notes.

In respect of case studies 2 and 3, reports, minutes of meetings and internal documents relating to the practice of adoption and fostering within CFWSP were collected. In addition, documents used by CFWSP staff to inform their work were collected. In

view of the need to respect confidentiality I did not seek to have access to case files or documents containing personal information about the children placed, or adoptive/foster carers.

14. Data Analysis

> Qualitative research involves almost continuous and certainly progressive data analysis from the very beginning of data collection. This process of analysis guides the researcher to focus and refocus observational and/or interview lenses, to phrase and rephrase research questions, to establish and check emergent hunches, trends, insights, ideas, to face oneself as research instrument. The final phase of data analysis is somewhat different, however, it takes place when the researcher has left the field and sits alone (Ely et al, 1991:140).

This quote captures well the process of data analysis which was adopted in this study. This not only involved an on-going process of introspection and of checking ideas against established theories, but also of sharing interpretations with participants. The second of these, sharing interpretations with participants, is considered 'central to establishing validity' (Ely et al, 1991:165).

Fuller & Petch describe the final phase of data analysis in qualitative research as one which involves reducing 'the initial mountain of data to an ordered set of themes'. This, they suggest, can only be achieved through 'familiarity with the data, absorption and reflection' (1995:85). Again these authors summarise well the method of analysis adopted in this study, in which the data was categorised and sifted for common themes and patterns. Each case study was analysed predominantly as a discrete unit and the findings are presented separately. However themes which emerged as common to more than one case study have been drawn together in the conclusion.

Theory generated by this research is 'grounded', in other words it has been constructed 'inductively' (Jorgensen:1989:113). Mark's (1996:212) description of the process by which theory is built in qualitative research is instructive:

> In qualitative research the researcher moves freely back and forth between data collection and theoretical analysis .... this back and forth process may continue for a long time, until the researchers are satisfied that they have examined enough data to determine that the theory is accurate.

15. Ethical Issues

Since ethical issues permeate every aspect of qualitative research, many have already been discussed. Ethical issues addressed earlier are, gaining permission to undertake the research; being open about the purpose of the research; establishing trustworthiness; establishing reciprocation with participants; feeding back observations and interpretations to participants; developing awareness of personal values, perspectives and potential biases; and presenting participants views faithfully.

One ethical issue which must be addressed in all research is confidentiality. This is particularly important when researching HIV/AIDS and adoption, both of which require a high degree of confidentiality to be maintained. It was largely for reasons of confidentiality that this research was focussed at an organisational level and did not directly involve service users. Only non-identifying information about service users was obtained. The limitations this placed on the research are discussed below. Permission was obtained, however, to name the organisations which participated in the study. In view of this it has been necessary to give pseudonyms to certain individuals. As certain individuals may nevertheless still be identifiable, if only within a small circle, this was discussed with those concerned, draft sections were shared with them and their agreement to proceed obtained.

16. Limitations to the Study

This study aims to look in depth at the response of two organisations to the impact of the AIDS epidemic for children. It is not the contention of this research that these are the only organisations in KwaZulu-Natal, let alone in South Africa which are taking similar initiatives. Moreover, as with all qualitative studies, care has to be taken about generalising to other organisations or other settings.

Another limitation is the lack of a service users perspective. (Service users would include members of the Child Care Committees developed by AOP or other members of communities targeted by the project, adoptive and foster parents, and children placed for adoption or 'cluster' fostering). In addition to problems of confidentiality, there were a number of practical reasons why it was decided not to involve service users in the study. The first was distance and accessibility. Service users were located in townships and rural areas around Pietermaritzburg, whereas I was based in Durban. Secondly, it would have been necessary to employ the services of an interpreter and/or a guide. All of these had cost implications, which was an important consideration since (apart from the preliminary phase) this study was self-funded. Thirdly, since the children placed for adoption and fostering were babies and toddlers it would have been impossible, or at least very difficult, to obtain the child's perspective.

Finally, although this research was conducted over a twelve month period, it provides only a 'snap-shot' of a particular period in history. The work of AOP and 'cluster' fostering were relatively new when the data collection ceased. AOP had expanded just before I withdrew and new developments within each of the 'initiatives' had occurred by the time draft sections were shared with participants. Further research would therefore be needed to answer questions concerning the longer-term impact of the initiatives and the implications of the initiatives for the children and their carers. Despite these limitations this study does break new ground in the field of HIV/AIDS research in South Africa. It provides a qualitative and comparative study in an area of research (the care and support of children) which has previously been neglected.

CHAPTER 4

THE NATURE AND EFFECT OF THE HIV/AIDS EPIDEMIC. IMPLICATIONS FOR CHILDREN

1. Introduction

The purpose of this chapter is to contextualise the problem which the HIV/AIDS epidemic poses for welfare in South Africa. HIV/AIDS is much more than a personal tragedy for an infected individual; every sector of society, both at a macro and a micro level, is affected. HIV/AIDS impacts on the demographic profile of a country and on labour productivity, it places pressures on the health sector, on housing, on education and not least on welfare. In countries like South Africa where AIDS has spread widely among the heterosexual population, there are devastating implications for families, in particular for women and children (Danziger, 1994; Whiteside et al, 1996; McKerrow, 1997a). HIV/AIDS presents the welfare sector in South Africa with tremendous challenges. Among these challenges is the task of developing appropriate and affordable support systems for growing numbers of affected children.

The chapter begins by describing and quantifying the problem. It describes the nature of HIV/AIDS and the current state of the global epidemic. It looks at reasons for, and the impact of, the heterosexual spread of AIDS in Africa. It describes the nature and extent of the epidemic in South Africa, and in KwaZulu-Natal in particular. It considers some socio-economic effects of HIV/AIDS and concludes with a discussion of the extent of the epidemic with respect to children.

2. What are HIV and AIDS?

AIDS (Acquired Immune Deficiency Syndrome) was first recognised as a syndrome of illnesses in 1981 (Berer & Sunanda, 1993:6). It is caused by the Human Immunodeficiency Virus (HIV), which is one of a group of viruses known as 'retroviruses'. Two major strains of HIV have been identified to date, though within

these there are many different variations. HIV-1 is most prevalent in Western countries, Asia, Latin America and most of Africa. HIV-11 is found mainly in West Africa, although it has been reported in Mozambique and is thought likely to be present in Kwa-Zulu-Natal. It is more difficult to detect than HIV1 and may take longer to affect individuals post infection. (Whiteside et al, 1995:4).

In order to develop, HIV has to enter the bloodstream, the main routes of transmission from one individual to another being through sexual contact, from contact with infected blood or from an infected mother to her unborn or newly born child. Whiteside et al (1995:3) describe the progress of the disease. Immediately after infection individuals are highly infectious, although at this stage they do not show any symptoms and will not have produced sufficient anti-bodies for the virus to be detected through testing. There then follows a 'latent period' in which the individual still does not show symptoms but the virus can be detected by testing. During the next stage individuals begin to develop 'opportunistic' infections and AIDS related illnesses, but HIV is a slow-acting virus and individuals can remain well or experience only minor symptoms for years. Initially bouts of illness may be of short duration and not particularly severe, but they become ever more debilitating as the disease develops.

The case definition of AIDS is:

> a list of minor and major illnesses which, alone or in combination are most likely to indicate that a person has AIDS and not something else (Berer & Sunanda, 1993:14).

Manifestations of AIDS are similar throughout the world, but there are age, gender and regional differences in the presentation of the disease (Fleming, 1993: 300-301). The length of time from HIV infection to the development of AIDS varies greatly, and is dependent on an individual's general state of health, socio-economic condition, age and access to health care (Berer & Sunanda, 1993:9). The average time world-wide has been put at 7-8 years (Whiteside et al, 1995:3), but this is generally higher in developed countries (Berer & Sunanda, 1993:9), and lower in less developed

countries. In South Africa the length of time from infection to the onset of AIDS is said to range between 3 years and 8 years (McKerrow, 1996a).

The length of time from the point of HIV-seropositivity to death is similarly variable, ranging from a few weeks to a possible 30 years, with a mean of 7-8 years (Whiteside et al, 1995:5). Although there has been some optimism about new drug treatments for AIDS patients, these are far too expensive to become widely available in less developed countries (Wood & Mason, 1997:6). As yet there is no cure or vaccine for AIDS, which is thought to be almost always fatal (UNDP, 1996:22).

3. AIDS Data and Projections of HIV Prevalence

Figures for the numbers of reported AIDS cases and deaths need to be viewed with a degree of caution. People do not 'die of AIDS'; it weakens the body's ability to fight off infections until death from one of these is inevitable (Baggaley,1994:5). TB or pneumonia, for example, may be recorded on the death certificate as the cause of death in order to prevent stigmatisation of the patient and his/her family. Under-reporting of AIDS cases is particularly prevalent in less developed countries, where people may not be seen by the formal health service, where there may be no incentive for records to be kept (Whiteside et al, 1995:6), or where the authorities may be reluctant for political reasons to admit the level of infection.

Projections of HIV prevalence are computer models using mathematical formulae and based on relevant in-put information from representative samples of a population, such as surveys of HIV testing of women ante-natal attenders. These projections are only as good as the in-put information available, as is explained by Whiteside et al:

> any attempt to forecast the course of the epidemic is fraught with many difficulties and uncertainties. These relate primarily to the large number of assumptions that must be made in building forecasting models, often with data that is not completely reliable...Uncertainty, however, should not deter ongoing attempts at developing realistic scenarios for the

> future course of the epidemic, since these are essential if we are to understand the possible impact of this disease on our society (1995:34).

Projections quoted in the following discussion should be read with these words of caution in mind.

4. The Global Epidemic

Estimates of the total number of people infected by HIV world-wide by the end of 1996 varied between 22.6 (United Nations AIDS Programme, cited in Mihill, 1996) and 30.5 million (Global AIDS Policy Coalition, 1996). At the end of 1997 UNAIDS revised its estimates to concur with the higher estimate (Whiteside, 1998). The majority of the adults infected were under 25 and half were women. 90% of the people now living with HIV/AIDS are in less developed countries (Mihill, 1996). Studies suggest that HIV infection rates may have slowed down in Europe and the USA and may have peaked in parts of central Africa (Global AIDS Policy Coalition, 1996), but there has been a steep rise in the figure for new infections in some areas of Asia which previously had low rates (Piot, 1996). This has raised concerns that:

> the sheer size of the populations at risk of HIV/AIDS in South and South East Asia means that the problem of parental deaths will eventually eclipse that of sub-Saharan Africa (USAID, 1997:4).

The nature of the epidemic in Western countries is quite different to that found in less developed countries. The main characteristics of the two types of epidemic are described by Whiteside et al (1995:4). In Western countries HIV is predominantly transmitted through homosexual/bisexual men and intravenous drug users. The male to female ratio is approximately 10:1, therefore mother-to-child transmission (also known as 'paediatric' or 'vertical' transmission) of infection is uncommon. Other modes of transmission are rare and overall levels of infection as a proportion of the population remain relatively low. By contrast, in less developed countries HIV is predominantly transmitted heterosexually. The male to female ratio is 1:1.3 The much higher ratio of

women infected means that mother-to -child transmission is widespread. Transmission through contaminated blood, and blood products, is a also a much higher risk in less developed countries. Antiretroviral drugs, which are proving able to diminish the levels of the virus for many patients in the West remain very expensive and out of reach for the majority of those infected in less developed countries (Whiteside, 1998).

5. HIV/AIDS in Sub-Saharan Africa

Africa, and in particular sub-Saharan Africa, is the worst affected part of the world in terms of the number of people infected by HIV. Over the past decade approximately eleven million adults and one million children have been infected in Africa (World Bank 1996:1). One result of the epidemic has been a marked reduction in human development as measured by indices such as life expectancy. According to the UNDP:

> without HIV/AIDS the average life expectancy in Africa by 2000 would have been 62 years. Instead it is likely to fall to 47 years (UNDP, 1996:22).

By 2000 it is predicted that AIDS will also have reversed some hard-won gains in improved infant and child mortality in Africa. In Kenya and Uganda for example infant mortality rates are projected to increase by 50%, and child mortality rates to double (Hunter & Williamson, 1997:9). The United Nations Children's Fund has projected that

> AIDS will cause more deaths in African children than either malaria or measles (cited in World Bank, 1996:9)

Heterosexual contact accounts for over 80% of HIV infection in sub-Saharan Africa (Green, 1994:1) which means that women in African countries have been particularly hard hit. Studies from several African countries, including South Africa, have found peaks of prevalence of HIV in women to be in the age group 20- 24 years (Fleming, 1994:3). There are a number of reasons, both physical and social, why women are particularly susceptible to infection. Firstly, there is a greater likelihood of transmission

because semen is deposited inside the woman's body and remains in the vagina for some time. This results in a greater likelihood of infection (Van Niftrik, 1994:10). Secondly, women's socio-economic disadvantages, their dependence on men and their lack of power to negotiate safe sex all add to their vulnerability to infection (see inter alia Berer & Sunanda, 1993). These factors are exacerbated in much of Africa where poor genital health and high STD rates among women are endemic, where access for women to health services is poor, and where high rates of poverty increases the risks for women of sexual exploitation (Evian, 1994).

The high prevalence in young women of child bearing age is of particular relevance for the impact on children, not only because of the risk of transmission of the infection, but also because women play the major role in the care of children. WHO has estimated that by the year 2000 two-thirds of the 10 to 15 million children projected to be orphaned world-wide by will be in Sub-Saharan Africa (WHO, 1993a).

There are many reasons which help to explain why Africa has experienced such high levels of HIV and AIDS and there is considerable literature on the subject (see for example World Bank, 1996; Barnett & Blaikie 1994; Green, 1994; Panos Dossier, 1992). Some of the main areas:

1. Poverty has always been prevalent in sub-Saharan Africa, but the situation worsened for poor people in many African countries in the last two decades due to the impact of economic recession and the implementation of structural adjustment programmes. It has been generally accepted that under structural adjustment policies the poor have suffered more than the better off (Messkoub, 1992:184). There is a high correlation between poverty and the spread of the HIV virus. Poor people have little access to health care and thus cannot afford or do not have access to condoms or to treatments that would help to prevent the spread of the disease, such as treatment of STDs (Panos, 1992:10-11). As Hunter & Williamson (1997: 18) note:

communities with the highest infection rates are often the most impoverished and marginal because these are the conditions conducive to rapid HIV transmission.

Since poor people tend to have less access to television and radios their access to information about HIV/AIDS is likely to be limited (Panos, 1992:11). Poor people are also likely to be more concerned about where their next meal is coming from than to worry about contracting a disease that will kill them in many years time. AIDS also exacerbates poverty (Evian, 1994:7). People affected by HIV/AIDS are predominantly the breadwinners of a family, so as they become sick and lose their income the whole family falls into poverty.

2. Movement of people from one area of the continent to another has been a major factor in the spread of the HIV virus. HIV infection in sub-Saharan Africa was first reported in Central Africa and it spread rapidly along trade routes, with truck drivers and sex workers being particularly vulnerable (Schoepf, 1993:51). Labour migration is also prevalent throughout the continent. Poverty forces people to leave their families to look for work, often moving from rural to urban areas. Sexual patterns may be affected by the weakening of previously accepted sexual norms of behaviour (Evian, 1994:6).

3. Women in poor socio-economic circumstances are particularly at risk of HIV infection. Women's relative lack of power affects their access to resources and information (Seidel, 1996:2), it prevents them being able to negotiate safe sex, it makes them vulnerable to rape, incest and early sexual intercourse with older men and it forces many into prostitution (Van Niftrick, 1994:9).

4. There is a greater risk of transmission of HIV where people already have a history of STDs, particularly those associated with genital ulcerations. In Africa, with its generally poor level of available health services, STDs often remain un-diagnosed and untreated. Rates of infection are much higher than in western countries (Panos, 1992:9). In Zimbabwe in 1990, for example, over 900,000 cases of STDs were

treated, which is about a quarter of the adult population and studies suggest that there is little stigma attached to male STD infection (Bassett & Mhloyi, 1993:128).

5. During the 1980' and 1990's, the decades which have seen HIV/AIDS spread throughout the African continent, sub-Saharan Africa has been badly affected by wars, political and social instability and economic decline. Wars disrupt the social fabric of society, create refugees, disperse families and break cultural mores. Soldiers are separated from their families for long periods and sex has traditionally been considered one of the spoils of war. Disruption on such a scale affects attitudes to risk taking, alcohol, drugs and sex can be seen as an escape from a difficult existence (Panos, 1992: 13).

6. For political reasons many governments in African countries, particularly in the early days of the epidemic, did not respond to the challenges posed by the spread of the virus, but rather engaged in a variety of responses including:

> denial, disbelief, lying, bureaucratic smothering of concern, rejection of the knowledge that is incomplete on both the epidemic as well as its treatment, and reluctance to confront an unaffordable medical crisis (Fredland, 1994:7).

The social and economic conditions detailed above have created the conditions which have promoted the spread of HIV/ AIDS. At the same time HIV/AIDS will severely impact on many of the socio-economic gains which have been made in African countries. Among the socio-economic effects of HIV/AIDS are, a decline in the growth of GDP per capita, a reduction in the demand for labour, an increase in the number of impoverished households, an increase in child labour, overstressed social and health services, less access to health care and a decline in school enrolment (Hunter & Williamson, 1997:11).

6. HIV/AIDS in South Africa and in KwaZulu-Natal

AIDS was first reported in South Africa in 1982. It emerged initially in the white homosexual population, but by 1985 heterosexually transmitted cases of HIV infection had been found in migrant labourers working in the mines (Patel, 1995:1).The epidemic has spread most rapidly among African heterosexuals. Predictions by the World Bank suggest that by 2005 eight million South Africans will be infected and that 300 to 500 people will die from AIDS-related diseases every day (cited in Hartley, 1996a).

As noted earlier, predictions need to be treated with a degree of caution. Surveys of HIV prevalence perhaps give a better idea of the progress of the epidemic in the population. Since 1990 annual surveys have been undertaken in South Africa among women attending antenatal clinics in the public health sector. Although pregnant women cannot be taken to be representative of the population as a whole they are, by definition, sexually active, so surveys of this population act useful as an indicator of the spread of the epidemic. The 8th Annual Survey, in October/November 1997, showed an average 16% of the women surveyed to be infected by HIV. This represented a 13% increase in the prevalence level since 1996. The highest rates of infection were in women aged 20-24 (20%) and 25-29 (18%) (Department of Health, 1998). The figures also show wide provincial variations.

KwaZulu-Natal is the province most severely affected by HIV/AIDS. It has consistently led HIV prevalence rates. In 1997 the prevalence rate among pregnant women was 27%, a rise from 20% in 1996 (Department of Health, 1998). Not all areas of the province have been equally affected. The North Coast region, around Empangeni, is the most severely affected, followed by Northern KwaZulu-Natal (Department of Health, 1997:8). In the medical wards of King Edward Hospital, Durban at the end of 1996 nearly 50% of patients were HIV positive, while in Hlabisa Hospital, in the north of the province, 58% of TB patients were HIV positive (Mhkize, 1996).

Many of the reasons for the spread of HIV infection in South Africa are similar to those which explain the spread throughout sub-Saharan Africa. However there are factors which are specific to South Africa. Writing in 1994, shortly after the first democratic elections in South Africa, Dirks argues that:

> Because...of the apartheid system, South African society is still characterized by a number of unique social and economic factors which have influenced, and will influence, the spread of HIV in the future. These include poverty, differences of the social and economic conditions based on racial separation, the preponderance of men in urban centres, the migrant labour system that separates men and women from their spouses, the size of the migrant labour population, the large number of densely populated single sex dwellings, the still enduring political tension in the townships, the status of women... and the fragmentation of curative and preventative health services (Dirks, 1994:2).

Another factor related to apartheid which may have affected attempts to reduce the spread of the HIV virus is the reported belief in the African population that AIDS is an idea which has been promulgated by whites as a way of discouraging sex among blacks (Whiteside et al, 1995:29).

Reasons to explain why the epidemic has progressed further and faster in KwaZulu-Natal than the rest of the country have been given by Whiteside et al (1995:23). These include high levels of poverty and of labour migration leading to disrupted family life. To these factors can be added the existence in the province of two large ports and a number of major national and international road and rail transport routes. As these authors explain, only 19% of the population of KwaZulu-Natal earn more than the average per capita income and the male absentee rate due to labour migration stands at 19% overall, but is as high as 44% in certain areas. KwaZulu-Natal has also experienced many years violent political conflict, which is a further contributing factor to the spread of HIV/AIDS.

7. Children Infected with HIV

Without medical intervention approximately a third of children born to HIV positive mothers will be infected by the virus. Most of these will develop AIDS and die within a few years. The remaining two thirds of children born to mothers infected by HIV will be born HIV positive (that is they will test as HIV positive, having been born with their mothers' antibodies) but will not actually be infected by HIV. Research suggests that most infections in babies occur at the time of birth, or shortly thereafter through breastfeeding. Recent research has found that interventions such as elective caesarian deliveries and treatment with the drug AZT are effective in reducing the percentage of children who acquire HIV 'vertically' from their mothers (Khan, 1996; Mercury Correspondent, 20-2-1998). However such strategies are unlikely to be affordable or available to the majority of infected women in less developed countries, like South Africa. A number of cost effective methods, such as douching the vaginal canal during labour, are being tested (Khan, 1996).

On average, babies who are infected will develop AIDS by the time they reach between 9 and 18 months. Their chances of surviving thereafter varies between 3 months and 2 years. Although a growing number of children are reported to be surviving beyond five years, these remain the exception. In KwaZulu-Natal most do not live to see their second birthday (McKerrow, 1996a).

A United Nations report has estimated that nearly three million children under the age of 15 world-wide have been infected with the HIV virus since the epidemic began (cited in Naidoo, 1997). Figures for South Africa suggest that over 150,000 HIV infected babies were born between 1990 and 1996. 57,000 of these were born during 1996, of which 30% were in KwaZulu-Natal (Department of Health, 1997:13). Projections for KwaZulu-Natal estimate that there will be around 10,000 new AIDS cases per year in children aged 0 to 4 in the province by 2004. This assumes that there is no major change in medical interventions. However, it is suggested that the numbers could be radically reduced to around 3,400 if treatment with AZT was made available (Wood & Mason, 1997). Whilst any measure which improves the survival rate in

children is clearly very welcome, the quality of life issues also need to be addressed. The sad fact is that children not themselves infected but born to HIV positive mothers, are destined to become AIDS orphans.

8. AIDS and Orphanhood: Definitions and Quantifying the Problem

As noted earlier a degree of caution needs to be used in interpreting estimates and projections. This is particularly pertinent in discussions of orphanhood, since the definition of an 'orphan' varies from study to study. An orphan may be defined as a child who has lost either their father (paternal orphans), their mother (maternal orphans), or both parents (double orphans). Some studies (UNICEF, 1991; WHO 1993b) have focused on children who are motherless, or who have lost both parents, on the premise that many African children grow up apart from their fathers. However, Hunter &Williamson (1997:2) argue that figures which exclude the death of fathers do not fully convey the impact of HIV/AIDS on children (in Africa) for the following reasons:

> Single mothers are the most impoverished members of these societies, and their ability to support children without the assistance of the father is very limited.
>
> In many societies, children whose fathers die of AIDS often lose their mothers soon after due to illness and social forces.
>
> In most of these countries, the social safety net provides only limited assistance to widows and their children.

Another problem in considering estimates and projections of orphanhood lies in the definition of a 'child' in relation to the upper age, which varies in the studies from 14 years in some to 18 years in others. The following projections are therefore presented with these provisos in mind.

In 1993 the World Health Organisation estimated that between 10 and 15 million children world-wide would be orphaned by AIDS or AIDS related diseases by the year 2000 and that two thirds of these would be in sub-Saharan Africa (WHO, 1993b). By mid 1996 it was estimated that 9 million children world-wide had already lost their mother to AIDS, over 90% of whom were living in sub-Saharan Africa (UNAIDS, 1996 in Foster, 1997:1).

A study of 23 countries severely affected by HIV/AIDS (including 19 in sub-Saharan Africa) has estimated that 15.6 million children in those countries will have lost either their mothers or both parents by 2000. By 2010 that number will have increased to 22.9 million. When paternal orphans are included in the projections the figures rise to 34.7 million in 2000, and 41.6 million in 2010 (Hunter & Williamson, 1997:1-2).

Gregson et al (1997:35) have projected rates of maternal orphanhood for children under 15 years for Kenya, Zimbabwe and South Africa. They estimate that by 2010 Kenya will experience a maternal orphanhood rate of 16%, while Zimbabwe will face a much higher rate at 34%. They considered a number of different scenarios for South Africa, based on different levels of behaviour change. Given a very optimistic degree of behaviour change (based on a 75% use of condoms in all casual relationships) they estimate a maternal orphanhood rate of 14%. However, given very little behaviour change, the maternal orphanhood rate in South Africa could reach 31% by 2010.

Two projections of AIDS orphanhood for KwaZulu-Natal have been made by Whiteside et al (1995:49) The definition of an AIDS orphan used in this study is a child under the age of 15 who has lost its mother through AIDS. According to the first projection, there will be 250,330 AIDS orphans in the province by 2000, with this figure rising to 921,610 in 2014. According to the second model, the figures would be 197,490 and 874,460 respectively. (It should be noted that these figures exclude children orphaned through causes other than AIDS.)

In contrast to projections of rates of orphanhood, which are made by mathematical formula, enumeration studies involve the direct counting of orphans. The importance

of enumeration has been emphasised at a number of international conferences on AIDS orphans. The benefits of enumeration have been identified as galvanising policy makers, attracting financial aid and encouraging people to look for solutions from local resources (UNICEF, 1991:8). However, in order to avoid stigmatisation the importance of evaluating the needs of all vulnerable children, not just AIDS orphans, has been stressed. Following these recommendations a growing number of enumeration exercises have been reported (Hunter & Williamson, 1997:18). These have tended to be in areas of sub-Saharan Africa where the epidemic is furthest progressed such as Malawi (Phiri, 1998), Uganda, Zambia and Zimbabwe (McKerrow, 1997a). Few enumerations have as yet been done in South Africa, an exception being a study in the Pietermaritzburg district of KwaZulu-Natal (McKerrow & Verbeek, 1995).

A number of trends emerge from studies of AIDS orphanhood. Firstly there has been an initial predominance of paternal orphans over maternal orphans as fathers tend to have been infected by HIV earlier than mothers (Webb, 1996a:8). This is set to change over time as more women develop AIDS and die. Secondly, there is a difference in the experiences of paternal and maternal orphans after the death of the first parent, since surviving fathers are much less likely to care for orphans than surviving mothers. For example, a recent study in Zambia of 300 orphans in 95 families found that only 6% of fathers were providing care to maternal orphans. These orphans were mostly being cared for by other relatives (Webb, 1996b). Thirdly, in addition to the impact of orphanhood on the individual children and their families, the growing number of orphans has a deep impact on the society as a whole. As Hunter & Williamson (1997: 3) point out:

> With orphans eventually comprising up to a third of the population under 15 in some countries this outgrowth of the HIV/AIDS pandemic may create a lost generation - a large cohort of disadvantaged, undereducated, and less than healthy youths. The threat to the prospects for economic growth and development in the affected areas is considerable.

9. Conclusion.

The AIDS epidemic in South Africa is a few years behind that in other countries in Southern and East Africa. However, rates of HIV infection in South Africa continue to rise and, in badly affected provinces like KwaZulu-Natal, will soon be on a par with some of the worst affected countries in the world. The heterosexual nature of transmission of the virus has particular implications for women and children. In the next few years an unprecedented number of children in KwaZulu-Natal will be affected by HIV/AIDS, and will need some form of alternative substitute care, either within or outside of their extended families. The AIDS epidemic will severely test the potential of welfare policies which promote 'developmental social welfare' and 'community care'. These policies rely heavily on the provision of care by the extended family, more specifically on the voluntary labour of women. Many women who would have been available to provide that care are women who will be affected by HIV/AIDS. Quite apart from being able to be the carers, these women will themselves need care.

Even before the advent of HIV/AIDS extended family networks in South Africa had been put under severe strain. Many of the socio-economic policies implemented throughout the 20th Century, culminating in the policies of apartheid, progressively disrupted family life, separating men from their wives and parents from their children. The next chapter views the effect of these policies on family life in South Africa. It then considers the impact which the HIV/AIDS epidemic has on children and the new challenges which it poses for the caring capacity of the extended family.

CHAPTER 5

WELFARE POLICY IN CONTEXT: CHALLENGES TO FAMILY LIFE - POVERTY, HIV/AIDS AND ORPHANHOOD

1. Introduction

This chapter looks at contemporary family life in South Africa and at the impact of the HIV/AIDS epidemic on children and their families. The last chapter presented mainly cold statistics, this chapter looks at the implications of the epidemic in human terms. It highlights the context of family poverty and family disruption within which policies which promote 'developmental social welfare' and 'community' care must be implemented. It aims to provide an understanding of the context within which the case study organisations in the empirical research which follows were operating. The chapter begins by looking at the changing nature of family life in South Africa and at the factors which have influenced change. It considers some of the stress factors which apartheid and pre-apartheid policies have had on family life, in particular on women and children. Particular reference is paid to the majority African population, because it is they who have been most adversely affected by past policies and who are now most severely affected by the AIDS epidemic.

The second part of the chapter considers new challenges for family life created by the HIV/AIDS epidemic. It focuses specifically on the implications for children and for their carers. As South Africa has yet to move to the phase of the epidemic in which many children are left orphaned this section draws on literature from African countries where the epidemic is further progressed. It mainly concentrates on the care of children by their kin, since literature relating to care by non-kin (through adoption and fostering) is considered in conjunction with the relevant case studies in chapters 7and 8.

2. Industrialisation, Migrant Labour and Apartheid: Implications for Family Life

In South Africa, as throughout the African continent, the extended, rather than the nuclear, family has been the norm. In traditional African society the extended family was, in economic terms, the unit of production. In addition to giving parents emotional satisfaction, children born into a family were regarded as an economic asset to the family as a whole (Pakati, 1984:14). As such, children were expected to perform useful tasks in the home from as early as possible, such as caring for younger children, or working in the fields (White & Woollett, 1992). Children were also assured of care and protection within the extended family should their parents die.

> For generations the extended family system, so prevalent throughout sub-Saharan Africa, has met most of the basic needs of children and provided a protective social environment in which they could grow and develop. Kinship systems have dictated various social, economic and religious obligations towards the family lineage as well as the social and material rights of the individual, especially of the children, within the lineage. Consequently, on the death of a biological parent the continued care of a child, within the extended family was guaranteed (McKerrow and Verbeek, 1995: 3)

Marriage is crucial to the continuation of a family since it determines rights of succession and inheritance of property through the 'legitimation' of children. In most Southern African societies patrilineal descent is the norm. The payment of a 'bride price' by the husband to his wife's family marks the transfer of the wife from her father's to her husband's family. In traditional Zulu marriages, for example, the payment of the 'bride price', or 'lobolo', has a bearing on determining to which family a child belongs. The payment of 'lobolo' upon marriage means that any child born to the woman would 'belong' to the father and the father's family. However, being the natural father of a child did not give a man any claim to that child unless he had paid 'lobolo', even if he was married to the mother. Illegitimate children were normally accepted as

part of the mother's family which assured that their needs too would be met (Pakati, 1984:13).

During the early 20th Century South Africa experienced a process of rapid economic and political change which impacted directly on many aspects of traditional African family life. In the first three decades of the Century a range of legislation was enacted which barred Africans from being employed in certain jobs, prevented them from buying land outside of specified areas and restricted their presence in urban areas (Lund Committee, 1996:15). Racially-based policies became progressively more restrictive after 1948 with the implementation of apartheid and the creation of Bantustans. Measures such as the The Population Registration Act and the Group Areas Act first classified everyone into a 'racial' category and then forced each group of people to live in specifically allocated areas. Many families were uprooted and disrupted through compulsory population relocations. Countless numbers lost their land and their means of livelihood. Africans were not permitted to stay in an urban area for more than 72 hours unless they had 'legal' work or were married to a man who had the necessary permission.

In order to pay the hut tax a growing proportion of African men had to move from the rural areas to work in the mines where they lived in hostels or townships. Women and children were left behind in the rural areas creating the situation today in which the majority of rural women live in women-headed households (Segar & White, 1992:62). When these women found it impossible to survive on the remittances that were sent back, they moved to urban areas to look for work. By the 1980's an estimated one in four women were separated from their husbands (Simkins 1983, cited in Zille, 1986:143). This level of separation not only disrupted marriages but also led to serious dislocation for children. (Burman, 1986:5). Many women who moved from the rural areas to seek work took employment as domestic workers and were not permitted to have their children to live with them. Such children were left behind with elderly parents or other relatives. In the past couple of decades, with the gradual relaxation of restrictions on movement women have taken their children with them to live in squatter camps on the edge of urban areas, or to live in hostels (Reconstruction and

Development Programme, 1996). Jones (1992) has graphically captured the life histories of 24 children who were raised in a hostel environment. The interviewees all described a childhood of inconsistent parenting, of high levels of movement between successive care-givers and personal uncertainty. Jones concludes that:

> Migrant labour has decimated African family life. In doing so it has robbed ... children (of) full access to the normal family membership which traditional African society provided for them (1992:272).

A rural way of life, in the sense of agricultural land with farms and villagers engaged in subsistence farming, such as is found in the rest of sub-Saharan Africa, no longer exists in most of South Africa. Apartheid policies created a situation in which 11 million Africans were crowded into areas which were too small to sustain them. These overcrowded conditions turned the rural areas into unproductive and environmentally degraded areas (Reconstruction and Development Programme, 1996:11). The rural population consists predominantly of those who are too old or too young to seek work. Many of these are women and children living in multi generational households. Those caring for children in rural areas have poor access to basic services such as primary health care, clean water or electricity. Children and their carers are exposed to the risks of poor sanitation and water supply. 17% of households in rural areas have to fetch water from more than one kilometre away, a task normally undertaken by women (Reconstruction and Development Programme, 1996:19).

Poverty is, however, not confined to rural areas. Associated with progressive urbanisation is a severe lack of accommodation and of inadequate facilities. Hirschowitz et al (1994:73) have described the South African urban environment as:

> characterised both by broken or internally separated families, by overcrowding and squalor and under-serviced townships. There is a widespread lack of access to services such as refuse removal, and to infrastructure such as sewers, water and electricity.

A large proportion of the urban population of South Africa live in townships, but a growing number also live in informal settlements on the periphery of towns and cities. Durban, for example, is thought to have the second largest informal settlements in the world after Mexico city (Durban Central Residents Association, 1993:6). Nearly a third of the population of Durban live in informal and peri-urban dwellings where there is a serious problem of overcrowding (Urban Strategy Department, City of Durban,1995:22). Homelessness is a reality for many urban dwellers. A survey undertaken in Durban in 1993 found that there were between 3,000 and 3,500 people living on the streets, 7% of whom were under 20 (Durban Central Residents Association, 1993: 9-11). Recent estimates of the numbers of children living on the streets of Durban suggest that there may be as many as 2,000 (Van Niekerk, 1996).

For many urban children, civil disturbances, violence and crime are a daily experience which intrude on family life (Richter, 1994:36). According to a UNICEF report 75,000 children were displaced by political violence between 1990 and 1993, mainly in KwaZulu-Natal and Gauteng (cited in Reconstruction and Development Programme 1996: 83). Such children will have experienced the damaging effects of moving to and from rural and urban areas and from one care giver to another, with no sense of permanence or security.

3. Poverty and Family Life in South Africa

Despite the political changes in South Africa since 1994, South Africa's wealth remains concentrated in the hands of the white minority. The distribution of income and wealth remains one of the most unequal in the world. According to a recent report on poverty and inequality (May, 1998:2) the poorest 40% of households receive only 11% of total income, while the richest 10% of households receive over 40% of total income. According to the same report poverty is not restricted to any one 'race', but is predominantly found among Africans (61%) and coloureds (38%), compared with 5% of Indians and 1% of whites. Most of the poor live in rural areas. Although only 45% of the population is rural, these areas contain 72% of the total population who are poor (May 1998:2). Women and children are especially vulnerable to poverty,

particularly in rural areas. The poverty rate among female-headed households is 60%, compared with 31% for male-headed households, while three children in five live in poor households (May, 1998:3).

Access to a job, which is the main route out of poverty, is a major problem for a large proportion of the South African population. 55% of people from poor households are unemployed (May, 1998:3). The unemployment rate for Africans is reported to be nearly ten times the unemployment rate for whites (Reconstruction and Development Programme, 1995). Unemployment figures also show a gendered pattern, with women, and particularly rural women, forming a significantly larger proportion of the unemployed (Valodia, 1996:56). Poverty has serious implications for contemporary family life in South Africa as the following quotation portrays:

> Poverty typically comprises continuous ill health, arduous and often hazardous work for virtually no income, no power to influence change, and high levels of anxiety and stress. The absence of power is virtually a defining characteristic of being poor, and is worsened for women by unequal gender relations. Poverty also involves constant emotional stress, and often public and domestic violence. Time is an important cost for the poor, especially for women, who are often solely responsible for child-care and domestic work; long working hours are exacerbated by seasonal demands (May, 1998: 3).

4. Trends in South African Family Life

According to a census in the Cape in 1904, marriage was the norm for Africans in South Africa. By 1960 however, marriage rates had declined considerably and they fell again between 1960 and 1980 (Simkins & Dlamini, 1992: 67). Alongside the drop in marriage rates there has been a corresponding rise in the number of female-headed or multi-generation households, consisting of grandmothers, unmarried daughters and their children (Simkins, 1986:16-42). There has also been a rise in the number of children born outside of marriage, or other formal partnerships. Burman & Preston-

Whyte (1992: xiv) note that caution needs to be paid to statistics on 'illegitimacy' as there are question marks over the accurate gathering of statistics and there are many forms of marriage and unions practised in South Africa, not all of which are recognised by the state. However, even with these provisos, rates of children born outside of formal unions have risen sharply (Burman & Spuy; cited in Bulletin for Human Sciences, 1996).

Many children are raised by single women. These households are commonly amongst the poorest in any society (Segar & White, 1992:6). Social security benefits for single parents in South Africa are minimal. Women are expected to be dependent on a male provider and to obtain financial support towards the care of their children from the father(s) through the courts. Such applications are subject to serious bureaucratic delays and leave women vulnerable to abuse by the fathers, thus many women have to rely on their own resources or those of their family for their survival (Lund et al, 1996:105).

Many never-married young women become pregnant as teenagers. There is a high incidence of teenage pregnancy in South Africa, particularly among African youth (Hirschowitz et al, 1994:91). Reasons include poor access to sex education and contraceptive services, but also cultural factors. Studies (Wood et al, 1997; Preston-Whyte & Zondi, 1992) suggest that teenage pregnancy is linked to pressures on young African women to prove their fertility. Unmarried motherhood therefore appears not to be such 'an unmitigated disaster' (Preston-Whyte & Zondi, 1992: 226) for young African mothers, as it might be in some other settings. Nevertheless high levels of teenage sexual activity have implications for the spread of STDs and HIV/AIDS. Early pregnancy impacts on young women and their offspring in other important ways. Pregnant schoolgirls may be unable to complete their schooling, and since there is a strong correlation between level of education and standard of living (May, 1998:3), this has long-term economic implications for them. Teenage mothers may not be either ready or able to provide care to their children. Children born to young mothers may not be accepted by subsequent boyfriends, or those boyfriends' families (Burman,

1992:30). These children therefore run the risk of a life of insecurity, being passed from one relative to another (Loening, 1992: 83).

Many African children spend at least a period of their childhood living apart from one or both parents (Jones, 1992; Simkins & Dlamini, 1992). Substitute care for the majority is provided by the extended family. Studies have shown quite high rates of mobility of children within extended families, with children moving from one carer to another and between rural and urban settings. A study in KwaZulu-Natal found 19% of children under the age of 17 to be living apart from their mother. Over 90% of those children were being cared for by close relatives. The research also found that a little over a quarter (27.4%) of all households surveyed included children who were not living with their own parents (McKerrow & Verbeek, 1995: 20-21). One explanation for the high rate of children living apart from their parent(s) is that frequent and lengthy separations of partners lead to high numbers of children born outside of formal partnerships. Thus:

> A frequent occurrence is that a mother has a child with one partner, out of a formal union. When she has a child later with another man, he will not agree to care for another man's child. She leaves the child, or children, with her own mother, or aunt, or other traditional guardian (Lund Committee, 1996:17).

A minority of children experience permanent separation from their parents, living on the streets, in children's homes or foster homes. Some of these children have been abandoned. Abandoned children are particularly likely to need some form of care outside of the extended family. The identity and family background of abandoned children is normally not known, making it impossible to seek alternative care for these children through the extended family. The problem of child abandonment can be found in many societies and is not new to South Africa. Nevertheless abandonment is reported to have been on the increase since the 1970's (Pakati, 1984:33). During 1990 for example, 300 African infants were abandoned in the hospitals of KwaZulu-Natal (Loening, 1992:84). In 1989 approximately 70 abandoned children were living in one

hospital near Pietermaritzburg (Thandanani, 1996). Between 1991 and 1995 Durban Child and Family Welfare Society dealt with 544 abandoned children (Ledderboge, 1996:2). Reasons for child abandonment include poverty, a negligible social security system, lack of accommodation, unemployment and stigma. Other contributory factors may be knowledge of, or fear by, the mother that she is HIV positive, is unable to access legal abortion or is un-informed about alternative services, such as adoption and fostering. Many abandoned children are born to adolescent mothers (Loening, 1992:84). One study in KwaZulu-Natal attributed the increasing incidence of child abandonment to the breakdown of the extended family and the weakening of traditional cultural values (Shazi, 1993:15).

5. The Impact of HIV/AIDS on Families

AIDS is a new, but very significant factor affecting family life. As yet the full impact of the epidemic on families in South Africa has still to unfold, and little has been documented. Although acknowledging contextual differences, the impact of AIDS on children and their families in South Africa is likely to be similar to the impact in other parts of Africa. This section therefore draws heavily on relevant literature from sub-Saharan Africa.

Unlike other epidemics, which typically affect the old and the young, the HIV virus in Africa infects young adults, those who are most sexually active. These are the breadwinners, the generation upon whom children and the elderly depend for care and support. The literature suggests that, even in African countries where HIV/AIDS has created a large increase in orphanhood, most orphans continue to be absorbed into the extended family, in particular through the efforts of female kin (Ankrah, 1994; Konde-Lule et al, 1995; Drew et al, 1996b; Webb, 1996a). Some writers note that, despite HIV/AIDS and high levels of poverty the African extended family has proved able to provide children with a stronger safety-net than in other regions of the world (Hunter & Williamson, 1997:17). However, many writers also express considerable concern, whether the extended family can continue to absorb ever-growing numbers of orphans

without financial and practical assistance (UNICEF, 1991:3; Fleming, 1994:4; Barnett & Blaikie, 1994:112; Whiteside, 1996b:11; Hunter& Williamson, 1997).

In many areas of Africa levels of poverty, already very high, have been worsened by the AIDS epidemic. Extreme levels of poverty among households caring for orphans is common (Drew et al, 1996a: 1). However, the economic impact on HIV/AIDS-affected households begins long before children are orphaned. HIV/AIDS reduces the time adults have to spend on income generating activities, while at the same time creating extra expenses, such as medicines and health care. According to Hunter & Williamson (1997:16) households affected by HIV/AIDS typically spend a year's income meeting funeral costs. AIDS counsellors and social workers are seeing an increased likelihood of breakdown in marriages and partnerships linked to HIV infection. AIDS counsellors in Zambia, for example, found that 30% of AIDS-affected families were already headed by single parents (predominantly single women) before the parent's death (UNICEF, 1991:12).

Children from HIV/AIDS affected families who have been born and brought up in urban environments, are frequently sent to live with relatives in rural areas. This increases the dependency ratio of rural households and compounds problems of rural poverty (UNICEF, 1991:5; Webb, 1996a: 9; Hunter & Williamson, 1997:17). This is not necessarily a new phenomenon although urban to rural migration is more common. In South Africa, children have often been sent to stay with grandparents in rural areas for a variety of reasons, such as to escape violence in the townships. Anecdotal evidence from AIDS counsellors, however, suggests that children in KwaZulu-Natal are now increasingly moving from urban to rural areas as a consequence of HIV/AIDS (Towell, 1996).

The burden of caring for orphans is provided mainly by women (Drew et al, 1996a; Webb, 1996a; Urassa et al, 1997). Women often lose their rights to property and goods on the death of their husband, which means they have few assets, and scant access to resources (Hunter & Williamson, 1997:17). Much of the extra economic strain created by HIV/AIDS, as well as the physical and emotional strain, is thus being

absorbed by women, many of whom are elderly. Studies show a high incidence of orphan households are headed by grandparents (Mukuyogo & Williams, 1991:12; Foster et al, 1995:7; Urassa et al 1997:4). Up to half of some countries' orphans are looked after by grandparents (Holt, 1997). Again these are predominantly grandmothers. Although grandmothers have traditionally provided care to orphans and other children separated from their parent(s) the AIDS epidemic has meant that they are relied upon more than ever:

> At each stage in the cumulative toll of deaths among its productive members, the wider family has to adjust, making arrangements to cope with offspring left behind. Within the extended family, options dwindle as one parent's death succeeds another and elderly relatives find themselves obliged to look after several sibling groups (UNICEF, 1991:5).

There are a number of problems relating to an over-reliance on grandparent care. The following were identified by Barnett & Blaikie (1994:119) in Uganda. Firstly, and most importantly, the next generation of grandparents will be severely depleted by AIDS. The children of AIDS orphans simply will not have any grandparents, so this source of care will not be available in the longer term. Secondly, many grandparents lack the energy to grow food or cultivate crops for market, so household nutritional status falls. Households headed by older grandparents are thus vulnerable to malnutrition and infectious diseases. Thirdly, many grandparents have problems in the 'discipline' of orphans, for instance getting them to school on time. Finally, many grandparents are unable to afford school fees, so orphans drop out of school.

6. Impact of HIV/AIDS on Children

All children have the same basic needs. These include food, clothing, shelter, health care, education/socialisation and emotional support. Children who are separated from a parent are more likely than other children to risk deprivation in one or more of these areas. Children orphaned by AIDS face additional problems. Firstly the slow onset of

AIDS means that children have to watch their parents go through a long period of gradual deterioration and wasting and, since many people die at home, even young children are faced with the responsibility for nursing a terminally ill mother or father (UNICEF, 1991:10; Jackson,1992:163). Secondly children who have lost one parent to AIDS often lose the second parent shortly afterwards thereby compounding the effects of bereavement (Barnett & Blaikie, 1994:7). Thirdly the secrecy and stigma surrounding HIV/AIDS means that parents are less likely to call on wider family help in the fear that the nature of their illness will be revealed, thereby putting more responsibility on their children. And finally, stigmatisation puts AIDS orphans at greater risk of being rejected or abandoned by their kin if the cause of the parent's death becomes known (UNICEF, 1991:11).

Children living in HIV/AIDS affected households become vulnerable and needy long before they become AIDS orphans (Jackson, 1992; Smart, 1995; McKerrow;1994). Mukoyogo & Williams (1991:8) have identified a number of ways in which children are at risk in terms of their health and welfare long before either parent dies. These authors describe a gradual deterioration in the economic security of the family as the breadwinner(s) become sick and unable to work. This leads to an increased risk of children dropping out of school because parents are unable to afford the fees and other expenses. A process of role reversal then begins in which the child tries to find ways (both legal and illegal) of bringing in income and adopts a caring role for the parent. As the parent becomes more sick there is a progressive deterioration in the standard of health care and nutrition which they are able to provide for the child.

Despite predictions of the expected rise in orphanhood from dating back to the early 1990's, remarkably little research has been undertaken into the impact of AIDS orphanhood in Africa. The lack of academic recognition of the orphanhood issue was noted by Fleming & Fleming (1993:7) who calculated that only 1% of communications at the Yauonde conference on AIDS in Africa in 1992 were addressed to orphans, though this was marginally better than the 0.3% at the international conference on HIV/AIDS held in Amsterdam in the same year. Although there has been some improvement since then, most notably into the health implications of orphanhood,

much of the available data is from small-scale research studies, or from the observations of those engaged in working with orphans, such as NGOs, paediatricians and social workers.

Organisations working with orphans have found that they are more prone to infections and are less likely to receive health care than other children. Young children who are cared for by grandmothers are considered to be particularly at risk (Mukoyogo & Williams, 1991:15). Orphaned children living with relatives may also receive less health care than natural children within a family (UNICEF, 1991:13). One study found that orphans may even be more disadvantaged in receiving health care than non orphaned foster children in the same household (Urassa et al, 1997:4).

A large study by the World Bank supports these findings (cited in Webb, 1996c: 9). This study, undertaken in Tanzania between 1991 and 1993, found an adverse impact on the nutritional status and growth of young orphaned children. Orphans were found to be more likely to be stunted (low height for age) than non orphans, although the incidence of wasting (low weight for height) was not much different. Children who had lost a father and those who had experienced a recent adult death were more likely to be stunted .

The death of a mother has been found to be linked to an increased incidence of child mortality. A study in Malawi found that maternal death resulted in orphaned infants and children having a three times greater risk of dying (Taha et al, 1995). For children who are bereaved there are few more devastating experiences in life than the loss of a parent. For children living in AIDS affected families the trauma of bereavement may have been experienced several times with the loss not only of parents (frequently after a protracted illness), but also of one or more sibling. Grief produces often overwhelming emotions, fear, anger, sadness and guilt. A child's grief is often denied or ignored and as a consequence s/he may develop one or more negative behavioural and psychological reactions. Such children often underachieve at school, others seek solace in drugs, alcohol or sex, thereby increasing their own risk of becoming infected by HIV (Mukoyogo & Williams, 1991; UNICEF, 1991; Ali, 1998:1).

One particularly important consequence of orphanhood in some parts of Africa is the risk that children will lose their right to claim inheritance to land and property. Problems in this regard may well begin once the male head of a household dies, as widows often lose their rights to land and property due to the absence of laws which protect women, a lack of access of women to legal advice and assistance or traditional customs and practices which disadvantage them (Lusaka Workshop, 1994:11). The risk of disinheritance to orphaned children is likely to be even greater. One orphans' project in the Rakai district of Uganda, reported that in 40% of families looking after orphans, the children entered their guardians' home with no resources of any kind (UNICEF, 1991:12). A study of 211 families caring for orphans in Zimbabwe did not find evidence for a high level of 'property grabbing' by relatives who were providing for the care of widows and orphans, despite many anecdotal reports of its occurrence. 76% of the families in the study reported that children had inherited property, while only 15% reported that property had been taken by relatives. The authors sound a note of caution, however, since the responses to the questions were often obtained from a relative 'who might have a vested interest in presenting the facts in a certain way (Drew et al, 1996a:82).

Many children in Africa face the prospect of being unable to complete their education due to poverty. Studies have shown that orphans are more likely to drop out of school than other children (Hunter & Williamson, 1995:14). One study in Zambia found that the proportion of orphans who were not enroled at school in an urban setting was 32%, compared to 25% of non-orphans. The situation was even worse in the rural areas where the rates for orphans not attending school were as high as 68%, compared to 48% of non-orphans (cited in Webb, 1996a:9). Girl orphans in Uganda have been found to be especially disadvantaged, this is attributed to the lower value placed upon female education, plus expectations that girls will assist in household duties and adopt caring roles (Konde-Lule et al, 1995).

In Tanzania many AIDS orphans are reported to have either dropped out of primary school or not to have started at all (Mukoyogo & Williams, 1991:14). However another Tanzanian study, which compared the position of orphans both with children

living with their own parents and with non-orphaned foster children, found similar rates of schooling for all three groups of children in the younger age range. The rates only fell significantly for boy orphans after the age of 12 and girl orphans after the age of 15 (Urassa et al, 1997:7). Interestingly the schooling rates for older non-orphaned foster children were similar to those of the orphans, which acts a reminder that all children who are separated from their parents are likely to experience disadvantage.

In some African countries AIDS has produced a situation in which there is no-one remaining within an extended family who is able or willing to care for orphaned children (Berer & Sunanda, 1993; Barnett & Blaikie, 1994; Foster et al, 1995; Foster, 1997). This has led to a rise in 'child headed households'. These have been defined as households:

> in which the caregiver responsible for the day-to-day supervision of younger children (including bathing children, dressing them, preparing meals, dealing with minor illness etc) is under the age of 18 years but is not their biological mother or father (Foster 1997:4).

Child-headed households have probably always existed in Africa, particularly at times of social dislocation such as war or famine, but a recent growth in incidence in Uganda, Tanzania and Zimbabwe has been linked to the AIDS epidemic (Foster, 1997:4). Interestingly, however, very few have been noted in Zambia, despite the high rates of HIV infection there (Foster, 1997; UNICEF, 1991; Barnett & Blaikie, 1994; Webb, 1996a).

Children who have lost both their parents may prefer to remain in their own household. This arrangement may have certain benefits. It can provide the orphans with a sense of continuity and security, ensure that they are not separated and improve their chances of retaining their rights to the family land or property. However there are also many problems associated with this arrangement. These households have been found to be a highly vulnerable group. According to Foster (1997:10) problems associated with child headed households are:

lack of adequate supervision and care
stunting and hunger
lack of adequate medical care
educational failure
psychological reactions
disruption of normal childhood/ adolescence
exploitation
early marriage or union
delayed marriage
discrimination

Where young children have been left to fend on their own, the age and gender of the eldest child have been found to be critical to their well-being. Writing of the situation in Uganda, Barnett & Blaikie found that:

> Even when girls are as young as 12, meals are cooked, water is fetched and some limited cultivation takes place. In contrast, with boys of the same age, concerned village women have often had to intervene to stop them having to beg for food and to avoid malnutrition (1994:117).

However there are consequences for these girl carers who may have to drop out of school in order to provide care to younger siblings (Konde-Lule et al, 1995), who have to prematurely adopt an adult role and who are especially vulnerable to economic and sexual exploitation (Smart, 1995:19; Foster, 1997:15)

The following quotation, taken from Zimbabwe community workers graphically sums up the experience of many orphans where support for them and for their carers is not available:

> Generally orphans are 'living an unhappy life.' They are reported to be neglected, suffer a lack of care, are not properly fed and have health problems. Often the carers do not provide school fees or uniforms, and

> the orphans cannot go to school, they will be required to do many chores at home first and thus often arrive late for lessons. Even very young children would be put to do some tasks. Continual hard work at home plus beatings, etc, may turn the orphan into a juvenile delinquent or cause them to run away and become street children, engage in petty stealing and end up behind bars (cited in Jackson, 1992:164).

7. Conclusion

This chapter has viewed contemporary family life in South Africa and has considered some of the factors which have brought about changes to more 'traditional' patterns of family life. It has focused in particular on the experience of African women and children. In addition the chapter has considered the impact of HIV/AIDS on children and their families, mainly through a consideration of literature detailing the experience of African countries where the epidemic is further progressed. It has discussed the importance for children of a strong extended family and has suggested that the African extended family is remarkably resilient. Nevertheless, evidence has also been presented concerning the negative effects of orphanhood on children, which suggests that there is little room for complacency.

Studies of HIV/AIDS and orphanhood generally agree that there is an urgent need for the development of community-based interventions which effectively target assistance to vulnerable children and families. This chimes closely with South African welfare policy which calls on welfare organisations to develop initiatives which are 'developmental' and 'community' oriented. To date, however, very few community-based initiatives focussing on the needs of HIV/AIDS-affected children have been developed in South Africa. Still less research has been undertaken which analyses the experiences of such initiatives. The present research aims to fill this gap. The first of three case studies is presented in the chapter which follows. It looks at a community based project to support HIV/AIDS-affected children.

CHAPTER 6

DEVELOPING A COMMUNITY-BASED PROJECT TO SUPPORT HIV/AIDS AFFECTED CHILDREN: A CASE STUDY OF THE THANDANANI ASSOCIATION, AIDS ORPHANS PROJECT.

1. Introduction

The White Paper for Social Welfare (Department of Welfare, 1997) spells out the importance of re-orienting the South African welfare system to one based on the principles of 'developmental social welfare'. Among the major goals of the new welfare policy are the building of 'human capacity and self-reliance'. Individuals and 'communities' are to be helped to find ways to be 'creative' and to find new ways to 'achieve their aspirations' (1997:preamble). For those individuals in need of care the emphasis is on community and family-based care rather than expensive residential facilities. For the majority of children, substitute care will mean care by the extended family (1997:41). Nevertheless the HIV/AIDS epidemic is placing increasing pressure on South African extended family networks already severely weakened by high levels of industrialisation and migrant labour, poverty and decades of apartheid policies. As the White Paper acknowledges:

> The majority of South African families and children live in unhealthy, unsafe disadvantaged communities (1997:39).

The previous chapter presented literature from countries of sub-Saharan Africa which showed how HIV/AIDS places severe strains on traditional family support networks. If South African children affected by HIV/AIDS are to receive an acceptable quality of care, and are not to be left to fend for themselves, extended family carers will increasingly need some form of support.

Child care organisations in South Africa have tended to operate predominantly in the 'welfarist' tradition, providing institutional care and remedial/ rehabilitative services. For organisations such as these, a major shift of philosophy and in methods of delivery

will be required if they are to adopt the developmental strategies envisioned in the new social welfare policy. There is virtually unanimous agreement in the literature that the only viable option for the care of HIV/AIDS affected children is the development of community-based programmes. This chapter presents the empirical data collected in respect of the first of three case studies. It looks at the implications for one non governmental organisation, The Thandanani Association, as it implemented a changing welfare policy and faced up to the challenge of AIDS. It explores what it meant in practice for this organisation, which was founded on welfarist principles, to develop service delivery along the lines espoused in the White Paper and to change its approach from 'doing welfare' to 'doing community development'.

The case study data is discussed with reference to literature on community-based programmes to support AIDS orphans, mostly from other parts of sub-Saharan Africa. Models of support which operate successfully in one context may not be appropriate in another, since cultural practices even within one country may vary from district to district (Drew et al, 1996b: 85). However, culture is not a static concept and, whether in Africa or elsewhere, people do not always operate in accordance with 'traditions'. There is, moreover, an increased likelihood that adaptations will be made to cultural norms and modes of behaviour when people are faced with extreme situations such as that produced by the AIDS epidemic. In Rakai, Uganda, for example, orphans are now being cared for by step-mothers and by lone fathers, both of which are unusual practices for the Ganda people (Barnett and Blaikie, 1994:111&113). So, whilst models of care need to be developed which are appropriate for South Africa, it is valuable to see what might be learned from the experience of other African countries.

The non governmental organisation (NGO) sector is at the forefront of efforts to tackle the HIV/AIDS epidemic in South Africa, as it is in the rest of Africa. Since both case study organisations involved in this research were NGOs, a brief discussion of the role of NGOs, has been included.

2. The Role of Non Governmental Organisations in Child Welfare

South Africa, in common with many other parts of Africa, has long been heavily dependent on NGOs, community based organisations (CBOs) and religious groups, for the provision of social welfare. The White Paper for Social Welfare recognises the important role which NGOs play in the delivery of social welfare. It notes the positive qualities of NGOs as their ability to:

> Innovate and pioneer new services and programmes, which if successful, (can) be replicated on a wider scale.
>
> Respond to local needs.
>
> Respond speedily, appropriately and flexibly to local needs.
>
> Promote grass-roots participation in decision-making and direct service delivery.
>
> Represent their particular constituencies on structures, such as policy-making and co-ordinating programmes, at all levels of government to ensure that interventions are appropriate.
>
> Mobilise communities to take action to meet their needs.
>
> Co-ordinate action at local level (Department of Welfare, 1997:17).

In those areas of Africa which have been badly affected by HIV/AIDS many community-based support programmes have sprung up. These often operate from churches or other community-based organisations, frequently with the support of NGOs and donor agencies. According to a report published by UNICEF:

> NGOs have a natural tendency... to be more sensitive than government services to human problems as they are experienced in the home and the community. They are also more flexible on policy issues: for example, the line between 'medical' and 'social' programming is blurred for most NGOs because of the pragmatic way in which they function. They focus on the human being and therefore tackle many dimensions of a given predicament; whereas government services compartmentalize needs- health, employment, education- and treat each one in isolation (1991:18).

Although these are important benefits, there are also significant problems associated with an over-reliance on NGOs. Programmes initiated by NGOs are often small-scale, reaching only a small proportion of affected people, they are often un-coordinated and frequently are not evaluated objectively. Coverage can also be very patchy. Moreover, the funding of NGOs is typically uncertain and resources frequently inadequate to the task, so projects may not survive long enough to make a significant impact (Flinterman et al, 1992:42).

There are no accurate figures available for the numbers of South African NGOs in the welfare and development field, but it has been estimated that there may be around 10,000 (Patel et al, 1995:1). Of these many play a prominent role in the field of child welfare. Some, such as the Child and Family Welfare Societies, are long established and have well developed infrastructures. Organisations like these are said to occupy the 'formal welfare sector'. They are staffed mainly by professionals and receive government funding, generally through the subsidisation of social worker posts (Department of Welfare, 1997:13).

There is a second, equally strong, tradition among NGOs in South Africa whose approach is more closely aligned to the developmental social welfare approach promoted by the 1997 White Paper for Social Welfare. This group of NGOs is known as the 'informal welfare sector' (Department of Welfare, 1997:14). Although some of these organisations received government subsidies, other have relied heavily on foreign

donors for their funding. NGOs do not, however, all fall neatly into these two categories. NGOs often alter their focus as new challenges arise. Some NGOs incorporate aspects of both the formal and the informal sectors, and may be 'multi-functional', that is provide care and welfare whilst also promoting change and development (Commonwealth Foundation, undated:22). The Thandanani Association is an example of an NGO which moved from providing care and welfare to children, to become 'multi-functional' as it responded to the challenge of the spread of AIDS in the locality in which it operated.

3. The Origins of the Thandanani Association and the AIDS Orphans Project

The Thandanani Association is based in Pietermaritzburg, KwaZulu-Natal. It was founded in 1989. At that time there were approximately 70 abandoned children living in the local 'African' Hospital. This was probably a result of the dislocation of family life created by high levels of political violence in the area. The problem was exacerbated by a strike at the hospital (Workshop, 19-4-1997). The Thandanani Association began its existence as a group of individuals who were concerned about the high numbers of abandoned children and the very poor levels of care and attention they were receiving on the wards. Organisations responsible for moving the children out of the hospital were over-stretched and unable to cope. Thandanani offered to work alongside the Child and Family Welfare Society of Pietermaritzburg (CFWSP) to help move children out of the hospital into adoptive and foster families (Interview, Abandoned Children's Project (ACP) coordinator, 25-4-1997).

Thandanani relied initially on voluntary labour, mainly of women. It had few formal structures or organisational systems and was based in an office made available to the Association by CFWSP. Much of the funding for the Association was secured from overseas donors (Interview, AIDS Orphans Project (AOP) coordinator 6-11-96). The organisation at this stage was therefore clearly situated within the 'informal welfare sector', and the approach of the organisation firmly rooted in the 'welfarist' tradition.

By 1994 Thandanani had achieved many of its original aims and was ready to consider diversifying its role. The number of abandoned children living in the hospital had been significantly reduced and those children who remained were experiencing a more acceptable quality of life. At the same time there were growing concerns about rising rates of HIV infection in KwaZulu-Natal. The situation of AIDS orphans in countries of Eastern and Southern Africa suggested that action needed to be taken urgently, before the epidemic in KwaZulu-Natal reached similar proportions. It was therefore decided that the Thandanani Association should broaden its focus and extend its services to respond to the challenge of AIDS (CBOs AGM Report, 1995-1996).

In 1995 research was undertaken by McKerrow & Verbeek in eight, predominantly African, communities around Pietermaritzburg, three rural, three urban and two peri-urban. The research aimed to:

> establish the current status of children in the Midlands of KwaZulu-Natal and to assess the current and future community response to the needs of children in distress (McKerrow & Verbeek, 1995:1).

(Children in Distress (CINDI) were defined as children under 17 years not living with their parent(s))

The research included a situational analysis of the eight communities (McKerrow & Verbeek, 1995:14-19). This found conditions in all eight communities to be 'poor and well below the norm for the country as a whole'. The areas were found to have a high proportion of women, children and the elderly, particularly in the three rural areas. Overall unemployment was found to be about twice the national average. There was a heavy reliance on state grants as the only source of income, particularly in the peri-urban and rural areas. Urban areas in the study were found to comprise of smaller nuclear families, whereas households in the peri-urban and rural areas comprised of extended families, or multiple families. Levels of income and employment were significantly lower in the peri-urban and rural areas where 'the average per capita monthly income was well below the poverty datum line'.

The research concluded that the following principles should underpin the development of care and support for children in distress:

Siblings should be kept together.
Children should remain in their communities of origin.
Children should remain in their own homes.
Communities are responsible for the day to day care of the children
State support should aim at enabling communities to care for their children rather than providing direct financial aid to individual children or families.
(McKerrow & Verbeek, 1995:2).

These principles coincide closely with the principles of developmental social welfare contained in the White Paper (Department of Welfare, 1997).

The results of the research were debated by welfare organisations in the Pietermaritzburg area and there was a general agreement that urgent action should be taken to try to implement the lessons learned. Thandanani was chosen as the organisation best placed to take on this task. The McKerrow & Verbeek research was therefore used as the starting point for a new venture for the organisation, the development of an AIDS orphans project. The new project was based on the principles established by the research, with service delivery targeted on the eight communities which had participated in the research. The translation of these principles into practice required Thandanani to reorientate its approach. It needed to change from an exclusively welfare-oriented organisation to one which would include a new 'developmental' approach.

4. From Welfare Agency to Development Agency

According to Broadhead:

> to be a development organisation it is essential to have a theory of poverty that directs (it) to its underlying causes. Without such a theory the organisation inevitably remains a relief and welfare agency, responding only to poverty's most evident symptoms (cited in Korten, 1990:4).

Developing this idea, Korten proposes a theoretical framework, or typology of development NGOs. He suggests that there are 'four generations' of strategies adopted by NGOs (see Table 1). This framework was utilised by the Thandanani Association to assist it in developing its understanding of what it means to move from a welfare agency to a development agency. Korten (1990:5) notes that many NGOs, like Thandanani, which are concerned with the predicament of the poor, began as relief and welfare agencies. However, while many NGOs remain in what he labels the 'first generation' of development organisations, others move on to 'look upstream', to search for the cause of the problem. A workshop, held in February 1996, identified the need for Thandanani to 'look upstream', in other words to change its focus from its existing role of 'doer' to adopt the new roles, of 'mobiliser', 'catalyst' and eventually 'activist/educator'.

Table 1. Strategies of Development -Oriented NGOs :Four Generations

	First Generation	Second Generation	Third Generation	Fourth Generation
Problem definition	Shortage	Local Inertia	Institutional and policy constraints	Inadequate mobilising vision
Time-frame	Immediate	Project life	Ten to twenty years	Indefinite future
Scope	Individual or family	Neighbourhoo d or village	Region or nation	National or global
Chief Actors	NGO	NGO plus community	All relevant public and private institutions	Loosely defined networks of people and organisations
NGO role	Doer	Mobilizer	Catalyst	Activist/ educator
Management orientation	Logistics management	Project management	Strategic management	Coalescing and energizing self-managed networks
Development education	Starving children	Community self help	Constraining policies and institutions	Spaceship earth

(Source, Korten, extracted from internal document, 3-2-1996)

To achieve this degree of change it was recognised that, in addition to a shift in attitudes, the organisation would need to make structural changes. It was decided that the organisation would need to grow, to develop more formal structures and become more 'professional'. In order to separate its welfare role from its development role it was decided that the organisation should split. The Abandoned Children's Project (ACP) would continue, and would maintain a welfare oriented service delivery, while a second project, The AIDS Orphans Project (AOP), with a community-based approach would be developed (Internal document, 3-2-1996).

The period between May 1996 and June 1997, when research for the present study was undertaken, was a time of major change for Thandanani as a whole and a period of rapid growth for the AOP. When my research commenced in May 1996 the project

consisted of a part-time, temporary co-ordinator and one full-time fieldworker. The project was based in one room provided by another NGO. There was no administrative assistance and few administrative systems. The project was officially launched at the end on November 1996. A new management committee was elected and the organisation's constitution amended. In December 1996 a project Director was appointed, and in January 1997 the project moved to its own premises. A project administrator was appointed, computers were installed and administrative systems developed. By the end of the research period, four more fieldworkers and a project co-ordinator had been appointed. A significant shift had also occurred in the funding of the Project. The securing of funds from the RDP and the Department of Health seemed to give the project a degree of financial security (at least for a three year period) and shifted the balance from its previous reliance on overseas funding.

5. Setting Objectives

Kotze & Swanepoel follow Chekki's distinction about objectives of community development. They note that:

> a distinction can be made between...process-oriented and task-oriented objectives of community development. The process oriented or general objectives refer to qualitative objectives such as self-help, participation, etc.; whereas the task oriented, or specific objectives refer to tangible, quantifiable objectives. These two sets of objectives are complementary (1983:12).

For Thandanani the main 'process-oriented objectives' identified for the AOP were to improve community awareness about the needs of children affected by HIV/AIDS, to promote the message that the state will be unable to provide for these needs, and to foster a spirit of self-reliance. The initial task-oriented objectives of the project were to take back the results of the McKerrow & Verbeek research to the participating communities, and to facilitate the establishment of child care committees in each of these communities.

Community development theory stresses the importance of local people chosing their own development objectives (Kotze & Swanepoel, 1983:2) and of 'inclusive participation' (Cary, 1970: 3). 'Inclusive participation' does not mean that everyone in a community must participate, but that all groups in a community should be given the chance to participate. Thandanani therefore sought to:

> consult with communities from the beginning and involve them in the planning process (Thandanani AGM report, 1995-1996:18).

The creation of Child Care Committees was considered to be particularly critical to the success and sustainability of the project. It was envisioned that each Child Care Committee would be trained and supported by the project and would then take responsibility for a range of activities. These included the identification of children in distress, the identification of potential substitute families for AIDS orphans and abandoned children and the development of ways to provide assistance to families caring for children in distress (Internal report, 7-3-1996; Interview, AOP fieldworker, 5-3-1997).

6. Entry into Communities

> I used to think community work is easy however as we were interacting with the community I realised that community work is a difficult task. (Fieldworker, AGM Report, 1995-1996:19)

In order to achieve its objectives, Thandanani appointed a community fieldworker (who I have called 'Sipho') to the new project in March 1996. Sipho had been involved in the McKerrow and Verbeek research and was therefore a known figure within the target communities (Internal document, 3-2-1996). For part of the time Sipho was assisted by a social work student and overseas volunteers. However, until June 1997 (when a further four fieldworkers were appointed) Sipho was the only employed fieldworker. There were therefore substantial periods of time during the period of this

research when Sipho was working on his own. In March 1996, AOP began to make contact with the target communities. The plan was to hold workshops in each of the eight target communities at which the results of the research would be presented. It was hoped that the outcome of these workshops would be the formation of action groups which would form the basis for the Child Care Committees (Internal report, 7-3-1996). Entry into the target communities, however, proved to be slow.

Progress was hampered by a number of factors. Firstly, the research results had to be put into a format that would be easily understood by workshop participants. This task was time consuming for the fieldworkers who had first to familiarise themselves with it and then to summarise and make it easily accessible (Internal report, 7-3-1996). Secondly, the fieldworkers were confronted by the issue of organisational credibility. The project was new and had to establish itself as trustworthy. In some areas the organisation lacked good contacts with community leaders who could vouch for them. Thirdly the fieldworkers faced logistical problems, for example a lack of transport (Internal report 1-4-1996).

Additional difficulties were encountered. The fieldworkers needed permission to enter the communities, which required them working through existing community structures. They were delayed by political conflict in two of the communities. In one area, attempts to set up a workshop had to be deferred indefinitely pending the resolution of conflict between individual community leaders. In a second area progress was hampered by a ruling made by one political party that all communication with organisations from outside the area must go through them. As Thandanani did not wish to be seen as biassed towards any political party, it was decided not to proceed in this community. In a third area progress of the AOP was delayed by preparation for local government elections. This area had also been devastated by floods a few months previously, so relief work was given priority over new initiatives (Internal reports 1-4-1996; 9-5-1996; Interview, AOP coordinator, 6-11-1996).

In one area a lack of trust in NGOs hampered progress. People in this community had prior adverse experience of an NGO which had promised assistance for the area, but

failed to deliver. In another area the project fieldworkers found themselves in competition with a number of other developmentally oriented NGOs which were already established in, or were proposing to work in, that community.

In view of these difficulties the AOP decided to concentrate efforts in only two communities of the original communities. These were the two communities where it was eventually possible to hold workshops. In order to protect confidentiality I have called the communities Ethembeni and Siyazama. The following information about these two communities has been extracted from the situational analysis of the area by McKerrow& Verbeek (1995:117-119). Ethembeni is a peri-urban area with a population of around 22,000. There is an average of 7.7 people per household. Many households comprise of three generations. The area has gravel roads, and limited access to basic services, for example there is electricity to some houses. There are three primary schools and one secondary school. Siyazama, by contrast, is a rural community of around only 6,000 people. The average size of households is about 8.4, again mainly consisting of multiple and extended families. There is very limited access to basic services such as power and water. There is one pre-primary and one primary school, but no secondary school. Siyazama is administered by traditional tribal authorities.

As Patel et al (1995:31) note:

> People who are reached by the NGOs tend to be (members of) the more organised communities who have developed vocal leadership and an ability to access the resources provided by the NGOs.

This has clear equity implications where a high reliance is placed on NGOs to deliver social welfare. Factors such as those identified by Patel et al seem to have facilitated the entry of AOP into both Ethembeni and Siyazama. Interest in the project by community leaders was a factor in both these communities. In Ethembeni a prominent individual from that community sat on Thandanani's Management Committee. This individual's influence helped to get the project accepted within that community. In

Siyazama the interest of the Traditional Leader was critical. In the words of the project co-ordinator, 'the chief simply gave his blessing and that was that'. Levels of organisation also influenced the progress made in these communities. In Ethembeni well-functioning development committees played a valuable role in assisting the project to gain a foothold in the community. In Siyazama, where democratic structures were of less importance, the chief ensured that workshops were arranged and well-attended (Interview AOP coordinator 6-11-1996; Sipho 5-3-1997).

7. Establishment of Child Care Committees

A series of workshops were run by the project in Ethembeni and Siyazama. These led to the establishment of action groups and later Child Care Committees (CCCs) in both of these areas. In Ethembeni, which covers a large geographical area, four separate CCCs were formed in different localities. The workshops were attended almost exclusively by women. Sipho's explanation was:

> Zulu men think that child-care is women's work and that women should deal with children's issues. Men have to do the hard work (Interview, Sipho, 5- 3- 1997).

The individuals who were elected to CCCs were exclusively women who were providing substitute care to one or more children who were not their own. Although a few younger women were involved, the majority were elderly and many were experiencing severe financial difficulties. Financial difficulties and the lack of status generally accorded to women and to 'women's issues' subsequently proved to be obstacles to the progress of the project. Sipho spells out the problem:

> Women in the communities have shown a willingness to address the problems of orphans and to make their care a priority. Community structures also seem to be prepared to look at the problem. The problem is they are not giving it priority (Interview, 5-3-1997).

Levels of poverty among the CCC members, and the advanced age of many of the women, also had an adverse impact on the development of the project. There were strong expectations that the AOP would provide material assistance to people caring for 'children in distress'. The fieldworkers increasingly struggled to find ways to motivate people whose major focus was ensuring that their basic needs were met and who were less concerned with wider issues of development. An inability to afford, or the lack of, transport meant that elderly women had to walk long distances over hilly terrain, making attendance at meetings difficult. Initial interest in the project began to founder once it became clear that there were to be no handouts. Some women who showed initial interest later refused to participate unless or until material assistance was forthcoming (Support Group meetings, 11-9-1996; 20-11-1996; 4-12- 1996).

8. Identification and Categorisation of 'Children in Distress'

As noted in chapter 4, enumeration of AIDS orphans has been recommended as a first step in the development of strategies to support affected children. The benefits of enumeration exercises have been identified as 'galvanising policy-makers', attracting financial aid and 'encouraging communities to look for solutions from their own resources (UNICEF:1991:8). However, in view of negative attitudes towards AIDS, identification of AIDS orphans runs a high risk of stigmatisation of the children and their families, so the recommended approach is to identify AIDS orphans alongside other vulnerable children.

With this in mind, AOP's approach was to suggest to each CCC that they should identify the children in their area whom they considered to be 'in distress'. The purpose of the exercise was to provide each of the CCCs with baseline information on the extent of existing need. This information could then be used by the CCC to raise awareness within the wider community about vulnerable children. It could additionally be used in planning measures designed to support those children and to monitor the growth in the number of children in need of assistance as the AIDS epidemic developed. Enumeration exercises were completed in two districts of Ethembeni (Areas 1 and 2.) and in Siyazama. Each of the three workshops attracted between 30

and 80 people and a total of between 200 and 300 children were identified as 'in distress' in each of the areas. In view of the high numbers of children identified, further workshops were held in order to break down the numbers into those children who might be considered 'least needy', 'middle needy' and 'most needy'.

The majority of the children were placed in the 'most' or 'middle' needy categories. Criteria were chosen by participants at the workshops by which to identify needy children. These criteria were agreed through a process of open debate. Although some of the criteria chosen for categorising the children varied, there was considerable consistency, particularly in the 'most needy' category. Orphans were considered to be a particularly vulnerable group, as were children being cared for by people not in receipt of state grants such as grandmothers, disabled parents and parents who are unemployed. (A detailed breakdown is provided in Appendix 4.) The categories chosen portray a clear recognition on the part of those attending the workshops of the significance for children of the availability of state social grants. Previous research has pointed to the critical role which state pensions play in the alleviation of poverty particularly for women and for the elderly in rural areas of South Africa. Old age pensions are paid out to approximately 1.7 million South Africans, but help to support many more members in each household (Lund et al, 1996:102).

The enumeration process highlighted the extent of need within each community and it raised a number of issues for Thandanani. Firstly, the enumeration process was an on-going exercise. More and more children were identified at meetings held following the initial workshops. AOP workers began to feel overwhelmed by the numbers of needy children being identified to the point where they were:

> tempted to get the communities to stop identifying (children) because of the ever increasing number (Internal report, 11-9-97).

Secondly, rather than encouraging people to look for solutions from their own resources, as suggested in the literature (UNICEF, 1991) this enumeration exercise actually seems to have raised expectations that outside assistance would be provided.

The full implications only became clear to the project several months later (Support group meetings, 6-5-1997; 3-6-1997). One reason which may be advanced to explain the raised expectations is an attitude which was found to be prevalent in these communities in McKerrow and Verbeek's research (1995:45), that the state is held to be ultimately responsible for the care of orphans. Thus while women in the target areas were found to express sympathy towards orphans and a willingness to help, Sipho found that:

> There is a problem because some of them think that the state should care for orphans (Interview, 3- 6-1997).

AOP workers found a strong association between orphans and the provision of material assistance.

> The problem is that whatever we try to do, when people think of orphans they think of handouts, they don't see the difference between me and a social worker (Interview, Sipho, 3-6-1997).

> In most cases Thandanani is always confused with the Department of Welfare. Whenever I attend a meeting I have to clarify the difference between Thandanani and the Department of Welfare. The fact that the organisation is helping to address the problem of orphans in the community, is the reason why it is perceived as a welfare organisation (Internal report, 8-4-1997)

Although there are moves within the social work profession towards the adoption of a more developmental approach, this change is only happening slowly (Gray, 1996:9) and social workers continue to be perceived as providers of material assistance. Thus, while AOP workers attempted to explain the developmental approach of the project and to describe their roles as community development workers, many people continued to see them as indistinguishable from social workers from the welfare department. Thirdly, the enumeration process, which involved the fieldworkers and members of the

child care committees in making house-calls to assess levels of need, may well have raised expectations that material assistance would be forthcoming (AOP Workshop, 19-4 1997) .

9. Community Development versus the Need for Welfare

A major aim of developmental social welfare is to promote self-help and self-reliance. According to Gray:

> This aim can only truly be realised through ... consciousness raising and empowerment (1996:12).

Consciousness raising in relation to the impact of HIV/AIDS on children, along with the empowerment of communities to mobilise assistance to children from within each community's own resources, were the two main aims of the AOP. In order to achieve these aims the organisation needed to divorce itself from its welfarist origins. Nevertheless, the growing demands on the project for material assistance could not be ignored. This issue was particularly prevalent between August and Christmas 1996 when pressures to provide food and clothing built up. This created both a moral dilemma and a professional challenge for the project. From an ethical viewpoint AOP felt under obligation to assist children whom it had identified as in dire need of food and clothing. This dilemma was intensified by the fact that a small amount of food aid had been donated to the organisation. Moreover, there were strong concerns that, without the provision of some material assistance, the project would founder long before its developmental objectives could be achieved (Support meetings, 20-11-1996; 4-12-1996).

These dilemmas have also been faced by organisations seeking to assist AIDS orphans in other African countries. Many of these organisations have found that it has been necessary to provide material aid such as food and clothes, or financial aid, such as help with school fees, at least in the early stages of their operations (Lusaka Workshop, 1994:6; Mukuyogo & Williams, 1991:23-24). However, their experience

has shown that this approach can be problematic. Firstly, provision of material aid can create dependency and be the cause of considerable distress when it is withdrawn, yet the budgets of NGOs are generally small and can only sustain the provision of help to a limited number of people and for short periods of time. Secondly, this kind of aid can create jealousies and inequitable situations between recipients and non-recipients. There are examples in the literature of orphans with many pairs of shoes in a village where no-one wore shoes (Lusaka Workshop, 1994:6) and of a woman who wept on discovering that she tested HIV negative because her children would not be eligible for assistance with school costs (Ddombo, in UNICEF, 1991:22).

Despite these drawbacks, the literature suggests that organisations which aim to provide support for orphans and their carers are inevitably going to be faced with the very real need to provide some form of material assistance. One community-based programme in Zimbabwe, for example, found that small amounts of well targeted material aid could make a real difference to very needy families. This programme used community-based volunteers to prioritise those families most in need. These volunteers distributed small amounts of aid (averaging approximately Zim.$11) to a large number of orphaned families, thereby avoiding problems of jealousy (Foster et al, 1995a:14). Nevertheless, this approach does not address the very real problem of sustainability, of what happens when funding for this kind of aid runs out.

According to Patel et al:

> For the NGO sector to begin to reach out to the poorest of the poor, it may be necessary for them to reformulate ways in which they combine developmental issues and direct poverty relief (1995:24).

This does not necessarily mean that every NGO should engage in both development and poverty relief. It could rather suggest a co-ordinated approach, with different NGOs adopting different roles. AOP sought to resolve its development-versus-welfare dilemma through such an approach. Rather than providing food aid directly, the project sought to link with another NGO, or CBO, which would provide material assistance on

its behalf. This proved to be a more difficult task than anticipated, since the majority of local NGOs contacted were also working within the 'developmental' paradigm and did not wish to be associated with the provision of poverty relief. Other NGOs were only prepared to offer material aid in crisis or disaster situations. The need for poverty relief was, however, one which was generally being faced by other NGOs (Support meeting 20-11-1996).

By November 1996 the local state Welfare Department had used up its annual budget for food parcels which can be made available to people awaiting social grants. This meant there would be nothing available from this source until April 1997. This crisis prompted local NGOs, including AOP, and the state Welfare Department to collaborate in the opening of a food bank in Pietermaritzburg (CINDI report, 1997:12). While it did not totally resolve the issue of material aid for AOP, the existence of the food bank noticeably reduced the pressure on the project to provide direct assistance. In an attempt to link food aid to the 'developmental' aims of the project, individuals who were referred to the food bank by AOP were the care-givers of 'most needy' children who had been particularly active in the CCCs (Interview Sipho, 5-3-1997).

The interface between development and welfare was also evident in a second issue. Non-receipt of social grants was identified by the Ethembeni CCC as a matter of concern due to the number of carers who were entitled to, but not receiving, social grants. Concern was expressed that carers were failing to receive grants due to fraud in the local welfare department. A lack of accountability and of good management has long been prevalent in the welfare sector in South Africa (Lund Committee, 1996:12) and the levels of fraud and corruption in the payment of social security benefits has been highlighted nationally as a matter in need of urgent action. CCC members could not expose the alleged fraud without risking repercussions and so turned to AOP for advice. The first line of action considered by the project was to 'empower' affected individuals to take legal action, linking them with sympathetic lawyers who would train individuals to take statements. Once sufficient statements had been gathered legal action could then be instigated against corrupt officials (Support meeting, 11-9-1996).

This line of action was not pursued due to advice received from a legal organisation consulted by project staff, that such action could lead to reprisals for those involved (Support meeting, 4-12-1996). These warnings were not without basis. There have been reported cases of shootings of individuals in KwaZulu-Natal who were attempting to tackle corruption in the social security system (Sithole, 1995).

An alternative approach was therefore adopted. Through networking, AOP had forged a relationship with the Black Sash (an NGO which provides advice and information to the poor). It was decided that Black Sash should provide workshops for the CCCs to provide training on eligibility and ways to access social security benefits. Black Sash also agreed to be present at grant distribution locations to ensure that individuals received monies to which they were entitled, but ultimately the CCC members should be able to undertake this role. Whilst this approach would only have an indirect impact on tackling fraudulent behaviour among welfare officials, it aimed to empower individuals without putting them at personal risk. A number of carers subsequently obtained grants through these efforts (Interview, 3-6-1997). As one support group member put it:

> a grant paid to a care-giver is going to be worth far more than anything she can earn from any income-generating project (Support meeting, 11-9-1996).

10. Conscientization and 'Doing' Development

Kotze and Swanepoel (1983:12) note that any community will have 'real' and 'felt' needs:

> Real needs are those that a community ought to have, viewed objectively. Felt needs are those that a community clearly expresses.

These authors argue that communities should be led to discover the 'real' needs through first satisfying the 'felt' needs. It is debatable whether there is any such thing as

an objective view of what is a 'real' need, since different individuals or groups will have a different construction of reality. Perhaps a more useful distinction in this context would be between immediate needs and long-term needs. In AOP's view the long-term need of the communities was that they should become aware of the needs of children before the full impact of the HIV/AIDS epidemic hit them, and that they should establish structures which could respond to those needs. The project therefore saw its main role as 'conscientizing' the communities. However the immediate needs as expressed by the community were for something more concrete, for food, for clothing and employment. Thus conflicting pressures were placed on the organisation, not only to act as welfare agency, but also to 'do' development. In other words to assist in the development of income-generating projects and to offer skills training.

Many NGOs working with AIDS orphans in other parts of Africa have concentrated their efforts on small-scale income generating activities. These organisations have often focussed on assisting women and orphans to develop skills which will enable them to make a livelihood (Webb, 1995a:6; Webb 1996c:9; Whiteside, 1992:9) In Zambia for example, small agricultural projects have been developed in which any profits made are distributed to those most in need as decided by a community committee (Webb, 1995b:6). In Zimbabwe (Whiteside, 1992:9) trials have been undertaken growing chillies to see if these would be an appropriate crop for cultivation by young people, including orphans. Questions remain however about the sustainability of such income generating schemes in conditions of severe economic stringency. With the exception of a few studies, mainly from Uganda, little hard data is available about the success or otherwise of such support strategies for orphans. Those studies which have been reported present a rather mixed picture. One study reported problems which are typical of many development projects, such as a lack of management skills, conflicting individual and group interests, low community participation, poor accessibility and unstable prices of goods and services, all of which impeded the success of the projects (Bajenja, cited in Webb, 1996c:9).

Although 'doing development', in the sense of engaging in economic upliftment, was not AOP's main aim, it responded to the needs of the community as expressed by the

CCCs. A range of ideas for income generating projects were put forward by the CCCs, particularly in Ethembeni. A small number of these ideas were put into practice (Support meeting 5-2-1997). AOP aimed to use the income generation projects as a means of getting its message across. It encouraged those involved in the income-generating projects to use any monies generated for the benefit of 'most needy' children.

Patel et al (1995: 32) contend that it is particularly difficult for NGOs to reach the most marginalised groups. Children are especially disadvantaged since they are dependent on adults to provide for them. AOP's task was a complex one. Unlike the welfare approach, which assists children directly, the developmental approach assists children through assisting adults. However fieldworkers found it difficult to keep the Child Care Committees focused on the needs of children. As expressed by one fieldworker:

> I find this project complicated. It's a children's project and we have to work with adults (Fieldworker,Thandanani AGM Report:1995-1996:19).

The income-generating projects proved useful as a 'rallying point' for the project (Internal document, 8-4-1997). However, concerns arose about the time-consuming nature of this kind of development work and whether it was diverting the project from its goals. The efficacy of small enterprises to support children in any meaningful way was also questioned. A lack of market research prior to setting up the income-generation projects meant that, for example, it was difficult to find a market for clothes produced by a sewing project (Support meeting, 5-3-1997; AOP workshop, 6-5-1997). Furthermore, it became clear that some of the 'most needy' children were unlikely to benefit from the income generating projects because their carers were either too elderly, or disadvantaged to become involved in them (Support meeting, 19-3-1997). Moreover, the project became concerned that it was in danger of not establishing its unique identity, and that it would be seen as 'just' another development agency. It was therefore decided that it would be preferable for the project to identify

NGOs operating in the area whose main objective was economic upliftment and to link them with groups which were considering starting an enterprise or requesting skills-training (Support meeting, 19-3-1997; Project workshops 19-4-1997; 6-5-1997).

11. Developmental Social Welfare and HIV/AIDS

Many of the issues faced by AOP will have been faced by many organisations trying to develop new community development projects. However, a number of issues which impacted on the organisation were specifically related to HIV/AIDS. One of the major problems concerned stigma. The objective of the AOP was to get communities ready to assist the growing number of children affected by AIDS. However, because of the stigma attached to AIDS, it needed to achieve this objective without actually identifying those children. As one member of the support group pointed out:

> It only needs one experience of a family being identified as affected by AIDS through their connection with Thandanani and then being ostracised by the community, and the project will be badly damaged (AOP workshop, 6-5-1997).

The project thus needed to promote the message about AIDS within the communities while at the same time creating a 'cover' for its activities. This created a problem about how to 'sell' the project to the communities and to funders. These problems are reflected in the search for an appropriate name for the project. The original title, AIDS Orphans Project, was good for fund-raising, but could not be used in the communities for the reason already stated. This title was therefore dropped in favour of the CINDI (Children in Distress) Project and then changed again to Community Programme. (The title CINDI was later adopted by the consortium of organisations working with HIV/AIDS affected children in the Pietermaritzburg area. For ease of reference the title AIDS Orphans Project (AOP) has been used throughout this thesis.)

The title CINDI created a lack of clarity for the project about which 'children in distress' were to be included in their target group (AOP workshop 6-5-1997).

Moreover, while it was possible to generate concern within the communities for the plight of orphans, interest floundered when it became clear that many of the children identified as 'most needy', were not orphans, but children of another stigmatised group, single teenage mothers. There was a reluctance from some members of Child Care Committees to expend energy in finding ways to support these children, due to fear that to do so would be seen as condoning teenage pregnancy (Interview, Sipho, 3-6-1997).

Attitudes towards HIV/AIDS had other implications for the AOP. Fear of AIDS frequently leads to denial by individuals and by communities. AIDS therefore remains a hidden problem, due to the fear of stigma. The implications of AIDS for children is particularly likely to produce avoidance and denial reactions as it is painful for adults to consider their own mortality. Furthermore, despite HIV infection rates of around 20% in the area around Pietermaritzburg (McKerrow, 1997b), the long incubation period of the disease meant that only a small proportion of those infected had developed AIDS and died. The orphan problem therefore was largely invisible, it was still a crisis waiting to happen. The experience of other African countries suggests that it is not until many families in an area have experienced the traumas of HIV/AIDS that isolation and secrecy begins to break down. Organisations working with HIV/AIDS affected children in other parts of Africa have typically been established once AIDS has become visible and large numbers of children left parentless (Denis, 1994). AOP was attempting to get support structures in place in advance of the full impact of the epidemic, but was faced with a situation where people were unable to see a need. Development theorists stress that people need to 'own' the problem. AOP struggled to maintain a momentum because other of other seemingly more immediate priorities, such as jobs, housing and roads (Project workshop, 6-5-1997; Interview, Sipho, 3-6-1997).

12. Pilot Project: Problems and Achievements

By the middle of 1997 AOP had restricted its activities to Ethembeni.The CCC in Siyazama had decided to link up with a local church and an NGO which was located

geographically closer than Thandanani (Support meeting 5-3-1997). Ethembeni thus came to be regarded as a 'pilot project' (AOP workshop, 19-4-1997). By April 1997 Child Care Committees had been established in six areas of Ethembeni (AOP workshop, 19-4-1997). However difficulties in maintaining momentum continued to be a problem. The reasons for this were identified as:

1. Poor meetings and workshop attendance by community members in some areas
2. Poor participation during meetings and workshops
3. High expectations stemming from dependency
4. Lack of motivation amongst Committee members
5. Wearing of many hats by certain Committee members
6. Lack of initiative by certain Committee members
7. Punctuality (AOP report, 8-4-1997).

By June 1997 only one of the Ethembeni Committees (Area 1) was functioning properly. The successful operation of the Child Care Committee in Area 1 was attributed to the presence of 'strong' and 'politicised' women who were already involved in community activities and who showed an interest in establishing a new committee focused on the needs of children. Expectations that the project would provide material assistance remained a major factor hindering progress in the other areas. Nevertheless, the inception of the CCCs had brought the issue of HIV/AIDS to the notice of people in all six areas of Ethembeni and formed a base on which progress could later be made (Interview, Sipho, 3-6-1997).

A number of income-generating projects were begun in Ethembeni to assist children identified as 'needy'. These included the establishment of a sewing project, a poultry project and the collection of clothes for distribution to the 'most needy'. These were only small-scale projects and the monies generated could never be sufficient to provide support to the numbers of children in need. However they were a useful vehicle through which AOP could be seen to be doing something positive to help.

A less obvious approach, but one which could be more productive in the longer term, aimed at countering the problems faced by families who were unable to afford school fees. In the light of evidence from other African countries about the risks AIDS orphans run in dropping out of school, this issue would seem to be particularly important. The high drop-out rate of orphans from school, has led many organisations assisting AIDS orphans in other parts of Africa to seek ways to help with school costs (Mukoyogo & Williams, 1991:24; Lusaka Workshop, 1994:8). These organisations have found paying school fees to be problematic. First, it is inappropriate to pay the school fees for an orphan when there are other children in the same family who might also be unable to attend school because of the fees. Secondly, paying fees is unaffordable for most organisations (Lusaka workshop, 1994:80). In Uganda the provision of school fees to families caring for orphans was found to cause the fees to rise further (Webb, 1996c:9). An alternative approach in Uganda, has been to negotiate free schooling in exchange for the provision of labour and materials to upgrade the school (Webb, 1996c:9). In Zambia compulsory school uniforms have been abolished as a way of relieving one unnecessary cost of schooling (Holt, 1997).

AOP's approach to the problem of school drop-outs was different again. This involved encouraging members of the CCCs to negotiate with school principals for the reinstatement of a number of the 'most needy' children who had been excluded due to non-payment of school fees (Project report, 8-4-1997; Interview, Sipho, 3-6-1997). This was achieved in part through ensuring that AOP made links with existing education forums, but also by encouraging members of CCCs to make themselves available for election to local school governing bodies. Under new school governance policy this would give those elected, and thereby disadvantaged children, a crucial voice in decision-making on matters such as exclusion (Support meeting, 5-2-1997; Interview, Sipho 3-6-1997).

13. Growth and Change for the AIDS Orphans Project

As has been noted, the period during which this research was undertaken (May 1996 to June 1997) was a time of major organisational change for Thandanani. Swarts

(1996:8) highlights the existence of clear direction and good planning as reasons for the success or failure of development projects. Up until the end of 1996 the AOP was very clearly in the early stages of organisational development. The focus of the temporary co-ordinator was on securing funds, on constitutional and attitudinal changes within Thandanani and on formally launching the new AOP project. Following the appointment of a Director to the AOP in December 1996, it was possible for the organisation to focus on a process of planning for the future. The first six months of 1997 were given to this process. In view of the uncertainties which had been around what should be the focus of the project's service delivery, it was felt important to clarify the mission of the project, to make decisions about its future direction and to set clear goals. In order to give all interested parties a say in the next phase of the project, workshops were held in April and May 1997.

A number of important decisions were taken following these workshops Of these one of the most critical was to expand the project. One of the most commonly mentioned drawbacks of NGOs is that their:

> activities are limited in scope by their nature and (they) therefore cannot have a national impact (Flinterman et al, 1992:45).

Far from having a national impact, by the middle of 1997 the AOP's scope was restricted to certain districts of Ethembeni. With only one fieldworker the coverage of the project was severely limited. It was therefore decided that the project should employ extra fieldworkers and attempt once again to target all the areas which originally participated in the McKerrow & Verbeek research. Sufficient funding was available to employ a further five fieldworkers, plus a co-ordinator, who would act as fieldwork supervisor. The organisation would also become more 'professional', fieldworkers would be appointed with appropriate qualifications and experience, but would be given additional on-the-job training as a matter of priority. The appointment of a co-ordinator would free-up the Director to engage in such activities as networking, promotion of the project and fund-raising (AOP workshops, 19-4-1997; 6-5-1997).

The vision of the project and its goals were also re-examined in the workshops. It was agreed that the original objectives for the project should remain largely un-altered, these were:

> Establish a 'Community Child Care Committee' in each participating community.
>
> Establish and maintain a register of children in distress for each participating community.
>
> Promote the ...models of care identified in the (McKerrow& Verbeek) research.
>
> Identify surrogate families within each participating community.
>
> Liaise with local CBOs and NGOs to access resources and to develop the necessary skills within each community to provide psycho-social support to children and their surrogate families.
>
> Promote the development of appropriate support structures to enhance the functioning of each alternative model of child care (Workshop Report, 19-4-1997).

Liaison and networking were identified as critical to the success of the project. The emphasis was to be on encouraging other organisations, for example the churches, to link with the CCCs. The earlier uncertainty about what the role of the project should do was resolved. Rather than 'doing development' the emphasis was to be on 'community action' and on being a networking and a linking agency. AOP would not become over-involved in the running of small scale income generation projects, but would link people interested in setting up such a project with others with that expertise.

14. Conclusion

The White Paper for Social Welfare promotes a welfare policy for South Africa which is based on the principles of 'developmental social welfare'. It recommends that organisations move towards service delivery which is 'people centred and developmental' (Department of Welfare, 1997:5), that they concentrate their efforts on developing ways which will 'build human capacity and promote self-reliance', rather than strategies which are reactive and remedial (1997:preamble). This chapter has presented a case study of an AIDS Orphans Project which was developed on these principles. The case study has highlighted some of the difficulties faced by the project during the first year of its life. It has considered the problems experienced in attempting to 'build self reliance' in a context of extreme poverty, in particular the tension between meeting immediate needs while working towards longer-term objectives. The case study has also looked at the important role which women played, both in providing 'community' care to needy children and in participating in 'developmental' activities through the Child Care Committees and micro-enterprises. The difficulty faced by women in getting children's issues given the necessary priority was noted as a potential barrier to the overall objectives of the project. Finally, the case study has highlighted issues of stigma and secrecy surrounding HIV/AIDS and the problem of trying to tackle a 'hidden' problem, such as AIDS orphans, in a developmental, pro-active manner. These themes will be developed further in the final chapter of the thesis.

The next chapter presents the second of the case studies. It looks one model of 'community' care for children who cannot be accommodated by the extended family, specifically adoption as practiced by the Child and Family Welfare Society of Pietermaritzburg.

CHAPTER 7

DEVELOPING APPROPRIATE WELFARE SERVICES FOR HIV/AIDS AFFECTED CHILDREN: A CASE STUDY OF THE 'INDIGENISATION' OF ADOPTION PRACTICE.

1. Introduction

The South African welfare system has been heavily influenced by western theories and was developed in the main to meet the needs of the minority white population. One of the important threads of current South African welfare policy is the need to redress the imbalances of the past and to develop more 'appropriate' welfare strategies. Services need to be developed which will help to overcome the 'social marginalisation of vast sectors of the population' (Department of Welfare, 1997: preamble). In other words ways need to be found to develop a more 'indigenous' welfare system, one in which practice is adapted to suit the contextual realities. Adoption is the only care option which provides children in need of a substitute family with legal permanence. In South Africa western-style adoption has not been a widely utilised option for African children, although other models of care mainly within the extended family have long been practiced. The HIV/AIDS epidemic, however, is set to place increasing pressures on the extended family and, as Hunter & Williamson (1997: 25) point out, the most vulnerable children are those who fall through the extended family safety-net.

This chapter explores the way in which the adoption service of the Child and Family Welfare Society of Pietermaritzburg (CFWSP) was changed in order to make it more accessible and 'appropriate' to the context within which it was operating. It also explores the linkages between CFWSP and other professionals working in adoption. Presentation of the data is discussed with reference to the relevant literature. As adoption in South Africa has been closely modelled on western adoption theory, and in view of a dearth of South African research, it has been necessary to draw heavily on western literature. In order to set the case study in context the chapter begins with a consideration of the changing nature of adoption.

2. The Changing Nature of Adoption: An International Perspective

There is little about the nature of adoption of children which is fixed. Ideas about adoption alter to reflect the attitudes, social policies, and socio-economic conditions of the society and the time in which it is practiced. Perhaps all that can be held to apply universally is that adoption is a legal process whereby all the parental rights and responsibilities of a child's birth parents are permanently extinguished and are vested in the adoptive parents. Modern adoption laws first appeared in Massachusetts in 1851 and were introduced into countries such as Britain, Australia, New Zealand and South Africa at the beginning of this century (Triseliotis, 1995:38). The nature of adoption has, however, undergone considerable change since that time.

Triseliotis (1995: 38-42) has identified four main factors which have influenced adoption policy and practice over the years. Firstly, economic and class factors. There has always been a link between adoption, poverty and destitution. For example, an important factor in the reduction of the number of babies available for adoption in European countries after the Second World War was improved welfare provision for single parents. Secondly, attitudes to non-marital births. The stigma which a society attaches to out-of-wedlock births, and its treatment of unmarried mothers and illegitimate children has a direct impact on the way adoption is practiced. In many countries since the 1970's, significant changes in social attitudes towards single parents have contributed to a marked reduction in the number of babies placed for adoption. Thirdly, attitudes towards inheritance. Adoption legitimates the inheritance of goods and property to persons who are not of the blood line. This was a major issue in many western countries earlier this century and it is still an important consideration in some parts of the world and in some cultures today. Care by relatives is likely to be a preferred practice in those societies where a high importance is placed on issues of inheritance. Finally, attitudes to heredity. The idea that behaviour such as immorality and criminality can be inherited has been a strongly held belief in many cultures. In many western countries this led to the development of adoption practices which aimed to screen out children who might be suspected of having 'bad blood' and to the careful matching of child and adoptive family.

Perhaps the most important change in adoption practice in the past few decades has been the move away from an adult-centred to a child-centred service. As an adult-centred service, adoption neatly solves the 'problems' of illegitimacy and single parenthood on the one hand, and of infertility on the other. The stigma attached to both these 'problems' led to an adoption service which promoted secrecy. Adoptive parents were given little or no information about the child's background and there was little emphasis placed on the need to share information about the facts of adoption with the adoptee or with anyone else. Consequently, 'adoptees were looked on as second class citizens and they felt like that' (Triseliotis, 1995:40). With adult-centred adoption came the notion of a 'complete break' from the past, of the adopted child being brought up as if s/he were the child of the adoptive parents. Little consideration was given to the impact of adoption on birth parents, many of whom were given little option but to give up their babies, and who were simply advised to put the adoption behind them and to get on with their lives.

The move towards more child-centred adoption began in Europe and the USA from around the 1970's. Research into adoption outcomes (for example Kirk, 1964) showed that success in adoption was related to an acceptance by the adoptive parents of the difference between adoptive and biological parenthood. The focus of adoption practice thus shifted to an emphasis on identity needs of the adopted child, on the importance of giving adopters full background information and of 'telling' the child about adoption. In many countries this led to the opening up of adoption records and the possibility for adoptees to trace their birth parents. As the number of babies available for adoption declined, adoption agencies began to look to the placement of children previously considered 'unadoptable', such as older children, children with disabilities or health problems and children from ethnic minorities.

During the 1980's, community care policies in western countries led to the promotion of adoption for children considered to have 'special needs' or to be 'hard to place' and to the closure of many children's homes. Research in Britain by Rowe & Lambert (1973) showed that many children 'drifted' in the care system. This was not only damaging for the children on an emotional level, but was a more costly option for the

state than placement in a family. Resources were thus diverted from residential care to the establishment of family finding units, along with the introduction of adoption allowances which would enable lower income families to adopt.

The placement for adoption of older children, who had memories of their birth families and often loyalties towards them, plus the emergence of birth parent (predominantly birth mother) pressure groups, brought about another fundamental shift in adoption theory and practice. Adoption in the 1990's has stressed the importance not only of 'telling' the child about adoption, but of a much broader 'openness' about adoption. There is an emphasis on trying to balance the needs of all three parties to adoption, adoptee, adoptive parent and birth parent. This has led to a much greater involvement of the birth parents in the adoption process (for example involving them in the selection of the adopters), on encouraging adopters and birth parents to meet, to keep in touch and, where appropriate, for adopted children and their birth parents to maintain contact. Adoption with contact is being promoted in many countries, including South Africa. It has been developed in particular in America and New Zealand, although the literature suggests that its effectiveness has yet to be established through research (Thoburn, 1990:20).

It is clear therefore that there are few elements that can be described as universal in the practice of adoption. Whilst adoption has certainly been influenced by research findings looking at 'success' rates, it has also been influenced by the changing nature of family life, by trends in child care policies and social work practice, by prevailing attitudes towards illegitimacy, infertility and single parenthood, and by the socio-economic and political climate. The empowerment of women in some societies, for example, has significantly influenced adoption practice, giving birth mothers a much stronger voice in the whole adoption process.

3. The Development of Adoption in South Africa

Legal adoption is not a recent phenomenon in South Africa. There is evidence to suggest that it was practiced in the Cape in the eighteenth century (Zaal, 1992: 380).

The first major adoption legislation, the Adoption of Children Act, was passed in 1923 and subsequently up-dated, most recently in 1983. Adoption services were developed through a network of welfare organisations predominantly the child and family welfare societies. For the past few decades the South African National Council for Child and Family Welfare has had the role of accrediting agencies which offer adoption services and of setting of goals and standards for those services. Nevertheless, due to general fragmentation of welfare services created by apartheid policies, an adoption system developed in which there was little overall co-ordination and this situation has persisted into the post-apartheid era. Only nine Child and Family Welfare Societies are currently accredited by the South African National Council for Child and Family Welfare. The Council does not know how many other non-accredited agencies are currently practising adoption (Schreuder, 1996). Moreover, although attempts have been made to regulate adoption practice by private social workers, such arrangements remain legal. The adoption system therefore is poorly co-ordinated and characterised by:

> a mixed and fragmented type of service delivery, variation in standards and differences in procedures being followed (South African National Council for Child and Family Welfare, 1996:1).

Adoption practice in South Africa has been strongly influenced by concepts which were developed in other countries, especially Britain and the USA. There has been a tendency for practitioners to adopt the various changes which have been advocated by western theorists, even though these did not take into account the very different context. Like many other western-inspired social policies in South Africa, adoption services were introduced predominantly for the white population.

Under apartheid only a small number of adoption agencies were accredited, all were urban-based and catered predominantly for the white population. Figures of adoptions in the 1980's show that, 60 years after the first adoption legislation, only a tiny minority of Africans had legally adopted. In 1987, for example, there were a total of only 301 adoptions by Africans, out of a total African population of approximately 30

million. This compares with a total of 2502 adoptions of white children out of a total white population of approximately 5 million (South African Institute of Race Relations, 1989:15). The following figures show a small increase in the number of African adoptions between 1979 and 1981 and a drop again in 1983. (Given that transracial adoptions were illegal at this time, 'African adoptions' can be taken to mean adoption of African children by Africans).

Table 2. African adoptions 1979-1983

Year	African Adoptions
1979	391
1980	417
1981	420
1983	331

(Source: South African Institute of Race Relations 1983; McKendrick & Dudas 1987, cited in Pakati, 1992:7).

These figures include adoptions by relatives (for example grandparents and step-parents) as well as adoptions by non-relatives. When the former are excluded the figures drop significantly. Of the 391 African adoptions registered in 1979, only 177 (45%) were adoptions of children by non- relatives (Pakati, 1984:62).

It has not been possible to establish national figures of African adoptions for the later 1980's and 1990's. As the country moved away from apartheid classifications of 'race', so separate adoption statistics for the 'racial' groups are less readily available. Figures provided by the South African National Council for Child and Family Welfare (Schreuder, 1996) show that the total number of children adopted through the nine accredited Child Welfare Societies in 1996, was 1,008. Of these, 262 were African. It was not possible to establish how many of these children were adopted by African families and how many were adopted transracially because, in keeping with a philosophy of 'non-racialism', separate figures are not kept. This lack of ethnic monitoring is unfortunate, since without it effective advice on changes to practice cannot be given.

Research into substitute care of African children in South Africa has tended to concentrate on informal kinship care (see for example Spiegel, 1987; Jones, 1993). There has been very little research into legal adoption of African children. Two studies of adoption among Zulus in KwaZulu-Natal (Pakati,1984 & 1992) and one on transracial adoption in the Durban area (Ledderboge, 1997) are exceptions . In the first of her studies, Pakati found that legal adoption was still in the main a 'foreign concept to the Zulu community' (1984:2). Her later research (1992) in three different areas of South Africa again found legal adoption to be relatively rare among Africans. However she noted that 'westernisation' led to a preference for adoption among some childless couples over more traditional methods of coping with childlessness. For these childless Africans, adoption was preferable to informal kinship arrangements because, unlike informal arrangements, the child could not be reclaimed by its parents (1992:282).

The question of the appropriateness of trying to introduce adoption as a concept into the African context is raised in some of the literature (UNICEF:1991; McKerrow & Verbeek, 1995; Parry, 1998). A number of reasons have been advanced as why adoption may not easily 'fit' with African traditions and culture.

First, contemporary western adoption involves an acknowledgement by adopters that adoptive parenthood is different from natural parenthood. For childless couples this means acknowledging feelings about infertility. It stresses the importance of telling the child about his or her background, and of 'openness' about the adoption. By contrast the importance which is placed on fertility in African societies tends to place emphasis less on the needs of the child to know about their identity and more on the needs of adults to have children (Preston-Whyte, 1993:66; Preston-Whyte & Zondi, 1992:237; Bandawe & Louw, 1997:546). To be childless is a major social stigma, therefore traditional methods of 'solving' the problem of childlessness are based on secrecy. Customs such as 'sororate' (in which a female relative, usually a sister, is impregnated by the husband of an infertile woman and bears a child which will be brought up as the child of the infertile woman) and 'levirate' (in which a male relative will take

responsibility for a widow and produce children on behalf of the deceased man) involve bringing up a child as if s/he had been a child of the marriage (Pakati, 1992:30).

Second, adoption entails the incorporation of a child not simply into a nuclear family, but into a whole new kinship network. In traditional African culture the boundaries of kinship groups have often been tightly drawn. Research on traditional Zulu culture, for instance, emphasises the importance of blood ties, formalising kinship ties through marriage, on belonging to the clan and on the sharing of common ancestors (Vilikazi, 1962; Preston-Whyte, 1980). Such structures clearly serve to make it more difficult to include an outsider such as an adopted child into a family, or at least to do so openly. As Triseliotis notes:

> families which have diffuse boundaries between themselves and the community as opposed to rigid ones, are readier to accept outsiders.The stronger the family unit and the loyalty to the wider family group, the less space is made for outsiders (1995: 40).

Nevertheless studies of family support systems in South Africa suggest that forces of social change, such as urbanisation and an increase in rural-urban mobility may be impacting on family structures to make them more fluid (Jones, 1995:1). Thus whilst kinship bonds remain strong for some people, for others

> ties of friendship, neighbourhood amity and very distant or even fictive kinship... provide support in times of need (cited in Jones, 1995:2).

Finally, the process involved in adoption is bureaucratic and often lengthy. It requires people to have contact with agencies which may be remote, un-welcoming and perceived as 'white'. Pakati suggests that there is a lack of knowledge in African communities about the concept of adoption and about how to become an adoptive parent (1992:281).

The case study which follows considers many of these issues. It looks at ways in which one adoption agency sought to change its procedures and practices in order to make them more accessible to and appropriate for African adopters.

4. The South African National Council for Child and Family Welfare: Guide-lines to Adoption Practice

As part of its role in setting 'standards' for adoption practice the South African National Council for Child and Family Welfare (hereafter referred to as the National Council) produces a series of guide-lines for adoption workers. One of the stated aims of the latest guide-lines (1996) is that it should be a:

> specifically South African guide (which will be of) practical value to South African adoption agencies (in the light of) the changing face of adoption practice in South Africa (1996:2-3).

The document asserts that:

> The basic principles of social work, including the principles underlying an adoption service, may be said to have universal applicability, but conditions and circumstances obtaining in a particular country must necessarily modify the practice through which those principles are applied. Among these are the history of the growth and development of social work in that country and the manner in which the work has traditionally been done; cultural factors, differences between its own law and those of other countries; availability of professional staff and of community resources. South Africa's cultural heritage has been drawn from many sources, and has been shaped by her history to result in traditions and in a culture which are specifically her own (1996:2).

However it also acknowledges that it:

> has drawn heavily upon the knowledge of other countries, and particularly upon the Standards for Adoption Service issued by the Child Welfare League of America (1996:3).

Although there is an acknowledgement that adoption practice is never static and that there are 'discernible new trends in the theory and practice of adoption work' (1996:192) there is a stated expectation that the guide-lines should be followed:

> It is important that guide-lines are followed, although individual agencies may need to formulate policies that may deviate slightly from the guide-lines in order to accommodate local needs (1996:3).

This document was the only written policy available to adoption workers in the case study agency at the time of the research. Guidance on practice is thus considered alongside other case study data in order to address the question of how far the 'standards' for adoption practice are relevant to the development of an 'appropriate' adoption system for African children.

5. A Case Study of Adoption Practice in the Child and Family Welfare Society of Pietermaritzburg

This case study explores the way in which one adoption agency, The Child and Family Welfare Society of Pietermaritzburg (CFWSP) sought to 'indigenise' adoption services in order to promote it as an option for African children. It looks at the context within which CFWSP was operating and the factors which prompted changes to the adoption service. It then analyses the changes which were made and looks at the linkages between CFWSP and other key players in the adoption process. It considers the issues and dilemmas which were raised for the adoption workers as they sought to develop new ways of operating which would better meet the needs of African children.

6. The Need for Change

CFWSP amalgamated with the Pietermaritzburg Indian and Edendale Child Welfare Societies at the time of the first democratic elections in 1994. These societies had been the product of apartheid policies, which dictated that different agencies cater for different 'racial' groups. At the time of the amalgamation HIV/AIDS had been identified as a major challenge for the new Society. The first annual report spells this out:

> Latest estimates suggest that by the year 2000 Pietermaritzburg and the adjacent areas will generate some 12,000 A.I.D.S orphans. Levels of H.I.V. infection in the province of KwaZulu/Natal continue to outstrip the rest of the country and we are about 2 years ahead in the development of the epidemic (Annual Report, April 1993 - March 1994: 6).

Additionally, CFWSP was faced with a continuing problem of child abandonment. During the early 1990's KwaZulu-Natal was badly affected by political violence and this was reflected in the large number of cases of abandonment in the area. In 1991, there were some 300 children abandoned in the Province as a whole (South African Institute of Race Relations, 1994:159). The area around Pietermaritzburg was particularly badly affected by violence and, in 1991, there were around 70 abandoned children living in the local 'African' hospital. Although some of these children could be returned to their families, a significant proportion became available for adoption. Working in co-operation with others (notably the Thandanani Association) CFWSP set out to try to achieve adoption placements for these children. By 1993 their combined efforts had reduced the numbers of abandoned children in the hospital to around 35 (McKerrow, 1996b).

In order to address existing and impending challenges, the agency embarked on a strategic review of its services. Adoption was identified as a significant part of a wider

strategy through which the agency would attempt to tackle the additional problems which would be created by the AIDS epidemic (Interview, Director, 15-5-1996).

7. The Organisation of Adoption Work within The Child and Family Welfare Society of Pietermaritzburg

At the time of this research adoption work in CFWSP was undertaken by a team consisting of two full time and two part time social workers under the direction of a supervising social worker. Each social worker held a case-load of around 100 cases. The supervisor was responsible for the overall planning and co-ordination of adoption work, and the co-ordination and placement of abandoned children referred to the agency. She also spear-headed the initial development of the 'cluster' foster care scheme (described in the next chapter). In addition she held a case-load of approximately 100 cases. The supervisor described herself as seriously overloaded (Interview, 5-3 1997) and left the organisation shortly after participating in this research. The team received administrative support from a full-time secretary. At the time of the research the team reflected the continuing influence of past policies in which adoption was not seen as a service for Africans. The team consisted of a white supervisor, three Asian and one white social workers. Although CFWSP employed African social workers none was allocated to the adoption team. Only one of the social workers on the team was a Zulu speaker.

Adoption work constituted approximately 20% of the work of the agency. A large proportion of the rest of the work undertaken by the agency consisted of the supervision of children who were being fostered by relatives. The adoption social workers felt that this, mainly routine, work was un-stimulating and a poor use of their skills and abilities. They believed that it diverted the agency from being able to undertake more innovative work. The adoption team had received a limited amount of in-service training in HIV/AIDS. However, none of the social workers had undergone any specialist training in adoption work, nor had it featured significantly in their University courses prior to qualifying (Interview, social workers, 4-12-1996). There was a very limited amount of literature about adoption available in the agency to assist

the social workers in the development of this area of work, or which they might use in the preparation of prospective adopters. There were no written agency procedures and the only written guide-lines available were those produced by the National Council. The supervisor had access in a personal capacity to the internet which she used to keep herself up to date, although she found that most of the information gathered was not directly relevant to the South African context. Weekly discussion sessions, led by the supervisor, were held as a form of in-service training. However there were few other in-service training opportunities specifically related to adoption (Interview, supervisor, 20-2-1997).

8. Profile of Children Placed for Adoption: January 1994 to December 1996

In order to provide a 'backdrop' to the qualitative data, background statistical information about the adoption work of CFWSP was obtained by means of a questionnaire (see appendix 2). This information was sought in order to gain some understanding of the scale of adoption work undertaken by CFWSP. Statistics were obtained for the three year period running from January 1994 (when the three child welfare societies amalgamated) to December 1996. The figures include foster carers who adopted their foster child, but not relative adoptions (by step-parents or grandparents). In view of the fact that adoption statistics for the societies which amalgamated were not fully integrated until January 1995, there may be a small margin of error in the figures.

Table 3. shows that the total number of children placed for adoption between 1994 and 1996 was 121 and of these children 56% were African. Only 10% of the African children were placed trans-racially. The vast majority of the children placed were babies and toddlers. There was an almost equal number of boys and girls placed.

Table 3. Number of children placed for adoption January 1994 - December 1996, by 'race'; showing number of transracial placements.

'Race' of Children Placed	Number and % of Children Placed	Number and % of Children Placed Transracially
African	68 (56%)	12 (9.9)
Asian	28 (23%)	0
White	16 (13.2%)	2 (1.6)
Coloured	5 (4.1%)	0
'Race' not recorded	4 (3.3%)	0
Total	121	14

Table 4 shows the primary reason why a child was placed for adoption. Where more than one reason was recorded on the case file, the judgement of the supervisor, who knew the cases, was used to identify a primary reason. Nearly 30% of all the children placed for adoption between 1994 and 1996 were abandoned. All of these abandoned children were African. Orphanhood appears to constitute a negligible reason for placement. However, given the increasing rates of HIV infection in the Pietermaritzburg area it is highly probable that a number of the birth parents of abandoned children would have subsequently developed AIDS and died.

Table 4. Primary reason for placing children for adoption: January 1994 - December 1996.

Primary Reason	Number	%
Birth mother a minor/unready for parenthood	63	52
Child abandoned	36	30
Poverty of mother	21	17
Child orphaned	1	1
Total	121	100

9. Profile of Adoptive Families

Between 1994 and 1996 CFWSP received 151 applications from prospective adoptive parents. Table 5 shows that 132 were subsequently accepted as suitable and that 76% of those accepted were African. Table 6 shows that nearly a quarter (22%) of the African adopters accepted were single women.

Table 5. Number of adopters accepted as suitable January 1994-December 1996 by 'race'.

'Race' of adopters accepted	No. of adopters accepted	% of adopters accepted
African	100	76
Asian	16	12
White	13	10
Coloured	3	2
Total	132	100

Table 6. Number of adopters accepted as suitable January 1994 - December 1996 by 'race' and marital status.

'Race' of adopters accepted	No. of couples accepted	% of couples accepted	No. of single women	% of single women
African	78	72	22	88
Asian	16	15	0	0
White	10	10	3	12
Coloured	3	3	0	0
Total	107	100	25	100

10. Services to Birth Parents

Between 1994 and 1996 a total of 86 birth mothers were counselled by CFWSP about adoption. These included all the birth mothers of the Asian, white and coloured children placed, but less than half of the birth mothers of the African children. The National Council's guide-lines stress the importance of providing adequate counselling to birth parents, including notions of open adoption (1996;197), but CFWSP found

that they were unable to follow this advice across the board. They therefore developed an approach which would be responsive to the varying needs of the different 'racial' groups. White birth mothers in general presented to CFWSP early in their pregnancy and could receive intensive counselling, including issues of open adoption. Asian and coloured birth mothers tended to be less well informed, but most would still present for counselling. However, the concept of open adoption was found to be much less acceptable in these communities, so much less emphasis was placed upon it. The high incidence in the number of African children who were abandoned severely limited the ability of CFWSP to provide any counselling at all to African birth mothers (Interview, supervisor/Lindiwe, 20-11 1996). Only 29 African birth mothers out of a possible 68 received any counselling and even those who did often only received a minimal amount as they tended to present late in the pregnancy.

The National Council guide-lines recommend that adoption agencies should try to educate the general public, and also the medical and legal professions, about adoption. They also advocate the development of birth mother support groups (1996:144). However, there is no specific advice on ways in which African birth parents might be reached in early pregnancy. In order to address this issue CFWSP embarked on an information campaign which aimed to reach out to African birth parents. This was done through measures, such as raising awareness about adoption through the media (including the Zulu media), with education counsellors and in clinics and hospitals. Through these efforts the supervisor believed they elicited response from African birth mothers who would not previously have seen CFSWP as there for them. Nevertheless she was conscious that many African women do not get ante-natal care, so even where community health workers have been well informed about adoption, many expecting mothers are not reached (Interview, 20-2-1997).

11. Recruitment of African Adoptive Parents

The key to promoting adoption lies in devising successful methods of recruitment of adoptive families. For social workers who are used to having more families who want to adopt than children available, the need to recruit requires a new approach. The

National Council guide-lines, however, devote little attention to this crucial area of practice. There is a recommendation that recruitment programmes of adopters for 'hard-to-place' children should be launched (1996:196), but no advice on methods of recruitment, or discussion of the specific issues to be addressed when recruiting adopters from different 'racial' and cultural backgrounds.

Literature from the USA and Britain shows that in the 1960's and 1970's, there was a general lack of understanding about, and knowledge of adoption within black communities (Costin and Rapp, 1994 cited in Pakati:1992:68). Little attempt was made by adoption agencies at that time to reach out to ethnic minority groups. It was generally accepted by adoption workers that adoption was not a part of black 'culture' and that black adoptive families simply could not be found. The development of transracial adoption as an option for black children found justification in such ideas. In South Africa apartheid legislation forbade transracial placements, but the scrapping of this legislation has led to its practice. Arguments similar to those used in the west concerning the difficulties of recruiting African families have been used to explain the need for the development of transracial adoption (Ledderboge, 1997:2). Recruitment efforts which used a community education approach, such as the 'soul kids' campaign in London, however showed that once black people in Britain were made aware of the needs of black children in care, and were given the message that they have something to offer, they would respond (BAAF:1991:1).

Making contacts with community groups, giving talks and setting up meetings has proved to be a particularly effective method of recruitment of black families in Britain, as has recruitment by 'word of mouth' (BAAF, 1991:2). Recruitment by word of mouth has also been found to work well in South Africa (Pakati, 1984:175). CFWSP identified public education and word of mouth as their most successful methods of recruitment, but believed that of even greater importance than any recruitment method was the initial response of the agency to enquirers:

> In the black community recruitment has just snowballed since the amalgamation and the (first democratic) election. There's now a greater

> knowledge about and access to Child Welfare in the black community and a greater knowledge about abandoned children. Some adverts have been put in the papers and around hospitals, but mainly recruitment has been by word of mouth. Pietermaritzburg is a small community and if people are treated with dignity they suggest to their friends that they should approach the agency. Being an accessible agency has been the most important factor rather than any specific type of recruitment. The problem is that most adoption agencies are not accessible in this way (Interview, supervisor, 20-2-1997).

Ensuring that people from rural areas have accessibility to an adoption agency is, however, more problematic, especially as the accredited adoption agencies in South Africa are all based in urban areas. Developing community out-reach campaigns to raise awareness about adoption in rural areas thus poses specific challenges. In 1992 Pakati called for research to be completed on adoption in rural African communities, however this remains a major gap in the literature. In view of this, an example of the recruitment of adopters in a rural area of KwaZulu-Natal is described below. This work was undertaken by a social worker (who I have called 'Lindiwe') and is included because she collaborated with CFWSP in the placement of abandoned children. The information presented was gathered through an interview with Lindiwe (25-4-1997) and its validity checked through sharing the results of the research with participating CFWSP staff.

During the early 1990's Lindiwe was employed as a social worker in a children's home in rural KwaZulu-Natal. In addition she acted in an out-reach capacity as a community social worker and as part of this role established a women's group. Lindiwe used the women's group to raise awareness about the needs of the children living in the children's home where she worked. Lindiwe also informed the women about adoption and made them aware that this was an option which was open to them. This was the first time many of the women had been aware that they could legally adopt a child. Lindiwe then embarked on a process of linking those children in the children's home who did not have contact with their birth families with a number of women who had

expressed interest in caring for a child. She arranged for them to get to know the children and later for the children to spend weekends with them. As the children developed relationships with their new carers Lindiwe began to receive requests from both the women and the children that the arrangements should be made more permanent through adoption.

Pakati (1984 & 1992) found that an important reason for the preference for adoption over caring for the child of a family member is that adoption is permanent and gives the carers full parental rights. Lindiwe similarly found that the childless women she worked with were reluctant to care for the child of a relative because they may have to relinquish the child in later years. She found that once people knew that adoption was 'for ever', recruitment of prospective adopters spread by word of mouth. By 1993 Lindiwe knew of approximately 30 families who were interested in adoption. She set up a support group to provide preparation for adoption and to address fears and myths about adoption issues. By 1997 Lindiwe estimates that she had recruited approximately 60 African adoptive families, mainly from the original rural area, but also from other parts of KwaZulu-Natal, other South African provinces and even one family living in Britain.

Previous research on adoption in South Africa has suggested that Africans do not adopt because of a complex set of cultural factors which act as barriers (Pakati, 1984 & 1992, Ledderboge, 1997). However Lindiwe found that, at least in one area of rural KwaZulu-Natal, there was an un-tapped interest in adoption. Four factors appear to have been significant in terms of recruitment. First, using a community out-reach approach through existing community forums to inform and educate people about adoption. Second, raising awareness within the community about children in need of families and linking people who expressed an interest to 'real' children. Third, allowing the positive experiences of adoption by a few people to spread gradually by word of mouth. Finally, responding positively to people who wish to adopt and establishing a support networks to deal with myths and fears about adoption.

12. Processing Adoption Applications

Successful recruitment is only a first step in ensuring the availability of sufficient numbers of adoptive parents. Experience in western countries has shown that the initial contact which an interested family has with an adoption agency is crucial, particularly for black families who often feel alienated by 'white' organisations. Guide-lines produced for British social workers for example state:

> It is important that workers understand the 'ripple' effect of negative and positive contact first experienced by individuals. Experiences are quickly shared within communities and decisions are made based on this information as to whether or not particular agencies are worth approaching or not. Hence the backlog of families awaiting assessment in some agencies, whereas others have few enquiries from black families (BAAF, 1991:3).

The South African National Council guide-lines again pay scant attention to the issue of ensuring a positive first contact with the agency. The emphasis in the section on prospective adopters is rather on the importance of determining the 'eligibility and suitability' of adoptive applicants via a 'preliminary screening' process (1996:57-63). There are a number of problems with this approach. First, 'screening' in adoption has traditionally been used as a way of limiting the over-supply of prospective adopters for the dwindling number of available babies. Whilst the need to establish suitability is indeed a necessary part of the adoption process, the stress on 'screening' at the early stages of contact is less appropriate when there is an over-supply of children and an under-supply of interested families. Second, the process of 'screening' tends to be authoritarian. Social workers in this model make critical decisions about individuals' lives and prospective adopters are disempowered. People from disadvantaged groups will find this an intimidating process and will need convincing that their interest in adoption is valued if they are not to be put off by the initial contact. It is for this reason that many adoption workers now use a more participatory and educative model, 'assessing' a family's suitability to adopt through education about the task and preparing

them for adoption. Finally, even if interested individuals are clearly not eligible to adopt due to a legal requirement, such as age or nationality, they may well approach the agency again at a later stage when their circumstances have changed, or they may know someone else who might be thinking of adopting. The response which they receive from the adoption agency to their enquiry will determine in which way the 'ripple' effect in the community will operate.

CFWSP adoption team were conscious that their response to potential adopters was important. They had identified accessibility as one of the most important reasons why they were losing potential African applicants. Other areas of practice were also identified as important. These are spelled out in an internal document:

> The following areas make it very difficult for Black applicants to complete the required screening process and to be placed on adoption waiting lists:
>
> Low levels of education and illiteracy, this makes it nearly impossible for many people to complete application forms, to obtain and supply references, to attend orientation groups, to submit profiles and to articulate their feelings and thoughts during the screening process. The financial cost and cultural insensitivity of medical investigations need to be looked at. HIV and infertility testing is often interpreted as discriminatory by Black applicants.
>
> Low socio-economic status, including inadequate housing, informal employment and small and sometimes irregular incomes.
>
> Logistical problems in attending interviews and group meetings required by the adoption agency; most Black families are dependent on public transport which is unreliable, sw's (social workers) have to provide transport if necessary.

> The inaccessibility of the adoption agencies for rural and semi-rural clients. The accredited adoption agencies are situated in the major cities. No infrastructure or expertise exists outside these areas of operation.
>
> Regrettably, many Black families are treated with suspicion when they attempt to adopt children. It often appears their motives are distrusted (Internal document, 31-10-1995).

In order to address these problems CFWSP decided to alter procedures which had been devised for a mainly white clientele. Under the previous system people who enquired about adoption were told that an application could only be processed when the 'lists' were open. This happened a couple of times a year, when a small number of applicants would be taken from the 'lists', were invited to 'orientation' groups and would commence screening. Unlike white and Asian adopters, who would normally make an initial enquiry by telephone, African adopters generally called at the office. They were either seen by a duty social worker and given lengthy application forms, in English, to complete, or else they were asked to leave an address or phone number and told that someone would be in touch. As many of these people lived in informal settlements it sometimes proved impossible to trace them.

The new system aimed to ensure that anyone enquiring at the office about adoption would be seen by one of the adoption workers. Intake workers and receptionists were trained to treat people sensitively and positively. There were no 'closed lists' for African applicants and waiting times for assessment were minimised as far as possible, through scrapping the requirement to attend 'orientation' groups. Application forms in Zulu were produced and forms were completed as a part of the interview procedure, where appropriate completed for the applicants by the social worker (Interview, supervisor, 3-3-1997).

13. Assessing 'Suitability'

Adoption is the only procedure which legally transfers parental rights in such a final way from one family to another. This places an expectation on adoption workers to ensure that they 'get it right', that they are providing a child with a 'better' life than s/he would otherwise have. This has led to a tendency in adoption practice to go for the conventional view about what makes a 'suitable' family (Hill, 1991). This has typically meant the nuclear family. Considerable emphasis may be put on such things as age, a stable marriage, secure employment for the husband, a wife at home to provide care for the child, suitable housing and good access to schools and medical facilities. Families from cultures with alternative family patterns which do not meet the conventional western family model may be seen as 'deviant or dysfunctional' because they do not meet expectations of what is viewed as 'right' or 'acceptable' (BAAF, 1991:3).

During the last decade the drive to find adopters for a much wider range of children has altered ideas about what constitutes 'suitability' to adopt. According to Pakati (1992:60) this shift has occurred in South Africa, however this does not seem to be reflected in the National Council's guidance. Certainly the guide-lines acknowledge that there is a need for agencies to be flexible. They also acknowledge a need to 'develop a greater understanding of the cultural needs of different population groups' (1996:196). Nevertheless, the overall impression is for two different tests of 'suitability', one which applies to families adopting children who can easily be found a home, and another to families adopting children who are less easy to place.

Thus although guidance recommends that agencies place upper age limits of 40 years for a female adoptive applicant and 45 years for a male, they suggest that there should be flexibility:

> when considering applicants for hard to place children, abandoned children, or babies and children with health or developmental problems (1996:59).

The guide-lines also up-hold the principle that 'the object of adoption is to give the child a home with a father and a mother', but recommend that single parents can be considered:

> where there are special circumstances such as blood relationship and existing family contact with the child concerned, or for the hard to place child in the absence of suitable couples (1996:60).

The implication that single parents are a second best choice does not reflect the realities of contemporary family life in South Africa, particularly for Africans, among whom single parenthood is common.

Again, apart from some discussion about types of marriages deemed to be legal for the purposes of adoption, there is little guidance about the need for cultural awareness or sensitivity in assessing different forms of marriage or partnerships. The guide-lines recommend a minimum of five years of marriage prior to an adoption application, in order to demonstrate stability, and a maximum of twelve years. The reasons given for the upper time limit is that people who delay applying to adopt may lack a 'real desire to parent a child', that they may have become 'set in their ways' (1996:61). Research, however, has shown that African couples often decide to adopt only after many years of marriage. In Pakati's (1992:149) sample of adopters, for example, the average length of marriage at the time of application was 12.9 years. This meant that the average age of the adoptive mothers in the same sample was 38.8 years, or only just under the recommended upper limit of 40, whilst the average age of the adoptive fathers, 53 years, was much higher than the recommended 45. Pakati's explanation for the relatively advanced age of African adoptive applicants is that the importance of child bearing is so strong in African culture, that childless couples will only consider adoption when they have reached such an age that they consider that there is no longer a chance of having a child by natural means.

In relation to income, employment and housing the guide-lines give little attention to levels of unemployment and job insecurity, especially amongst Africans. Nor do they

make reference to the fact that many people live in overcrowded conditions, or in areas where there are few facilities. Suggestions for example (1996: 68-69), that enquiries should be made whether prospective adopters have made any financial provision for the future by way of insurance or other means, or the expectation that the 'wife' obtain six months maternity leave, or that the social worker should observe whether the 'wife is over house-proud' and whether the pool is child safe, contain assumptions based not only on 'race' and culture but also on class and gender.

14. 'Indigenising' Adoption Practice

The CFWSP adoption team recognised that if they were serious about placing African children for adoption they would need to make their practice far more accessible. They identified the need not simply to alter their procedures, but also to question their assumptions about what constituted a 'suitable' family. They found themselves increasingly faced with having to make decisions about adoptive applicants who were living in 'third world' rather than 'first world' conditions. Many of the African families who approached them were living in poor quality and over-crowded accommodation, in informal settlements, had very low or uncertain incomes, and lived in multi-generational households (Interview, social workers, 4-12-1996). CFWSP were approached by couples living in various forms of marriage or partnership, and by a significant proportion of single prospective adopters. The team found that, although many of the women had male partners, the women were in effect socially, emotionally and financially independent. They also found that a female applicant would sometimes put her father or her brother down on the application form as 'husband', because the real husband was away working and they thought that another male should be put forward in his stead (Interview, supervisor, 4-3-1997).

The organisation was faced with the need to take professional risks in making adoption placements with such families, since there was little previous experience and negligible literature on which to judge the likelihood of success for the placements they made. There were additionally some personal risks for the social workers, as they were increasingly required to 'go townshipping' (as they termed it) that is to make home

visits to townships in which there were high levels of crime and violence (Interview, Director/supervisor, 14-11-1996). The potential for these factors to have a negative impact on the work of the team was highlighted during the course of this research when a social worker from the fostering team was held up at knife point and the decision had to be taken to suspend visits to the area in which the attack occurred until protection from the local political structures could be negotiated (Interview, social workers, 4-12-1996).

In 1994 the rural social worker, Lindiwe approached CFWSP with the suggestion that they might consider using the group of prospective adopters whom she had recruited for some of the abandoned children they had on referral. Prior to approaching CFWSP, Lindiwe says she had approached a number of other adoption agencies which were located closer to the interested families. She had, however, found considerable resistance among social workers (of all 'races') in those agencies to the idea of placing children in rural areas. She had found that there was a generally accepted view that urban life was preferable to rural life, and that it would be doing a disservice to children to place them with rural families. One adoption agency met with Lindiwe and the group of prospective adopters and agreed to 'screen' them, but subsequently decided not to proceed. According to Lindiwe the reasons for rejection of the families included issues relating to the personal circumstances of the applicants, such as advanced age, single parent status and polygamous marriages, as well as issues relating to the realities of rural life such as poverty, lack of water and electricity, poor access to health care and poor schooling (Interview, Lindiwe, 24-4-1997).

CFWSP adoption workers agreed to meet with Lindiwe and with the rural families and, having done so, decided to consider them as potential adopters. It was decided that a co-operative approach would be the best way forward, that Lindiwe would undertake the assessments of the families and would link with the local child welfare in the area where the families lived. This agency would formally approve the families and undertake supervision of the placements up to adoption. However, since CFWSP would be the organisation responsible for matching the child with the families, the CFWSP adoption team also needed to be assured that the families were suitable as

adopters. The team therefore spent time, with Lindiwe's assistance, considering their assumptions and prejudices and in looking at how these might act as a barrier to families coming from a 'third world' environment. Issues which were addressed included changing methods of assessment of a family's financial stability from a consideration simply of income and employment, to a view of family wealth which took into account such things as a family's goats and sheep; being prepared to assessing an entire extended family as the adopters rather than simply an individual or a couple; and considering the positives for children (such as good support networks) which might exist in a polygamous marriage (Interviews, social workers, 4-12-1996; supervisor, 5-3-1997; Lindiwe, 25-4-1997).

15. Secrecy versus Openness in Adoption

Three of the most important tenets of modern adoption are first, that reasons for adoption and details about background should be made known to an adoptee, in order that s/he might develop a clear sense of identity. Second, that a child should be brought up in the full knowledge of the adoption. Third, that adoption should be an open topic, at least within the immediate family, but preferably within the extended family and the wider community. These all rely on a recognition by adoptive parents of the differences between adoptive parenthood and biological parenthood. The National Council guidelines stress the importance of these issues:

> Among the matters which will need to be discussed (with prospective adopters), one of the most important will be that of telling the child that he is adopted (1996:77).

> The attitude to adoption of the couple's own parents and the members of their immediate family should be ascertained... it is important to know whether the adoptive parents will have to contend with antagonistic feelings from them which in turn could have an adverse effect on the child (1996:76).

Most adoption literature assumes that background information about the child can be made available to the adopters. Very little attention is paid to the issue of abandoned babies, since abandonment is a much rarer phenomenon in more affluent societies. Helping adoptive parents to understand that they should tell a child about his/her background when they do not even know the identity of the birth parents is a complex task on which there is little available guidance from western sources. Nor, despite the high rate of child abandonment in South Africa, does this issue receive any special attention in National Council guidance. Moreover, principles of 'openness' in adoption do not easily translate into societies in which there is a strong stigma attached to infertility. The little South African research which is available (Pakati, 1984; 1992; Shishuta, 1996) suggests that maintaining secrecy about a child's background is the norm rather than the exception among African adopters and foster carers. These studies found a marked reluctance among African adoptive and foster parents to tell children about their origins. This was not only due to a need on the part of childless couples to keep their infertility a secret, but also due to fear that 'telling' would seriously undermine their relationship with the child. These fears applied even where children were fostered by relatives (Shishuta, 1996:120). A similar opposition to 'telling' has been found elsewhere in Africa, for example in Malawi where Bandawe & Louw (1997) found strong views among foster carers that children should not be told that they were fostered.

This discrepancy between western adoption theories and the influence of opposing cultural norms created a difficult ethical dilemma for CFWSP as the social workers worked with increasing numbers of African adoptive applicants who made it clear that there was a strong likelihood that children placed would be brought up in ignorance of their adoption. This was especially problematic in view of legislation which enables adoptees to have access to their birth records when they reach adulthood. The organisation was faced with the reality that to reject applications on the grounds that the adoption would remain a secret, would result in the rejection of many of African applicants. It was therefore decided to adopt an approach which would be sensitive to the different cultural contexts from which adoptive applicants came. It was decided that it was inappropriate to expect African adopters to embrace concepts which had

been developed in very different contexts. They recognised that it was only in recent years that 'open' adoption had become an acceptable idea amongst white adopters. They had also noted that while 'open' adoption was still not acceptable to the majority of the Asian adopters they worked with, there had been a perceptible shift away from an insistence on total secrecy, reflecting changing social attitudes in that community.

The team therefore adopted a working model which took different approaches to the issue of 'openness' with adopters from different 'racial' and cultural groups. All adopters were encouraged to tell a child and close family members about the adoption, but this was not insisted upon if there was a high chance that a child might be rejected by the family, or by the wider community. The main stipulation was that, in all cases, partners of adoptive applicants must be informed of, and included in, the application. This was because there had been a number of instances where women applied to adopt having told their partner they were pregnant. These women wanted a baby to be placed by a certain date so that they could pass the child off as their own. Ways in which adopters could explain the arrival of a new child were discussed with applicants. As extra-marital affairs of men tend not to be generally stigmatised, and family lineage is patriarchal, one frequently-used 'cover story' was to introduce the child as an extra marital child of the male partner (Interviews, director/supervisor; 14-11-1996; social workers, 4-12-1996; supervisor, 5-3-1997).

Interestingly, the need for secrecy was reportedly less of an issue for the group of rural adopters recruited by Lindiwe. The setting up of a support group seems to have helped to overcome some of the problems of secrecy. Although the whole group agreed to be bound by confidentiality, adopters were much less isolated. Support group sessions were used by Lindiwe to stress the importance of telling the children about adoption and of the dangers inherent in children learning the truth from someone other than the adopters. However, Lindiwe did not believe that the prospective adopters should be turned down by agencies on this issue because 'openness' was a concept which was alien to them. More important in her view was the need to develop post-adoption support, so that adoptive parents could be helped to talk about adoption as the children matured (Interview, Lindiwe, 25-4-1997).

16. The Importance of Inter-Agency Co-operation

Adoption usually requires that a number of agencies and professionals work together to perform different roles in the adoption process, although these will vary from country to country. The list which follows illustrates the complexity of the adoption process and the importance of good inter-agency co-operation:

1. Counselling of birth parents and obtaining background information. This role may be undertaken by the social worker from an adoption team in a child welfare society, by a different social worker from the same agency, by a social worker from another child welfare agency, or by a hospital social worker.

2. Tracing the birth parents of an abandoned child. This role may be undertaken by the police, by a child protection unit, or by social workers.

3. Preparing children for placement and obtaining documentation about the child. This role may be undertaken by hospital-based social workers, by social workers from the adoption agency, by another child welfare agency, or by a residential child care worker or a foster parent.

4. Providing medical information on the child. This may be undertaken by a community or a hospital-based doctor, or by a doctor engaged by the adoption agency as a medical adviser.

5. Recruiting prospective adopters. This role may be undertaken by the social workers responsible for undertaking adoption assessments, by other social workers in that agency, by residential child care workers, or by community- based 'homefinders'.

6. Assessing prospective adopters. This role may be undertaken by one social worker working alone, or co-working with other social workers.

7. Approval of adoptive parents. This role may be the responsibility of adoption agency staff, or of an independent committee appointed on behalf of the agency.

8. Support of the placement. This role may be undertaken by the agency which assessed the adopters, or by another child welfare society located nearer to the home of the adopters.

9. Legalisation of the adoption. This role may be undertaken by judges, magistrates, commissioners or other officers appointed by the courts.

CFWSP's working relationship with Lindiwe has already been described, however the adoption team had to work co-operatively with a number of different organisations in order to achieve adoptive placements. By way of illustration, the placement of each abandoned child with one of the rural families recruited by Lindiwe is shown in the following table.

Table 7. Roles of Key Players in the Adoption Process

Lindiwe	Recruitment/assessment and support of adopters
Child Welfare in adopter's locality	Approval of adopters/supervision of placement
Thandanani Co-ordinator	Obtaining reports and documentation
Hospital Social Workers	Seeking potential extended family carers
Child Protection Unit	Attempts to trace child's birth parent
Paediatrician	Completing medical information on child
CFWSP adoption team	Matching child with adopters
Commissioner of Child Welfare	Legalisation of adoption

Any process which involves such a diverse number of organisations, individuals and professions runs a high risk of bureaucratic delays, professional jealousies, mistrust and a breakdown in inter-agency co-operation. Children who might otherwise be placed for

adoption can easily get caught up in the system and as a result remain in inappropriate and costly hospital or residential care. Poor co-operation between agencies appears to have been one contributing factor to the high number of abandoned children who were living on hospital wards in Pietermaritzburg in the late 1980's. The Thandanani Association, Abandoned Children's Project (ACP), was formed at that time to find family placements for these children. ACP identified the need not only to recruit adoptive families, but also to try to break down some of the bureaucratic barriers. Although ACP's homefinding role gradually fell away, the need for someone to liaise between the various agencies remained. The co-ordinator of the ACP explained the benefits of her role as follows:

> I can concentrate on the needs of abandoned children and can make sure that they don't get forgotten. The hospital is very big and the clientele is very needy. There are only four or five social workers in the hospital and they have many competing demands on their time. My role is to give sole attention to the abandoned children and do what is needed to get them moved out of the hospital. Coming from an outside agency it has been possible to act as a link person and to get people to take responsibility for performing their roles (Interview, 25-4 1997).

The ACP co-ordinator's role included:

1. The identification of abandoned children in the hospital and referral of the children to CFWSP. Monitoring the progress of the children, providing up-dating information to CFWSP and assisting CFWSP where appropriate in decision-making about the children's future.

2. Monitoring the progress of the Child Protection Unit's enquiries into tracing the birth parents and encouraging CPU officers to complete their reports swiftly.

3. Liaison with the hospital social workers, monitoring the progress of reports and encouraging an early completion of these reports.

4. Liaison with the doctor responsible for medical examinations of the children and encouraging a swift completion of reports.

5. Ensuring that each child has a birth certificate.

Since the intervention of Thandanani, the numbers of abandoned children living in the hospital and the risk of them being left to 'drift' in the system have been greatly reduced. There have been benefits too for the CFWSP adoption team, who have been relieved from much of the time-consuming task of chasing paperwork and freed-up to concentrate on other roles, such as the recruitment, assessment and support of adoptive families (Supervisor, 20-2-1997).

Some of the positive links which the CFWSP adoption team built with a variety of organisations and individuals have been explored in this section. A significant gap, however, was the lack of opportunity for CFWSP adoption workers to meet with workers from other adoption agencies. There was a dearth of forums through which ideas could be exchanged, policy debated, strategies planned or resources shared. The development of strong links between adoption agencies is necessary if the best use is to be made of the available resources. In Britain, for example, one of the significant factors in the shift from placing healthy babies to placing children with 'special needs' was the development of local adoption consortia and a national adoption exchange. Through these means agencies were able to debate policy and to ensure that agencies seeking adoptive placements for 'special needs' children had access to all suitable adoptive families. The National Council has recognised the value of such a system for South Africa and has suggested the establishment of:

> an adoption resources exchange, which would be effective in the co-ordination of adoption services and which would establish and maintain a central register of applicants and to which agencies could refer in cases where the right adopters for a particular child were not locally available (1996:194).

For such a system to operate successfully however, there would need to be some agreement among adoption workers about 'standards', including views of what constitutes a 'suitable' adopter. CFWSP, however, found that their approach to the recruitment and assessment of black families was not necessarily shared by other adoption agencies. Thus there were instances when other agencies were reluctant to use CFWSP's adopters, even though they did not have readily available adopters of their own for a particular child (Interview, director/supervisor, 14-11-1996).

A further problem area for CFWSP lay in the fact that South African Commissioners of Child Welfare have considerable powers of discretion and judicial independence in relation to adoption. CFWSP found that the courts were at times reluctant to grant adoption orders to their African adopters. According to an internal document the Commissioners at times use their powers:

> in a manner which is not based on solid legal and child-rearing principles. Many decisions and strategies of Commissioners of Child Welfare are not in the interest of the child concerned (Internal document, 1995.)

Matters of particular concern to the Commissioners of Child Welfare were the financial stability and the marital status of some of the applicants. A further problem lay in the reluctance of Commissioners to make abandoned children legally available for adoption by dispensing with the consent of the birth parents. There are two possible explanations for this. According to CFWSP:

> Abandonment is a vague and undefined concept in our law- this results in a situation where many children become trapped in the legal and welfare system. Procedures for dealing with these children are unclear and results in confusion and unnecessary delays. Different courts and welfare agencies differ on the ways to deal with these children (Internal document: 1995)

The National Council agrees that there is a problem but does not see this as lying within the legislation:

> The problem is not so much with the section (of the act) as with the reluctance of Commissioners to dispense with parental consent (1996:206).
>
> Commissioners seem to be afraid to use this article and children are left in foster care (1996:207).

As all the abandoned babies were African this meant that there was a greater chance that these children were more likely to be deprived of an adoptive placement than children from any of other 'racial' groups. The CFWSP adoption team therefore needed to spend time in discussion and consultation with local Commissioners of Child Welfare in order to help them to consider the needs of abandoned children and the realities of African family life.

17. Conclusion

Adoption as currently practiced in South Africa draws heavily on western theory and research. Adoption theory and practice are not, however, fixed. Ideas about adoption have taken many different forms reflecting the attitudes, social policies and socio-economic conditions of the time and place where it is practiced. This case study has looked at possibilities for, and barriers to, the development of a more 'indigenous' adoption service for South Africa. It seems likely that the numbers of African children who are adopted in South Africa will remain small in proportion to the numbers given substitute care by their kin. However, the AIDS epidemic is set to diminish the ability of the extended family to cope and there will be a growing need for other forms of care for children who fall through the traditional safety-net. As most HIV/AIDS affected children in South Africa will be African, this study has concentrated on the development of an adoption service for African children. The chapter has highlighted the critical part which agency procedures and professional attitudes play in making a

service more accessible to African adopters and birth parents. It has looked at the potential clash between western adoption theories and African cultural norms, for example the stress on 'openness' as opposed to the need for secrecy due to the stigma of childlessness. The study has also looked at the complexity of the adoption system and has highlighted the importance of inter-agency and inter-professional co-operation. These themes will be explored further in the last chapter of the thesis.

The next chapter looks at another type of family care developed by CFWSP. It was the practice of CFWSP at the time of this research to place abandoned children who tested HIV positive in foster care rather than for adoption. Reasons for this and the 'cluster' foster care model which was developed are described in the following chapter.

CHAPTER 8

MAXIMISING RESOURCES: A CASE STUDY OF A 'CLUSTER' FOSTER CARE PROJECT FOR HIV POSITIVE CHILDREN.

1. Introduction

The main theme of the third case study is resource maximisation. Public expenditure is currently subject to tight fiscal control in South Africa in line with the government's macro-economic strategy, GEAR. The White Paper for Social Welfare exhorts service providers to 'maximise (their) existing potential' (1997:5), that is to find cost-effective ways to use resources. The promotion of community care appeals to policy-makers as a cost-effective means of providing care for vulnerable individuals. There is little dispute that community care is often preferable for an individual's psycho-social development than institutional care. It is also generally much less expensive (at least from the state's perspective). However, as feminist writers have pointed out, 'community' care policies cannot be implemented without a cost. Savings to the state may simply be transferred to the individuals (generally women) who are the care providers.

Abandoned children infected by the HIV virus often spend their lives in costly hospital or residential care. This chapter looks at a community care initiative, a 'cluster' foster care scheme, developed by the Child and Family Welfare Society of Pietermaritzburg for HIV positive children to get children out of hospital and institutional care. This case study traces the development of the scheme. It considers the implications, both for the project and for the carers, of developing the scheme in a climate of financial constraint and in a context of widespread poverty. In order to place the 'cluster' foster care scheme in context, the chapter begins with an overview of the theory and practice of foster care and traces the development of fostering in South Africa. It then considers the growth of special fostering schemes, before moving to a discussion of the case study data.

2. Foster Care: An International Perspective

Fostering is probably the most widely practised form of substitute care for children world-wide. There are many different kinds of fostering, and definitions of 'foster care' vary internationally. A recent review of foster care in twenty two countries (Colton and Williams, 1997: 44-49) found considerable diversity in the way fostering is both defined and practised. Kinship foster care, which is the most common form of fostering in Africa, is not defined as 'foster care' in all countries. In Ireland, for instance, only children placed with non-relatives are said to be 'fostered'. In some countries foster care is defined as applying only to children placed through official channels, whereas in others it includes children living in informal arrangements. In some countries foster care is seen strictly as a temporary arrangement, whereas in others the norm is for long-term and quasi-adoption placements. Given these diversities Colton and Williams suggest the following inclusive, if rather cumbersome, definition of foster care:

> 'Foster care' is care provided in the carers' home, on a temporary or permanent basis, through the mediation of a recognised authority, by specific carers, who may be relatives or not, to a child who may or may not be officially resident with the foster carers (1997: 48).

3. Foster Care in Africa

Much of the literature on fostering in Africa emanates from West Africa (Goody, 1982). A study of fostering in West Africa by Isiugo-Abanihe (1985) identified five main types. Most of these are informal arrangements which rely on fostering within the extended family.

1. Kinship fostering. Used as a way of ensuring the most effective use of resources within a kin group and strengthening kinship ties.

2. Crisis fostering. Used to provide care for children whose parents are unable to care for them due to death, separation or other crisis.

3. Alliance and apprentice fostering. Used to give children a chance of social mobility, usually by sending them to live with someone who can teach a trade.

4. Domestic fostering. Used more often with girls than boys, to provide domestic assistance, normally to a relative.

5. Educational fostering. A contemporary form of alliance/apprentice fostering which entails fostering children out to an individual who agrees to fund their education.

Foster care throughout Africa consists predominantly of informal fostering by relatives. A few African countries have state-run fostering services, but these are typically over-stretched. In recent years it has been left to the NGO sector to develop fostering services in response to the increase in orphanhood due to HIV/AIDS (Parry, 1996). Since NGOs are generally small and unable to provide universal coverage, fostering schemes are typically restricted to small pockets within a country (Hampton, 1990:18; Barnett and Blaikie, 1994:120; Mukoyogo &Williams, 1991: 120).

There are only a few examples in the literature of innovative fostering schemes in Africa. These include models which provide care for an orphaned group of children in their own home rather than moving them to a foster home. These models either entail foster carers moving in to live with the children, or, where the children are older, volunteers providing regular home visits to monitor the progress of the children and to give emotional and practical assistance (Chandra Mouli, 1992:47; Barnett & Blaikie, 1994: 121; Foster et al, 1995). One interesting new approach is being developed for AIDS orphans living on commercial farms in Zimbabwe. Approximately one million children live on these farms. Their parents tend to be isolated from their extended family, which means that when they die, care options outside of the extended family need to be sought for the orphans. The Farm Orphan Support Trust (FOST) is working closely with the Zimbabwe Department of Social Welfare to pilot and monitor different models of foster care. The models identified so far include recruiting older women to care for a number of children, appointing older siblings and neighbours to oversee the care of young children, and encouraging families to care for non-related

orphaned children without having to undergo legal formalities. Benefits have been identified as minimising disruption for children, keeping siblings together, preserving children's culture and identity, promoting community involvement, protecting future employment opportunities in agriculture for children and being a relatively low cost option. Nevertheless schemes such as this require resources, and FOST has recognised that competition for international funds will increasingly outstrip supply as the AIDS epidemic spreads. Innovative forms of funding to enable the expansion of the scheme are being explored. These include raising funds from the business sector as well as identifying areas of indirect government support, such as free education and health care for orphans, and the possible introduction of tax credits for farmers who provide good schemes (Parry, 1996:12-13 & 1998).

4. Foster Care in South Africa

Many children in South Africa live apart from their parents either temporarily or permanently. Kinship care is common, especially in the African population. These arrangements are generally informal, being agreed between individuals without recourse to formal rules and regulations. By contrast, formal foster care is defined by law and its practice is informed by regulations and procedures. Like adoption, the practice of formal fostering was introduced into South Africa and has been based on fostering theories developed in the west.

In the late 1980's a Committee of Inquiry found that most children in formal foster care were in 'unplanned, long-term placements' (de Bruyn, 1990:106) and it sought to rectify this by stressing the importance of restoring children to their parents. Fostering was seen as essentially a temporary phenomenon and the main aim of welfare services was to work towards restoring children to their parents. This model reflected western fostering theory of the 1980's (Maluccio et al, 1986; Fratter et al 1991; Triseliotis, 1991) which placed emphasis on the importance of 'permanence planning' for children. The fostering process, like the adoption process, is lengthy. Fostering applicants must be assessed and trained prior to approval. Foster carers are also subject to 'statutory supervision' from social workers for the duration of the placement. A foster care order

gives foster parents temporary custody of a child. The court must be satisfied that foster care is in the child's best interests and requires an extensive social work report on all the circumstances. Foster care orders are granted for a maximum of two years at a time and, in order to be renewed, the court requires an up-to-date social work report. Foster care orders normally terminate when the child reaches eighteen, although they can be extended in exceptional circumstances (Bosman-Swanepoel & Wessels, 1995: 47-49).

A foster care grant is payable to authorised foster carers amounting in 1997 to R340 per month (Neilson, 1997). In 1995 approximately 55,000 grants were being paid, at a cost to the state of around R200 million per year (Report of the Lund Committee, 1996:80). Unlike most other benefits, the foster care grant is not means tested (Black Sash/Department of Welfare, 1996:5). Foster care grants were originally introduced to assist non-relatives to foster white children, so it was often difficult for Africans to obtain them.

Figures which give a 'racial' breakdown of foster carers nationally are not readily available (Lund Committee, 1996:80). Figures provided by the South African National Council for Child and Family Welfare for the purpose of this research (Table 8) shows that only 17% of the 9188 children in foster care through the Council's affiliated Societies during 1996 were African.

Table 8. 'Racial' breakdown of children in foster care through Child and Family Welfare Societies affiliated to the National Council for the year 1996.

'Race' of foster children	Number	Percentage
African	1582	17
Coloured	4048	45
Indian	973	10
White	2585	28
Total	9188	100

(Source: South African National Council for Child and Family Welfare, 1996a)

However these figures do not necessarily reflect the national picture since the Child and Family Welfare Societies serve mainly urban areas. Moreover the numbers of

foster children represented in these figures is only around 16% of the total number of children for whom foster care grants are being paid nationally (9000 as % of 55000). Neither do the figures reflect the 'racial' breakdown of fostering work undertaken by individual affiliated Societies. Statistics on fostering were provided by CFWSP through a brief questionnaire (See appendix 3). Table 9. below shows that 60% of CFWSP's foster carers were African, representing a far higher proportion than the national figure of 17%.

Table 9. Number of Foster Families with Child and Family Society of Pietermaritzburg at Sept 1997 by 'race', and whether related or un-related to foster child.

'Race' of foster families	No. of foster families	% of foster families	No. of kin carers	% of kin carers	No. of non-kin carers	% non-kin carers
African	399	60	300	75	99	25
Coloured	130	20	54	41	76	59
Indian	114	17	74	65	40	35
White	20	3	4	20	16	80
Total	663	100	432		231	

Note: Although these figures relate to foster families, not foster children, the vast majority of foster carers are caring for children of the same 'race'.

Table 9 also shows that three-quarters of African foster carers with CFWSP are related to their foster children. This compares with only 20% of white foster carers. Durban Child and Family Welfare Society, which was contacted for the purpose of comparison, confirmed that foster care by relatives is also more prevalent among African than white foster families with that Society (Neilson, 1997). Unfortunately the South African National Council for Child and Family Welfare does not break down statistics on fostering into related and non-related foster placements, so it is not possible to make any comparisons with the national picture.

Rather than being temporary arrangements, open to social work intervention and the possibility of restoration of the child to his/her parents, many kinship fostering placements are made in the expectation that they will be long-term or permanent arrangements. Shishuta (1996:117) found that 80% of foster families in his study had been caring for their 'foster' child for an average of four years before they made

application to become formal foster carers. In many cases the main need of kinship carers is for financial, not social work, support. Shishuta found that most relative foster carers:

> approached the Welfare organisation mainly because of the need for material and financial assistance (1996:117).

The use of the foster care system as an 'income maintenance' measure to assist families to care for the children of relatives is a well-established practice in child welfare. In the absence of other forms of state assistance, particularly for African families, social workers have used the foster care grant to obtain state support for relatives caring for children (Neilson, 1997). In the 1980's the South African government recognised that foster care grants were increasingly being used for this purpose and tried to put a stop to the payment of these grants to relatives. However the welfare sector successfully opposed the move (Lund Committee, 1996:80). In May 1998 a new social grant, the Child Support Grant, was introduced. This grant is available to people caring for children under the age of 7, subject to a means test. Although there are no immediate plans to alter the foster care grant, it remains to be seen what effect the introduction of the new benefit will have on the operation of the existing grant. As the Child Support Grant is paid at a much lower rate (R100 per month as opposed to R340) and is means tested, it is likely that demand for the foster care grant from relative carers will continue, and may well rise.

5. Specialist Fostering Schemes

Colton and Williams' identify two 'diverging' trends in fostering internationally:

> The first trend... is towards placing children with relatives who often receive very little in the way of financial or other support. The opposite trend is towards the professionalisation of foster parents (1997:47).

There are two main reasons for the second trend, the 'professionalisation' of fostering. First, there has been a growing recognition in many countries that caring for children

who would have previously been institutionalised (such as children with disabilities or life threatening diseases) is a demanding task. Foster carers are thus increasingly required to undergo special training and to develop skills which are over and above those of 'normal' parenting. Secondly, there has been a growing recognition that fostering is reliant on the availability of women's labour. The changing position of women, particularly in more affluent societies, means that ways have had to be found to entice women into fostering. As Colton and Williams point out (1997:47):

> increasing numbers of women in the workforce have meant that fewer are available to care for foster children in their homes - unless they receive at least as much money for foster care as they would earn at work.

In some countries there has been a proliferation of 'professional' fostering schemes in the last decade. These schemes typically pay foster carers a fee, or an enhanced allowance, in addition to the ordinary fostering allowance. These payments are usually made in recognition of the extra costs incurred in caring for a child with special needs, and of the opportunity costs involved to carers (normally women) who have to leave work or reduce their hours to foster a child (Berridge, 1996; Pithouse and Parry, 1997; Argent and Kerrane, 1997). As a British guide for social workers on the fostering of children with disabilities points out:

> As we know that it is three times more expensive to bring up children with disabilities than other children, it is not logical to approve families to do a job and then prevent them from doing it properly (Argent and Kerrane, 1997: 46).

There is considerable agreement in the literature that fostering, rather than institutional care, should be the option of choice for children who cannot be cared for by their parents. There are two broad reasons for this. Firstly, family care is preferable to institutional care for a child's physical, emotional and psychological well-being. Children placed in institutions risk losing their rights to land or property as well as their

identity and their cultural heritage. They are also at risk of neglect and sexual or physical abuse, since they are frequently isolated from outside sources of support (Barnett and Blaikie 1994:121). Secondly, the cost of institutional care makes it a prohibitive policy option for many countries. According to the World Bank, orphanages in Tanzania are a staggering twenty times as expensive as a typical foster care programme (Klouda, 1993:4). In South Africa it has been calculated that the cost to the state of maintaining a child in institutional care is three times the cost of the foster care grant (Lund Committee, 1996:83).

Welfare organisations must find new solutions for the care of children which make the best use of severely limited resources. The development of special foster care schemes is one option which has not as yet been given very much attention in South Africa. Such schemes require an initial injection of funds and some redirecting of resources to this area of work, but these costs are still only a fraction of the cost of residential care. If this option is not explored South Africa could face a similar situation to that in Zambia which has been forced to re-open orphanages to care for the growing number of AIDS orphans (Goliber, 1997: 33). The remainder of this chapter considers one example of a 'community' based alternative for the care of HIV positive children.

6. 'Cluster' Foster Care for HIV Positive Children: The Need for a Scheme

During 1996, the Child and Family Welfare Society of Pietermaritzburg (CFWSP) experienced an increase in the number of abandoned children on referral who were HIV positive. The referral rate averaged around two or three children per month. The HIV status of the children came to light through the Society's pre-adoption medical screening procedures. These procedures are designed to provide adoptive applicants with medical information about the child they propose to adopt. HIV testing of pre-adoptive children raises a number of ethical dilemmas for social workers, in which the rights of the child not to suffer discrimination or stigmatisation have to be balanced against the rights of prospective adopters to be provided with full information about a child. CFWSP decided that (quite apart from the potential for legal action by adopters who were not fully informed) it would not be in the best interests of a child who was

HIV positive to be placed with adopters who were unaware of this fact. HIV tests were thus undertaken on all pre-adoptive children. The results of the tests however raised further dilemmas, since approximately two-thirds of the children who tested HIV positive would lose their mother's antibodies at around 18 months. However, it was impossible to predict which children would sero-convert, and plans for their future could not be put 'on hold' for 18 months. The organisation therefore decided that all those children who tested HIV positive would have to be considered as potentially developing AIDS and dying (Interviews, director/adoption supervisor, 14-11-1996; adoption supervisor 20-2 1997).

In 1996 a new children's home had opened in the Natal Midlands with the aim of accommodating HIV positive children. However, places in this institution had filled within a few months of opening. CFWSP saw a major crisis developing as the HIV/AIDS epidemic unfolded, and a new initiative was considered to be critical. Discussions about appropriate responses established two principles. The first principle was that HIV positive children should wherever possible be afforded the opportunity of family life, rather than being placed in an institution. HIV positive children clearly have a number of special needs. These include ensuring that their immune system is supported (for example through the supplementation of a child's diet with vitamins), that good standards of hygiene are maintained to prevent the spread of infection, and that there is early identification and treatment of opportunistic infections (McKerrow, 1997c:29). Whilst these needs might arguably be provided within a children's home, CFWSP felt the children's need for 'normal' social interaction was much less likely to be met within a residential setting (Interview, Director, 15-5-1996).

The second principle was that children who tested HIV positive should be placed in foster care, rather than for adoption. There were two main reasons for this decision. Firstly, despite the changes made to adoption practice (as discussed in the preceding chapter) many of CFWSP's adopters were childless couples, who were often desperate to have a child. Although it was normal practice to make adoptive applicants aware that there were children 'with special needs' who needed adoptive homes, the social workers considered it unethical to in any way influence childless couples to accept a

child who might develop AIDS and die. Secondly, it was recognised that families caring for an HIV positive child would continue to need practical and emotional support from the agency after an adoption order was granted. This was problematic, not only because the secrecy surrounding many adoption placements meant that adopters did not normally seek post-adoption support, but also because the organisation did not have sufficient resources available to provide it. The possibility of a later adoption placement for children who sero-converted was left open. It was foreseen that existing foster carers would be offered the chance to adopt the child in these circumstances (Interviews, adoption supervisor, 20-2-1997; cluster foster care coordinator (CFCC), 3-6-1997).

7. 'Cluster' Foster Care Scheme: The Initial Phase

The idea for a 'cluster' foster care scheme was developed during 1996. No extra resources were made available to the workers to develop the project in its initial stages. The term 'cluster' fostering was chosen because it was anticipated that a number of HIV positive children would be cared for in each foster home and that the foster carers would be linked together in a self-support network (Interview, CFCC, 3-6-1997). 'Cluster' fostering models have been developed in other countries, for example Israel where:

> up to twenty foster families living in a single neighbourhood take up to twelve children each (Colton and Williams, 1997:46).

Although CFWSP's scheme was not consciously based on any existing model, there are clear similarities with the Israeli example.

In July 1996 a two day 'summit', which I attended, was held in Pietermaritzburg to bring together welfare organisations from the KwaZulu-Natal Midlands concerned with the care and support of children affected by HIV/AIDS. Representatives from Thandanani and CFWSP attended the meeting. The outcome of the summit was a programme of action which envisaged the development of a series of social 'catch-nets' for the care of children affected by HIV/AIDS. Importantly the response of

organisations would be a co-ordinated one, with a minimum of overlap and specific roles allocated to each. As a result of the summit a working group was established to ensure the implementation of ideas generated. This consortium subsequently took the title CINDI (Children in Distress). CFWSP was represented on this group, along with Thandanani and three other NGOs. Among the roles allocated to CFWSP was the piloting of the 'cluster' foster care scheme. The group subsequently made a successful bid for funding through the RDP and the Nelson Mandela Children's Fund. In mid 1997 the 'cluster' foster care project received sufficient funding from this source for the appointment of a full-time project coordinator for one year.

Table 10 presents figures for the first year of the 'cluster' foster care scheme. Twelve foster carers were approved, and all twelve had children placed with them during the year. Only two out of the twelve children were placed trans-racially. The vast majority of the children were less than two years of age at the time of placement. Five of the children subsequently died in placement. Despite an average of one placement per month, the project was still unable to meet the demand for placements. Thus a further eight HIV positive children could not be accommodated through the scheme and were placed in children's homes.

Table 10. Number of HIV positive children placed and number of 'cluster' foster carers approved in the first year of the scheme: July 1996 - June 1997

	African	White
Number of HIV Positive Children Placed	12	0
Number of foster carers approved	10	2

8. Recruitment, Preparation and Assessment of 'Cluster' Foster Carers

The 'cluster' fostering scheme was built upon many of the lessons learned by CFWSP through their adoption work. As these have already been discussed it is intended only to concentrate here on issues relating specifically to 'cluster' fostering. The initial recruitment drive for carers was aimed at local African women. It was undertaken by

community workers from CFWSP, who targeted women at venues such as soup kitchens. The response to this recruitment was unexpectedly positive, with twenty women expressing an interest. Social workers had expected that the stigma of HIV/AIDS, or fear of contracting AIDS from the child, would act as barriers to recruitment. However these factors did not appear to be of as much concern for the prospective carers as they were for the social workers (Interview, adoption supervisor, 5-2-1997).

Special preparation and training is vital for prospective foster carers of children infected by HIV (Skinner, 1991:139 O'Hara. 1993:60). CFWSP therefore provided the twenty women with HIV/AIDS awareness and information through Pietermaritzburg ATIC (AIDS Training and Information Centre). A post-course evaluation suggested that, although the course was helpful, what the foster carers required was a more practical training. A further day's training (covering such issues as hygiene, universal precautions, the management of opportunistic infections and nutrition) was later provided, by a hospital paediatric outreach worker, to applicants who had been screened and found to be suitable (Interview, CFCC, 3-6-1997).

The criteria used for assessing the suitability of applicants differed only slightly from those used to assess prospective adopters. Slightly older applicants (in the age range 35 to 60) were preferred. This is in line with international experience. For example in Scotland, suitable foster carers to children with HIV are considered to be:

> mature people who have already had children of their own and have had good rewarding child care experience (O'Hara, 1993:60).

Assessing an applicant's motivation was seen as particularly important. The scheme had been promoted within communities in which poverty is endemic and where job opportunities are few. Most of the women who responded to the initial recruitment were very poor and it transpired during assessment that many of them believed that what was on offer was a form of employment. Due to this misunderstanding there was a large drop-out from the first group of applicants. Only four out of the twenty

enquirers were eventually approved (Interview, CFCC, 3-6-1997). Reasons for the high number of unsuitable applicants appear to be a lack of clarity about the fostering scheme during the recruitment process and poor targeting of recruitment. The original concept of 'cluster' fostering was in effect not that dissimilar to a small children's home or a 'community home' and this may well have been the message that was inadvertently relayed during the recruitment.

9. Supporting Placements

Prior to the appointment of a project co-ordinator in June 1997 no extra resources were made available to develop 'cluster' foster care. No adjustment was made in terms of staffing, so the social workers involved in the scheme took on this new initiative in addition to their existing work. Even more critically, the scheme was established without any extra money being made available to provide foster carers with financial or material support. Social workers expressed concern about the sustainability of the scheme, which was dependent on state provision of foster care grants. Their concerns were firstly, in the short term, that the long delays commonly experienced in the processing of the grant would mean that foster carers would be unable to continue to provide care and placements would breakdown. Secondly, that in the medium term, money for foster care grants would cease to be available altogether, leading again to the return of children to the care of the organisation (Interview, social workers, 4-12-1996).

Unlike specialist fostering programmes developed in more affluent countries, no additional financial support was available to act as an inducement to promote recruitment of 'cluster' foster carers. Nor were resources available to compensate carers for the additional costs involved in caring for a sick child. 'Cluster' foster carers were entitled to the same benefits as any other non-kin foster carer, and subject to the same procedures to obtain payment of the foster care grant. For the first six weeks of the placement (before the completion of legalities) the foster carers were eligible for a Place of Safety Grant, amounting in 1996/7 to R180 every two weeks. However, once the legalities had been completed in terms of the Child Care Act No 74 of 1983, this

grant ceased. At this stage the foster carers had to make an application to the Welfare Department for a foster care grant. Although it should only take 'two to three months maximum' for a grant to be processed (Black Sash/Department of Welfare, 1996:13), it was common for foster carers to wait anything between three months and a year to receive the money (Interviews, adoption supervisor, 5-2-1997; CFCC, 3-6-1997).

The concerns of the social workers about the slow payment of the state grant proved to be very real. In June 1997 applications made by 'cluster' foster carers eight to nine months previously (in September/October 1996) had still not been processed. Attempts by CFWSP to intervene with the local Welfare Department proved to be fruitless. For those foster carers, who had no alternative means of financial support, the situation was critical. The additional costs involved in caring for a sick child, such as medicines, special diets, extra nappies etc, could not be met by the foster carers. One placement had already broken down when the foster carer realised that there would not be any money forthcoming, and the future viability of two further placements was uncertain. The desperation of these foster carers showed through their almost daily contact with the agency, and this was matched by the frustration of the social workers, who were able to provide very little in the way of material assistance (Interview, CFCC, 3-6-1997).

10. Formalisation and Development of the Scheme

With the appointment of a project coordinator in mid 1997 the scheme was placed on a more formal basis and a number of changes were made. The following information was obtained from an interview with the coordinator (3-6-1997). The original idea of 'clustering' a number of HIV positive children in each foster home had never been put into practice as it had quickly become clear that caring for more than one sick child at a time would soon exhaust the physical, financial and emotional capabilities of the foster carers. It was therefore decided that only one child would be placed with each foster carer at any one time. A change of name for the scheme was discussed but no suitable alternative was agreed upon.

In view of the slow payment of the foster care grant and the problems this had created, plus an underlying fear among the social workers that the foster care grant would be phased out by the government, it was decided to try to recruit (in the words of the coordinator) 'more economically stable families', such as teachers or other professionals. In other words, people who could afford to provide care without being totally reliant on the foster care grant. Although recruitment would continue to be focused on the African population, a major concern of the coordinator's was that fewer suitable 'economically stable' African families would be found, and consequently that more HIV positive children would be placed trans-racially. This was perceived by the coordinator as a retrograde step, but one which she felt they had no choice but to take.

An important motivating factor among the first group of 'cluster' foster carers had been identified as religious belief. There was a strong belief among some of the carers that 'God's children should be cared for' and that they may be able to 'save' or even 'heal' an HIV positive child. A study of foster carers in Malawi similarly found that people came forward to foster a child who was HIV positive 'because God would have expected them to' (Bandawe and Louw, 1997:545). In order to capitalise on these sentiments, it was decided to focus the next phase of recruitment on religious organisations.

Carers of HIV positive children need to maintain good levels of household hygiene and to support the child's immune system through proper nutrition (McKerrow, 1997c:29). As no additional resources were available from within the Society or through the RDP funds to support the 'cluster' foster care scheme, one of the roles of the project coordinator was to seek sponsorship in order to develop a 'start-up kit' for each new foster carers. This would consist of items such as nappies, plastic gloves, milk powder, Vaseline and Jik. Although fund-raising was necessary for the success of the project, this meant that a senior social worker's time was diverted from the tasks which she was trained to perform.

In June 1997 the 'cluster' foster care scheme for HIV positive children had only recently become formalised. The availability of funding had enabled the appointment of a coordinator who could concentrate on the development of the scheme. The 'cluster'

foster care concept was also evolving and changing in response to the challenges faced and the lessons learned. It was therefore decided to undertake follow-up research several months later in order to monitor the progress of the scheme. This following information was obtained through an interview with the project coordinator on 19-11-1997.

Between June and November 1997 a further seven children had been placed through the scheme (6 HIV positive babies and 1 with Hepatitis B). One of these babies subsequently died. Two very sick HIV positive babies had also been placed in residential care, both of whom died shortly after placement. A total of ten new 'cluster' foster carers had been recruited during this period, and nine out of the ten subsequently approved. This was a much lower fall-out rate than among the original group of applicants, and it represented a better use of scarce resources, as social workers had not been not engaged in assessing unsuitable applicants. The improvement was attributed to having focused recruitment on groups of people who were identified as likely firstly to be sympathetic to the needs of HIV positive children, and secondly to be more 'economically stable'. However, as had been predicted, there were implications in terms of the 'racial' mix of applicants recruited by these methods. Of the nine foster carers approved, only five were African, the other four were white.

The targeting of religious organisations and community groups had proved to be a successful method of recruitment. The use of existing foster carers can be a powerful tool in recruitment (BAAF, 1991). An offer by one of the 'cluster' foster carers to give talks to church groups had therefore been welcomed, especially as it helped to free-up valuable social work time. Another important source of recruitment was found to be among nurses who were working with abandoned children on the hospital wards. These nurses often grieved the loss of 'their' children when they were moved from the hospital. Social workers recognised that here was an excellent source of potential 'cluster' foster carers, especially as the nurses already had many of the skills needed to care for an HIV positive child.

The original idea of the 'cluster' fostering concept, the placement of several HIV positive children in each foster home, had been found not to be viable given the physical, emotional and financial demands which the children placed on their carers. However, interestingly the 'cluster' idea had not died, although a slightly altered version was under consideration. The project had received enquiries from two individuals (one white, one African) both quite separately proposing that they could foster a number of HIV positive babies. Both individuals were supported by relatives or friends who had offered to assist in the care of the children. Both had also managed to drum up interest in the idea and offers of financial support, through for example the church. Neither of these situations had been fully assessed by the time of the research, but the project coordinator was hopeful of pursuing the idea of a modified definition of the 'cluster' concept. Instead of one adult and a 'cluster' of children, this new model would involve a 'cluster' of both adults and children. From a resource point of view this was very attractive because only the principle carer would need to be assessed. Since several babies could then be placed there would be a significant saving of social work time.

Support available to foster carers had improved somewhat by November 1997. All of the original group of foster carers had received their foster care grants including back-pay. No further placements had failed, despite a wait of up to one year for financial assistance. There had also been some reduction in the time taken by the Welfare Department to process the grants. For example, the grant in respect of the last placement made had been processed in 'only' three months. Once received, the level of the foster care grant appears to have been sufficient to meet most of the needs of the carers. In addition the project coordinator had managed to obtain generous donations of baby milk, nappies and Vaseline from local firms and suppliers. These were available to the foster carers while they awaited the processing of the grant. A spin-off from the recruitment drive was a growing fund of donations from individuals and groups who could not offer a home to a child, but were prepared to help financially. In view of these improvements the agency no longer needed to consider subsidising foster carers while they awaited their grants.

Finally, the scheme seems to have brought clear benefits for the children placed. According to the project coordinator the children placed in foster care generally 'thrived' much better than those placed in children's homes, probably due to the individual care and attention they received. In some cases the improvement in their physical condition had been far greater than expected:

> We have seen the babies flourish when they are placed with families. If we can extend their life-expectancy then it will be worth it (Interview, 19-11 1997).

11. Conclusion

Faced with a macro-economic strategy which emphasises 'fiscal discipline' in the public sector, welfare organisations are increasingly needing to develop services which make the best use of resources. 'Community', rather than institutional, care is promoted by the White Paper for Social Welfare not only because it is considered a more appropriate form of care for vulnerable individuals, but also because it is more cost-effective. This chapter has traced the development of a 'cluster' foster care scheme for HIV positive children. It has considered what it means in practice to develop community care in a climate of budgetary restraint. The study found that much was achieved with only a minimum of resources. Foster carers for HIV positive children were successfully recruited, even though this is a group of children who are generally considered among the most difficult to place. However, the study also highlighted the dependence of the scheme on the state for the provision of foster care grants and the difficulties which slow payment of the grants posed for the foster carers, many of whom were poor women. The delays created a situation in which foster carers were left for many months to provide care from their own resources. The result was that the cost of caring was transferred for the state on the 'community', in other words onto women, many of whom were poor. These themes are developed further in the concluding chapter.

The final chapter draws conclusions from all three case studies. It pulls together issues and themes raised by the research and discusses some implications for South African welfare policy.

CHAPTER 9

CONCLUSIONS

1. Introduction

The three case studies have focused on specific themes in developmental social welfare. This chapter aims to bring together the threads from these studies and to consider the lessons learned. It looks at the case studies against the broader policy climate and goes back to some general themes and issues which cut across all three cases. As the research methodology used in the case studies was qualitative, conclusions are presented with the need for care about generalising to other settings in mind. Nevertheless the study has raised a number of issues which it is hoped could be of relevance in the search for strategies to support HIV/AIDS affected children.

2. Social Development and Economic Development in South Africa

Current welfare policy reflects a tension which lies at the centre of the government's economic and social policy. This is a tension between the egalitarian objectives of the Reconstruction and Development Programme (RDP) and the neo-liberal macro-economic strategy known as the Growth, Employment and Redistribution Strategy (GEAR). The RDP and GEAR derive from very different historical and ideological bases. The RDP was designed to address the inequalities of the past through a Keynesian approach to the promotion of economic growth. This approach would include using public investment as a means to promote development and employment, and taxation to foster the redistribution of wealth. If necessary such an approach could require an increase in government borrowing. The monies raised could be used for social spending, including welfare.

GEAR, however emphasises the need to control government spending through a tight fiscal policy. The GEAR strategy views the promotion of economic growth and the creation of employment through the private sector (thereby reducing poverty) as the

best approach to economic and social development. This approach, which restricts government borrowing and allows for no major increases in taxation, represents a distinct shift from the state interventionist principles underpining the RDP. The shift to a neo-liberal economic policy has been labelled by a growing number of critics as an abrogation of social commitments made in the RDP. There are fears that, as in Britain under Thatcherism, the poor will have to wait for any wealth created through the market to 'trickle down' to the poor (Pilger, 1998). Nevertheless, there are marked differences between Thatcher's Britain and South Africa in relation to social policy, at least at the level of rhetoric. In Britain, social policies were heavily influenced by laissez-faire ideas of the New Right with their emphasis on:

> the 'logic' of economic rationality, rather than ideas of social obligations (Culpitt, 1992:2).

By contrast, the South African government maintains a commitment to pursue the social 'obligations' of the RDP. This entails reprioritising state spending with the aim of alleviating poverty, meeting basic needs and promoting the equitable delivery of social services (Department of Finance, 1998:1.1, 1.2). Nevertheless, GEAR's tight fiscal policy means these goals must be achieved within existing resources rather than from increased taxation or government borrowing. Moreover, social spending now has to be spread among far more people. GEAR is, furthermore, a long-term strategy and its success is by no means guaranteed. Moreover it is doubtful whether GEAR takes into account the impact of HIV/AIDS on the economy.

According to the Health Minister, Dr Nkosazana Zuma, estimates show that by the year 2000 the AIDS epidemic will cost the South African economy R8 billion per year, or 1% of the country's GDP. Even so, as Dr Zuma conceded, this figure does not account:

> for related costs like the cost of caring for all the children who are orphaned when their parents die (quoted in The Mercury, 19-3-1998).

The demands on social spending due to HIV/AIDS, particularly in health and welfare, are already increasing. It seems remarkable, therefore, that the impact of the epidemic appears not to have been factored into the government's spending plans for welfare up to 2001 (Department of Finance, 1998). By the end of the financial year 1997/1998 the welfare budget was already showing signs of severe strain. A number of provinces, including KwaZulu-Natal, seriously overspent on their welfare budgets and had to appeal for government assistance (Broughton, 1998). In the Eastern Cape this led to the suspension of pensions and grants and to the closure of some services (Smith, 1998). The overspend seems to have been due at least in part to under-funding by central government because of faulty provincial demographic statistics, exacerbated by a degree of mismanagement.

3. Developmental Social Welfare

Whilst not opposed in principle to state welfare, the present government is constrained from adopting a 'statist' approach due to a lack of sufficient resources, the global dominance of free-market ideas and an apparent unwillingness to tackle redistributive goals by this means. Nevertheless, many of the underlying principles of the RDP are mirrored in the White Paper for Social Welfare. The approach of the White Paper is to try to marry social and economic policy through the promotion of 'developmental social welfare'. Central to the concept of developmental social welfare is the belief that investing in 'human capital' through social programmes will promote economic development.

The influence of human capital theory in welfare policy can be seen in the emphasis on investing in 'human capacity' and promoting 'self-reliance'. Rather than promoting development through extensive public investment (as per a Keynesian approach), a limited amount of public investment is seen as kick-starting 'self-reliance' within a market economy, predominantly in the informal sector. Welfare organisations are urged to find ways of helping people to become 'self-reliant', rather becoming passively dependent on welfare hand-outs. Unlike education however, where funding is typically on-going and aims to reach all children, there seems to be a tendency for welfare

programmes to be based on a one-off injection of assistance and for funding to be sufficient to reach only a small number of beneficiaries. The idea appears to be that once start-up funding has gone, enterprises which have been developed are to be left to the vagaries of the market. The Flagship Programme for Unemployed Women with Children Under Five provides a good example of the one-off injection in human capital approach. This scheme provides funding, for three years, to enable women to become 'economically and socially independent and to escape the poverty trap' (Department of Finance, 1998:6.61). However, as Midgley (1995:104) points out this approach, which he terms 'individualist':

> can only be effective if there is a vibrant economy which permits individuals to function as rational economic actors. Individuals can only meet their own needs and those of their dependants if there are jobs, opportunities for self-employment and sound prospects for investment.

These conditions clearly do not apply in large parts of South Africa where there is large-scale unemployment, and few opportunities.

This research has highlighted some problems experienced by one organisation's attempts to promote 'self-reliance' in conditions of extreme poverty. In the first case study, many of the individuals caring for children were not in a position to become involved in income-generating ventures. Many were elderly women, living in remote areas without adequate transport. Moreover they were already struggling to cope with the demands of providing care. These conditions are likely to worsen as more people in their productive years become sick from AIDS related illnesses. Additionally, the income generated by the projects which were established with the help of the AOP was minimal and totally insufficient to meet the needs of large numbers of needy children. This raises the question whether projects like AOP need to be much clearer about what they can and cannot be expected to achieve in relation to economic development and whether they should establish clearer boundaries between their role and that of other sectors. AOP was moving in this direction towards the end of this research with an increased emphasis on networking with NGOs whose main focus was income-

generation. Whilst targeting of government funds on women and children is to be welcomed, there seems to a danger of a growing expectation on the welfare sector to deliver economic development, which, it could be argued, might be more appropriately the responsibility of other departments such as labour, or trade and industry.

4. Defining Concepts

The White Paper recommends that welfare organisations embrace the developmental social welfare paradigm, which encompasses a number of different concepts and strategies. These include community development, community action, community care and community work. Although these concepts share many underlying principles, each is different in its approach and methods. Although these concepts are regularly debated and refined by academics and development specialists, this study found that there is far less clarity among welfare practitioners about the meanings of the various terms and how the jargon might be operationalised. A more detailed analysis of broad concepts such as 'building human capacity' or 'promoting self-reliance' seems to be needed if organisations, like AOP, are to be able to make the change from 'doing welfare' to 'doing development'.

The term 'community development' seems particularly prone to be used in a generic sense, to describe a range of different interventions. This lack of clarity may prove to be especially problematic for organisations whose roots do not lie in the 'development' paradigm. Community development was the term originally adopted to describe the approach which AOP intended to adopt. In retrospect, perhaps 'community action' might have been a better description, as the emphasis was to be on awareness-rasing and 'conscientising' rather than skills development or income-generation. It took several months before AOP fully recognised that 'community development' did not necessarily mean giving priority to income-generation activities. This lack of clarity meant that making the change from 'welfare' to 'development' was neither a quick, nor a cheap, alternative. The need to determine what 'doing development' should mean in practice, resulted in valuable time being lost while aims and objectives were clarified.

5. Promoting Developmental Social Welfare in a Context of Poverty

Even before the HIV/AIDS epidemic has begun to make a major impact on the South African economy, over half of all South African children live in poverty (Department of Welfare, 1997:1). All three case studies in this research have highlighted the context of poverty within which the organisations studied had to operate. Each of the initiatives was affected by poverty among the service users, albeit in different ways.

In the first case study, poverty among individuals caring for 'children in distress' seriously hampered progress in the setting up of Child Care Committees. The Child Care Committees were seen as the vehicle through which AOP would encourage people to become aware of the needs of children in their communities and to prepare for the impact of AIDS. These committees were made up of women who were among the most disadvantaged of the community, not least because they were elderly and caring for children who were not their own. These women were in need of immediate material assistance, and they struggled to understand why an organisation which promoted the needs of 'children in distress' did not assist them materially. This created a tension, and a difficult ethical dilemma for the AOP. The very process of identifying 'needy' children (one of the major objectives of the project) contributed to the pressures on the project, as this brought forward evidence of 'real' children without food and adequate clothing. The project's focus on long-term, 'developmental' goals, not on providing immediate relief, created the very real possibility that several of the Child Care Committees would cease to function.

In the second case study, adoption workers were faced with applications from prospective African adopters who were much poorer than applicants from other 'racial' groups. Assessing suitability to adopt is fraught with the potential for judgemental decisions to be made based on a lack of cultural understanding and sensitivity. In order that African applicants would not be automatically 'screened out' on financial grounds, social workers had to gain an understanding of how to assess financial 'suitability' in terms which were more appropriate to the context. This entailed examining their own attitudes and changing from making judgements about financial 'suitability' based on

factors such as income and employment stability, to a more appropriate understanding of family wealth. This approach included assessing factors such as wealth held in the form of animals in the case of rural families, and a consideration of all sources of financial support available through extended family networks. This is a far cry from the advice given in the National Council guidance that social workers should check applicants' insurance cover, or whether the 'wife' can take six months maternity leave.

In the third case study the poverty experienced by a number of the original group of 'cluster' foster carers, as they awaited receipt of foster care grants, threatened the continuity of several placements. Although there was a pool of willing African foster carers, the levels of poverty experienced by these families, combined with the unreliability of the welfare system in processing the grants, led the social workers to re-focus recruitment on more 'economically stable' applicants. The unfortunate implication of this move was a decrease in 'suitable' African applicants and an increase in trans-racial placements. This case portrays the need for NGO initiatives such as this to be supported by the state.

6. Meeting Basic Needs: The Role of the State

Despite the cost to the national budget the government accepts that well-targeted and well managed social security spending can play an important role in meeting basic needs and alleviating poverty (Department of Finance, 1998:1.3). This study has highlighted the importance of social grants, not only in poverty alleviation, but also as a means of promoting 'community' care. The first case study found that social grants were a critical factor in determining whether or not children were categorised as 'most needy'. It was children from families not in receipt of social grants who were in desperate need of material aid for food and clothing, and who risked exclusion from school for non-payment of fees.

This research has also highlighted problems which risk bringing the system of social grants into disrepute and which adversely affect its efficacy. In the first case study allegations of fraud in the payment of benefits were noted as a serious concern, while

in the third case study the length of time it took to process the foster care grant almost caused the breakdown of a number of fostering placements of HIV positive children. The government accepts that eradicating such problems is vital and has allocated R100 million in each of the financial years 1998/1999 and 1999/2000 to improve system management (Department of Finance, 1998:6.59). Assuming the system can be made more efficient, this research suggests that well-targeted social grants can be used to promote more cost effective programmes for children. As was seen in the third case study, social workers found that it was relatively easy to place HIV positive children in foster homes, rather than far more costly residential care. Foster carers came forward who were able and willing to provide care for these particularly 'hard to place' children as long as they were in receipt of the ordinary foster care grant.

The AIDS epidemic is likely to create a need for foster care to be developed on a more 'professional' basis in South Africa, as more children will require care by non-kin. However, concerns about whether the foster care grant will survive in the medium to long-term were expressed to the researcher by a number of participants during the course of this study. These concerns centre around the inter-play between the foster care grant and the new child support grant, since both will in future be available to kin-carers. The foster care grant is a larger monthly amount and there is concern that numbers of people will try to switch to the foster care grant in preference, causing a sudden new demand on the budget.

Financial constraints are a major factor influencing any family's decision to foster or to adopt. Experience in countries such as Britain which have introduced adoption allowances, suggest that these can have a positive impact on the recruitment of adoptive families from less affluent groups, such as ethnic minorities. Calls for adoption subsidies in South Africa have long been made by those working in the field. As far back as 1992 the adoptions manager of the Johannesburg Child Welfare Society said:

> We are working very hard to recruit black adoptive parents but we have to empower the black community to adopt, and that probably means

financially subsidised adoptions. (cited in South African Institute of Race Relations, 1993:308).

At present, however, there are no state subsidies or start-up grants for adopters in South Africa. CFWSP social workers found that many of the African families who applied to adopt were poor. It seems likely that the pool of recruits could have been even larger if an adoption allowance, or alternatively a settling-in grant, had been made available.

7. Maximising Resources Through 'Community' Care

The welfare sector is being squeezed by a macro-economic strategy which emphasises fiscal 'discipline' in public sector spending. At the same time it is faced with the prospect of growing demands created by HIV/AIDS. Welfare organisations must therefore develop cost effective services which make the best use of scarce resources. 'Community' care, such as foster care, is a far more cost-effective option for children than residential or hospital care, at least as far as the public purse is concerned. As the third case study showed, fostering schemes such as the 'cluster' foster care scheme can produce considerable savings to the state. Very few extra resources had to be found to enable the development 'cluster' foster care. In contrast with the experience of an emergency fostering project in Cape Town (Murray, 1997:31) where financial incentives seem to be required in order to retain carers, incentives to recruit potential carers for HIV positive children were not needed. Once the normal foster care grant was paid, it seemed to be sufficient to the needs of the carers. Nevertheless, the scheme was dependent on the state. Lengthy processing of foster care grants by the Department of Welfare put some of the placements at severe risk of breaking down. Given the costs involved in recruiting, assessing and supporting placements, such a breakdown would have represented a gross waste of resources. With only a small injection of extra resources it might have been possible for CFWSP to subsidise the foster carers while they awaited the payment of the grant. The social workers noticed a major reduction in the demands made on them by the foster carers once the grants were paid. The extra cost of subsidisation could perhaps therefore have been off-set

against social work time spent providing support to maintain the placements while the grants were awaited.

8. Gender Issues in 'Community' Care

Beveridge-style welfare was based on notions of 'familism' which assumed that women would provide care to children and other dependents. Although South African welfare policy contains rhetoric which emphasises gender equality little appears to have changed concerning assumptions about the role of women, and it seems possible that women risk being doubly affected by the 'developmental social welfare' approach. At a time when HIV/AIDS will significantly increase the burden of caring for women, they are not only exhorted to develop 'self-reliance', by engaging in income-generation initiatives, but expected to provide 'community' care for a range of vulnerable family members. When a family member becomes sick, it is women and girls who typically take responsibility for caring. For women who are themselves infected, extra caring responsibilities may combine with their own failing health.

Despite an acknowledgement that women will be the 'key providers of care', negligible attention is given in the White Paper to ways in which women are to be supported in their caring role. The White Paper asserts that:

> community programmes and home-care programme will take into account the social and economic needs of women... care givers (Dept of Welfare, 1997: 52),

but does not develop ideas for how this might be achieved. This research suggests that much more will need to be done to ensure that the 'social and economic needs of women care-givers' are adequately addressed.

The first case study found that developments of a 'community' nature which involve the needs of children rely heavily on women volunteering their services. It was almost exclusively women who showed interest in the work of AOP. As in many other

settings, children's issues were regarded as women's issues. The Child Care Committees which were established relied on the voluntary labour of poor, unemployed, often elderly women, many of whom were caring for 'children in distress' without any form of support. These Committees were not, however, given sufficient status in relation to other, 'community structures'. Women did not have the power to push the issue of AIDS orphans to the top of the local political agenda. AOP was not able to affect much change during the period of the research, neither in involving more men nor in regard to the priority given to 'women's issues'. Nevertheless it was working towards empowering Committee members through the provision of skills training, in areas such as running effective meetings.

'Community' care policies for children are reliant on women's labour. Although women often have little choice whether or not to provide care, foster carers and adopters are essentially volunteers. The third case study found that there was a pool of women prepared to offer their services to care for children. As the number of AIDS orphans and HIV infected children rises, there will be a need to capitalise on the preparedness of women to offer themselves as foster carers, or adopters. Previous studies in the western have shown that the provision of 'voluntary' care of this kind is not affected by finance alone. Leat (1988) for example found that finance in this type of caring is 'both crucial and largely irrelevant'. Indeed social workers would be concerned if factors such as 'a sense of satisfaction' (Baldwin& Twigg, 1991), or of 'doing the right thing' (Finch & Mason, 1993), were not at least as important as financial considerations when considering the motivation of foster carers. However, there is clearly a danger that 'community' care policies could become exploitative of women.

Although there was clearly no intention on the part of CFWSP to exploit the 'cluster' foster carers, many struggled to provide care for up to a year out of their own resources while the foster care grants were being processed. This meant in effect that the whole of the cost of caring during that period was transferred directly from the state onto the women. Even after the foster care grant was paid (and back-dated to the beginning of the placement) the cost of care had shifted significantly onto the women.

9. HIV/AIDS: Specific Issues for Welfare Organisations

The stigma which is attached to HIV/AIDS and its modes of transmission, leads to feelings of guilt, shame and denial, not only for individuals, but for families and whole communities. Those affected typically become isolated and their problems hidden. The experience from other African countries suggests that it is not until many families in an area have experienced the traumas of HIV/AIDS, that isolation and secrecy begins to break down. Organisations working with AIDS orphans in other parts of Africa have mainly been established once AIDS has become visible and large numbers of children have been left parentless. South Africa has been described as in the middle of an HIV rather than an AIDS epidemic. In other words many people infected by HIV as yet remain well. HIV/AIDS therefore remains a 'hidden' problem and is not as yet seen as a high priority. Organisations working in the field of HIV/AIDS are thus faced with a number of specific difficulties to overcome.

Developmental social welfare aims to be pro-active, rather than reactive and remedial. In attempting to address the AIDS epidemic pro-actively, AOP faced a significant barrier. As previously noted, development theorists stress the importance of a 'fit' between development initiatives and their context. Kotze & Kotze (1995:8) state that:

> The people 's meaning-giving context is the only framework within which they can relate to developers. It is the framework within which development initiatives obtain meaning. It will either permit or block development, depending on whether there is a 'fit' between development initiatives and their context. People will not be steered, influenced or 'taken with' unless the development initiative has positive meaning within their context.

AOP's objectives were hampered by the very nature of the problem which they wanted to address. Assistance could not be targeted solely on children affected by HIV/AIDS, because this risked stigmatising them. However, the lack of an obvious 'AIDS orphans problem' meant that this issue did not have 'positive meaning' for many. This made it

difficult to get the needs of children given priority in the face of more immediate needs, such as housing, roads and water. Previous studies in KwaZulu-Natal (Lucas & Harber, 1997:21) have found that other, more immediate, priorities, such as the need for jobs, or better housing, are generally of far greater concern as development priorities than AIDS. Moreover AIDS is a topic which typically produces responses of fear and denial. AOP was not only trying to promote an unpopular message, but also to get people ready to respond to a need (AIDS orphans) that was not yet a major problem, or at the very least was a hidden problem. Widening its target group to include 'children in distress', aimed to overcome the risk of stigmatisation of AIDS orphans, but created uncertainties in terms of project focus. This lack of clarity concerning target groups made it difficult to get across the message within the communities, losing the support of some people who did not wish to be seen as assisting, for example, the children of single parents for fear this be construed as condoning teenage pregnancy.

10. Developing Appropriate Welfare Services

'Appropriateness' has been defined as:

> the development of authentic social service methods and models of service delivery responsive to the political, economic and socio-cultural context (Patel, 1992:162).

Developing welfare services which are appropriate to the South African context is an integral aspect of welfare policy. It is sometimes argued that adoption is an inappropriate model of care for African children because it is a western implant. Local research into the adoption of African children by African families is seriously lacking, but Pakati's (1984 & 1992) studies suggest that some aspects of western-style adoption may not 'fit' well with African beliefs and practices. However, adoption is not a static concept and many different forms are practised world-wide. Although it seems likely that the numbers of legally adopted African children will remain small, this study found that the development of a more culturally sensitive service made adoption more

accessible to and appropriate for African families. Barriers to the promotion of adoption for African children were identified as agency procedures and professional attitudes. Measures taken by CFWSP to mitigate some of the effects of these barriers included a more pro-active approach to the recruitment of African families and the development of a more culturally sensitive assessment of 'suitability'.

A second barrier to the promotion of adoption may lie in 'traditional' ideas of kinship which make it more acceptable for the childless to care for a child from within an extended family than for an outsider. Previous studies (Pakati, 1984; 1992) have found that these ideas may be changing among some westernised, urban Africans, who seem to prefer the permanent nature of adoption over the 'traditional' option of caring for the child of a relative. Similar views were found in this study among prospective adopters in a rural area of KwaZulu-Natal, where an unexpectedly high number families were recruited by 'Lindiwe'.

Another possible barrier lies in the clash between contemporary adoption theory, with its emphasis on 'openness', and the emphasis on maintaining secrecy about an adoption in the African population due to the stigma surrounding childlessness. As one of the most basic tenets of western theory is that a child should be brought up in the knowledge of the adoption, this created a difficult dilemma for CFWSP social workers. Rather than turn away African families who could otherwise offer a good home to an abandoned child, this agency chose to place children for adoption in the knowledge that they would most likely not be informed about their origins. This practice flies in the face of modern adoption practice. Judged against the guidance produced by the National Council for Child and Family Welfare this aspect of CFWSP's adoption practice runs the risk of being criticised for failing to address the long-term welfare of the children placed. However, CFWSP are not alone in their attempts to marry African and western approaches to childcare. A similar clash between western attitudes towards childhood and African 'traditions' has recently been reported by social workers working with African families affected by HIV/AIDS in London (Matovu et al, 1998; Mudari, 1998). The implications of CFWSP's approach for the identity needs of children cannot be answered by this research as the children were still too young for

such issues to have surfaced, nor is there any other South African research against which the validity of theories of openness might be tested. A longitudinal study of the children's development would answer these questions, but the AIDS epidemic will not wait while this is done.

11. NGOs and the State: A Partnership?

NGOs have been in the forefront of developing programmes to address HIV/AIDS in South Africa as they have in the rest of Africa. In KwaZulu-Natal the NGO sector has taken the lead in developing responses to the needs of children affected by HIV/AIDS. However, there are drawbacks to an over-reliance on NGOs. As the first case study found, the scope and coverage of an NGO can be very restricted. For most of the first year AOP was operating with only one fieldworker, and in only one of the original target areas. Although the project was able to expand into several more areas after extra funding was secured, coverage was still limited to a few communities around Pietermaritzburg.

The South African government has made a commitment to work 'in partnership' with the NGO sector. 'Partnership' implies that the state will play its part to support NGOs. One important role which the state can play is the provision of:

> an overall organisational framework by which the social development activities of diverse groups can be facilitated, coordinated and harmonized (Midgley, 1995:150).

There is, however, negligible evidence of government attempts to coordinate a response to children affected by HIV/AIDS in KwaZulu-Natal. The involvement of the Pietermaritzburg's Transitional Local Council (TLC) with CINDI (the forum of organisations concerned with children affected by HIV/AIDS) is an exception. The involvement of the TLC has been identified as critical to the successful development of CINDI, particularly in its successful bid for RDP funds (Loudon, 1998:1)

Despite the rhetoric of 'partnership' NGOs are often reliant on the state for funding, which makes them vulnerable to the demands of government. State funding for NGOs is also notoriously uncertain. One piece of research found that NGOs face such 'daunting obstacles and hurdles' in obtaining government funding, that the researchers were left wondering whether the government is just 'paying lip service to the importance of NGOs', or may even be 'going to abandon this sector entirely to the impact of market forces' (Gulati et al, 1996). In 1997 AOP attracted funding from a variety of sources, including government funding, and the future of the project seemed reasonably secure. However, follow-up contact with the project, in early 1998, established that funding had once again become a major problem. Health department funding for the project was no longer available, and overseas funding was once again being urgently sought.

State subsidisation of social work posts forms a substantial part of the funding of child welfare societies such as CFWSP. For example, a workload analysis undertaken by another child welfare society (situated on the outskirts of Durban), found that statutory cases took up 75% of social work time. However, as the state subsidy covered only 63% of this expenditure, the state was in effect being subsidised by the organisation (Kruger & Motala, 1997:93). CFWSP found that statutory work left little space for the development of innovative, and potentially more cost effective, models of care. The 'cluster' foster care scheme could therefore only be developed in a formal way given extra funding from the RDP (which was only for one year), and through fund raising efforts of the project coordinator.

12. Looking Forward

The area around Pietermaritzburg, where this study was undertaken, is characterised by high levels of poverty and unemployment. HIV infection rates are among the highest in the country, and continue to rise year by year. The experience of neighbouring African countries graphically portrays what the future is likely to hold for South African children in areas severely hit by the HIV/AIDS epidemic. However,

despite the often bleak picture painted by this study, there seem to be a few glimmers of hope and this chapter concludes by looking at some possible ways forward.

A recent study (Hunter & Williamson, 1997:22) has identified six intervention strategies which can help the state and NGOs to better target efforts to support children affected by HIV/AIDS:

1. Strengthen the capacity of families to cope with their problems. This includes empowering women and improving their access to economic resources.

2. Stimulate and strengthen community-based responses. For example through improving community decision-making, providing training, organising cooperative daycare or orphan visiting programmes.

3. Ensure that governments protect the most vulnerable children and provide essential services. This includes building adoption and fostering services, protecting abused/neglected children, protecting children's property rights.

4. Build the capacities of children to support themselves. For example by helping them stay at school, protecting them from exploitation and reducing household dependence on children's labour.

5. Create an enabling environment for affected children and families. This includes reducing stigma, enhancing laws which protect children's rights and improving awareness of the problems.

6. Monitor the impact of HIV/AIDS on children and families. For example by improved data collection and better estimates of orphan numbers.

The approach proposed by these writers chimes well with the 'developmental social welfare' approach promoted by the South African government and a number of these strategies have been addressed in this study. However, to be effective this type of 'holistic' approach will require a degree of coordination and collaboration between individual NGOs and between NGOs and the state which is at present lacking in South Africa.

Welfare organisations seeking to support HIV/AIDS affected children are clearly faced with a wide choice of possible strategies and, as AOP found, they are unlikely to be in a position to engage in the full range. Like AOP, organisations will need to play to their strengths. They will need to determine whether, for example, to concentrate efforts in the promotion of income generating activities, or whether their skills and resources would be better used in activities such as helping bereaved children, supporting caregivers, raising awareness among community leaders, or improving child care facilities. The importance of collaboration between organisations and with other sectors, for example the Department of Trade and Industry, will be essential if gaps in provision and the possibility of overlap are to be avoided.

Setting up a community-based project requires painstaking work in order to assess needs and establish trust. Progress, as AOP experienced, can be slow and subject to set-backs. This slow progress contrasts starkly with a rapidly developing AIDS epidemic. Nor does this approach provide immediate relief to needy children. This raises some questions concerning the future role of 'welfare' in South Africa. If all welfare organisations are to work within the 'developmental' paradigm, who is to be responsible for ensuring that the basic survival needs of the most vulnerable are met? Can this be left to the state alone? Patel (1995:24) has suggested that NGOs may need to look at ways in which developmental issues are combined with poverty relief. This need not necessarily mean that every NGO should engage in both 'development' and 'welfare', but could suggest a collaborative approach, such as the CINDI forum.

This study has highlighted some aspects of the gendered nature of 'developmental social welfare'. If the experience of AOP is typical, then it seems that more will need to

be done to ensure that women's needs are not overlooked in the desire to find solutions for the care and support of children. Ways to empower women and improve their access to economic resources include:

Improving women's access to credit.
Reducing demands on women's labour in order to free them to undertake other productive activities, for example supporting community-based child care.
Improving basic infrastructure, for example extending piped water to rural areas.
Protecting women's rights to property and inheritance.
Ensuring access to health services.
Providing psychological support (Hunter & Williamson, 1997:23).

The South African government has already begun to take action in a number of these areas, notably improving access to piped water and extending health services in rural areas. There appears to be a need, however, to ensure that a gendered analysis of all policies and programmes is undertaken at both the macro and the micro-level. One way could be for policy makers and programme designers need critically to examine the effect of their policies and programmes to examine the true costs for women.

Hunter & Williamson (1997: 26) point to the role which governments need to play in protecting the most vulnerable children, those who fall through the family safety-net. This study has looked at two possible models of care for such children, adoption and 'cluster' fostering. Although developed within the NGO sector the success of these initiatives were reliant on government backing in a number of ways. First, in order to develop and expand family-finding activities, extra resources need to be redirected to this activity. Funds could perhaps be found by an innovative use of existing budgets. Two examples may be releasing social workers from routine statutory work by using auxiliaries to supervise kinship fostering placements, and (following the model used by 'Lindiwe') the use of residential workers as community-outreach workers to undertake family finding.

Second, the state needs to develop mechanisms which will enhance new initiatives rather than hinder them with bureaucracy. The development of the 'cluster' fostering scheme was hindered by an inefficient social security system. If similar schemes are to be developed in other regions the government will need to make clear its commitment to retaining and streamlining the foster care grant system. In addition to improving the existing system, a more radical option could be to give welfare organisations the authority to approve foster carers, thus saving the costs incurred in court hearings, and to delegate budgets to these organisations, thus enabling grants to be paid from the date of a child's placement. Another idea which has been advanced (Neilson, 1997) is the introduction of a new category of family carer, a 'kinship' carer, supported by a 'kinship' care grant. 'Kinship' carers could be formally approved to care, but not through the courts. This could help create a much clearer distinction between kin and non-kin foster care, and perhaps promote the development of a more 'professional' fostering service.

Third, the government could consider the introduction of new types of grant to support 'community' care. The introduction of adoption allowances, along with other changes to traditional adoption practice, could help to increase the pool of potential adopters and thus bring significant savings in both residential and hospital costs. Present fiscal constraints may seem to provide little hope of adoption allowances being introduced, but the HIV/AIDS epidemic makes it imperative that many more families are enabled to adopt. If the state does not make investments of this kind and give children the chance of a stable family life, the costs which the state will have to meet will certainly rise down the line, on correctional services, for example, or drug and alcohol rehabilitation.

This study has also highlighted some areas where change can be brought about at practice level. The promotion of adoption as a mainstream option for abandoned children serves as an example. CFWSP were assisted in this through the efforts of the rural social worker 'Lindiwe'. Historically adoption has not been an area of work in which many African social workers have been employed. (There were no African social

workers in CFWSP's adoption team at the time of the research.) The success which 'Lindiwe' had in the recruitment of rural African adopters may well have been due, at least in part, to her ability to communicate with adoptive applicants in their own language and to address any fears and concerns from a shared understanding of significant cultural issues. The involvement of more African social workers in this area of work might help to overcome some of the potential barriers to adoption.

Social workers at CFWSP chose to place HIV infected children with foster carers, rather than adopters. This decision was taken for two reasons. Firstly, because most adopters were childless couples who tended not to maintain contact with the agency after the granting of the adoption order and secondly, because the agency did not provide on-going post adoption support. These barriers could perhaps be overcome relatively easily, firstly through encouraging adopters to keep in touch with the agency and secondly through the development of a post adoption service. Although the latter would require some extra resources, these could be more than off-set against the need for fewer residential and hospital beds.

The complexity of the adoption system and the number of professionals involved in an adoption placement has been highlighted by this research. Adoption may well be seen as too costly an option unless more streamlined procedures are devised. CFWSP social workers had few opportunities for an exchange of views, ideas and resources with other agencies. The guidance available did not meet their needs since it did not include advice on developing more culturally appropriate practice. Greater cooperation between agencies could perhaps be achieved through the establishment of provincial and national forums for the exchange of ideas, information and resources, and the development of training and research.

This study has concentrated on just three initiatives developed in one small area of one province in South Africa. Its findings are limited by the scope of study and the nature of qualitative research. As noted in chapter two, this research provides only a 'snapshot' of the initiatives studied, the work of the organisations will have moved on since the fieldwork was completed, new solutions will have been found to problems

and new issues will have emerged. There is a need for considerable further research into other innovative strategies to support HIV/AIDS affected children, in other contexts and other areas of the country. This research is limited in not providing a service-user's perspective, from for example the women elected to the Child Care Committees, the foster and adoptive parents and, most critically, the children. Future research needs to consider ways to incorporate these perspectives.

This study raises the question of whether it is possible to mobilise an effective 'community' response for HIV/AIDS affected children, especially while it remains a 'hidden problem', and while jobs, land and a lack of opportunity remain the major concern of the poor. If GEAR fails to deliver jobs and to tackle poverty, can 'developmental social welfare' realistically be expected to fill the gap? The government intends to reduce the budget deficit in the belief that by doing so money will be released for social spending in the medium to long term. Developing communities is also a long-term process, but the AIDS epidemic is progressing with great speed. HIV/AIDS saps the capacity of individuals, families and communities to be economically productive. Unless welfare services are better resourced in the short term to provide the support needed to enable people to remain economically active for as long as possible, the long-term costs will be far greater, and any economic benefits which GEAR might produce significantly reduced.

Finally, this study has attempted to draw on three contextual perspectives in analysing different approaches to the issues under consideration - a western experience, a wider African experience and a specifically South African experience. On a personal note, these also reflect the experiences and background of the writer. Although South African welfare policy has needed, and still needs, to move away from a reliance solely on western influences, this study argues that there is much to be learned from all three perspectives.

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Appendix 1

Dates of Meetings Attended and Interviews Completed

Case Study 1: Thandanani AIDS Orphans Project

Dates of Meetings	Type of Meeting
14th June 1996	Thandanani AGM
11th September 1996	Support group
20th November 1996	Support group
4th December 1996	Support group
5th February 1997	Support group
5th March 1997	Support group
19th March 1997	Support group
19th April 1997	Workshop
6th May 1997	Support group
17th June 1997	Workshop

Dates of Interviews	Interviewee
15th May 1996	AIDS orphans project co-ordinator
6 November 1996	AIDS orphans project co-ordinator
5th March 1997	AIDS orphans project fieldworker ('Sipho')
3rd June 1997	AIDS orphans project fieldworker ('Sipho')

Case Studies 2 and 3: Adoption and Cluster Foster Care, Child and Family Welfare Society of Pietermaritzburg

Dates of Interviews	Interviewee
15th May 1996	CFWSP Director
14th November 1996	Director and adoption team supervisor
20th November1996	Adoption team supervisor and rural social worker ('Lindiwe')
4th December 1996	Group interview with adoption and fostering social workers
5th February 1997	Adoption team supervisor
20th February 1997	Adoption team supervisor
5th March 1997	Adoption team supervisor
25th April 1997 Project	Co-ordinator, Abandoned Children's
25th April 1997	Rural social worker ('Lindiwe')
3rd June 1997	Coordinator 'cluster' foster care project
19th November 1997	Coordinator 'cluster foster care project

Appendix 2

QUESTIONNAIRE: ADOPTION POLICY AND PRACTICE : Child and Family Welfare Society of Pietermaritzburg

I. Information about Children placed for adoption between 1994 and 1996

1.1 What was the total number of children placed for adoption through the agency between 1994 and 1996?

Total -------

1.2 Breakdown of total number of children placed for adoption between 1994 and 1996 and whether placed trans-racially.

Number Placed	Number Placed Trans-racially
Black	
White	
Coloured	
Asian	
Not/known	

1.3 Breakdown of total number of children placed for adoption between 1994 and 1996 by age.

0-1 year	2-4 years	5-7 years	8-10 years	over 10 years

1.4 Breakdown of total number of children placed for adoption between 1994 and 1996 by gender

Male ------ Female ----- Total ------

1.5 What are the main reasons recorded why the above children were placed for adoption?

REASON FOR ADOPTION	NUMBER
Child orphaned	
Child abandoned	
Child rejected	
Mother a minor	
Poverty of birth parents	
Health problems of birth parent(s)	
Other	

1.6 Did any of the children placed for adoption between 1994 and 1996 come from families where the parent(s) were known to be HIV+ or to have AIDS?

Yes (number) ----- No -----

Give any examples

1.7 Were any of the children placed for adoption between 1994 and 1996 known to be HIV+ at the time of placement?

Yes (state number) ----- No - -----

1.8 Have any of these children subsequently developed AIDS?

Yes ----- No -----

If yes, have any of the children died from AIDS post placement?

Yes (state number) ---- No -----

Give examples--

1.9 Have any children dealt with by the agency between 1994 and 1996 been deprived of an adoption placement or had a placement delayed due to their HIV status?

Yes (state number)- ---- No -----

1.9.1 If yes, where were they placed or what decisions were made about their care?

----

2. Services to Birth Parents.

2.1 How many birth parents have been counselled about adoption by the agency in the years 1994 to 1996?

Total ------

2.2 Breakdown of the total number of birth parents counselled by the agency betwen 1994 and 1996 by 'race'

	Number
Black	
White	
Coloured	
Asian	
Other	
Not Known	

3. Adoptive Parents: Statistical Information

3.1 How many formal applications were received by the agency from prospective adoptive parents in the years 1994 to 1996?

Number of joint applications by couples -------

Number of applications by single parents --------
Total ---------

3.2 Breakdown of the total number of adoption applications by 'race'

	Number
Black	
White	
Coloured	
Asian	
Mixed 'race' couple	
Not Known	

3.3 Number of applicants approved as adopters in the years 1994 to 1996.

Number of couples -------
Number of single parents -------
Total -------

3.4 Breakdown of total number of adoption applicants approved between 1994 and 1996 by 'race'

Parents	Number of Couples	Number of Single
Black		
White		
Coloured		
Asian		
Mixed 'race' couple		
Not Known		

3.5 Number of adoption applications made between 1994 and 1996 which were withdrawn or not completed.

Total -----

3.6 Number of applications made between 1994 and 1996 which were not accepted by the adoption committee.

Number of couples -------
Number of single parents -------
Total ------

4. Staffing and Training

4.1 How many social workers are responsible for adoption work in the agency?

Number of full time ----------
Number of Part-time ----------

4.2 Describe any responsibilities other than adoption work which these social workers have ?

4.3 What is the average case load of the social workers who are responsible for adoption work?

Number of Cases ----------
Adoption cases as an estimated proportion of total caseload ---------

4.4 What specialised training specific to a)adoption and b) HIV/AIDS have the social workers received in the years 1994 to 1996?

4.5 How many of the social workers are speakers of Zulu or any other African language?

Number -----
Languages spoken --

4.6 Describe the administrative support which is available to adoption workers?

4.7 What information and literature is available for social workers to use in their adoption work? Is this available in Zulu or other African languages?

Appendix 3

QUESTIONNAIRE ABOUT FOSTERING: Child and Family Welfare Society of Pietermaritzburg

1. General Fostering

1.1. Number of Foster Children Placed through the Society ---------

1.2. Number of Approved Foster Carers
Related ---------- Non-Related ----------

1.3. Number of Approved Foster Carers by 'Race'

African	
White	
Coloured	
Asian	

1.4. Number of Foster Carers Related to Foster Child(ren) -----------------

1.5. Number of Related Foster Carers by 'Race'

African	
White	
Coloured	
Asian	

1.6. Number of Non-Related Foster Carers by 'Race'

African	
White	
Coloured	
Asian	

2. Cluster Foster Care

2.1 Number of applications received from prospective 'cluster' foster carers ------------

2.2 Number of 'cluster' foster carers approved ------------

2.3 Number of 'cluster' foster carers approved by 'race' ------------

African	
White	
Coloured	
Asian	

2.4. Number of children placed with 'cluster' carers -------------

2.5. Age of children placed

0-1	2-4	5-7	7-10	10+

2.6. Number of children Placed by 'race'

African	
White	
Coloured	
Asian	

2.7 Number of children placed who are HIV+ -----------------

2.8 Number of children who have died in placement ------------------

2.9. Number of children placed with other 'special needs (specify need) ----------

Special need

2.10. Number of placements which have broken down (give reason) --

Reason --

Appendix 4

Indentification of 'Needy' Children.

Table 1. Siyazama

Category	Community Chosen Criteria	Number of Children
Least Needy	Both parents unemployed, but there is some source of income	
	Parents are teenagers at school	
	Children are schooling, but there are problems with school fees and uniforms	**16**
Middle Needy	Breadwinner receives state pension	
	There is no money for school fees or uniforms	
	Single parents	**105**
Most needy	Parents are unemployed	
	Children have no clothes, no school fees	
	Children are not schooling	
	Caregivers are grannies who do not get a pension	
Total		**214**

Table 2. Ethembeni. Area 1.

Category	Community Chosen Criteria	Number of Children
Least Needy	Child cared for by granny with no pension, but child has a single employed parent who provides	
	Child has caregivers who abuse alcohol or drugs	**6**
Middle Needy	Teenage pregnancy, mother still schooling	
	Child not accepted by or supported by second spouse	
	Unemployed single parent	**104**
Most Needy	Orphans	
	No food, no clothes, no bedding material/ blankets	
	Children not schooling	
	Parents unemployed, doing small jobs for neighbours	
	Children of mentally/physically disabled parents not receiving disability grants	
	Granny not eligible for state pension	**120**
Total		**230**

Table 3. Ethembeni, Area 2

Category	Community Chosen Criteria	Number of Children
Least needy	Child has unemployed parent who provides financially but this is insufficient	
	Child has caregivers who abuse alcohol or drugs	**29**
Middle Needy	Teenage pregnancy, mother still schooling	
	Problems with school fees, no school uniform	
	Working single parent with insufficient income	
	Granny receives pension but family cannot survive	**153**
Most Needy	Orphans	
	No food, no clothing, no bedding materials/ blankets	
	Children not schooling	
	Parents unemployed/ single parents are schooling	
	Children of mentally/ physically disabled parents not receiving disability grants	
	Granny not eligible for state pension	**127**
Total		**309**

(Source: Thandanani internal document, Sept 1996)