Welfare policy and the family in post-apartheid South Africa: Care for orphans and vulnerable children in the context of HIV/AIDS and widespread poverty in Kopanong Municipality, Free State

Submitted by

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Declaration

This thesis is my own work. I know that plagiarism is wrong. I have used the Harvard referencing style for in-text citation and list of references. Every significant contribution to, and quotation in this thesis from the works of other people has been cited and referenced accordingly.

Date: ***9th March 2009.***

Place: ***University of Cape Town.***

Signed: ***……***

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Dedication

This thesis is dedicated to the memory of my late father, Ntate Litsietsi Tamasane, who has been a huge source of inspiration to me. He still is.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral Drugs
AZT	Azidothymidine
CSG	Child Support Grant
CBO	Community-based Organisation
CBCW	Community-Based Care Worker
DoA	Department of Agriculture
DoE	Department of Education
DoH	Department of Health
DoHA	Department of Home Affairs
DoSD	Department of Social Development
DOTS	Directly Observed Treatment Short Course
FSG	Free State Government
FSGDS	Free State Growth and Development Strategy
GDP	Gross Domestic Product
GGP	Gross Geographic Product
GHS	General Household Survey
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDP	Integrated Development Plan
NGO	Non-Governmental Organisation
OAP	Old Age Pension
OFS	Orange Free State
OVC	Orphans and Vulnerable Children
OVC Census	Orphans and Vulnerable Children Census
OVC PPS	Orphans and Vulnerable Children Psychosocial Survey
RDP	Reconstruction and Development Programme
Stats SA	Statistical Services of South Africa
VCT	Voluntary and Counseling and Testing
NACOSA	National AIDS Council of South Africa
STIs	Sexually Transmitted Infections
TAC	Treat Action Campaign
HAART	Highly Active Antiretroviral Therapy
SMG	State Maintenance Grant
TB	Tuberculosis
IMR	Infant Mortality Rate

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Abstract

Despite the lack of evidence, a huge body of literature continues to suggest that there is a crisis of care for children who are orphaned by AIDS. Based on a study of Kopanong Municipality in Free State, this study investigated extended family care for orphans and other vulnerable children in the context of ubiquitous poverty and the high prevalence of HIV/AIDS. It asked whether the application of current welfare policies recognises or facilitates extended family care for orphans. The care for orphans has been conceptualised in terms of the lack of adequate number of members of extended family who would provide care for orphans and the quality of care which orphans receive from their carers. To address questions of care for orphans and implications for welfare policies, this study employed both quantitative and qualitative research techniques to gather information on the prevalence of orphans, their living conditions, and types of care and support available, available welfare services and access thereto. The study found extended family support for orphans to be resilient, notwithstanding the high number of orphaned children and the high level of income poverty in Kopanong. This was the case despite the fact that only 20 per cent of carers were receiving social grants for eligible children. This suggests that access to social grants does not play a significant role in influencing decisions regarding care for orphans. Extended family care extends to non-orphans, too. Nearly half of non-orphans lived with extended families. This finding then, contradicts views which suggest that orphans face a crisis of care due mainly to the declining role of extended families. However, the bulk of the caring responsibilities lie with grandparents. While concerns have been raised about the quality of care which grandparents are likely to provide, no evidence could be found to substantiate claims that the quality of care is inferior. The study found poverty to be a serious problem. However, where poverty was severe, orphans and non-orphans were equally affected. This observation challenges the appropriateness of orphanhood as a screening tool for welfare assistance as evidenced by a review of the scholarly literature on this subject. The study joins a chorus of calls for the introduction of a universal social grant in South Africa.

Chapter 1 The context of orphans and vulnerable children in South Africa: An introduction to the study

Introduction

This thesis is concerned with extended family care for orphans and other vulnerable children in the context of the ubiquitous poverty and the high prevalence of HIV/AIDS in South Africa. It investigated the notion of the 'crisis of care' for orphans, and critically examined the role of post-apartheid welfare policy in strengthening, or not, extended families' social safety net for orphans and other vulnerable children. It has employed the conceptual framework of social capital to analyse the intricate and complex nature of social networks embedded in extended families.

The advent of the HIV/AIDS pandemic superimposed on widespread poverty in South Africa raises important questions concerning the extent and nature of extended family care for orphans. As a result of ubiquitous poverty, high HIV/AIDS and orphan prevalence, concerns have been raised about a possible 'crisis of care'. This crisis of care is conceptualised in terms of the lack of extended family care for orphans due to the decline of the institution of extended family and the likely poor quality of care, especially since the bulk of extended family care is provided by grandparents, who are assumed to be too old and/or too poor to look after their grandchildren.

Subsequently, there is a heavy focus on 'AIDS-orphans' by aid agencies and certain government departments. It is argued here that this practice diverts attention away from the critical task of redressing the colonial and apartheid legacies of poverty and inequality, and their impact on most African extended families. Since 'AIDS-orphans' are deemed to be in need of special care, provision for material support is often made for those caring for them, leaving those caring for other poor children on the fringes. This exclusive focus on 'AIDS-orphans', therefore, raises important questions about, firstly,

the conceptualisation of orphanhood in South Africa, secondly, the role of welfare policies in the whole jigsaw.

James Coleman's concept of social capital has been used here to explain the intricate nature of extended families' networks of social support that facilitates care for orphans, and to explain the likely impact of government's policies, institutions and processes on these networks of extended family care for orphans and other vulnerable children. The term 'social capital' is a dynamic concept, with multiple uses. As a theoretical frame of reference it has been used to describe economic development, the functioning of democracies, prevention of crime, and population health development. In this dissertation it has been used to analyse complex extended families' processes and networks of inter-connected entitlements, obligations and genealogy maintenance.

Notions and idioms of obligation (genealogy maintenance) and entitlement (kinship ties) attach a special meaning to the notion of care for vulnerable members which facilitates their care and support (McDaniel 1990; Bengu 1996; Johnson 2000; Broodryk 2002; Chidester, James and Dexter 2003; Young 2003). These norms of obligations, expectation and reciprocity that govern the behaviour and actions of families' members (actors within a social structure) facilitate social capital (Coleman 1988; Fursterburg 2005). This is defined as social networks, informed by trust, that enable people to participate in reciprocal exchanges, mutual support and collective action to achieve shared goals (Chidester, James & Dexter 2003: 324). The quality of care provided by members of extended families has come under harsh scrutiny in the present era.

This study then looks at how these norms influence caring behaviour by members of extended families, and the role of the state through its welfare system. The state, through welfare policies, has an indispensable role of enhancing extended family care. However, the relationship between the state and families has historically been characterised by conflict (Marx 1967; Bourdieu 1998; Rynburn 1998). Esping-Andersen's (1990) typology of welfare regimes has been used to analyse the relationship between the post-apartheid state and extended families in the context of widespread poverty and high

prevalence of HIV/AIDS. It is argued here that the post-apartheid welfare regime is characterised by a *liberal welfare capitalism* that marginalises children from poor families whose biological parents are still alive, yet live in poverty.

Children orphaned and made vulnerable by HIV/AIDS

The advent of the HIV/AIDS epidemic with the subsequent increase of adult mortality rates has seen a corresponding increase in the number of orphaned children. Different estimates of orphan prevalence have been offered. UNAIDS/UNICEF (1999) estimates that before the onset of AIDS, orphan prevalence was between two-per cent and two-to-five per cent in South Africa (see Smart 2000 as well). As recently as 2002 a national study carried out by the Human Sciences Research Council (HSRC) found eight per cent of children aged 0-15 years to have lost *both* biological parents (Shisana & Simbayi 2002). This number increased to 11 per cent in the subsequent study of 2005 (Shisana et al. 2005). UNAIDS (2004) predicts that the prevalence rate of double orphans will increase to 18 per cent by 2010[1].

However, the definitions of an orphan, particularly those used by the international aid agencies, are ambiguous, discriminatory and contrast sharply with traditional African definitions of orphanhood. According to these definitions orphanhood is seen as the loss of either the mother or both parents. Therefore, the focus is on the loss of *biological parents*. This definition excludes children whose biological parents are both alive, but who face equally difficult economic hardships such as poverty or prolonged separation from their children – which are the key defining features of orphanhood in the majority of African traditions. They also ignore the impact of the death of surrogate parents, especially grandmothers whom, as the study will indicate, bear the greatest burden of caring for dependent children whether orphaned or not.

The UN definition regards an 'orphan' as a child under the age of 15 who has lost a *mother* or *both parents*, and who lives in difficult conditions, which include a lack of

[1] Estimates vary depending on the source used. They should be taken as an indication of the dimension of the problem rather than an accurate count.

food and access to services and support (UNICEF/UNAIDS 1999; UNAIDS 2000; 2002). However, the literature indicates that while orphans, and in particular children orphaned by AIDS, do face some unique challenges, many of the areas of vulnerability that they face, such as hunger, being unable to pay school fees and access to health care services, are shared by other children living in poverty; children who may also not be living with their biological parents even though they are alive (Wilson. et al. 2002; Bray 2003; Croke 2003; Giese et al. 2003; Meintjies et al. 2003; Skinner et al. 2005; Meintjies & Giese 2006). Indeed, in the context of many African traditions, the concept of orphanhood, where it exists[2], is related directly to poverty (see Wilson et al. (2002) and Meintjies et al. (2003))[3]. For example, in their important survey of the literature on definitions of orphanhood, Meintjies & Giese (2006) found that in many African languages in South Africa, the term orphan is strongly associated with poverty irrespective of the orphan's age or absence or not of biological parents[4]. Thus, in this study, the term orphan is used with caution, because the UN definition does not make sense in most African communities.

Another problem with a focus on biological orphans relates to the under- or over-count of orphans. Skinner et al. (2004) point out that the current definition in which orphans are seen as children under the age of 15 who have lost a *mother* or *both parents* excludes up to two or three times as many orphaned children because they have lost a father, rather than a mother. The UNAIDS has chosen not to try and count or target paternal orphans in many parts of the developing world. It argues that fathers are often only loosely connected to children and the households in which they live.

[2] Croke (2003: 73) notes that a *Zambian Situational Analysis of orphans* (UNICEF 1999) discovered that there was no actual word for 'orphan' in the local language.

[3] For example, in their studies on the conditions of orphans and vulnerable children in Limpopo Province of South Africa, Wilson et al. (2002) and Meintjies, et al. (2003) found that it was not uncommon for research participants to understand the term "orphan" to refer to children living in poverty, whether their biological parents were alive or not.

[4] For example, the *Shangaan* (which is commonly spoken in Limpopo Province) term for orphan is *ixiswana* meaning a poor person. The root for the Sesotho (This language is dominantly spoken in Free State, the location of the study) term; *kgutsana* relates to having nothing like *mofutsana* – a poor person, a common person. The equivalent of Zulu for orphan is *intandane* – also meaning a poor person.

However there are problems associated with this approach, especially in the South African context. Research reveals a high number of absent fathers, either due to work (migration), divorce or death, leaving many households headed by women. Female-headed households have been found to be disproportionately poor. The effect of this state of affairs on fatherless children needs to be understood. Equally important is the fact that these definitions, which associate orphanhood exclusively with the loss of biological parents, ignore the psychosocial impact of the death of relative carers on orphans.

The question of cut-off age in defining orphanhood is also problematic. The UNAIDS/UNICEF definitions of an orphaned child above, puts a cut-off age of 15 years. Many African communities dispute this definition (Croke 2003[5]: 65; Skinner et al. 2004). In their study of the community definition of an orphan Skinner et al. (2004) point out that the majority of communities consulted argued that any persons who are dependant on parents or extended families should be considered as children, by definition; orphans, if they have lost one or both parents. However, the general consensus was that 21 years of age should be considered the cut-off age. In the African context childhood is associated with dependency. As long as a young person is dependant on parents or adult relatives, he or she is a minor.

For this reason many have argued that rather than focusing exclusively on orphans, interventions that are aimed at alleviating child poverty should include children who live in poor households as well. For, many have observed that while orphans, and in particular children orphaned by AIDS, do face unique challenges, many of the areas of vulnerability that they face, such as hunger, being unable to pay school fees and poor access to health care services, are shared by children living in poverty as well (Wilson et al. 2002; Bray, 2003; Meintjies et al. 2003). These are referred to as *vulnerable children* (UNICEF & UNAIDS 1999; Croke 2003; Meintjies & Giese 2006). Subsequently, debates on

[5] Croke (2003: 65) notes that in Malawi, community-based organisation members defined an orphan as a child or young person up to the age of 21 years whose biological parent or parents had died. The community saw young people above 18 years as orphans if they were still a drain on the household's resources; for example, if they were male orphans who were unemployed or males or females orphans continuing their education, or if they were vulnerable in some other way, for example, if they had learning difficulties or were physically disabled and needed support.

childhood poverty in South Africa, make reference to *orphans and other vulnerable children* (OVC). Nevertheless, the term OVC is widely acknowledged as referring to the context of AIDS as Meintjies & Giese (2006: 409) point out.

Since this study deals with orphanhood in the South African welfare policy context, the definition that is being used is the one used in legal discourse which defines orphaned children as children under the age of 18 who have lost a mother, father, or both parents due to death or permanent desertion.

The state, family and care for 'AIDS orphans'

Many have been warning that there is a looming 'crisis of care' for 'AIDS-orphans' in South Africa (Smart 2003; Freeman, Nkomo & Meintjies 2004; Marais 2006; Whiteside 2007). In addition, it is argued that the 'unparalleled increase' of orphanhood presents unimaginable societal problems that call for urgent and swift government response (see Bicego, Rustein & Johnson 2003; Bhargava & Bigombe 2003; Skinner et al. 2004; Marais 2006; Whiteside 2007). However, these views have been challenged by a number of commentators as will be highlighted below (see Ankrah 1993; Foster 2000; Bray 2003; Mberengwa & Johnson 2003).

Arguments of a pending 'crisis of care' for orphans are premised on observations that see South Africa as experiencing an 'explosion' in the increasing number of orphans largely due to HIV/AIDS-related deaths. It is argued that many families, especially the *idealised* extended family, will not cope because the problem is too enormous (Booysen & Arntz 2002; Freeman, Meintjies & Nkomo 2004; Marais 2006; Whiteside 2007). Secondly, care for orphans is suspect since the bulk of the responsibility lies with grandparents who are deemed, in general, to be too old to care for children (Croke 2003; Whiteside 2007. Last, but not least, the limited support forthcoming from families, many of whom are overburdened by poverty, means that without rapid state intervention the situation will become acute, hence the exclusive focus on 'AIDS-orphans'. Expansion of orphanage services and the acceleration of foster care placement are the often suggested solutions.

On the other hand, an important group of researchers challenge these views. They argue that the institution of extended family in South Africa is still very much a strong binding force, and continues to shape the lives of its members (Murray 1980; Wallerstein & Smith 1992; Steyn 1995; Russell 1993, 1998, 2004; Mehlwana 1996; Nzimande 1996; Spiegel, Watson & Wilkinson 1996a, 1996b; Smit 2001; Broodryk 2002; Ziehl 2002, 2003). Moreover, despite the many assaults on it – such as colonialism, globalisation, apartheid, and endemic poverty – it is resilient and survives, because the intricate web of networks of social support is still very much its feature.

Some proponents of this view go as far as saying that the problems associated with HIV/AIDS and poverty may in fact be strengthening the institution of extended family as relatives are regularly called upon to support one another (Ankrah 1993; Foster 2000; Mberengwa & Johnson 2003; Nyamukapa & Gregson 2005). In this view, material support from the state is considered indispensable, but only insofar as it complements rather than undermines extended family care. Also in this view, orphanages are considered a social anomaly[6]. Instead; the underlying assumption is that the African extended family, as defined by notions of kinship ties and genealogy maintenance, attaches a special meaning to the concept of care and support for children, as well as orphans.

This thesis argues that views of a 'crisis of care' for orphans, above, ignore the fact that orphans have always been a phenomenon in Southern African societies, and that disease, war or mass relocations have, at various points in history, brought sudden large increases in the orphan population (see Bray 2003, 2003; Phillips 2005). Extended families have always absorbed and cared for children whose biological parents may have died (Ankrah

[6] Criticisms levelled against orphan centres are that while they often provide high quality care in terms of material needs such as food and clothing, institutional orphanages have limited capacity to meet the psychosocial needs of vulnerable children and orphans (Drew, et al.. 1998; UNAIDS, 2000). They are very expensive to run (Booysen & Arntz, 2002), and do not easily integrate the children in their care into the community. Besides, the ever-increasing number of orphans and vulnerable children highlighted above is likely to exceed the capacity of orphan centres to cope, where they exist.

1993; Foster 2000; Mberengwa & Johnson 2003; Lund 2006). Therefore, orphans have not lost household membership by virtue of having lost biological parents.

All the same, it is acknowledged here that the combined effects of high levels of poverty, the socio-economic impacts of HIV/AIDS and the increase of orphans due to the AIDS epidemic are likely to place strains on extended family-based social safety net (see also Foster et al. 1995; Mutangadura 2000; Desmond & Gow 2002; Booysen & Arntz 2002; Townsend & Dawes 2004). However, the extent of this strain and the unresolved debate about extended families and care of orphans needs to be investigated. Without strong evidence, policy interventions either way may do more harm than good.

Prominent views on welfare policies are that they should be *redistributive* in nature and *reduce poverty* (Mishra 1983; Kenworthy 1999), and thereby strengthen family social safety net. In South Africa, social security, as embodied in the welfare regime, is a socio-economic right enshrined in the Constitution (Lund Committee 1996; Taylor 1999; Child Health Policy Institute & Black Sash 2000:3; Malan 2005; Flemming 2004). The Constitution also endorses the rights of children as outlined in the Convention of the Rights of the Child. Social security, used synonymously with the term welfare, in this study, refers to government actions aimed at decreasing the economic uncertainties of individuals by ensuring them a minimum living level[7].

However, the analysis of current welfare policies, in South Africa, has to be set within a proper historical context. Inherited from the racist apartheid government these welfare policies were designed to support a small number of Whites who were disadvantaged by capitalism; they were premised on the assumption of full employment (Nattrass & Seekings 1997; Lund Committee 1996; Lund 2006; Taylor 1999). No provision was made for the unemployed or impoverished. The contemporary South African situation of

[7] Examples of social security are: 1) social assistance – which refers to State provided basic minimum protection to relieve poverty, subject to qualifying criteria on a non-contributory basis; 2) social insurance – which refers to a mandatory contributory system of one kind or another, or regulated private sector provision, concerned with the spreading of income over the life cycle or the pooling of risks (see van der Merwe, 2000: 718). The day-to-day use of the term refers to social assistance. The use of the term social welfare in this thesis should be understood in this way.

very high unemployment is different. It therefore needs to be asked whether current welfare policies deal adequately with this challenge.

Although state provision is better than it was under apartheid, it is important to assess whether it is sufficient, to determine who benefits, who has access and who is excluded, and to consider how welfare policies support 'AIDS orphans'. This study also investigated the role of post-apartheid welfare policies in strengthening extended family care and support for orphans and other vulnerable children in the context of the high prevalence of poverty and HIV/AIDS in South Africa. Specifically, it considered the extent of orphan prevalence. It looked at who cares for orphans. It further investigated the role of non-family carers, the processes and factors involved in arranging orphan placement, challenges facing carers, the poverty confronting other vulnerable children and their carers, and how the welfare policy addresses, or fails to address these questions.

The study is located in the African community of Kopanong Municipality in the Free State Province. Free State is one of the poorest provinces of South Africa. It has the third highest HIV/AIDS prevalence in the country after KwaZulu-Natal and Mpumalanga. Kopanong is a small-town local municipality servicing rural communities residing on white-owned commercial farms. It comprises nine small towns, with a combined population estimated at 55,945. The population consists of a high number of economically inactive people. Nearly two thirds of the economically active population reported no income in the Census 2001 and an additional 14 per cent received less than R500 a month (Stats SA 2002). As a result, there is now widespread economic dependence on state welfare grants in Kopanong (Marais 2004; Nel 2005; Lochner & Atkinson 2006). It also has a large proportion of children on the one hand and very old people on the other. Historically, this was due to migration, with young, able-bodied adults moving to cities to look for work opportunities.

In this, Kopanong is very much similar to many other rural municipalities across the length and breadth of South Africa. Kopanong, then, is an important case for the questions this study poses, that is; whether current welfare policies strengthen the

extended family social safety net or not, and the implication of this on family care and support for orphans and other vulnerable children.

This study has employed both quantitative and qualitative research methods to gather data on the numbers of orphans, their living conditions, types of care and support available in Kopanong. This included the investigation of the role of government, non-governmental organisations, community-based organisations, and individual members of the community.

The quantitative research methods employed included the analysis of the raw data collected in a Census of Orphans and Vulnerable Children conducted by the HSRC – *OVC Census* – (HSRC 2003) in Kopanong and Kanana late in 2003, as well as a sub-sample survey of the census, the HSRC's *OVC Psychosocial Issues* Survey – *OVC PSS* – (HSRC 2004c) that was conducted early in 2004, and a limited analysis of the General Household Surveys of 2002 to 2006 and the recent Community Survey of 2007 (Stats SA 2008).

The *OVC Census* (HSRC 2003) targeted all households in the nine towns comprising Kopanong. It looked at the biographic details of all members of each household, and relationship to the head of the households. It asked whether they were orphans, whether any received a grant, as well as the type of grant. It asked about school attendance, vulnerability as measured by food intake, income, and household living conditions (see Jooste, Managa & Simbayi 2006). The response rate was 99 per cent.

The *OVC PSS* (HSRC 2004c) targeted a representative sample of 791 households and registered a response rate of 91 per cent, with 718 questionnaires completed. Its main aim was to investigate the conditions of orphans and vulnerable children in their households (Simbayi et al. 2006). In addition, and as mentioned above, this study conducted a limited analysis of Stats SA's General Households Surveys (GHS) covering the period from 2002

to 2006 as well as the Community Survey of 2007 (Stats SA 2008[8]). The analysis focussed on orphan prevalence, care arrangements and access to services such as social grants and education to compare trends over time, especially in Free State.

The qualitative research included face-to-face interviews with key informants. These included orphan carers, government officials (teachers, nurses and social workers), members of civil society organisations, and community leaders. This was carried out by the author between March and April 2005.

Organisation of the thesis

This study is premised on the view that the full extent of the impact of HIV/AIDS on families cannot be completely understood outside the analysis of the political economy of South Africa and particularly on the processes of social reproduction. The next chapter, Chapter 2 discusses the role of the extended family in providing a social safety net for its vulnerable members – this is part of its social reproduction role. It also illustrates how the legacies of colonialism and apartheid characterised by land and livestock dispossessions, forced labour and the system of migrant labour destroyed the economic independence of African societies. This had serious repercussions for the institution of extended family. It shows how land and livestock dispossession, the development of capitalism in South Africa and the system of apartheid corroded, but did not destroy, the African extended family. It places these discussions within the theoretical framework of social capital, demonstrating its usefulness in analysing the dynamics of the complex relations that constitute the basis of care for orphans.

Chapter 3 interrogates the combined effects of the twin-problems of AIDS and poverty. It argues that they pose the greatest threat to the social safety net among poor South Africans, the majority of whom are Africans. The debates on the link between AIDS and poverty have often sent confusing messages. Chief among them is the assertion that

[8] The Community Survey is the largest survey to be concluded in South Africa covering nearly 2.5million dwelling units all the provinces. This has carried following the decision by South African Cabinet to mover away from the 5-years to 10-year censuses. This created a gap in information or data between Census 2001 and the envisaged Census 2011.

AIDS causes poverty. This chapter argues that the relationship between AIDS and poverty is not causal, rather, AIDS exacerbates poverty. In addition, Chapter 3 provides a critical analysis of South Africa's welfare regime. It shows how the welfare regime in South Africa has been adopted from Europe and was designed to meet the temporary needs of a small White population. As such it may not be appropriate in the present situation of both ubiquitous and growing long-term poverty as a result of HIV/AIDS. It further argues that the primary weakness of these policies is the targeted intervention to certain social groups considered to be 'in need of cash' when over half of the population live in poverty with no immediate prospect for employment.

Chapter 4 provides a detailed background to Kopanong and discusses both the quantitative and qualitative methods of research employed. The quantitative approach analysed the census and survey of orphans and vulnerable children that was conducted by the HSRC in 2003 and 2004 respectively. A limited analysis of Stats SA's GHS as well as the Community Survey of 2007 was conducted to corroborate findings of the HSRC's studies. Face-to-face qualitative interviews were conducted with key informants to deepen understanding of the role of the welfare system in enhancing extended family care for orphans. The chapter also provides a socio-economic profile of Kopanong that illustrates the disproportionate number of economically inactive individuals. Moreover, it shows Kopanong to be an impoverished area with limited job opportunities that exacerbates migration by job seekers.

It is within this context that the question of care for orphans is discussed. The notion of the crisis of care for orphans is conceptualised in two ways. In the first place, some researchers argue that extended families are unable to cope with the high number of orphans. This means that orphans will grow up without parental guidance. It is assumed that the outcome of this will be growing social problems. Secondly, some argue that the quality of care that orphans receive is questionable as most of them are cared for by grandparents. Chapter 5 addresses the former. It argues that while there is a high level of orphan prevalence in Kopanong, there is no indication of a crisis of care. Orphans are cared for by members of extended families. Extended family care extends to non-orphans

too as nearly half the children, whose biological parents were alive and present, lived with other relatives, rather than their biological parents. This clearly illustrates the centrality of broader familial or kinship ties among African communities in Kopanong.

Chapter 6 addresses ambiguities concerning the question of the quality of care for orphans, and simultaneously challenges the practice of singling out orphans for material support while leaving out other equally, if not more, vulnerable children. This chapter shows that while households accommodating orphans are mainly female-headed households, and are usually headed by grandmothers with limited income and poor access to child grants, there is no difference between orphans and non-orphans in terms of vulnerability (measured by school attendance and intake of meals). This highlights that definitions that see orphanhood solely in terms of the loss of biological parents are misguided. Singling out orphans for social assistance is discriminatory, and maybe inappropriate.

Chapter 7 discusses post-apartheid South African welfare policy designs and implementation further. Drawing from the research findings, it argues that singling out orphans for material support is not only inappropriate, but it has the potential to weaken extended family networks of social support. Limiting access to welfare benefits to certain categories of carers is propagating discord among different types of carers with serious repercussions for the institution of extended family. It also highlights the critical role of welfare agencies in promoting or obstructing access to welfare services by most vulnerable sections of the population. This is analysed using Espeng-Andersen's (1990) typology of welfare capitalism.

Chapter 8 concludes the discussions by summarising the main findings of the study and examining their implications for theory and policy. It concludes that while there is a high prevalence of orphanhood in Kopanong, there is no crisis of care. This is primarily due to the sacrosanct notion of extended family in the African context. Yet, welfare policies are not adequately enhancing extended family care for orphans, primarily through the design and implementation processes. In this way, this study is adding a voice to the chorus of

calls for expanded coverage of social assistance to all vulnerable children, irrespective of their orphan statuses.

Chapter 2 The African extended family in the context of the South Africa's political economy – from primitive accumulation to racial capitalism

Introduction

The perceived threat of the 'crisis of orphans care' due to HIV/AIDS has revived debates on the role of the family in providing a social safety net in South Africa, and on the nature of the relationship between the family and the state. On the one hand there are those (Booysen & Arntz 2002; Freeman, Meintjies & Nkomo 2004; Marais 2006; Whiteside 2007) who argue that there is an imminent crisis because extended families are not coping due to the magnitude of the problem. Moreover, extended families' care has come under harsh criticism owing to the disproportionate number of grandparents who provide care for orphans. On the other hand, others (Giese, et al., 2003; Meintjies, et al., 2003; Meintjies, et al., 2004; Meintjies & Giese 2006) argue that the crisis confronting families, if any, is not the lack of *care*, but the lack of *cash* – which has its origins in the colonial and apartheid regimes.

This chapter will discuss the effect of the past regimes, colonial and apartheid regimes, on the African extended families. It argues that although African extended families have come under assault for over 200 years, the social safety net which the extended family provided, although fragile, remains. While the current democratic government has sought to address the problems brought about by the colonial and apartheid governments, the legacy of geographically and racially defined poverty lingers on. The situation is exacerbated by the HIV/AIDS epidemic.

The state and extended families in South Africa

The impact of the state on African extended families can be traced to (i) the early colonial era leading to the advent of modern capitalism signified by the discovery of diamonds and gold; (ii) the proletarianisation of African agriculturalists in the post-diamond and gold-discovery period; (iii) the dawn of the apartheid government, which further institutionalised African poverty and (iv) the post-apartheid era.

The colonial state and the African extended family (1650s-1880s)

It has been observed that the problem of poverty in South Africa is a consequence of colonial and later the apartheid government's strategies and policies. These were aimed at supporting capitalist accumulation by maximising profits using coerced cheap African labour (Wolpe 1972; Davies 1979; Marks & Atmore 1980; Slovo 1988)[9]. It is generally accepted that the high levels of poverty in South Africa are a direct result of capitalist-driven industrialisation policies of the colonial and apartheid eras. In turn, such high levels of poverty have had a profound impact on the structure of the African social, political and economic systems. This has had serious repercussions for the institution of the extended family and its capacity to fulfil the domestic reproduction role that encompasses in the main, the care and support for its vulnerable members.

Put differently, the development of capitalism in South Africa took place on the back of the exploitation of its *human* and natural resources. The exploitation of *human resources* rested on the partial destruction of the indigenous populations' political and economic systems, and the proletarianisation of African labour. In particular, the impoverishment of

[9] However, some have pointed out that economic impacts of colonialism were not felt in the same way throughout the country. For example, the communities of Herschel in Eastern Cape and Mpondo on the south east coast were thriving communities' way into the late nineteenth century (see Bundy 1980; Beinart 1980). In the Free State, sharecropping among Africans developed around this time (Keegan 1986; Edgar 2005; Atkinson 2007), although the Free State black sharecrop farmers were the hardest-hit by drought, animal diseases, wars and the Native Land Act No. 27 of 1913. Loudon (1960) and Slater (1975) illustrate that initially, the colonial system had a minimal impact on the African farmers in Natal. Nevertheless, the discoveries of diamonds and later gold and the advent of apartheid witnessed a clinical implementation of the policies of proletarianisation as the basis for capital accumulation.

African families and households through proletarianisation weakened their economic capacity to provide adequate social safety nets for vulnerable members.

Central to the destruction of the social, political and economic structures of the African communities was the process of the land and livestock conquests – a process that has been described as primitive accumulation in the Marxist literature (Marx 1967; Hart 2007; Masondo 2007; Perelman 2007). In *Capital Vol. 1*, Marx (1967) observes that the expropriation of land was at the core of the development of capitalism. Expropriations were followed by tax imposition in order to force the landless wage-labourer to offer their services for low wages. He notes:

> In the history of primitive accumulation, all revolutions are epoch-making that act as levers for the capitalist class in the course of its formation; but this is true above all for those moments when great masses of men are suddenly and forcibly torn from their means of subsistence, and hurled onto the labour-market as free, unprotected and right-less proletarians. The expropriation of the agricultural producer, of the peasant, from the soil is the basis of the whole process (Marx 1967:876).

In South Africa, the destruction of the political and economic systems of the indigenous people can be traced to early European encroachment into the country.[10] This intrusion was characterised by livestock theft and land conquest, initially for farming, but later as a strategy to force locals to provide labour power on farms, as cheap labourers (see Slater 1975; Guy 1980; Beinart 1980; Delius 1980; Newton-King 1980; Worden 1994). Writing about *farm labour*, Doreen Atkinson observes that;

[10] The first Europeans to settle in South Africa were the Dutch. The Dutch East Indian Company (VOC) set up a refreshment station at Table Bay, in the Western Cape, in 1652, under the direction of Jan Van Riebeck. The VOC started small-scale agrarian activities to supply ships with fresh food. These operations soon expanded and had virtually covered the rest of the Western Cape by the late 17th century (Worden 1994; Keegan 1996; Newton-King 1980). However, the expansion took place on the back of bitter territorial struggles between the indigenous San and Khoikhoi communities against the VOC contingent (Marks 1975; Ross 1983; Mitchel 2002). The local communities could not sustain the resistance to the incursion. By the 1690s, the process of land dispossession had been virtually completed as the Khoikhoi and San were defeated, had lost their cattle and were reduced to tributary status (Worden 1994). As a result, from then on some Khoikhoi began to work alongside imported slaves as labourers (Marks 1972; Legassick 1980; Newton-King 1980; Worden 1994; Keegan 1996; Terreblanche 2002).

> The story of farm labour in SA is largely one of transformation of an independent black peasantry into a landless workforce defined by race. The story's key themes are the consolidation of land ownership by white farmers through pass laws and the influx control, and the entrenchment of quasi-feudal social order on the farms (Atkinson 2007: 15).

Part of the strategy of creating a labour force led to the imposition of taxes. Paying the taxes meant that men had to access cash. Bundy (1995), Masondo (2007) and Guy (1980) note that the hut tax was introduced on Zulu land as a specific mechanism to proletarianise the peasantry who had to work for a wage in order to earn money to pay tax. Peasants were forced to sell their cattle to raise cash or even paid with cattle, thus depriving them of their livelihood and in the process forcing them to enter wage labour. The Land Act No. 27 of 1913 had a similar effect on the Free State peasantry. As will be explained below, the Land Act forbade Africans from purchasing land outside the 'reserves'. Sharecropping, a means by which Africans had hitherto resisted proletarianisation, was also outlawed, thereby forcing once prosperous agriculturalists to seek employment from white counterparts.

Indigenous populations, who were taken as slaves or indentured labour on settler farms, lost control over their social and family life[11]. They were subjected to the dictates that the patriarchal masters meted out against their slaves and servants. They could be hired out to other masters without regard for their family wellbeing (Keegan1986, 1987, 1996). Their children were subjected to the indentureship system which tied them to their masters for certain periods of time (Keegan 1986, 1996; Terreblanche 2002). The raiding for livestock included the kidnapping of children for the purpose of indentureship (Newton-King 1980; Kirk 1980; Keegan 1986, 1987; Atkinson 2007).

The apprenticeship (indenture) system was a form of slavery that tied black labourers to the Boer households by capturing them young and bringing them up as 'decultured'

[11] In essence, the struggle for livestock and land was also the struggle for scarce labour (Davies, O'Meara & Dlamini 1984; Terreblanche 2002). While the Dutch East Indian Company (VOC) had initially discouraged the use of local labour by farmers, the Company abandoned this policy due to the need to reduce the administrative costs of importing slaves from other African countries and East Asia, as well as expensive European contract workers. The Company therefore, encouraged the use of the Khoikhoi and San as labourers. This practice was soon replicated in other parts of the Colony.

dependants (Keegan 1986; Atkinson 2007). It had the characteristics of both slavery and the wage labour system. While apprentices could be released at the age of 21 (men) and 18 (women), and could be granted a degree of independence as they reached 'maturity' and married, they were tied to the colonial economy for life as their livelihood depended on wage labour. Furthermore, they might have been loaned stock by their owners thereby tying them permanently up to their owners. The farmer was thus not burdened with the expense of maintaining adult dependants. This phenomenon therefore potentially affected the family structure of the Khoikhoi, the San, and other black populations.

Indentureship was soon exported to the Republic of the Orange Free State (OFS), which is the location of this study. Like in the Cape Colony, the OFS farmers also battled to attract the labour of Africans due to their relative economic independence, hence the introduction of the system of indentureship. In the OFS, the system of indentureship was regulated by means of an ordinance of 1856 (Keegan 1986; Atkinson 2007) and had equally devastating effects on the political, economic and social system of Basotho – the then majority ethnic group of Africans residing in the present-day Free State. As peasants, in the situation of abundant land, their success rested on family size which ensured the availability of labour. Therefore, the settler farmers targeted African families through the indentured labour system; dispersing members across the region. But, the social ties were difficult to break, as will be illustrated and explained below.

Britain took control of the Cape Colony in 1806.[12] Their arrival threatened the political and economic interests of the Dutch farmers. Moreover, the escalation of land value drove many farmers into destitution (Davies 1979; Worden 1994; Keegan 1996). These events set off what came to be known as the *Trek* – which was a series of episodic migrations in the 1830s by Boers who took with them the Khoikhoi servants and former slaves, who constituted half of the 12 000 trekkers (Terreblanche 2002).

[12] The British seized the colony from the Dutch in 1806. Various reasons for the seizure have been offered. Chief among them is the British quest to extend its international market. Other reasons include; (i) the desire to guarantee the security of British imperialism's vital sea-going trade with India (Newton-King 1980; Davies, O'Meara & Dlamini 1984), and (ii) an attempt to stem French colonial domination (Terreblanche 2002; Seekings & Nattrass 2005).

The Trek led to bloody battles for land control in the Eastern Cape, inhabited mostly by the Xhosa nation (Lester 1998). The combined Boer and British forces ultimately defeated the latter in 1835 on the back of the sixth frontier war (see Lester 1998)[13]. This united onslaught against local polities was extended to the rest of the country. The defeat of Africans meant the permanent loss of their livelihood strategies: land and livestock, and access to wild life. This process was fortified by the rural enclosure movement of 1865-1910 (see Van Stitter 2002). Africans were confined to the less arable land, thus making subsistence farming difficult.

With its vast grazing and fertile agricultural lands, the OFS attracted mostly Dutch *Trek* farmers who were encouraged by the great wool boom of the 1840s (Keegan 1987: 7-8). Subsequently, the battle for the control of land ensued. The Orange River Sovereignty (1848-54) oversaw land accumulation by the Boers which the Bloemfontein Convention of 1854 failed to reverse (Watson 1980; Keegan 1987).[14] The land accumulation included the looting of livestock in military expeditions, the carrying off of women and children to serve as labourers in homes and fields (Keegan 1986: 196-6) [15]. Prompted by the collapse of the wool trade and the subsequent need to diversify into the wheat trade, the Boers seized Basotho land to farm. By the 1860s the Basotho who occupied this area had lost most of their land and livestock to the Boers.

The Basotho were pushed into the hills and mountains of modern Lesotho. Overtime, as returns from agriculture declined, Basutoland became a reservoir of cheap labour for the OFS Boers as well as the mining industry. Furthermore, the decline of Basotho economic independence was also precipitated by drought, locusts, and foot-and-mouth disease in 1891, 1892 and 1893, rinderpest and drought in 1896-8 and by the South African War of 1899-1902 – otherwise known as the Anglo-Boer War (see van Onselen 1972; Watson 1980; Keegan 1986). Impoverished and without access to adequate land and livestock,

[13] Thus, while Dutch and British settlers resisted each other's influence, they acted in unison to defeat indigenous communities for common economic interests (see Mbeki 1987).
[14] The Bloemfontein Convention of 1854 facilitated the creation of the Orange Free State Republic (Keegan 1987).
[15] van Onselen (1996) explains that the war displaced many African communities in the western Transvaal, separating husbands from wives, mothers from children. Moreover, the war disrupted any farming activity; the basis of livelihood for Africans of this area.

Basotho streamed onto white-owned farms. This state of affairs signalled the twilight of the independent African peasantry.

Keegan's (1986) observation about the pattern of Basotho influx into the Boer-owned farms is particularly relevant to this study. He records that thirteen Basotho families a day were reportedly entering the Winburg district in June 1886. He further notes that often several sharecropping households (who were of the same patrilineage related by marriage; brothers-in-law, cousins) would stay close to each other, often on the same farm. Some formed small village settlements and would pool their labour resources, even though they were farming separate productive units (Keegan 1986). Thus, Africans migrated, settled and subsisted as *families*. Despite the unsettling setbacks meted out by the forces of colonialism, extended families seem to have remained intact – as far as family size and feelings of belonging, togetherness, mutual obligations and reciprocity are concerned. And Keegan's observations also suggest that they continued to cooperate in productive activities.

van Onselen's (1995) biography of a MoSotho sharecropper, Kas Maine, supports this view. He indicates that Hwai Maine, Kas' grandfather, travelled with up to 30 members of the family at one time in search of a place where he could share-crop in the late 19th century. van Onselen (1995) further notes that according to a survey that was carried out in north western Transvaal in 1910 – in response to complains of shortage of labour by farmers due to diamond diggings in the area – McLetchie had eight extended families in his farm Zandfontein; Norman Anderson had seven at Mooilaagte and that W.K. Jelliman had six at Niekerk's Rust.

This pattern of settlement persisted despite attempts in 1881 to reduce the number of families that resided on a farm. It is therefore, not uncommon to find extended families residing on one farm or a group of relatives staying in one township across small towns of the Free State in the present era (Source: Personal experience. The author was born and bred in this area). This pattern of settlement and resettlement has provided and continues to provide a crucial social safety net through family and kinship ties. Therefore,

while the colonial governments succeeded in weakening African groups economically and politically, they failed to break the communal spirit as embodied in the cooperative relations within extended families which persist to this day.

The proletarianisation of Africans and the migrant labour system (1850s-1960s)

The discovery of diamonds in Kimberly in 1867 and gold in Langlaagte (Johannesburg) in 1886 marked the birth of modern capitalism – profit-oriented private accumulation of wealth – in South Africa. These developments exacerbated the marginalisation of African social, economic and political systems. The discovery of diamonds and gold precipitated a growing demand for labour. This in turn, led to a struggle between farmers and the mining conglomerates over the scarce labour (Denoon 1967; Legassick 1974a, 1974b; Legassick & Wolpe 1976; Davies et al. 1976; Davies 1979; Davies, O'Meara & Dlamini 1984; Morris 1980; Wolpe 1980; First & Davies 1980; First 1980; Worden 1994; Terreblanche 2002; Butler 2004). The diggings on the mines required large amounts of labour. At the same time, the mining adventures led to an agricultural boom due to increased demands for agricultural produce to feed the labourers which also required large amounts of labour. This led to an intensified campaign to deprive Africans of farming and agricultural land as a strategy to coerce them to work on the mines and white-owned farms.

The location of the study, OFS, did not escape the onslaught wrought by capitalism as perpetrated by competing demands for labour between the mining conglomerates and commercial farmers.

In OFS, a diamond was discovered in 1870 on a farm that would later be called Koffiefontein, south of the province. Heavy mining operations took place in the 1870s. Mining in such areas as Jagersfontein followed thereafter. Africans living in this area were not immune to processes of land dispossession, livestock conquest and exploitation of labour. The relative success of peasants of this, and the surrounding, areas exposed them to the wrath of colonising farmers.

There is ample evidence to support the view that prior to the discovery of the minerals, settler farmers (including Trekkers) had settled alongside African farmers as co-traders, with some African labourers exercising a relative amount of economic autonomy as sharecroppers, peasants or tenants (Willan 1979; Keegan 1986, 1987; van Onselen 1996). All this changed as the demand for labour increased on both the mines and farms, and the value of the land rose (Loudon 1969; Legassick 1980; Slater 1980; Keegan 1986). In OFS, the political and economic independence of the Basotho made it difficult for the Boers to attract labour (Willan 1979; Keegan 1986; van Onselen 1996; Seekings & Nattrass 2005; Atkinson 2007). The shortage of labour led, first, to the acceleration of land conquest and secondly, the introduction of the draconian passes laws and the masters-and-servants law[16].

As land conquest accelerated and the movement of Africans was severely curtailed, proletarianisation developed rapidly. The main drivers for proletarianisation of Africans were land control and the industrial policies. The control of the land was implemented in late 1800s. Following the discovery of diamonds and gold, the Glen Grey Act of 1894 was used to deny Africans access to land. The Act limited the amount of land each family could own, thus restricting wealth creation amongst African producers. Africans were restricted to certain areas, reserves, which restricted farming and other agricultural opportunities. The Pass Law of 1896 ensured that every male 'native' was employed for part of the year, thus limiting economic and social freedom. 'Vagrancy' or lack of paid work was a punishable crime.

[16] Introduced in 1854 the Pass Law sought to control movement into and within the state by means of pass system; it made an African without an honest livelihood, that is employed by a Boer, liable for criminal prosecution and it empowered authorities to disperse squatter communities on white-owned land if they inconvenienced neighbouring Whites. The Masters-and-Servants Law was enacted in 1873. Its purpose was to ensure swift and effective access to the criminal courts for the prevention of desertion, insubordinate behaviour or dereliction of duty. These laws were introduced largely as a result of petitions by Orange Free State farmers to the authorities (Murray 1989). Further legislation followed. These measures built on already existing environment of subjugation and control with varying degrees of success. Earlier in the Cape Colony, the Vagrancy Act of 1809 was meant to tie the Khoikhoi to White employees by requiring them to be permanently contracted to White employers through a pass system (see Mbeki 1978). The Masters and Servants Ordinance of 1841 regulated the contact between the Whites Master and Blacks Servants and "was the first of the many repressive measures introduced in the Cape Colonial authority to create a system of racial domination and racial capitalism" (Terreblanche 2002: 201).

To increase the supply of labour, the Union of South Africa (established in 1910) passed the Native Land Act (No. 27) of 1913 which was amended in 1936. The Native Land Act forbade the purchase or lease of land by Africans outside the designated areas (reserves) and outlawed sharecropping, which was predominantly practised in the OFS (Willan 1979; Keegan 1986; Wolpe 1980; van Onselen 1996; Atkinson 2007). In the main, the Native Land Act of 1913 served to prevent Africans from re-purchasing European owned land which had been acquired through conquest – thus remedying the problem of shortage of African labour on White farms (Wolpe 1980). The land allocated for the reserves covered a mere 13 per cent of the country's landmass. The Acts, therefore, removed the means by which Africans had hitherto resisted both incorporation into the migrant labour system of the mines and wage labour on the farms.

As many have observed, the Native Land Act of 1913 had many loopholes that hampered its full-scale implementation throughout the country (Loudon 1969; Slater 1975; Bundy 1980; Beinart 1980; Keegan 1986, 1987). However, OFS suffered the most acute impact of the Law. It led to immediate and drastic evictions of African tenants (Keegan 1986; Atkinson 2007). Many landlords took the opportunity in the winter of 1913 of removing Africans who would not sell off their excess livestock or submit to the authority of the landlord. Subsequently, many families lost their livestock as they wandered around the countryside looking for farmers who would be prepared to take them in as *squatters* (Keegan 1986; Atkinson 2007).

The effects of the Native Land Act of 1913 on African peasants of the OFS have been described by Sol Plaatje (1916). Plaatjie visited OFS and northwest Transvaal between July and September 1913 to investigate the ramifications of the Act. He noted that sometimes peasants who were travelling in search of a place to sharecrop with white farmers lost their cattle from hunger due to the lack of fodder. Africans travelling with dying stock risked imprisonment. Those who failed to get satisfactory terms from landowners were forced to sell their stock for anything they could fetch and had to find work with White employers.

Based on this observation, Keegan (1986: 191-2) describes the Native Land Act of 1913 as legislation for "a capitalist agriculture in which all the productive resources were the property of and put in motion under the organising authority of the White employer of labour." Because of the violence unleashed by Boers against peasant Africans in the OFS between 1918 and 1924, Murray (1989) observes that compulsion was an integral component of primitive accumulation and that extra-economic coercion has always accompanied capital accumulation in South Africa. The Native Land Act of 1913 had the double impact of displacing families and depriving Africans of the opportunity to subsist gainfully on the land, thereby weakening their economic independence.

Other measures which led to wide-scale impoverishment of Africans included the discriminatory labour market policies, especially in the mines. The Mines and Works Act of 1911 laid the basis for the statutory colour bar in the work place. This Act condemned Africans to low-paying jobs. In 1911 Black Labour Regulations Act made it an offence for a Black miner to break his employment contract or for anyone to attempt to persuade a worker, by offering higher wages, to break his contract.

This measure is one of the reasons that real wages of Black miners remained roughly constant between 1911 and 1972 whereas white miners' real wages increased steadily from 1922 (Davies 1979; Davies et al. 1976; Wolpe 1980; Terreblanche & Nattrass 1990; McGrath 1990; Terreblanche 2002; Seekings & Nattrass 2005). Terreblanche (2002) argues that migrant wages did not remain constant. He says that in real terms, migrant workers on the gold mines earned 20 per cent less in 1960, and 8 per cent less in 1972, than they did in 1911. Black wages could be paid at a level designed to support a single migrant with access to rural resources rather than at a level needed to support an urban worker and his family. In its report on the African miners' wages and conditions in 1943, the Lansdowne Commission observed:

> The gold mining industry in the Witwatersrand has indeed been fortunate in having secured, for its unskilled labour, native peasants who have been prepared to come to the Witwatersrand for periods of labour at comparatively low wages. But for this fortunate

> circumstances the industry could never have reached its present stage of development – some mines could never have opened up; many low-grade mines would have been unable to work with any prospect of profit; and, in the case of the richer mines, large bodies of ore, the mining of which has been bought within the limits of playability, could never have been worked, with the result that the lives of the mines would have been considerably curtailed.

This was a comprehensive system of economic force to contract labour, and was based on the principle that migrant workers could be paid less than a subsistence wage because they had an agricultural subsistence base in their areas of origin. This principle was maintained until the 1970s, despite the drastic deterioration of socio-economic conditions in the overpopulated 'reserves.'

The 'free' labour of Africans subsidised capital accumulation in the South African mining industry even during the periods of market turbulence which hit mines hard, minimising profit margins (Davies 1979; First 1980). As First (1980) observes, the Witwatersrand reefs were very deep, dispersed and of low-yield ore, which required substantial capital outlay. Furthermore, price controls by powerful nations such as the United States, through the gold standard, made it difficult for gold mines to pass the costs to consumers (First 1980). This meant that profits could only be secured through low levels of costs and high output – cheap labour. First (1980: 9-10) observed that "the two imperatives of gold mining were thus the minimisation of costs and maximisation of output, and the most *important cost minimisation lay in the cost of labour"* (the author's emphasis).

The long-term consequence of rural proletarianisation, coupled with the labour system has been the destruction of an African peasant farmer, thus, ensuring the production and reproduction of cheap labour. This situation was buttressed by apartheid's racial capitalism.

The apartheid state and extended families

The ascension of the National Party to political office in 1948 witnessed the final onslaught on the economic independence of Africans. The National Party came to power, with a clear mandate to protect the interests of poor Whites, especially Afrikaners, and those of the farmers – Boers (Innes & Plaut 1978; Drew 2000; Terreblanche 2002; Seekings & Nattrass 2005). The industrial boom during the World War II, particularly in the manufacturing sector, attracted more African labour from rural areas due to better wages. Growing competition for labour was particularly felt in the OFS, whose agriculture-based economy was highly labour intensive.

In response, the government introduced a plethora of legislation. This legislation further weakened Africans economically, thus, indirectly forcing them to seek employment on the White-owned farms, industries and mines, and giving impetus to the policy of job reservation. In 1949 unemployment insurance was taken away from Africans earning below £182 p.a. and from casual and seasonal labourers, as a direct result of the complaints by farmers that the insurance discouraged Africans from seeking work, thus worsening the shortage of labour (Atkinson 2007)[17].

In 1952 the National Party government enacted the Black (Native) Amendment Act and the Black Abolition of Passes and Co-ordination of Documents Acts to address the problems of labour particularly in the agriculture and manufacturing sectors. The Acts served to minimise shortage of labour on farms by controlling movement into the cities on the one hand, and curbing oversupply of labour in the urban areas on the other hand. This Act trapped many Africans to low paying agricultural employment.

The Group Areas Act of 1950 extended the principle of separate racial residential areas, particularly in the cities. The Native Resettlement Act of 1954 gave the state the power to

[17] Free State farm workers were excluded in big numbers as their farm wages were far below the mark (Keegan 1987; Atkinson 2007). This was meant to accommodate the wishes of commercial farmers who petitioned the legislation in the first place.

override local municipalities and to forcibly remove Africans to separate townships, and in some cases to the reserves (see Sapire 1994)[18].

With these measures, the rural population in the reserves grew significantly. Freund (1984) notes that in 1940 only 40 per cent of the population resided in these areas, but by 1980 about 54 per cent resided in the area that covers merely 13 per cent of the country's land mass.

These relocation measures were buttressed by the creation of 'homelands' or 'Bantustans' in 1959 for different African ethnic groups. These 'homelands' were based on the 'native areas' – as proclaimed in the Native Land Act of 1913 and the Bantu and Trust Land Act of 1936[19]. In the main, the Bantustans/ Reserves were created to, first, make more land available to white farmers and second to provide a pool of cheap African labour through further impoverishment (Legassick & Wolpe 1980).

The reserved land was unable to accommodate Africans or to enable them to make a decent living. The results were overcrowding and abject poverty. Movement in and out of the Bantustans was strictly controlled through labour bureaux which channelled labour to where 'it was most needed'.

The impact of these policies and practices on African wellbeing is demonstrated by the severe economic conditions in the Reserves/Bantustans. Simkins (1983) found that the reserve inhabitants were unable to provide for their subsistence requirement from agricultural production from as early as 1918. The Houghton & Walton (1952) study of Keiskammahoek in 1949 found the value of subsistence agriculture amounted to 20-25 per cent of the average family's cash income. Half of cash income came from remittances

[18] Sapire's (1994) work, demonstrates the impact of one of the native resettlement acts on the social, political and family life of Africans in the "urban" location of Brakpan in the 1940s. Of particular interest is how the laws displaced and scattered families all over the Witwatersrand.
[19] Terreblanche (2002) notes that between 1960 and 1989 there were 3.5 million forced removals of people from areas where they lived to their so-called homelands (Bantustans) who were found to be of 'incorrect' ethnicity for their location.

sent by family members who were living and working elsewhere in the country (see Nattrass 1977, 1981; Seekings & Nattrass 2005).

According to the Carnegie report of 1984 (see Abedian 1984), the proportion of the total population (including those in the homelands areas) living below subsistence in 1980 was estimated to be 50 per cent. For Africans throughout the country, the proportion was estimated to be nearly two-thirds (60-65 per cent), whilst for those living in the reserves no less than 81 per cent of the households were living in dire poverty.

It could be argued that the economic hardships in the reserves posed serious challenges to the extended family's ability to provide adequately for needy members. Moreover, the poor wages paid to migrant workers made regular remittances to rural areas difficult, thus furthering abject poverty (Wolpe 1980; Seekings & Nattrass 2005). Therefore, the co-operative and caring obligations widely cherished among kin, which are essential for stable and secure traditional family life, were placed under great strain and had to be adapted to the new economic situation (Wolpe 1980).

The migrant labour system, introduced after the discovery of diamonds and gold, contributed significantly to the potential economic limitations of extended families (Posel 2001; Foster 2000; Butler 2004; Head 2003; Ramphele, 2000, 1993; Spiegel, Watson & Wilkinson 1996a, 1996b, Montgomery et al. 2006). For as Spiegel, Watson & Wilkinson (1996a) observe; "the effects of oscillating migrant labour from the 1920s, combined with the enforced relocations of the apartheid era in the 1950s led to new perspectives on domesticity of rurally based households, always in flux with income-earning individuals as sometimes there, sometimes not." The family was stretched across space, with one or more members absent from the rural home to earn income, and the rest remaining in the rural home, subsisting on remittances provided by those absent members and whatever small amount crops they could produce (Spiegel, Watson & Wilkinson 1996a).

One of the major changes was the absence from the family, for a large part of the year of its able-bodied adult male members. Nattrass (1977) indicates that in 1936, on the census

date one out of every three males in the age cohort 15-64 was absent from home. By 1970 this proportion had increased to more than one out of every two and in KwaZulu-Natal, it was as high as eight out of every ten in certain regions.

The consequences of these measures were, firstly, less agricultural production in the reserves. Secondly, large numbers of women shouldered the burden of raising a family alone. Finally, many children grew up in fatherless households. These factors impacted negatively on families' socio-economic stability; a fact that needs to be taken into cognisance in the current welfare regime[20].

The problems of dramatic population growth in rural areas and the ensuing high levels of poverty were a direct result of the forced resettlement, the migrant labour system which undermined peasant agriculture, and the structural unemployment caused mainly by capital-intensive and skills-based methods of production that were adopted in key sectors of the economy – agriculture, mining and industries – mainly through mechanisation in the 1970s.

With mechanisation, the labour of many poor, illiterate or semi-literature Africans became superfluous, to a point of being obsolete thus creating a surplus of unskilled labour. Technological advancement led to an increasing demand for skilled labour. This marked the genesis of the structural unemployment crisis in South Africa.

According to Greenberg (1980), 438 000 black workers were retrenched from agricultural employment between 1960 and 1971. Between 1971 and 1973, an additional 248 000 lost their jobs. Research by Stats SA (2000) indicates that between 1970 and 1990, the number of people employed in the agricultural sector dropped from 1.6 million to 1.2 million. Terreblanche (2002) and Seekings & Nattrass (2005) indicate that unemployment increased from 1.9 million in 1970 to 4.8 million in 1995. At the same time, the potential

[20] Crucially, while the apartheid system of governance succeeded to weaken the extended family's economic independence and its social structure, it failed to eradicate the social relations embedded in this structure. In fact some argue that, rather than weaken extended families, migration might have strengthened its social and economic ties (Gelderblom & Kok 1994).

labour force increased by almost 4 million (or 42 per cent). In the same period, 1970 to 1995, the number of African workers employed in the formal sector decreased by 203 000, or 3.8 per cent while the number of non-African workers employed increased by 1.3 million (or 45 per cent).

The wages of Africans fell sharply in this period (McGrath 1990; Terreblanche & Nattrass 1990; Terreblanche 2002; Seekings & Nattrass 2005). Economic hardships in the reserves, subsequently drove many people into urban and semi-urban areas where employment prospects were perceived to be better.

This was a trend that had been developing over the course of the century. Wolpe (1980) indicates that the percentage of the African population in the urban areas increased from 12.6 per cent in 1911 to 23.7 per cent in 1946 and by 1971 was approximately 38 per cent. This number has since increased dramatically. Over half of the South African population is now urbanised according to Stats SA (2008).

Small towns, adjacent to farms, have been the immediate recipients of farm worker immigrants. Atkinson (2007) indicates that with the capitalisation and mechanisation of commercial agriculture, and the subsequent redundancy of the labour of farm workers, many were encouraged to move to the labour reserves; Bantustans. However, many settled in nearby small towns, illegally (Atkinson & Buscher 2007; Atkinson 2007).

Table 2.1 below, illustrates the scale of migration to small towns by farm workers. It shows that small towns grew much more rapidly than larger towns and cities between 1991 and 2001. During the same period, small towns experienced economic decline, thus exacerbating the problem of unemployment.

Table 2.1 Net-migration to cities and small towns in the Free State Province.

	Cities	Regional towns	Middle order towns	Small towns
1991	1028 841	124 042	257 515	245 168
2001	1097 182	158 617	355 661	435 607
Changes per annum 1991-2001	0.9%	3.1%	3.5%	8.9%

Source: Marais (2004).

The consequence has been the creation of the 'under-class' (Seekings & Nattrass 2005), drawn mostly from the unskilled and unemployable masses of people. As many have argued, the capital and labour-intensive growth path of the 1970s laid the foundation for post-apartheid economic policy regime (Harries 1993; Adam 1997; Terreblanche 2002; Seekings & Nattrass 2005; Bond 2006).

Extended families in post-apartheid South Africa

Despite the social, economic and political havoc wrought by the legacies of colonialism and apartheid, extended families' social relations are strong. This is demonstrated by a survey of literature covering the period just before and after the fall of apartheid. In his study of migrant labour and changing family structure in the rural periphery of Southern Africa in the 1970s, Murray (1980) found twelve out of sixteen household heads in Rampedi ward, in Mochudi, belonged to segments of an agnatic core lineage. They were all related in the male line to the founder of the ward. He further observed that while the mean household size was 6.6 persons, the households varied considerably in size and composition: they included basic nuclear families, single parent families, families with children from various marriages, and more complex three-generation families.

In the late 1980s and early 1990s, Steyn (1995) conducted a survey of family relationships within households in the urban areas of South Africa. In both studies she concluded that by and large African families maintained their extended nature. In their study of *Domestic diversity and fluidity among some African households in Greater Cape Town* Spiegel, Watson & Wilkinson (1996a) found at least 61 percent of the households

surveyed did not comprise nuclear-family units. In her paper, *The family and Social Cohesion*, Ziehl (2003) used data from the 1996 census to paint a broader picture of family patterns in South Africa. The study revealed that, on the whole, Africans do not follow the nuclear family pattern and a relatively large proportion of households are extended. Russell (2004) used the Census 2001 data to arrive at a similar conclusion. These findings are vitally important. For, it is argued that if families are becoming nuclear they will be, or are already, unable to provide care and support for orphans, given the predicted drastic increase of orphaned children due to high numbers of HIV/AIDS-related deaths of young adults in South Africa.

Historically, care for children in African communities is not confined exclusively to biological parents (Broodryk 2002; Nyamukapa & Gregson 2005). As Broodryk (2002) notes, in African family life, a child has many fathers and mothers, and brothers of his natural father and mother are also regarded and respected as his/her fathers and his/her mothers. He contends that there were therefore no orphans in 'traditional' Africa. If the natural parents of a child die, the other fathers and mothers in the extended family automatically take over custody of the child.

Many authors have pointed out that the practice of distributing and, or circulating children amongst relatives is continent-wide in Africa, almost certainly predating the economic and political upheavals of colonialism and industrialism. African children are expected to circulate between kin as needed, for errands and companionship (Mbiti 1969; Martin & Martin 1978; Kayongo-Male & Onyango 1984; Russell 1984) or because their parents cannot care for them adequately (Martin & Martin 1978).

Mbiti (1969) argues that it is the practice in some societies to send children to live for some months or years with relatives. Kayongo-Male & Onyango (1984) indicate that in African tradition, elder siblings sometimes had authority equivalent to the authority of their parents over young children. The elder siblings were highly respected by their younger brothers and sisters, and were expected to sacrifice for the younger ones as if they were their own children. This practice is commonly found in South Africa.

In a study carried out in 1949 Hellmann (1956) found 31 per cent of children in a black Johannesburg township to be living with rural relatives. Schapera (1971), writing of the Kgatla of Botswana in the thirties, reports that a relative with no children, or with children of only one sex would ask for the loan of a child, but often enough parents agree beforehand that their next child will be 'born for' some particular relative, to whom it is accordingly given soon after weaning. (The author of this study has personally experienced this practice as he was brought up by his biological uncle for whom he was born). van der Waal (1996: 51) describes how in the Northern Province, children were circulated between households. Over a quarter of all children observed during one year had been fostered by maternal grandparents and other matrilineal relatives or their own older sister. In the same manner, children who have lost parents for any reasons are easily absorbed in the family structure.

The Project for Statistics on Living Standards and Development survey (PSLSD 1994) found that 20 per cent of South African children were not living with either parent, while in the KwaZulu-Natal Midlands region another survey found one in three under 16 years old was not living with his/her mother. These children were living with relatives.

The study by Meintjies et al. (2003) in Limpopo Province indicates that in many instances children were cared for by their grandparents. In their recent study on (HIV/AIDS orphans) orphan guardianship in South Africa, Freeman, Nkomo & Kleintjies (2004) found that 30 per cent of respondents who had children living with or dependant on them had dependants who were not their biological children.

Similar practices are observable elsewhere in southern Africa. In their study of orphan prevalence and extended families' care in a peri-urban community in Zimbabwe, Foster et al. (1996, 1997), report that extended families continue to remain the predominant orphan caring unit. They further noted that there were no examples of orphaned children being looked after by someone who was not a close family relation. Moreover, a recent report by the UNAIDS (2006) on AIDS orphans in Zimbabwe has highlighted the

strength of extended families in the face of economic hardships exacerbated by HIV/AIDS, as relatives adopt their relatives' orphaned children.

The notion of circulating or exchanging children alluded to above has resonance with the concept of foster care. As Kayongo-Male & Onyango (1984) and Moser (1996) point out fostering can be seen as a conscious strategy to more effectively pool the burden of childcare in terms of availability of resources, shelter, the presence of adults, food and clothing. Fostering takes place for a variety of reasons. In the first place, children are often fostered by adult relatives who have no children of their own (Martin & Martin 1978; Kayongo-Male & Onyango 1984). These children provide company and help for those who would otherwise be alone.

Secondly, fostering may take the form of exchange of children, say between married brothers each taking one or more children from the other. These fostered children all know their biological parents, but spend much of their life away from their biological parents and they often call their uncle, aunt and their biological parents father and mother (Kayongo-Male & Onyango 1984).

Thirdly, fostering also takes the form of parents giving their children to another family hoping that the child will have a chance for a better life. The autobiography of the former State President of South Africa, Mr Nelson Mandela (Mandela 1994) as well as the unauthorised biography of the current State President, Mr Thabo Mbeki (Gevisser 2007), provides a clear example of children who are moved among relatives in order to afford them a better life. Both were sent away to live with relatives in order to access better education. They both speak fondly about it and their experiences.

Henderson (2003) further observes that the African system of fostering differs from the western notion in two respects. Firstly, according to African customs, parents retain rights over their children. Therefore, there is no equivalent to westernised adoption where all rights are transferred from one set of parents to another. Biological parents may visit their

children and make financial and material contributions to their upkeep and education. They may also recall them to their natal families.

Secondly, fostering among Africans differs from Euro-American forms where it is perceived as a temporary measure to make up for the lack of care by biological parents. In contrast, fostering among Africans is viewed positively, and is seen to add incrementally to the skills and experience of the children. Neither does fostering in Africa necessarily suggest inadequacy in biological parents' parental care[21].

In addition, as McDaniel (1990) observes, children who live with relatives other than their biological parents become ambassadors for their families and reinforce relatedness across networks of kin. Therefore, fostering children serves to perpetuate the family name and different families' members. It also serves to maintain the link between the ancestors and the living. The children would eventually be in charge of remembering the dead through maintenance of family shrines or in other ways.

Crucially, child welfare experts believe that children will be better served if their care is provided by members of extended families within the community of origin, rather than by strangers (Rynburn 1998; Berrick & Barth 1994). It is often argued that placement with kin has advantages over 'foster care'. Firstly, children are often spared the trauma of placement with strangers in strange environments. Secondly, the likelihood of contact with natural parents' relatives appears greater and thirdly relatives have a special investment in their kin[22] (Dubowitz et al. 1993, 1994). These suggestions are rooted in

[21] Fostering among Africans in South Africa has gained unsavoury reputation due the manner in which it was designed and implemented by the apartheid authorities. It was designed to allow the state to intervene where parents were 'failing' to provide adequate care for their child/children. As an intervention measure, the state removed vulnerable children from their families, sometimes by force, and placed them with foster parents, who in most cases were non-relatives. Foster parents were then paid a monthly grant for the upkeep largely of vulnerable children who were in their care. The heavy-handed approach of the state has caused a great deal of opposition from Africans to the point of stigmatising vulnerable children. In my small community in Free State, foster children were referred to as haas-haas; an Afrikaans name for rabbit. This name was used to invoke pity for fostered children, but at the same time perpetuated stigma, for no one wanted to have their children referred to in this manner.

[22] With the advent of colonialism, new socio-economic arrangements incorporating the values, norms and social relations of the colonisers were introduced. Their purpose was not the welfare of the colonised people (Dixon-Fyle & Mulanga 2004; Dixon-Fyle 2002; Nabudere 2006). Under the new system, nature

the observation that societies have inherent social safety nets that precede the advent of the central state and its welfare function.

The strength of extended families as a source of social safety net lies in the conceptualisation of the term amongst Africans. For Africans, the conceptualisation of family transcends the 'two parents and their children' definition of nuclear family, and the biological and kinship ties that go with it[23]. As Amoateng & Richter (2007: 12) note, it is best to speak of 'families' in the African conceptualisation of the *family*. These family forms include cohabitation, same-sex marriages, adoption and the fact that in some communities, parents may be living with other relatives, in addition to their children. Even where relatives live far apart, contact might be quite regular.

Those opposing this definition see the family as a group of people directly linked by kin connections (Mbiti 1961; Murray 1980; Kayongo-Male & Onyango 1984; Russell 1984, 1998, 2003, 2004; Okoth-Ogendo 1989; Nzimande 1996; Broodryk 2002). This is referred to as an *extended family* or *kinship*. Extended families link a wider circle of people who are related by blood or marriage (Nzimande 1996; Kanyogo-Male 1984) and even strangers (Broodryk 2002; Murray 1980) who normally identify with and care for one another. What is of critical importance in this approach is not 'blood' ties alone; but notions of obligation and mutual help.

Kinship, too, refers to social relationships between those related by blood, marriage, or self-ascribed association that extends beyond the marital dyad, the nuclear family of parents and dependant children, or one parent (McDaniel 1990; Mehlwana 1996; Young

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was to be dominated and exploited to produce accumulation, employment-related benefits replaced kinship-related benefits, a male breadwinner was presumed head of a nuclear family, and women's social and economic roles were downplayed (see Dixon-Fyle & Mulanga 2004: 3; Lund 2006). These are the conditions under which African South Africans provide support for immediate and extended family members in the present era.

[23] The meaning of the term family is contested across the social sciences. At the centre of the dispute are questions relating to the size of the family (two parents and their children versus two parents, their children and other kin members); relationships within the family (marriage versus cohabitation; biological children/members versus adopted children/members), and the associated purpose or role (genealogical maintenance versus economic interdependence) of the family.

2003; Russell 2004)[24]. The cornerstone of kinship is mutual aid, care and communal interest (Sharp & Spiegel 1984; Young 2003). This invokes the notion of 'Ubuntu'. 'Ubuntu' is seen as an expression of community life and collective responsibility that invokes notions of caring for and sharing with each other (Bengu 1996; Broodryk 2002; Chidester, James & Dexter 2003).

Moreover, the term family defined narrowly or broadly, is also conceptualised as a *household* (Wallerstein & Smith 1992; Russell 1993, 1998, 2004; Moser 1996). According to this view, a household is a group of people who normally live together in the same dwelling and consider themselves a unit in making plans and decisions about daily life. Members of a household may not necessarily be kin, but depend on one another for their livelihoods. Given the fluidity of families due to processes of migration and urbanisation in South Africa, this is also the common definition of a family. Statistics South Africa (Stats SA 1996, 2002) defines a household along these lines.

In this study, a family is conceptualised as an extended family of members related through kinship or economic ties – either living together, in close proximity or connected by social or/and economic links. This way of living generates a pool of resources from which family members can benefit. It can therefore be argued that family constitutes the vital source of *social capital* for orphans[25].

[24] It is generally held that kinship is one of the strongest forces of African life, for its imagery pervades African discourse, and people give meaning to their relationships through describing them in kinship terms (Young, 2003). Kinship is seen to control social relationships between people in a given community by governing marital customs and regulations, and determining the behaviour of one individual towards another (McDaniel 1990; Young 2003; Daly 2003). It binds together the entire life of the group. It is the centre for the day-to-day organisation of domestic production, and for the distribution of income and authority (Al-Haj 1995; Russell 2004).

[25] Of vital importance for this study, is the fact that the South African courts and Parliament have begun to recognise new types of family forms that do not fit within the traditional definitions. Gay and lesbian relationships are recognised by law; unmarried fathers have been granted limited rights over their illegitimate children, customary and Muslim marriages have their rights extended (see Rosa 2004: 7).

Social capital – what contributions?

The concept of social capital is a helpful theoretical framework to analyse the intricate web of family relations that constitute sources of social support, especially with regard to care for vulnerable members of families. It has the potential to help explain how the normative factors – internal or external – that drive members of extended families to act in certain ways towards each other, and the extent to which members of a structure (extended families) feel obliged to do things for the collectivity – that is, members of the extended family.

The concept of social capital has been used in different ways. It has been linked to economic development (Grooteart 1998; Krishna & Shrader 1999), the smooth functioning of democracies (see Putnam 1993; 1995; Wollenbreaka & Selle 2003), prevention of crime, and population health (Krishna & Shrader 1999; Veenstra 2002; Thomas 2003). In this study, social capital is being used to explain the role of family in providing a social safety net (Coleman 1990; Thin 1996) or social cohesion (Chidester, James & Dexter, 2003). The work of Coleman in this regard is enlightening. As such, it will form the basis of the analysis.

While social capital can be traced to the works of Durkheim, Karl Marx, Max Weber and George Simmel (see Wall, Ferrazzi & Schryer 1998), its popularity in the discipline of sociology is attributable to the work of Pierre Bourdieu and James Coleman. Bourdieu first used the term in the 1970s to refer to the advantages of and opportunities accruing to people through membership of certain communities. He contends that families possess different symbolic and material resources which enable them to gain advantages for their members. How families generate and mobilise these resources ultimately affects the success of their members.

Coleman used social capital to describe a resource for individuals that emerges from their social ties. He used examples of families' social relations to demonstrate how closer

social relations affect children's academic performance. He concludes that children who have more support from parents (whereby one parent works and the other looks after children's welfare in a nuclear-type family) and other siblings, are more likely to do well compared to others with less family support (especially where both parents are working, or in single-parent situations where parents have less time for children's school work).

Central to the notion of social capital is the view that social capital consists of resources embedded in structures of social relations to which members of the collective have access (see Bourdieu 1998; Coleman 1988, 1990; Putnam 1993, 1995; Portes 1998; Lin 2001a, 2001b) for a variety of uses – some socially acceptable (e.g., support from relatives) others less so (e.g., mafia and gang groups). Families, civic movements, business clubs, labour unions are examples of such structured social relations.

Coleman (1988) argues that these social relations are regulated by deeply held norms of obligations and expectations. Members of the collective act in the interest of others, thus, the possession of social capital means that individuals are embedded in a system of normative obligation created by a social consensus. At the family level, support for one another is regulated by these factors. Social capital, at the family level, could therefore be defined as relations of social support embedded in norms of obligations and expectations to which family members have access. In the current South African context that is characterised by high rates of poverty and HIV prevalence, this means that relatives of orphans are obliged and expected to provide them with care and support, in terms of the dictates of the norms and the values of their family systems – the social contract.

The assertion that families constitute the prime locale of social capital is informed largely by the viewpoint that sees social capital as a resource of social relations embedded in social structures (see Coleman 1988 1990; Bourdieu 1998; Putnam 1993, 1995). For Coleman, families' relations are seen as playing influential, in fact a functional role in children's educational performance, thus improved living conditions – through better education. Bourdieu (1998) maintains that dominant families use their different privileges to advance the interests of their children and to exclude others.

Putnam sees families as instilling civic values (which to him constitute social capital) and its members are crucial for the smooth functioning of democracy. Portes (1998), Lin (2001a, 2001b) and Fukuyama (1999) have demonstrated families' role, through networks of social relations, in individual members' entrepreneurial endeavours. The central thesis is that families are the root of social relations (through reproduction, socialisation and production functions), and therefore, the prime locale for social capital.

Norms of obligations, expectation and reciprocity that govern behaviour (actions) of family members (actors within a social structure) facilitate social capital. These norms guide members to act in the interests of the collective – extended families – because, firstly, it is expected of them, secondly, it is the right thing to do, and lastly, their actions will be rewarded, either directly by helping them in times of need or indirectly by helping their children.

Coleman's (1988) thesis in this regard is of particular relevance. He regards social structures that invoke norms of rule, expectations and obligations, as facilitating mutual help. He maintains that a prescriptive norm within a collective that constitutes an especially important form of social capital is the norm that says one should forego self-interests in the interests of the collectivity.

> A norm of this sort, reinforced by social support, status, honour, and other rewards is the social capital that builds young nations, strengthens families by leading family members to act selflessly in the family's interest, facilitates the development of nascent social movements through a small group of dedicated, inward-looking, and mutually rewarding members, and in general leads people in the interest of the general public good (Coleman 1988: 105).

Social capital has been located at the level of the individual, the informal social group, the formal organisation, the community, the ethnic group, and even the nation. The generic term the *macro-micro* level has been employed to denote this phenomenon (see Figure 2.1). The macro level refers to *institutional context* in which organisations operate. It includes the formal relationships and structures such as the rule of law, legal

frameworks, the political regime, the level of decentralisation and the level of participation in policy formulation process (see Wollenback & Selle, 2003 and Krishna & Shrader, 1999). As illustrated in Figure 2.1, this could explain the government's welfare programmes and policies for its 'poor' citizenry, especially when tragedies such as famine, poverty and epidemic diseases strike.

The *micro* level refers to horizontal organisations and social networks. Family and kinship relations and other face-to-face interactions constitute primary examples of micro level of social capital responsible for the production and reproduction of social safety net for orphans. The level of analysis or measurement that has been followed in this dissertation is the family. But unlike Coleman above, the focus is on the embedded systems of normative obligations created by social consensus that facilitate social care and support for orphans.

There are two types of social capital that can be found at the micro level; *cognitive* and *structural* social capital. Cognitive social capital refers to values, beliefs, attitudes, behaviour and social norms. Structural social capital on the other hand includes the composition and practices of local level institutions, both formal and informal. Examples include family, as well as extended families, and community-level organisations.

As can be observed, the family is seen as the primary locus of social capital, operating at micro level, and assuming cognitive and structural forms. As the primary locus of social capital, family is the strongest and most intimate force of networks of support – the thick line on Figure 2.1 points to this fact.

Moreover, Figure 2.1 also illustrates the fact that the micro level of social capital operates within certain *policies, institutions* and *processes,* and *shocks and vulnerability contexts*. This implies that government institutions administer policies that have a bearing on the functioning of micro-level type of social capital. For example, welfare policies can influence families' position and determine access to services. Calamities such as sudden

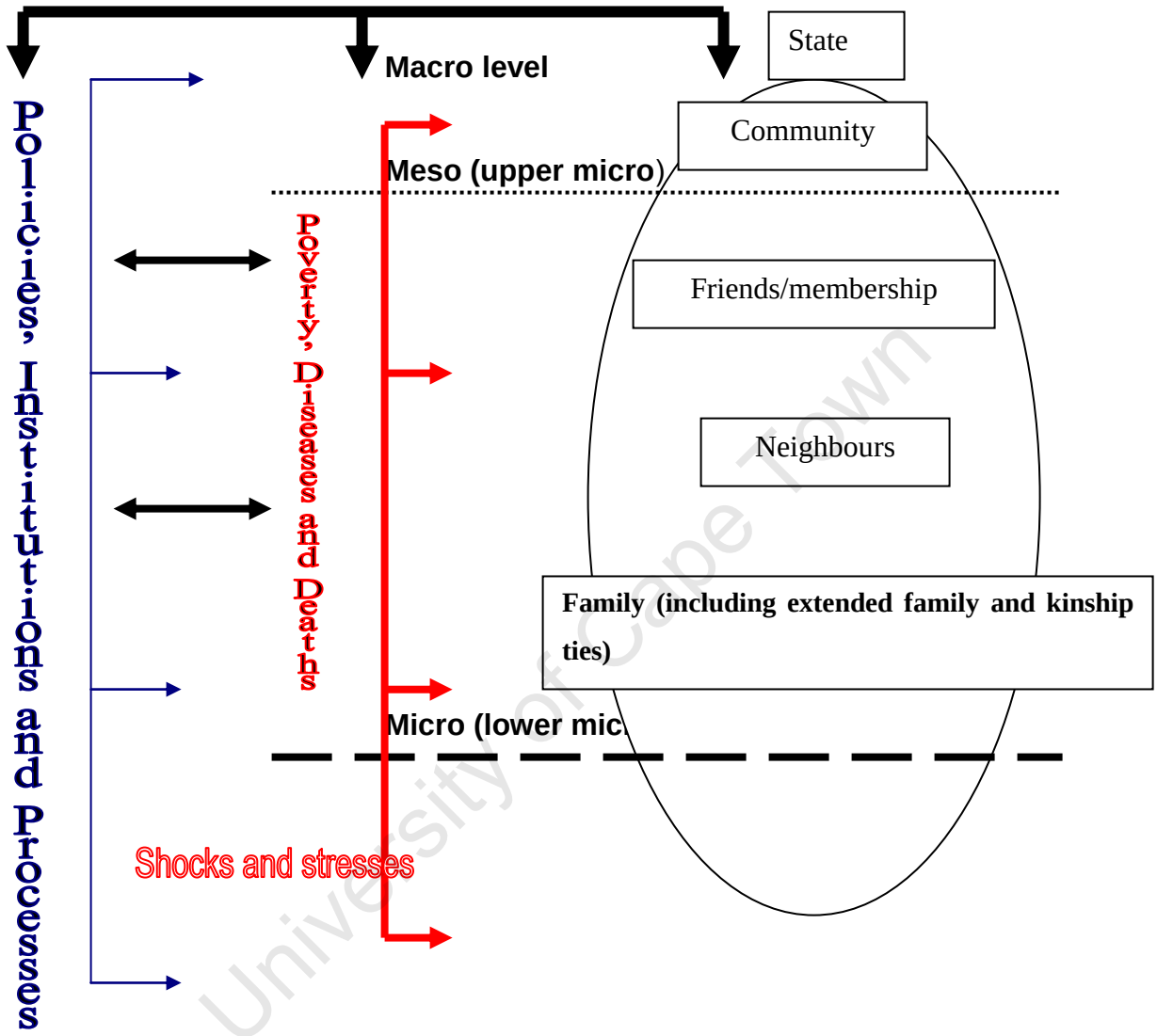
death, prolonged illness or poverty affect extended families' way of functioning, that is, the ability or otherwise to look after the vulnerable members.

Chidester, James & Dexter (2003) note that in a family, neighbourhood or local community, social capital can be located in a person's or group's sympathy or sense of obligation towards another person or group that may produce a potential benefit, advantage and preferential treatment to that other person or group of persons beyond that which might be expected in a selfish exchange relationship.

Therefore, social capital dictates that members of families are under obligation to look after one another. The extent to which members are prepared to comply with the expectations is an individual choice that comes with risking sanctions from members of the collective: the family. This is conceptualised as mutual obligations.

Mutuality can be realised in two complementary ways: first as an effect of assumptions about common interests that can be advanced through social exchanges – 'I will cooperate with you now hoping that you will do the same for me later' – and then as expectation which must be fulfilled within certain time limits in order for the relationship to continue – 'I collaborated with you before, thus I anticipate your aid at this time' (Kelly 1995: 216).

Figure 2.1 Types and levels of social capital*



Moreover, cooperation within families is facilitated by the fact that it is underpinned by biology. All animals favour kin and are willing to undertake one-way transfer of

* It is worth noting that the model presented above is adapted from the sustainable livelihood framework. The framework represents an analysis, planning and evaluation tool used in development discourse. In analysis and planning for development, the framework recognises that (rural) people have assets (capital) on which social or community development interventions could leverage. These (assets/capital) include; social, human, financial, physical and natural. People use these assets to pursue livelihood strategies. There are 'external environmental' factors that impact on these capital assets, and ultimately livelihood strategies. These factors may include; vulnerability context (such as diseases, sudden death) and institutions and processes (governments or donors, and government policies). In addition, institutions and processes may be operationalised at the micro, meso or macro levels. It is the notions of capital assets and micro-meso-macro-level of analysis (operationalisation) that adds value to the model presented above.

resources (if needs be) to genetic relatives, in a way that vastly increases the chances of reciprocity and long-term cooperation within kin groups (Fukuyama 1999).

Further, as pointed out by Sampson, Morenhoff & Earls (1999), the active maintenance of intergenerational ties, the reciprocal exchange of information and services among families, and the shared willingness to intervene on behalf of children yield positive externalities that potentially benefit all the children. Fursterberg (2005) further notes that the concept of family invokes common norms and levels of trust, commitment, attachment, and exchange that produce a sense of mutual obligations among members. This explains the norm of caring for children of members of extended families. This practice serves the dual purpose of dispensing social capital, and the strengthening of extended families' or kinship's ties.

Fursterberg (2005) further notes that children are full players in a family system. That is, in addition to face-to-face encounters, children become involved in the outside world, which becomes a source of connection to school, religious organisations, and community life. This is referred to as *bridging social capital* (Portes 1998; Leonard, 2004, 2005). Therefore, while children are beneficiaries of social capital, they also facilitate or strengthen it.

The starting point for building such connections often begins with strengthening bonds with extended families, which typically has a strong stake in rendering support and sponsorship. Fursterberg (2005) points out that as grandparents and other extended kin become more involved, the child (and parents) becomes embedded in a web of obligations and affiliations. Thus, social capital helps children in families to experience interdependent living across the generations, among others (Hogan 2001).

Moreover, in addition to being the carriers of extended families' ties across generations, children constitute a resource or investment for the family (Coleman 1994). Parents raise their children with the hope that they will look after them during their old age, and as a result sacrifice resources to make sure that their children receive the education upon

which to build a better future that will enable them to look after their parents (Hofferth & Iceland 1998).

Key to the survival of this practice, though, is the existence of effective enforcement of norms by families through sanctions. Once this breaks down, as Coleman (1994: 45) points out, it releases adult members of extended families from the obligation to have children and raise them well, and it releases children, once adult, from obligations to care for parents and to carry the name of families with honour. This is the critical contribution which the concept of social capital makes to our understanding of the complex nature of extended families' relations which produce a source of social safety net for vulnerable members.

It would, however, be naïve to assume that all is well within all families. Critics, mostly from feminist quarters, have questioned the assumption that families necessarily function in the best interest of all members (Viljoen 1996; Giddens 2001). One of the central concerns is the domestic division of labour (Holman & Burr 1980). This viewpoint holds that women continue to bear the main responsibility for domestic tasks (such as childcare, and housework) and enjoy less leisure time than men, despite the fact that more women are working in paid employment outside home than ever before.

The second critcism has drawn attention to the unequal power relationships that exist within many families (Cheal 1991; Giddens 2001). As Giddens (2001) observes wife battering, marital rape, incest and the sexual abuse of children have all received more attention as a result of feminists' claims that the violent and abusive sides of families' life have long been ignored in both to academic context and legal and policy circles.

The study of caring activities is a third area where feminists have made important contributions. The central argument is that not only do women tend to shoulder concrete tasks such as cleaning and childcare, but they also invest large amounts of emotional labour in maintaining personal relationships.

Fourthly, families could also become an arena for tension relating to disputes over property inheritance. There are anecdotal reports of relatives depriving orphans from wealthy families of their inheritances.

Similarly, both the advocates and critics of the concept of social capital agree that social capital has both negative and positive consequences for the society. It has been noted that the norms of exclusivity exclude non-members. Therefore, the same strong ties that help members of a group, often enables it to exclude outsiders (Kelly 1995; Portes & Landolt 1996; Maluccio et al. 2001).

Moreover, more often than not, membership in a social network is based on ascriptive criteria such as ethnicity, race, gender, national background, and social class. Norms that emphasise family/kinship ties potentially make it difficult for non-relatives to adopt orphans.

Furthermore, the trend within the literature on social capital of idealising families as the most productive site of social capital and therefore a pillar of civic virtue and democracy (Putzel 1997) is not without fault. Families are hierarchical organisations and one of the more important sites of reproduction of patriarchal relations within society. For these reasons, feminists see families acting as the sites of transmission of chauvinism, sexism and racism across generations. As the primary locus of social capital that fulfils socialisation of the young, families are likely to perpetuate these practices by passing these values on to those that are being socialised, thus, entrenching the undesirable status quo.

However influential the role of kinship and extended families in caring for children, including vulnerable ones and orphans, there is a perception that the problem of orphanhood as a direct result of the HIV/AIDS pandemic that is superimposed on wide-spread poverty, is calling on extended families as a source of social support in a way that threatens their ability to cope. For it is envisaged that due to high numbers of children orphaned largely by HIV/AIDS in South Africa, extended families may become

overwhelmed and possibly reach saturation point (see Foster et al. 1995; Townsend & Dawes 2002; Giese et al. 2003; Meintjies et al. 2004).

Conclusion

This chapter has argued that the colonial and apartheid governments have succeeded in weakening social, political and economic institutions among Africans in South Africa. It has been argued that the Land Acts in particular had the double impact of displacing families and depriving Africans of the opportunity to subsist gainfully on the land/agriculture, thereby weakening their economic independence. The long-term consequence of rural proletarianisation, coupled with the migrant labour system has been the destruction of an African peasant farmer, thus, ensuring the production and reproduction of labour for capitalist enterprises. Apartheid policies of racial capitalism victimised Africans, severely impacting on the institution of the extended family's ability to provide a social safety net by weakening its economic independence and creating a rural-urban divide.

It has also been argued that unemployment, which is the main cause of poverty, is due to the structure of the economy. The South African economy is driven by wage labour. The shedding of labour and decline in job creation results in poverty. High unemployment is fuelled by a lack of skills amongst the unemployed. Yet, despite the social, economic and political havoc brought about by the legacies of colonialism and apartheid, family *social relations* seem strong.

The concept of social capital has been helpful in this regard. Its philosophical contribution is the fresh understanding of how normative factors drive members of the family to act in certain ways towards each other, and the extent to which members of the collective feel obliged to do things for each other. Nevertheless, some researchers and policy makers fear that in the present era of the HIV/AIDS epidemic the pressures on the extended family will intensify.

Chapter 3 Poverty and HIV/AIDS in South Africa and welfare policy responses

Introduction

Chapter 2 argued that the African concept of family is much broader than the Euro-American one. In African families 'orphans', in the Euro-American sense, do not exist. Extended families absorb 'orphans' as well as the non-orphaned children of relatives. The theoretical analysis of social capital offered by James Coleman shed light on the mechanisms that bind families together. The chapter further suggested that despite the assault of colonialism and apartheid, the extended family with bundle of norms of obligation is still a critical. However, to argue that the family may be resilient is not deny that it is also under pressure. It is shouldering the combined strains of poverty and HIV/AIDS. This chapter examines these strains and the government's response through the welfare system.

Poverty and HIV/AIDS in South Africa

Definitions of poverty range from the objective/absolute to subject/relative analysis/measurement of wealth and wellbeing of human beings (UNDP 1998; Krishna Kumar, Gore & Sitaramam 1996; Beccaria 1997; Seoane 1997; Woolard & Leibbrandt 2001; Motloung & Mears 2002; Meth & Dias 2004; Oosthuizen 2008). Key issues in measuring poverty are the *identification of problems* (Bhorat 1999, 2000; Leibbrandt & Woolard 1999; de Swart et al. 2005). This involves specifying which individuals are poor and how poor they are, and the aggregate problem of constructing an index of poverty using the available information on the poor and ensuring that the answers are robust (Leibbrandt & Woolard 1999). Three decisions that need to be made include: (i) the choice of indicator of living standards – that is, expenditure or income data, (ii) the selection of a poverty line – that is, absolute or relative poverty (UNDP 1998; Krishna Kumar, Gore & Sitaramam 1996; Wilson 1996; Bhorat 1999, 2000; Beccaria 1997; Seoane 1997; Noble, Ratcliffe & Wright 2004; de Swart et al. 2005) and (iii) the choice

of an aggregate poverty measure – that is, the head count ratio or poverty gap (Sen 1976; Joshi 1997; Leibbrandt & Woolard 1999; Serumaga-Zake & Naude 2002).

Some debates argue that the definitions of poverty (Becarria 1997; UNDP 1998; Noble, Ratcliffe & Wright 2004; Magasela 2006; Noble et al. 2005a; Barnes et al. 2007) should look beyond income and expenditure and consider unmet social needs. In this approach poverty means more than simply a lack of income. It is not measurable by quantitative methods alone. The UNDP states; "Since income is not the sum total of human lives, the lack of it cannot be the sum total of human deprivation" (UNDP 1998: 25)[26]. The UNDP approach investigates whether the household is actually satisfying its needs. A household is then regarded as poor if the thresholds for all, or some, of the different basic needs are not reached. In addition to focusing on food and non-food (subsistence) items, the unmet basic needs method focuses on the deprivation of access to basic aspects such as safe drinking water, health and education – referred to as a *social wage*. Poverty definitions and measures that rely on income/expenditure usually fail to take the social wage into account. South Africa's Reconstruction and Development Programme (RDP) recognised the significance of including the social wage in the definition of poverty;

> It is not merely the lack of income which determines poverty. An enormous proportion of every basic need is presently unmet. In attacking poverty and deprivation, the RDP aims to set South Africa firmly on the road to eliminating hunger, providing land and housing to all our people, providing access to safe water and sanitation for all, ensuring the availability of affordable and sustainable energy sources, eliminating illiteracy, raising the quality of education and training for children and adults, protecting the environment, and improving our health services and making them accessible to all (African National Congress 1994:54).

What the discussions above highlight is that the definition and measurement of poverty used in any balanced study needs to be carefully weighed and clearly defined. In this study, poverty levels will be analysed at both the individual and/or household level, and focusing on income/expenditure and other unmet basic needs. The universally used

[26] The UNDP (1998) indicates that although income-based poverty focuses on an important dimension of poverty, it gives only an incomplete picture of the many ways in which human lives can be destroyed.

income threshold of US$1 (purchasing power parity) per day is used to measure income-related levels of poverty, unless stated otherwise. Reference will also be made to the social wage interpreted here as access to social services. Considering these discussions, this study defines poverty as the lack of access to basic services including cash or income.

However, it is important to remember that the purpose of this research is not to define and debate poverty. Rather, the concept of poverty is used to highlight the challenges facing families in the context of the HIV/AIDS epidemic. In a dedicated study of poverty the ways of capturing and measuring its many dimensions would be critical. Here, it is enough to give broad indicators, particularly since the people being researched are by any international measure desperately poor: materially and financially.

There has been a significant increase on social spending, particularly on welfare, health, education, and housing by the current government. Butler (2004), Bhorat & Kanbur (2006:6), Seekings (2007a) and Kamau (2008) observe that by the late 1990s, 80 per cent of total spending was assigned to the African population and less than ten per cent to Whites. Furthermore, the UNDP (2003:8) indicates that the South African government expenditure on health increased from 366 million in 1995 to 375 million in 2002, while expenditure on welfare increased from 184 million to 214 million during the same period. There has also been significant increase in the take up of social grants. It is estimated that more than 12 million South Africans received social grants as of 10 August 2008, the majority of whom were children – more than 8 million (DoSD 2008).

Improved access to bulk services as illustrated in Table 3.1 (see also Hemson 2006; Leibbrandt et al. 2006; van der Berg 2006; Lund 2006). According to Table 3.1, electricity connectivity rose from 54 per cent in 1993 to 80 per cent in 2004. The number of households with piped water rose from 59 per cent to 68 per cent, 1993 and 2004, respectively. The figures have increased since. According the Community Survey 2007, conducted by Stats SA in 2007, about 97 per cent of households in Free State had access to piped water (Stats SA 2008). The survey has further recorded a dramatic increase in

the telephone or cell phone connections from 28 per cent in 1993 to 55 per cent in 2004 (Stats SA 2008).

Table 3.1 Infrastructural provision, 1993-2004

	1993		2004	
	Number (million)	**% of total**	**Number (million)**	**% of all households**
Households using electricity for cooking	3.8	45	n/a	n/a
Households using electricity for lighting	4.4	52	n/a	n/a
Households with electricity connections	4.6	54	9.8	80
Households with piped water supply inside house or in yard	5.0	59	8.3	68
Households with flush or chemical toilet on site	4.5	53	6.9	56
Households with a landline or cell phone	2.4	28	6.7	55
Households with formal housing	5.8	68	8.4	69
Total number of households in South Africa	8.5	100	12.2	100

Source: Seekings (2006a).

The democratic dispensation has also witnessed housing for the poor on a massive scale. More than one million houses have been built for people who had no formal shelter previously (Gelb 2006:19). This resulted in nearly two-thirds of the total population living in formal dwellings. According to the Community Survey of 2007 (Stats SA 2008), on average nearly two-third (70.6%) of South Africans lived in formal dwellings. Free State (71.0%) along with other five provinces (Western Cape – 83.4%, Limpopo – 83.2%, Northern Cape – 80.4%, Mpumalanga – 77.0% and Gauteng – 73.5%) recorded higher percentages of households living in formal dwellings compared to the rest of South Africa. However, social policy experts (Spiegel, Watson & Wilkinson 1996a, 1996b; Bond 2006; Hemson 2006) criticise the government for a narrow focus on quantitative targets, undervaluing housing quality, physical durability and also the diversity of housing demand and broader community development.

Other improvements in terms of service delivery include free medical services now given to expectant mothers as well as children under the age of seven. School food programmes reaching about 5 million children have been introduced. There has also been infrastructure development aimed at supplying rural communities with water and roads.

Despite the commendable improvements in the provision of bulk services, poverty remains pervasive. Analysis of the results in the 1999 October Household Survey and the 2002 Labour Force Survey by Meth and Dias (2004) suggests that the number of people in the bottom two expenditure classes (R0–R399 and R400–R799 per household per month) increased by about 4, 2 million over the period. They also observe that the state's best efforts notwithstanding, the number of people falling below the poverty line, defined as people earning less than US$1 per day, increased between 1999 and 2002, probably by at least 2 million (Meth and Dias 2004).

Estimates of poverty by the Human Sciences Research Council (HSRC 2004a) show that the proportion of people living in poverty in South Africa did not change significantly between 1996 and 2001. The Human Sciences Research Council (HSRC) further found that those households *living in poverty have sunk deeper* into poverty and the *gap between rich and poor has widened* (HSRC 2004a) (author's emphasis). Based on this analysis, the HSRC concluded that the poverty *gap*[27] has grown faster than the economy, indicating that poor households have not shared in the benefits of economic growth. In 1996 the total poverty gap was equivalent to 6.7 per cent of gross domestic product (GDP). By 2001 it had risen to 8.3 per cent. Table 3.2 illustrates the percentage of population that live in poverty in South African provinces and the share of poverty gap in 2001. According to Table 3.2, 57 per cent of South Africans lived in poverty. In the Free State 1.8 million people or 68 per cent of the province's population lived in poverty.

[27] A poverty gap measures the required annual income transfer to all poor households to bring them out of income poverty (HSRC 2004a: 1).

Table 3.2 Percentage of poverty and share of poverty gap in 2001

Province	No. of poor persons (million)	% of population in poverty	Poverty gap (R billion)	% of Share of national poverty gap
Eastern Cape	4.6	72	14.8	18.2
Free State	1.8	68	5.9	7.2
Gauteng	3.7	42	12.1	14.9
KZN	5.7	61	18.3	22.9
Limpopo	4.1	77	11.5	14.1
Mpumalanga	1.8	57	7.1	8.7
North West	1.9	52	6.1	7.5
Northern Cape	0.5	61	1.5	1.8
Western Cape	1.4	32	4.1	5.0
South Africa	25.7	57	81.3	100

Source: HSRC, 2004a.

Poverty in South Africa has regional, race and gender dimensions. Certain provinces have higher levels of poverty. Table 3.3 shows that overall, since 1996, poverty levels have increased in five provinces, decreased in three and stayed the same in one. Everatt's data (2006) indicates that poverty levels increased by 1.3 per cent, in the Free State between 1996 and 2000.

Table 3.3 Poverty by province 1996 and 2001

Province	1996	2001	% change
Limpopo	50.4	47.1	Down 3.3%
Eastern Cape	48.5	47.6	Down 0.9%
KwaZulu-Natal	39.5	39.3	Down 0.2%
Mpumalanga	37.1	37.2	Up 0.1%
North West	33	38	Up 5.0%
Free State	31.5	32.8	Up 1.3%
Northern Cape	24.3	24.3	No change
Gauteng	20.1	20.8	Up 0.7%
Western Cape	14.6	16.7	Up 2.1%

Source: Everatt (2006)

The fact that poorer households have not shared in the proceeds of economic growth is reflected in the rise in inequality between rich and poor (HSRC 2004a; Seekings & Nattrass 2005; Seekings 2006). The HSRC study found that South Africa's Gini coefficient rose from 0.69 in 1996 to 0.77 in 2001.[28] Studies by Leibbrandt et al. in 2004 and 2005 indicate that the Gini coefficient rose by about five percentage points over five years, from 0.65 to 0.7 and from 0.68 to 0.73, respectively[29]. Using the Income and Expenditure Survey data of 1993 & 2000 and the household survey (Census) data of 1996 and 2001, Bhorat & Kanbur (2006:4) indicate that income inequality has increased with Gini coefficients increasing from 0.565 to 0.577 between 1993 & 2000, while on a 1996 & 2001 comparison the Gini rose from 0.68 to 0.73.

The van der Berg et al. (2006) model of income distribution indicates that overall income inequality rose through the 1994-2004 period. Moreover, the UNDP *Human Development Report* indicates that South Africa's Human Development Index has declined steadily after a brief rise in 1995 (UNDP 2003). [30] Generally, despite some differences in survey and sampling designs, post-1994 surveys showed a consistent pattern: unemployment was higher for Africans than for other race groups, higher for women than for men, and higher in rural than in urban areas (see Wilson 1996; Bhorat 1999; 2000; Ngwane et al. 2001, 2002; Motloung & Mears 2002; Serumaga-Zake & Naude 2002; Meth & Dias 2004; Seekings & Nattrass 2005).

As argued above, poverty remains obstinately widespread. In his recent study of estimates of poverty line in South Africa, Oosthuizen (2008) found that between 45 per cent and 57 per cent of South Africans lived below the absolute poverty line of R364 and

[28] To indicate inequality the HSRC used the Gini coefficient, which can vary from 0 in the case of a highly even distribution of income, to 1 in the case of a highly unequal distribution (HSRC 2004a: 1).
[29] The former study used the 1995 and 2000 Income and Expenditure Survey data while the latter study compared data from the 1996 and 2001 Population Census.
[30] The Human Development Index (HDI) is a measure of well-being developed by the United Nations Development Programme (UNDP) and reported in the UNDP's annual *Human Development Report*. The HDI comprises three components: an 'educational attainment index' constructed out of adult literacy rates and gross school enrolment rates; a 'life expectancy index' derived from data on life expectancy at birth; and an index of GDP per capita taking into account purchasing power. The UNDP selected these variables for the HDI because they were easily measured and together provide a good indication of social and economic well-being in a country or region.

R442 per capita per month, respectively. This figure represents the lower bound poverty line[31].

These high levels of poverty are fuelled by 'structural unemployment' (Terreblanche 2002; Seekings & Nattrass 2005). The current economic trajectory is unable to create job opportunities for those seeking work. In 2005 about 50 per cent of African entrants to the job market could not find jobs in the formal sector. According to the Labour Force Survey for 2005, between 26 per cent and 40 per cent of total labour force in South Africa was unemployed depending on whether a strict or expanded definition of unemployment is used[32] (Stats SA, 2006, see also Bhorat & Oosthuizen 2006). Makgetla (2006: 74) further indicates that in 2004 unemployment for Africans, using the broad definition was 48 per cent, compared to 28 per cent for Coloureds and Asians and 8 per cent for whites. Two thirds of the unemployed were Africans under the age of 30. Seekings (2006: 14) has succinctly summarised the reasons for this poverty;

> Poverty in South Africa is rooted in deagrarianisation and unemployment. South Africa's poor are not land-holding peasants, supplementing subsistence production with occasional sales of agricultural produce, casual employment or remittances from migrant labour. South Africa's peasantry was slowly destroyed in the course of the Twentieth Century. Forced removals from large commercial farms, overcrowding in the 'homelands' or 'Bantustans', low-quality schooling, poor links into urban and industrial labour markets, and the growing capital-intensity of production in most economic sectors resulted in the growth of unemployment among unskilled workers and of mass poverty among them and their dependents.

The effect of proletarianisation policies on Africans and their families are well summarised by the Lund Committee thus;

> The migrant labour system and the influx control measures separated men from their families for long periods; the Bantustans locked people into rural areas. There was a systematic dispossession of families of land, then

[31] Oosthuizen used the Income and Expenditure Survey of 2005/2006 to create estimates of poverty lines for South Africa, absolute and subjective poverty lines.

[32] The South African government uses the broad and narrow definitions of unemployment to distinguish between those who are unemployed and are actively looking for work, and those who are unemployed but have given up efforts to look for employment for various reasons.

> cattle. There was no natural development of small towns, which would have brought local work opportunities. Educational facilities were under-developed. Diseases contracted in the mines were 'exported' to the Bantustans (Lund Committee 1996).

Unemployment, and consequently poverty and inequality, in South Africa, have a gender dimension as well. Makgetla (2006) notes that for African women, the overall unemployment rate was 56 per cent, compared to 7 per cent for white women. Her calculations reveal that three quarters of African women less than 30 years were unemployed (see also Bond 2006)[33].

Efforts to curb unemployment among Blacks have not been very effective because they focus on those with skills and experience. Given the legacies of apartheid education policies, not many Black South Africans possess post-matric qualifications. The level of education offered in mainly African schools is generally of inferior quality (Fedderke et al. 2000).

Children are particularly vulnerable to poverty. Moreover, the impact of poverty on children has long-term consequences, and increases the chances of passing their poverty onto the next generation. Several studies of childhood poverty in South Africa have been carried out (see Streak 2000; Woolard & Leibbrandt 2001; Dieden & Gustafson 2003). They all come to the same conclusion. Childhood poverty in South Africa is severe. It is estimated that child poverty based on income and food insecurity range between 59 per cent and 75 per cent of the child population (Meintjies & Giese 2006: 418).

Jacobs et al. (2005:61-64) estimate that 43 per cent of children have inadequate access to water, and 39 per cent have inadequate sanitation. Using child's eligibility for social grant as a proxy for determining household's poverty, Noble et al. (2005) found that 7 million children under the age of 11, out of 11 million were eligible for social grants – implying

[33] Moreover, there are obvious discrepancies with regard to wealth distribution as black population continue to suffer the lowest incomes. Makgetla (2006: 76) indicates that in 2004, estimates suggest that 40 per cent of African employed people earned under R1000 a month in 2000, compared to 20 per cent of Coloureds and Asians, and 5 per cent of whites.

that they were living in poor households. As Noble et al. (2005) note, this suggests that 67 per cent of children under the age of 11 were living in poor households.

In their study of the *South African Index of Multiple Deprivation of Children*, Barnes et al. (2007:21-25)[34] found that 81 per cent of children in South Africa experienced income and material deprivation, 50 per cent experienced unemployment deprivation, 24 per cent of children were in the wrong grade for their age, and six per cent were not in school, while 77 per cent experienced living in environmental deprivation and 25 per cent experienced adequate care deprivation. The consequences of childhood poverty include; malnutrition, stunted growth, non-attendance of school, poor completion rate of school leavers (Case & Ardington 2004; Ardington 2007; Sienaert 2007), and consequentially a high rate of unemployment (Kamau 2008). Poverty among children is intricately linked to the family or household's situation and is thus a good indicator of a family or household's poverty.

HIV/AIDS in South Africa

In South Africa, over 5.4 million people out of a total population of approximately 48 million were thought to be infected with HI-virus by the middle of 2005 (DoH 2006a; Dorrington et al. 2006). Based on the surveillance of pregnant mothers attending public health clinics, the Department of Health (DoH) found 30.2 per cent of expectant mothers to be HIV positive. Extrapolated to the national population, this represents 11.25 per cent or 5.3 million people living with HIV/AIDS (DoH 2006a). The number has since climbed

[34] According to index model developed by Barnes et al. (2007), children may be counted as deprived in one or more of domains. Using the South African Census form, the model produced five domains of deprivation; (i) income and material deprivation – children living in a household that has a household income below 40% of the equivalent household income, children in a household without a fridge and children living in a household with neither TV nor a radio; (ii) employment deprivation – children living in a household where no adults are in employment; (iii) Education deprivation – children (9-15) in the wrong grade for their age and children (7-15) not in school; (iv) living environment deprivation – children in household without piped water in their dwelling or yard or within 200 metres, a household without pit latrine with ventilation or flush toilet, without use of electricity for lighting, without access to telephone, children living in a shack, children living in a household that is crowded, and (v) adequate care deprivation – children whose mother and father are no longer alive or not in the household and children in child-headed households.

to 5.6 million even though the incidence levels have dropped slightly to 29 per cent in 2006 (DoH 2007).

HIV/AIDS affects women, youth and poor people disproportionately (Shisana, et al. 2005; Shelton 2005; Dorrington et al. 2006; Marais 2006; Preston-Whyte 2006; Whiteside & Lee 2006; Hosegood et al. 2007; Manjansala 2007). A HSRC-led national household HIV survey has shown that women are significantly more likely to be HIV-infected than men: 20 per cent of adult women (15-49 years) were estimated to be living with HIV in 2005, compared with 12 per cent of men. Among young people (15-24 years), women were four times more likely to be infected with HIV than men (Shisana et al. 2005). One in four women between the ages of 20 and 39 years is thought to be living with HIV (Shisana et al. 2005).

According to the same study HIV infection levels were higher among the poor especially among people living in urban 'informal' areas. In such areas, average adult HIV prevalence was 17.6 per cent, compared to the assumed national prevalence of approximately 11 per cent. In addition to the burden of caring for those suffering from the disease, women are often expected to provide care to the sick and those left vulnerable by AIDS: orphans (Nattrass 2004a; Iliffe 2006)[35].

Access to treatment is still extremely uneven. The ASSA2003 model estimates that by the middle of 2006 some 711 000 people were in need of Anti Retroviral Treatment (ART) drugs which delay the onset of AIDS. Only 225 000 people were receiving the drugs (Dorrington et al. 2006). Forty-seven per cent of deaths that occurred in 2005 were attributed to AIDS-related complications (MRC 2005)[36].

[35] Nevertheless, new research indicates that men do play a caring role, too. In their study of men's involvement in the South African family in KwaZulu-Natal, Montgomery et al. (2006) found that men were positively involved with their families and households in a wide range of ways: caring for patients and children, financially supporting immediate and extended family members and were present at home, thereby enabling women to work or support other households. The challenge is further to investigate this practice throughout the country and identify gaps, especially the training of men as carers.

[36] Hosegood et al. (2007) put this figure at more than 50 per cent. Furthermore, the ASSA2003 model estimates that over 900 people died of HIV/AIDS daily by the middle of 2006.

The impact of AIDS registers in different ways at different levels of the society, namely, demographic, individual, household, community, workplace and service provision sectors levels (Allen & Thomas 2000; Barnett & Whiteside 2002; Marais 2005; Iliffe 2006). Of particular relevance to this study is the impact of HIV/AIDS on individuals and households. Where a person is known to be HIV-positive, he or she is frequently the subject of stigmatisation, discrimination or even hostility in the community and at work, particularly where community members and colleagues have little understanding of HIV/AIDS (Deacon & Stephney 2007).

As a consequence, people living with AIDS are often forced to leave their jobs and are isolated in their communities. A study by the International Labour Office (2000) found that persons with HIV infection or AIDS-related illnesses frequently have no opportunity to obtain decent jobs. In a pilot study in Soweto to investigate the link between HIV/AIDS and unemployment Naidu (2003), found that of those who were HIV-positive and unemployed, more than two thirds said they had lost their jobs due to the illness. And those who were infected but still employed said illness had forced them to miss work on an average of 30 days in the two months prior to the survey interview.

The toll of HIV/AIDS on households can be very severe. It includes the loss of income, additional care-related expenses, the reduced ability of carers to work, and mounting medical fees and funeral expenses (UNAIDS 1999, 2002; Cross 2001; Wyss et al. 2004). The study by Booysen (2003); Booysen et al. (2003) and Booysen & Arntz (2003) in the Free State found that income levels appeared to drop significantly after an AIDS death – due mainly, it seemed, to high funeral expenses, and the loss of earnings.

AIDS also adversely affects children. The literature argues that children face the risk of losing opportunities for school, health care, adequate nutrition, development, and shelter (Verner & Alda 2004). Some literature see girls as especially vulnerable as they are often removed from school as a coping strategy, and also because the girls' education is viewed as "less of a priority", since it is expected that they will marry and will belong to another family (Grant & Palmiere 2003). Additionally, with the death of a parent, children

experience profound loss, grief, anxiety, fear, and hopelessness with long-term consequences such as psychosomatic disorders, and disturbed social behaviour (Smart 2003; Williamson 2000; Townsend & Dawes 2003; Cluver & Gardner 2006; Cluver, et al. 2007)[37].

Children's future is jeopardised as educational opportunities are reduced. Children are withdrawn from school to care for the sick or to do odd jobs for extra income. Among 'AIDS-affected' households surveyed in the Free State, Gauteng, KwaZulu-Natal and Mpumalanga provinces, about 5 per cent of boys and 10 per cent of girls were out of school. The main reason was the lack of money for school fees, uniforms and books, as well as, in the case of girls: pregnancy (see Pelser et al. 2004; Hosegood et al. 2007).[38]

UNAIDS (1999), Booysen & Arntz (2002), Willan (2004), Marais (2005) argues that household structure changes radically as older siblings take up the role of household-heads.[39] Other households may be headed by grandparents who are too old to execute their responsibilities effectively. The task of taking up the role of being household head may force children into labour at an early age (Desmond & Gow 2002 Mutangadura 2000). Furthermore, financial hardships may include loss of income, savings and property (UNAIDS 1999 and UNAIDS 2002b). This in turn leads to or exacerbates mal-/under-nutrition among orphans and 'vulnerable children' (Booysen & Arntz 2002).

The relationship between AIDS and poverty is symmetrical, but it is not causal. Just as AIDS exacerbates poverty and inequality, so poverty and inequality facilitate the transmission of HIV. For example, the absolute level of poverty increases the susceptibility of the poor to infection from HIV due to a lack of disposable income for

[37] However, in their important study of The psychological well-being of children orphaned by AIDS in Cape Town, South Africa, Cluver & Garnder (2006) found no evidence of higher levels of self reported emotional and behavioral problems in orphans, using the SDQ, compared with non-orphans.

[38] However caution should be sounded, because the study by Booysen et al. (2003) found that roughly the same proportion of children from 'non-affected families' – or the control group – was not attending school in Qwaqwa. Therefore, people generally face education barriers. AIDS may increase the problem in some places.

[39] The phenomenon of child-headed household is seen as another threat posed by HIV/AIDS. Without giving evidence many have argued that 'we are beginning to see the reality of child-headed household as a result of AIDS-related deaths (Willan 2004: 111).

purchasing condoms, and poor access to health facilities and HIV prevention programmes. In situations where the disparity between rich and poor is particularly great, data suggests that the poor and most disadvantaged are more vulnerable to HIV infection for these reasons and others which are outlined below (Allen & Thomas 2000; Baylies 2000, 2002; Barnett & Whiteside 2002; Cohen 2002).

Central to understanding the link between poverty and AIDS is the level of nutrition and people's susceptibility to HIV infections (see Jackson, et al. 2000; Nattrass 2002; Barnett & Whiteside 2002; Loevinsohn & Gillespie, 2003). A malnourished person is more susceptible to parasite infestation. As Nattrass (2002) and Loevinsohn & Gillespie (2003) point out, chronic parasotosis often leads to chronic immune activation, which in turn may exhaust the immune system and render it less capable of successfully repelling invaders, as well as hastening the transition from HIV to AIDS.

Furthermore, as Nattrass (2002) illustrates, medical research that focuses on the immune system's response to HIV shows that malnutrition and parasite infections increase HIV susceptibility, not only to opportunistic infection after HIV infection, but also to HIV transmission, as they increase susceptibility to other infectious diseases. She further notes that micro-nutrient deficiencies (particularly Vitamins A, C, and B) undermine the body's natural defences against HIV infection – i.e., skin integrity and mucous membranes) thus contributing further to vulnerability to HIV infection. These co-factors have been extensively studied by Stillwaggon in her recent book (2006).

Poverty strains families' ability to provide a social safety net to vulnerable members, and AIDS exacerbates the situation. The cost related to care for AIDS-patients, funeral expenses and potential loss of income-earners is likely to push families further into poverty, thus threatening the social safety net. Taking on orphans could be construed as worsening the economic burden of the families. As the study by Hosegood, et al. (2007) indicates, the cumulative effects of AIDS on a household (family) extend to other related households (families). This situation hits women and poor rural families hardest. Thus the twin problem of poverty and HIV/AIDS, it is argued, poses a serious threat to extended

family social safety net for vulnerable members, particularly orphans. This state of affairs has prompted debates on the role of extended families' social safety net *vis-à-vis* welfare policies.

Numbers of writers argue that the South African government has failed to address the problems of poverty and inequality and to mitigate the impact of HIV/AIDS on individuals, families and communities. The reasons given are current HIV/AIDS policy (Willan 2004; Butler 2005; Feinstein 2007; Nattrass 2004, 2007) and neo-liberal economic policies (Terreblanche 2002; Bond 2006).

The political environment of any country has a huge bearing on the successful implementation of HIV/AIDS interventions (Parkhurst & Lush 2004)[40]. While the ruling African National Congress (ANC) has been praised for having started well by realising the threat of HIV/AIDS, (Willan 2004; Butler 2005; Nattrass 2004, 2007) these authors argue that the position of senior leadership seems to have changed over time with serious consequences for the country and its people.

HIV/AIDS Policy

The South African's government obfuscation about HIV/AIDS policy is demonstrated by actions of the leadership. In particular, the former State President Thabo Mbeki and his Minister of Health, Dr Mantombazana Tshabalala-Msimang, are notorious for advocating policies stances that were at odds with the science of the virus and the views of health practitioners, lobby groups and civil society. However, this was not always the case.

Immediately after its un-banning in 1990, the ANC coordinated a meeting in Maputo attended by civil society, government and progressive health professionals which resulted in the establishment of National AIDS Council of South Africa (NACOSA) in 1992 to

[40] Using South Africa and Uganda as a case study, Parkhurst & Lush (2004) conducted an analysis of the political circumstances that facilitated the success of a particular HIV intervention. The focus is on how the political, bureaucratic and health systems contexts within each country influenced these prevention initiatives. They found the Ugandan situation more favourable to effective interventions in all but one area of focus; health systems.

coordinate HIV/AIDS activities. NACOSA developed an AIDS Plan which was adopted by the Government of National Unity after 1994. The AIDS Plan was followed by the establishment of the HIV/AIDS and Sexually Transmitted Infections (STIs) disease programme in 1996 (Willan 2004; Butler 2005). In 1998 a National Interdepartmental Committee on HIV/AIDS and Partnership Against AIDS were instituted to encourage a multi-sectoral response. In 2000 the National AIDS Council and the National HIV/AIDS and STI Strategic Plan (2000-2005) were launched.

The National AIDS Plan faced criticism on the grounds that it lacked consultation; failed to address all the implications of the epidemic; did not have clear targets or dates, and was also silent on anti-retroviral drugs (ARVs) (Willan 2004: 112-113). Moreover, there was a lack of political leadership and confusing messages about the causes of AIDS; how it is transmitted; and the toxicity of ARVs (Willan 2004; Butler 2005) [41]. As a result, Butler (2004) and Willan (2004) argue, the roll-out of ARVs was slow. Prevention messages have failed to curb the spread of the disease (Campbell 2003).

It took a High Court ruling initiated by the Treat Action Campaign (TAC) against the South African government to realise some progress. In 2005 the High Court ordered the State to make AZT available to expectant mothers. Since then ARVs have been introduced in public sector clinics under a phased plan. By 2006 about 200 000 people were on ARVs. The 2007-2011 Strategic Plan aims to reduce new HIV infections by half and to expand HAART coverage to 8 per cent. Subsequently, by 2006 about 200 000 people were on ARVs. This is about 37 per cent short of government's target. With the recent reshuffle of government portfolios, the present State President, Mr. Kgalema

[41] The often-cited lack of leadership from the government and senior politicians is directed particularly to the State President and the Minister of Health, Dr Mantombazana (Manto) Tshabalala-Msimang. Both are blamed for the government's slow response to the HIV/AIDS challenges. They are seen to be at the forefront of the debate that denies the link between HIV and AIDS. President Mbeki's stance has been prompted by scientists and journalists work who question the link between HIV and AIDS. They claimed that AIDS is caused by a compromised immune system. This, it is claimed, could explain the spread of the disease in Africa. The 'AIDS dissidents', as they are commonly known, accuse the pharmaceutical companies of forging the link between HIV and AIDS so that they can reap huge profits from the sale of AIDS drugs. These, they are argue are very dangerous. A very small minority questions the existence of the virus.

Motlanthe has appointed a new Minister of Health, Barbara Hogan. This move has been interpreted as representing a change in policy and attitude towards the epidemic.

In this context of high infection rate hitting the poor and unemployed hardest, welfare policies play a crucial role.

Overview of apartheid South Africa's welfare policy

The social welfare system is the overall system put in place by the state to protect the wellbeing of its people. This is done through a variety of programme interventions social security payments, old age pensions, unemployment pay, and social services. In apartheid South Africa, welfare services were directed at the minority white population, with very small provisions for small sections of the oppressed population[42]. Ubiquitous poverty was the foundation of the system of exploitation on which accumulation rested. Unemployment pay for the African labour force would have blocked the flow of cheap labour to the mines, farms and industries. It did not therefore exist, even as unemployment started to grow from the 1970s onwards.

South African welfare policy can be traced back to the second decade of the 20th century[43]. In 1911 income support was introduced for white miners with phthisis and silicosis and compensation for injuries sustained. The Children's Protection Act was introduced in 1913 and the first Workman's Compensation Act was made law in 1914 (Bhorat 1995; Nattrass & Seekings 1997). African miners were not eligible for such income support. While the Children's Protection Act provided maintenance grants for children, very few of these grants reached African parents and none were given to rural Africans whose children were expected to be cared for in the reserves by guardians or chiefs (Bhorat 1995; Nattrass & Seekings 1997).

[42] Moreover welfare services design was residual; meaning that remedial services were offered once social problems had already manifested (Dutschke 2008; Dutschke & Monson 2008: 23). Crucially, the system ignored the role of the ubiquitous poverty and the impact of the inequities of health care and education services. Moreover, where available, social assistance was offered to certain sections of the population

[43] Some authors trace this origin to the 1930s and 1940s (Seekings 2007b). As Seekings (2007b: 3-4) assessed, views of these authors are shaped by the Carnegie Poor White Commission of 1929-32 and the depression and drought that coincided with it.

The Old Age Pensions Act of 1928 entitled poor Coloured and white males over 65 years and females over 60 years to draw old-age pensions. Africans and Indians were excluded. The State argued that Africans could rely on their rural kinship ties to assist them in old age (Bhorat 1995; Lund Committee 1996; Nattrass & Seekings 1997; Taylor 1999). Urban Africans were excluded on the basis that they were not easily discernible from their rural counterparts.

OAPs were extended to urban Africans in 1944. However, the amount paid out to Africans was much lower than that of Whites and Coloured until 1993 when equalisation measures were introduced. The OAP was means-tested taking into account the income and assets of the applicant and his or her spouse. If an applicant's child was in a position to maintain the applicant, the latter was effectively disqualified.

In order to expand social assistance coverage, in 1936 White and Coloured blind persons over the age of 19 could collect the means-tested pension, referred to as the Disability Grant. This provision along with the OAP was only extended to Africans and Indians in 1944 although Africans received much less than other race groups (Bhorat 1995; Nattrass & Seekings 1997; Seekings & Nattrass 2005). The underlying rationale was that welfare made Africans *economically independent* and therefore, less likely to provide cheap labour.

In 1992, as the apartheid regime was coming to an end, a new welfare system was introduced. The *Disability Grant* was reformed such that it accommodated individuals who were poor and who were unable to support themselves through work owing to their disability. This was defined as "any person who has attained the prescribed age and is, owing to his or her physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance"[44].

[44] There is a temporary and a permanent disability grant. The temporary disability grant is paid to individuals whose disability will last for a continuous period of between six and twelve months. The

The Unemployed Benefit Act of 1937 is another important legislative development of its times. It covered 88 000 workers but excluded all agricultural, domestic and African miners and workers earning less than £78 per annum (Bhorat 1995; Keegan 1996). The Free State population was hardest-hit by this legislation as the majority eked out a living on meagre farm wages. In fact the clauses that excluded farm workers were a result of a petition by Free State farmers who interpreted the measure as threatening the already scarce availability of cheap labour (Keegan 1986, 1996; Atkinson 2007).

In 1941 the War Veterans Pension Act was passed. It excluded Africans who had served in the Native Military Corps in the First World War. In the same year cost-of-living allowances were introduced to shield pensioners from inflationary conditions, and although pensions were paid to all races, stratification in payment continued. The majority of Africans, particularly those residing in small towns, farms and the reserves were excluded from these provisions. *Grant in Aid* is an additional grant payable to individuals who are in receipt of Disability Grant, War Veteran's Grant or OAP and who require full-time attendance by other persons because of their mental or physical disabilities. The individual must not be cared for in an institution that receives a subsidy from the State for the care and housing of such persons (Whitworth, Wright & Noble 2006: 34).

The Children's Act of 1937, along with Child Care Act No. 74 of 1983, constitutes one of the legislative provisions for children's welfare. The Acts sought to prevent children from becoming socially maladjusted or delinquent as a result of growing up in bad conditions

permanent disability grant is paid to individuals whose condition will continue for a continuous period of greater than twelve months. The number of recipients of the Disability Grant has grown drastically in recent years. It rose from 600, 000 in 2000 to almost 1.3 million in 2004 (Nattrass 2004a; 2004b). As many have observed, this is due in part to the AIDS epidemic. AIDS-patients with a CD4 cell count lower than 200 cells per millilitre of blood are eligible for the Disability Grant. An analysis of a sample of disability grant files, by CASE (2000), reported that the number of disability grants for people who were immuno-compromised rose from 27 per cent in 2001 to 41 per cent in 2003. However, as Nattrass (2004b: 3) further points out, AIDS is not the only reason for the rapid take-up in disability grant. The increase was facilitated by institutional changes to the disability grant system that enabled local decision-makers to respond to growing pressure from citizens to use the disability grant in part as a form of poverty relief. CASE (2000) documents this state of affairs in greater detail, highlighting the role that has been played by government officials and medical officers who empathised with poor unemployed people.

at home. The Acts made provision for the state to intervene where children were being neglected and to rehabilitate those who were already delinquent. Emphasis was placed on probation of children in need of care, delinquent children and parents. It is for this reason that the welfare system has been characterised as residual, that is, it reacts to problems that manifest themselves, rather than proactively preventing the occurrence of problems – many of which are related to poverty. Parents received financial assistance made to mothers – the Foster Child Grant (Seekings 2006c: 23-4). This grant will be discussed in detail in the following section.

In addition to the Foster Child Grant (FCG), a *Child Maintenance Grant* (CMG) was introduced in 1987 to cater for the needs of poor single White and Coloured mothers with children less than 18 years of age. The CMG was a form of financial support designed to protect a mother and her children in the 'unusual' event that the marriage ended in a divorce, or if the father died or deserted the family (Lund Committee 1996; Taylor 1999; Lund 2006)[45].

The SMG was modelled on a similar grant in England (Lund Committee 1996; Taylor 1999; Lund 2006). The assumptions about family life on which the SMG were based were similar to those held by Lord William Beveridge in his model for the British welfare state (Taylor 1999; Lund 2006). The 'normal' family form was a two-generation unit, with a father as the main breadwinner, in a country with *full employment*, with a mother at home looking after a number of children; if working, she would be working for a low wage.

The administration of the CMG and FCG remained discriminatory. Grants for Coloured, Indians and White children stopped at 18 years; those of Africans at 16 years. Ironically, the CMG could only be obtained if the mother was in paid employment. This reduced the number of eligible black mothers given high levels of employment among African women. People residing in Bantustans were in *de facto* excluded from the scheme.

[45] The introduction/expansion of grants for coloured South Africans can be interpreted as part of the apartheid states strategy to divide the oppressed and win allies among them.

By the late 1980s, the grant paid a basic R430 per month to the single parent, plus R135 per child up to the age of 18 years, subject to a limit of two children. A single mother with two children could receive as much as R700 per month (Taylor 1999: 22; Lund 2006: 160). However, access to the grant was *de facto* race-based. Coloured and White single parents were the main beneficiaries. Coloured mothers constituted 60 per cent of the grant recipients (Taylor 1999). Even after the removal of racial restrictions on access, there were very low-take up rates among African recipients (Taylor 1999: 22).

This apartheid welfare model supported *nuclear families* and was premised on the *assumption of full employment* (see also Halsey 1993; Nattrass & Seeking 1997; Taylor 1999). The welfare state in England was used as a means to relieve men who were *temporarily* out of work, and the maintenance of mothers *without men* to connect them to the economy (Halsey 1993; Nattrass & Seekings 1997; Ryburn 1998). This policy was appropriate to support the white population of South Africa from temporary unemployment and to support single mothers or families experiencing social stresses. However, as argued above, it was never designed to include the majority of the country's people, the unskilled and semiskilled labour force.

The post-apartheid welfare state

The South African Constitution envisages a society that respects the equality and dignity of every woman, man and child, and a society that cares about its people's socio-economic wellbeing as much as it cares about their personal and political liberty (Pendlebury 2008). In terms of the Constitution of the Republic of South Africa, Act 108 of 1996, s27(1)(c), everyone in South Africa has the right to have access to social security, including those unable to support themselves and their dependants. Furthermore, section 27 of the Constitution (Act No. 108 of 1996) affirms the universal rights to social security, including appropriate social assistance for those unable to support themselves and their dependants, mandating the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of

these rights. Social security aims to protect vulnerable members of society from social contingencies and risks, such as unemployment, disability and poverty.

Children have a special place in the Constitution (Act 108 of 1996). Section 28[1][c] of the Bill of Rights in the South African Constitution guarantees every child the right to social services: "Every child has the right to basic nutrition, shelter, basic healthcare services and social services". In a dramatic departure from the previous welfare regime, the current welfare policy recognises and therefore promotes the role of extended families in providing care for its children. This is demonstrated in the Department of Social Development's (DoSD) policy paper, the *White Paper for Social Welfare of 1997* (The White Paper 1997). The White Paper recognises the family as the basic unit of society. It seeks to strengthen and promote family life through family-oriented policies and programmes in order to ultimately minimise the necessity for state intervention. The White Paper has therefore, been hailed as a significant welfare policy intervention aimed at reforming the apartheid residual welfare system to bring it in line with the new constitutional framework and binding international law (Rosa 2004; Dutschke 2008; Giese 2008; Proudlock & Jamieson 2008).

The Children's Act No. 51 of 2005 further entrenches children protection by providing for a range of services that are primarily aimed at strengthening and supporting families and communities to care for and protect children. If families are unable or unwilling to care for their children, the Act provides for State alternative care[46].

In the present dispensation, the social assistance part of the social security system comprises an Old Age Pension, a Child Support Grant, a Foster Child Grant, a Grant in Aid and Care Dependency Grant, a Disability Grant, Social Relief of Distress, free health care services to mothers with children up to 7 years old, public health care, a Military

[46] Services which were regulated in the Child Care Act, No. 51 of 2005 and which the Children's Act now continues to provide include; (i) protection services for children who have suffered abuse, neglect, abandonment or exploitation (ii) foster care (iii) adoption and (iv) child and youth care centres. Services provided for in law for the first time include; (i) partial care early childhood development programmes, (ii) primary prevention and early intervention programmes, (iii) support programmes for child-headed households, and (iv) drop-in centres providing basic services (see Proudlock & Jamieson 2008).

Pension and grants related to armed struggle during apartheid, and disaster and nutrition relief, the Unemployment Insurance Fund and the Road Accident Fund. The latter two constitute the social insurance arm of the social security system in South Africa. Apart from free health services, grants related to veterans of the armed struggle against apartheid, and nutrition relief, the basis of policy has been the extension of the previous system to embrace more people.

The OAP (and to a greater extent, the Child Support Grant) has been described as one of the Third World's exemplary poverty reduction mechanisms, redistributing from the rich to poor, being gender-sensitive, invigorating the rural economy and contributing to household cohesiveness (RDP 1995; Lund 1999; van der Merwe 2000; Malan 2005; Seekings & Nattrass 2005)[47].

The pension is estimated to be worth twice the median per capita income of African households (Case & Deaton 2004), and is used to purchase provisions within households. The pension is paid out to a majority (92 per cent) of the elderly who live in households where there is at least one person under 20 years of age for each person of pensionable age (Moller & Devey 1995). Moller & Devey (1995) note that these households are made up of 30 per cent two-generation families and 61 per cent three-generation extended families. This means that pensioners are under pressure to use these grants not for themselves but to sustain their families. The old age pension has become, for many families, their only source of income.

The uptake has grown drastically since the dawn of democracy. According to the DoSD media statement on 10 August 2008, 2.2 million people were receiving the OAP on that

[47] Research shows that 66.8 per cent of the reported income for the poorest quintile of households comes from the Old Age Pension and State Maintenance Grant, 13.4 per cent of the next poorest quintile with the other three quintiles together reporting only 8.0 per cent of total income from this source – welfare grants (Woodlard et al. 2003). Woodlard (et al. 2003) used data from the 2000 Income and Expenditure Survey. Along with other social assistance-related cash grants discussed below, the Old Age Pension amount has constantly increased each financial year over the last five years. The current value is R940.00 per month, as of 01 April 2008. However, despite the consistency in the increase of the old age pension amount payable, the increase is not linked to the inflation rate and its real value is still significantly lower than it was in 1994. Other cash grants such as the Disability, Care Dependency and Foster Child grants, discussed below, show a similar pattern.

date (DoSD 2008). Although parity in levels of OAP for the different racial groups was achieved in 1994, until recently women qualified for the benefits at the age of 60 and men at 65. The government is now addressing this disparity[48].

While the government has retained the Unemployment Insurance Fund as a limited cover for people who lose their employment, this does not include those who have never been employed. This is a big gap in the welfare system, since there are many South Africans who do not have jobs and never have but who also do not access other welfare grants. This anomaly puts great pressure on the other grants which for many effectively become a social security grant for the whole family. Despite extensive debate about measures to deal with this situation no change is imminent.

A less known *Social Relief of Distress* is a temporary payment for families who are in extreme financial need and who are unable to meet their most basic needs. In order to be eligible to receive social relief of distress the individual must meet one of several qualifying conditions, such as the death of a breadwinner or an appeal against the suspension of a social grant. The payment is made monthly or for any other period for a maximum period of three months, and may be extended for an additional three months in exceptional circumstances (see Whitworth, Wright & Noble 2006: 35). This Grant is mostly accessed by guardians who provide care to eligible vulnerable children while applications for FCG are being processed.

The *Care Dependency Grant* (CDG) is a form of social assistance for primary carers for children with mental and/or physical disability. The seriousness of the disability of the child is confirmed through a medical assessment. The child must be between one and 18 years of age. The child should be living with the primary carer at home for *more than six months*. The value of the grant is R940 per month, as of 01 April 2008. The CDG is means-tested. The combined annual income of the applicant and his or her spouse after all the deductions referred to in the social assistance regulations have been made, must

[48] In his latest budget speech, the Minister of Finance has sought to address this anomaly in a phased-in fashion with the qualification age for men lowered to 63 in April 2008 with the ultimate aim of reaching parity by 2010.

not exceed an amount determined by the Minister by notice in the Gazette. This currently stands at R48 000 per annum.

Table 3.4 compares different types of child-care grants, criteria for eligibility, the amount payable and the duration. The annual income has not been revised since 1992. The CDG can be extended to beneficiaries to the age of 21 if they are still at school. Alternatively, those older than 18 years with disabilities qualify for an adult disability grant. However, there is no specific provision for children with chronic illnesses, including HIV/AIDS, requiring special care (Child Health Policy Institute & Black Sash 2000:4).

Table 3.4 Comparison of types of grants, eligibility, amount and duration (2007)

Type	Who is eligible	Means test amount	Amount payable	Duration
Child Support Grant	Primary care-givers of a child under 14 years; resident; SA citizen	Household income below R9 600 per annum; or below R12 200 if in rural area or informal dwelling	R210* per month per child	Until child's 14th birthday or death of child or carer
Foster Care Grant	Foster parents of children under 18 years; foster parents and child residents of SA	Income of less than twice the annual amount of the grant	R650* per month per child	Until the child turns 18 or 21 years old if the child is at school
Care Dependency Grant	Parents or foster-parents for a child between 1 and 18 years who receives permanent home care due to severe disability; parents and child resident of SA; medical report	Combined annual income of family between R48 000.	R940* per child per month	Until the child turns 18 years old

*As of 01 April 2008. Source: Department of Social Development (2007).

Introduced in 1998, the CSG is a monthly cash grant paid out to the primary carers of children living in poverty. When it was introduced, it had a cash value of R100 per month and was available to children who were eligible on the grounds of their carers' poverty, and who were six years of age or younger. The grant was aimed at addressing the anomalies of the CMG of 1987. Access to the CSG is through an administrative procedure managed by DoSD, and does not require a court order or the services of social workers.

Both the amount of the grant and the age-eligibility criteria has changed, since then. As of April 2008, the value of the grant is R210 per month. The rise from R100 per month in 2000 to R210 in April 2008 has kept pace with inflation in the eight years of the grant's existence (Anttila, et al. 2006: 2; Leatt 2006: 5). In 2003, the government announced an extension to the age eligibility that has been phased in over three years. From April 2003, children of the ages of seven and eight became eligible. From April 2004, nine- and ten-year olds became eligible. As of April 2005, children aged eleven, twelve, and thirteen became eligible. This will be extended to 15-years-old in 2009.

A person is eligible for the CSG for her/his children if s/he is the primary carer of a child under the age of 14 years and passes the means-test set out in the social assistance regulations. This currently stands at less than R800 or less than R1100 per month if applicants live in rural or urban areas, respectively. These amounts have not been revised since they were introduced (Leatt 2006; Lund 2006; Wright 2006; Samson, et al. 2007). According to Samson, et al. (2007), the thresholds for 2005 should be R1300 per month for rural and R1750 per month for urban residents respectively, if adjustment to the 2006/7 inflation level was made. Furthermore, while its annual increase has kept pace with inflation, the CSG amount is not based on the real costs of raising a child in South Africa. Moreover, the income thresholds for both rural and urban areas, does not take into consideration the number of children supported by the carers.

The means-test is aimed at ensuring that the poorest families who require financial assistance in order to meet the basic needs of the child receive the grant. The carer of the

child for whom the grant application is being made also needs to supply his/her identity document, the birth certificate of the child, proof of income and, where applicable, a marriage certificate.

The carer does not need to be a biological parent; s/he simply needs to provide a proof that s/he is the primary person providing for the daily needs of the child. A carer may apply for CSG for any number of his/her biological children. However, the maximum number of non-biological children is six.

Various estimates of the take up, using different methods of analysis have been calculated. Overall, estimates indicate a rapid rise in uptake, albeit differing from one province to another and one municipality to another. Using reports of the administrative database – SOCPEN – of DoSD Leatt (2006) indicates that at the end of March 2006, 7.08 million children were in receipt of these grants.[49] According to recent media statements issued by DoSD, the number of who receive social grants has since increased to more than 8 million (DoSD 2008). Budlender et al. (2005) calculated eligibility for the CSG by using raw 2003 General Household Survey data. By these calculations, it is estimated that across South Africa, 65.3 per cent of children ought to be getting a CSG. The study found the eligibility rates vary quite considerably across the provinces (see Table 3.5).

According to Table 3.5, there is not a 100 per cent uptake in any of the provinces. However, the uptake rate is lowest in some of the poorest provinces; KwaZulu-Natal, Limpopo, Free State and North West.

[49] As outlined in the methodology section of her report, Leatt (2006: 2) says the Department of Social Development uses two types of reports. The first are called "daily reports" and are a daily record of the number of grants being disbursed. These reports give the cumulative number of beneficiaries, the number of recipients and the amounts dispersed in that month per province and nationally. In addition, the department generates a series of five reports on the Child Support Grant and its extension.

Table 3.5 Take-up versus eligibility for CSG, 0 – 14 years, as of March 2006

Location	Total number of children in province (0 – 14)	Proportion eligible for CSG	Number eligible	Actual take-up, as of March 2006	Take-up rate of eligible (%)	Take-up of total child population (0 – 14) (%)	Number eligible but no access
Eastern Cape	2,205,694	73.3%	1,616,774	1,357,528	**84%**	62%	**259,246**
Free State	725,750	70.5%	511,654	400,491	**78%**	55%	**111,163**
Gauteng	2,137,682	47.1%	1,006,848	837,667	**83%**	39%	**169,181**
KwaZulu-Natal	2,905,733	70.8%	2,057,259	1,623,059	**79%**	56%	**434,200**
Mpumalanga	999,662	68.2%	681,769	589,456	**86%**	59%	**92,313**
Northern Cape	240,585	65.1%	156,621	115,650	**74%**	48%	**40,971**
Limpopo	1,890,829	71.6%	1,353,834	1,163,423	**86%**	62%	**190,411**
North West	1,131,625	71.1%	804,585	573,970	**71%**	51%	**230,615**
Western Cape	1,227,683	49.3%	605,248	414,022	**68%**	34%	**191,226**
National	**13,465,243**	**65.3%**	**8,792,804**	**7,075,266**	**80%**	**53%**	**1,717,538**

Sources: Budlender et al.. 2005; Leatt 2006 (SOCPEN daily reports to end March 2006)

Using the SOCPEN data to estimate the number of children under eleven years who were eligible for CSG, Noble et al. (2005: 3) estimate that there were 7.39 million children under eleven whose carers were eligible to receive the CSG and there were 11 million children under eleven in South Africa in total, in 2005[50]. This implies that the carers of 67 per cent of children were potentially eligible to receive CSG (Noble et al. 2005: 3). In the Free State, the areas with the highest eligibility rates were Tswelopele, Phumelela and Nketoana (85% of all children under eleven years of age).

The study further indicates that all municipalities in the Free State (with the exception of Metsimaholo) had eligibility rates of 60 per cent and above with Metsimaholo (58%), Matjhabeng (61%) and Mangaung (62%) having the lowest eligibility rates. However, the study found four municipalities to have a take-up rates of less than 50 per cent. Kopanong had a take up rate of 45 per cent at the other end of the scale, while Metsimaholo and Tswelopele had a take up rates of over 80 per cent.

[50] The methodology used in this analysis is explained in Barnes & Noble (2006).

Using a longitudinal study Case, Hosegood & Lund (2005) assessed the reach and early impact of the CSG in the Umkhanyakude District of KwaZulu-Natal focusing on children under seven years old. The study found that the grant uptake was as high as 80 per cent and reached children from poor backgrounds. The DoSD notes that in 2006 according to its beneficiary profile of carers of the child support grant, over 65 per cent of carers of children receiving the child support grant were single parents and about 94 per cent of them were African. Moreover, more than 11 per cent of the carers have never received any formal education, while 71.5 per cent received one to eleven years of education. Over 85 per cent of the carers are unemployed.

However, when linking the grant receipt with other variables, the study by Case, Hosegood & Lund (2005: 477) found that not all the poorest children were being reached by the grant as only half of the two per cent of the poorest children – defined as children living in households with two or fewer assets, whose mothers have six or fewer years of schooling, and whose mothers are not employed – were receiving a CSG.

The Case, Hosegood & Lund (2005) study found that the grant had positive outcomes on the school enrolment on children. Using the older siblings of children under study – the former not being recipients of the grant at the time of its introduction – the study found a negative and significant relationship between school enrolment and grant receipt. Children, who were not receiving the grant at that time, were less likely to be enrolled in schools. Below we look at the *Foster Child Grant* (FCG).

While its origins can be traced to the apartheid era, the FCG is being discussed in this section due to its currency. Introduced in 1983 in terms of the Child Care Act, No. 74 of 1983, the FCG is designed to provide assistance to children who have been defined as 'in need of care'. This could include; a child who has been abandoned or neglected, a child who has been physically, sexually or emotionally abused or ill-treated by his or her parent or guardian or the person in whose custody he or she is; a child who is an orphan and has no parent or guardian who might be left in the care of grandparents or other relatives; a child who has a parent or guardian who cannot be traced; a child who displays behaviour

that cannot be controlled by his or her parents or guardian; a child who lives on the streets.

Children are placed in the custody of foster families by the Children's Court. It is a legal requirement that the foster parent be under the supervision of a social worker. The intention behind foster parenting is to provide some support to *non-relatives* who are willing to provide a child, who is temporarily without related carers, with a nurturing and safe home environment. The assumption of the Act is that the child will return home, after the provision of family reunification services, to the care of his or her biological parent(s) (Lund Committee 1996; Meintjies et al. 2003).

A foster care parent is eligible for the FCG if the child is placed in the care of his/her custody in terms of the Child Care Act, No. 74 of 1983. Children up to the age of 18 years are eligible for this grant. However, in order to enable the child to complete secondary school, the FCG can be paid until the end of the year in which the child reaches the age of 21 (Anttila, et al. 2006: 2). As of April 2008, the value of the FCG is R650 per month, R420 more than the CSG. The high value of the FCG creates an incentive for non-biological carers of orphans to seek it rather than the CSG (Lund Committee 1996; Meintjies et al.. 2003; Streak 2005; Leatt 2006).

The FCG is not means-tested in the same way as other grants. Fostering is not seen as an issue of poverty (Lund Committee 1996; Leatt 2006). However, the child's income is taken into consideration. This could be from a trust fund, for example, or contributions from the child's biological parents (Lund Committee 1996). If the child's income per annum exceeds twice the annual value of the FCG then no grant is paid. If it is less, then the full grant is paid.

Initially, placements in foster care were made for a maximum period of two years at a time, with ongoing monitoring by social workers. The application has to be reviewed in order to continue the placement (and the foster child grant) (Child Care Act No. 74 of 1983, s.16). However, the Children's Act No. 38 of 2005 now allows for courts to make

permanent foster care orders in specified circumstances [section 186]. This reduces the costs of the two yearly reviews by social workers and the court that are required by the Child Care Act, No. 74 of 1983. Nevertheless, social workers and the courts are still required to evaluate the first placement decision. The shortage of social workers and the slow functioning of the judicial system mean that there are lengthy delays in awarding foster care grants.

Many have observed that whilst the FCG is not supposed to be used to assist people affected by poverty, in practice it is being used in this way as thousands of carers who have taken in children orphaned by HIV/AIDS are applying for and receiving the FCG to help them gather sufficient income to meet the basic needs of the child (Bhorat 1995; Meintjies et al.. 2003, 2004; Streak 2005; Leatt 2006; Giese 2008). This leaves children from poor backgrounds and children over fourteen, whose parents are still alive, with the CSG which is three times less than the former grant.

The up-take rate of the FCG has increased considerably, both as a result of increased public awareness of the grant, and of increasing numbers of children being orphaned (Meintjies et al. 2003; Leatt 2006). Using the SOCPEN data, Leatt (2006: 1) illustrates that there has been a 42 per cent increase in the number of these grants paid out between April 2003 and April 2004. At the end of April 2004, 202,516 FCG were in payment. One year later that figure stood at 261,475. By the end of March 2006, a total of 317,434 FCG were in payment. Therefore, between April 2004 and March 2006 the number of FCG being disbursed increased by 57 per cent.

Conclusion

This chapter argued that post-apartheid South Africa is characterised by growing poverty, growing unemployment and growing inequality despite government interventions to reduce all three. More than half of the population live in conditions of poverty and unemployment levels are as high as 38 per cent – using an expanded definition of orphanhood. The majority of the poor and unemployed are Africans, with women worst-

affected. Unemployment among Africans is in excess of 50 per cent. Efforts to eradicate unemployment are hampered by the structural nature of unemployment and the lack of skills amongst the unemployed. The chapter has argued shown that HIV/AIDS is deepening poverty. It has argued that despite impressive extensions of the social welfare system to cover many more people and to increase the amount of benefits, there are still gaps. This is partly because the old regime's welfare system was intended, in the past, to support whites who were temporarily unemployed or unable to care for their children. It was not meant to cover the basic needs of impoverished Africans because cheap labour was the basis of the accumulation regime.

The new government has extended welfare benefits dramatically, equalised the rates across the 'racial' groups and increased payments. However there is still a gap. Crucially the long term unemployed receive no support unless they can access a CSG or a disability grant, or have a pensioner in the household. This is likely to have a negative effect - by deepening poverty - among families supporting the additional burdens of caring for someone with HIV or AIDS. Further, the discrepancy between the amount of the CSG and the FCG, where the latter is over three times the former, has the unintended consequences of creating divisions in poor communities. There have been numerous calls on the government to deal with these problems in the welfare system. One of the most powerful, supported by a broad alliance of labour, religious and other groups in society is for a payment to be made to all South Africans, in the form of a basic income grant, which is taken back from those who do not need it through the taxation system. It would mean that the costly system of welfare grants administration, the need for numerous documents which discriminates against the very poor and illiterate, and means-testing would fall away. With it so would the divisions among families caring for poor children and those adopting orphans who receive a much higher benefit. These issues were investigated in details in Kopanong Municipality in the Free State. Chapter 4 describes Kopanong and why it was chosen as the site of the study and then discusses the research methodology used.

Chapter 4 Research Methodology and background to Kopanong Municipality

Background to the study and the research design

The hypothesis of this study is that, contrary to most of the literature in the field, children orphaned by AIDS are being absorbed into their extended families and well-cared for. To test this hypothesis a research study was undertaken in Kopanong Municipality in Free State. Kopanong was chosen as the site for the research for two reasons. Firstly, it is a poor rural municipality with high levels of unemployment and out-migration. In this, it is similar to many hundreds of rural municipalities across South Africa. Secondly, the author was fortunate in being able to draw on data from a series of studies undertaken by the Human Sciences Research Council (HSRC) between 2003 and 2004. This provided very useful baseline data, from which the author was able to launch his own study, as well. This chapter will describe the study setting and then the research methods used to investigate whether or not the HIV/AIDS epidemic has led to a large increase in the number of orphans, and a decline in support from their extended families.

Kopanong is a town of 55945 people. It is situated in a semi-arid area of the Southern Free State. Water supply especially for agricultural purposes is limited. In the past the White settlers farmed maize and raised sheep and cattle. Today more and more commercial farms are turning to game management. The other main activity was gold mining. In both sectors labour has been shed since the late 1970s.

Most of the people living in Kopanong are African and poor. Drawn originally to work on the mines and farms many have settled in the area. The migration of men means that the sex ratio is skewed towards women as in most other former labour reserve areas. The population reflects South Africa's population structure as a whole. Nearly one-third (31%) of the population are under 15 years. There are few elderly people and most of them are women. As in other places across South Africa elderly women often care for their children's children while the parent(s) are working or seeking work elsewhere.

Kopanong is therefore similar to many other small towns in South Africa. While the findings of this study cannot be generalised to the whole country, they do yield important questions that should be investigated elsewhere. This was the objective of this study: to investigate the widely-held belief that many orphaned children are not being absorbed by their extended families and if they are being accommodated in extended families' households, they are not faring well.

As pointed out above, the second reason Kopanong was chosen is because base line data existed which the author was able to use. The HSRC, and its partners within the Southern African Development Community[51] region, was commissioned by the WK Kellogg Foundation to develop and implement a 5-year intervention project which focused on orphans and vulnerable children as well as families and households coping with an increased burden of care for children affected by HIV/AIDS. The project was implemented in Botswana, South Africa and Zimbabwe. In South Africa, the project was piloted in Kopanong in the Free State Province, and Kanana in North-West Province (HSRC 2004b).

About the study area: Background to Kopanong

This section provides detailed background information to the area. In particular, the section will highlight the socio-economic situation of Kopanong, that is, the extent of poverty, levels of service delivery and support for the poor, and HIV/AIDS prevalence and the vulnerability of children. These social questions are addressed at the provincial (Free State), district (Xhariep District Municipality) and local municipality (Kopanong) levels.

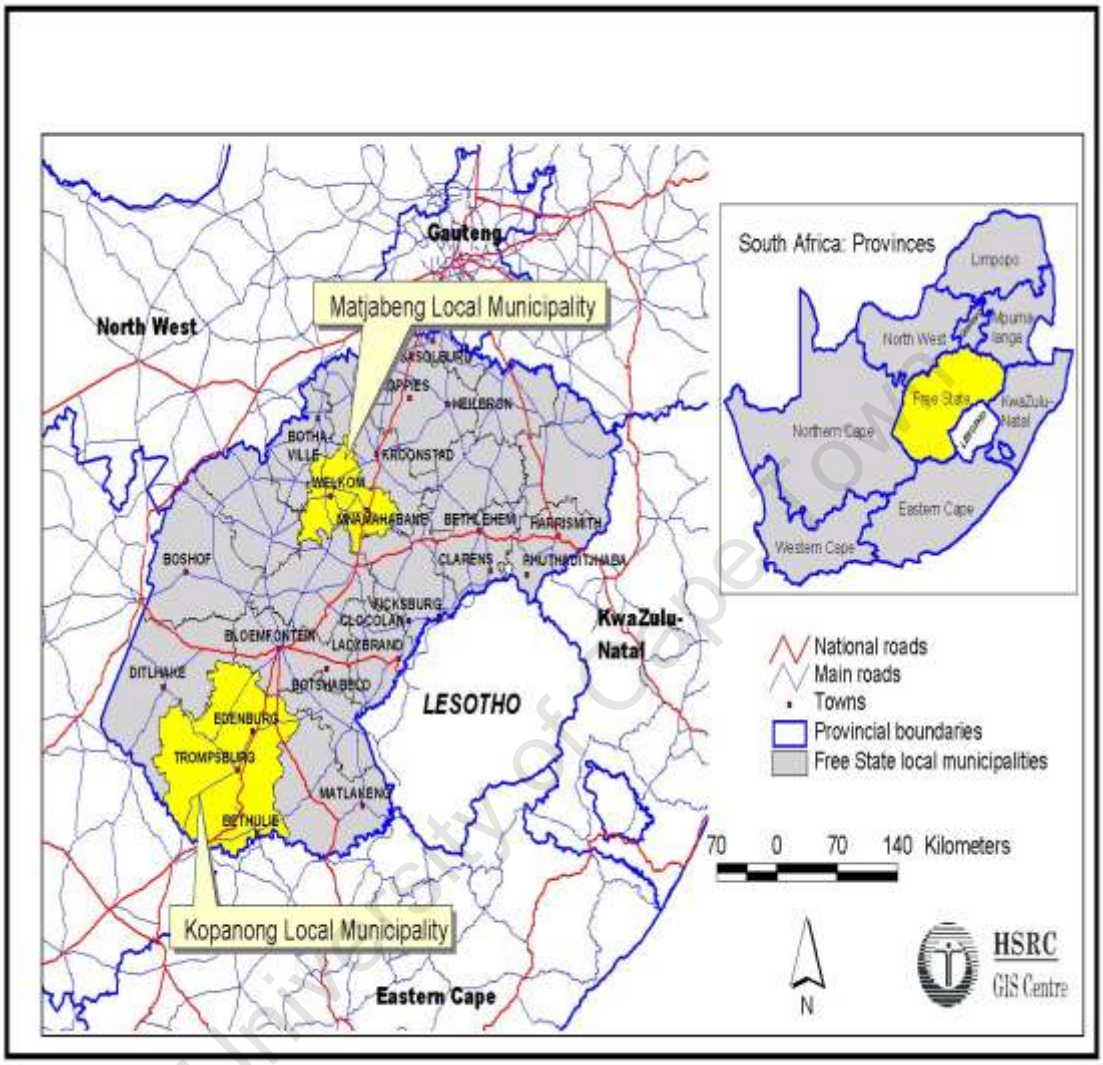
[51] Partners included; the Nelson Mandela Trust in South Africa, FACT in Zimbabwe and the Masiela Trust in Botswana.

The Free State Province

The governance system in South Africa is divided into four spheres: national, provincial, district and local governments. The district and local governments are also referred to as municipalities. South Africa has nine provinces of which Free State, the location of the study area, is one. The Free State province has five district municipalities: Motheo, Lejweleputswa, Fezile Daba, Thabo Mofutsanyana and Xhariep. Kopanong is one of three local municipalities in Xhariep District.

As depicted in Figure 4.1 the Free State Province is centrally located. It represents 11 per cent of the total land area of the country (Free State 2007: 10). Although it is the third largest province in South Africa, covering 192 480 km², it has the second smallest population of 2 706 775 (Stats SA 2002). The population density in the province is 22 persons per km^2, making it the least populated province after Northern Cape Province.

Figure 4.1 Map of the study site



Source: HSRC, 2004

*This map has been adapted from the HSRC's report. For the purpose of this report, Matjhabeng Local Municipality constituted an intervention site for a related project which does not form part of this study, but the map is very helpful in identifying Kopanong.

About, 71 per cent of the population of Free State live in urban settlements while 809 000 people (29%) still live in rural and semi-rural areas (Butler 2004; Free State 2005). However, the specific definition of urban is problematic as a large percentage of people reside in small and medium-sized towns. The Free State Growth and Development Strategy (FSGDS) has divided the province in terms of economic functionality, into large

urban areas (Bloemfontein, Botshabelo, Thaba Nchu, Free State Goldfields – Welkom, Virginia, Odendaalsrus, Allenridge, Hennenman – Sasolburg), two regional towns (Bethlehem and Kroonstad), 11 medium-sized towns (Ladybrand, Ficksburg, Senekal, Phuthaditjhaba, Reitz, Heilbron, Frankfort, Viljoenskroon, Harrismith, Parys, Bothaville), and 52 small towns (Free State 2007). The nine towns comprising Kopanong fall under the latter category, and are regarded as semi-rural.

Historically, the basis of the Free State economy has been large-scale commercial farming (principally maize and wheat) and gold mining. However, this province has faced a continuous economic decline for the past thirty years. By 1998, it had a total Gross Geographic Product (GGP) of R44.1 billions which was about five per cent of the National Gross Domestic Product (GDP) (Free State 2001); a decline of four per cent since 1980 (Free State 2005). Since then there has a further decline in the Province's contribution to the GDP (Free State 2007). This decrease in the relative contribution can, to a large extent, be attributed to negative growth in mining at an average rate of -4% per annum for the period 1980 to 1999 (Free State 2007: 11).

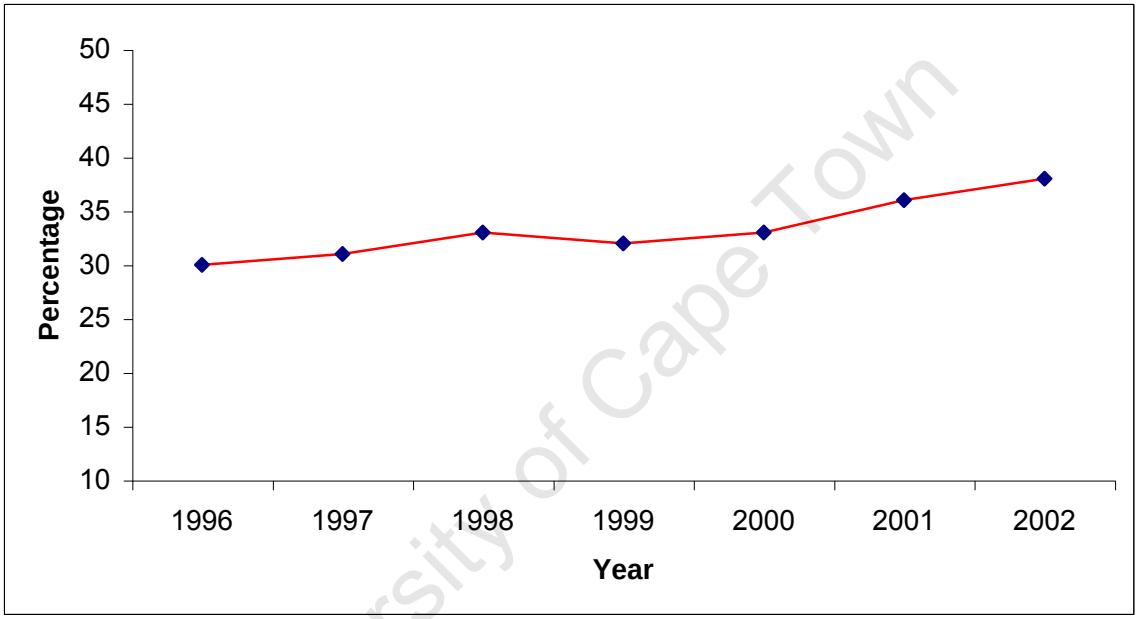
The Provincial economy has not performed well since 1996. The average economic growth rate for 1996 to 2000 was one per cent, and for 2001 to 2003 it was one per cent (Statistics SA, 2006 and FSDGS, 2007). For the period 1996 to 2004 the average economic growth rate for the Province was less than one per cent compared to three per cent for South Africa as a whole.

Although declining at a rapid pace, the mining industry is still the second biggest employer in the Free State. It is responsible for some 14 per cent GGP of the province; one per cent less than the Government Services sector in the province.

Unemployment, using the expanded definition of able-bodied persons aged 18 years or more who are unemployed, including those who are discouraged to look for work, has increased sharply with the reduction of the mine labour force and continued shedding of labour from the land (in commercial agricultural sector). This process coincided with the

advent of the democratic dispensation. As illustrated in Figure 4.3, the numbers of unemployed increased from 30 per cent in 1996 to 38 per cent, in 2002. However, unemployment has since dropped to 27 per cent in September 2006, the latest date for which figures are available. This decline is attributed to the closure of mines (Free State 2007: 25).

Figure 4.2 Unemployment levels in the Free State Province 1996-2002, using the expanded definition of unemployment



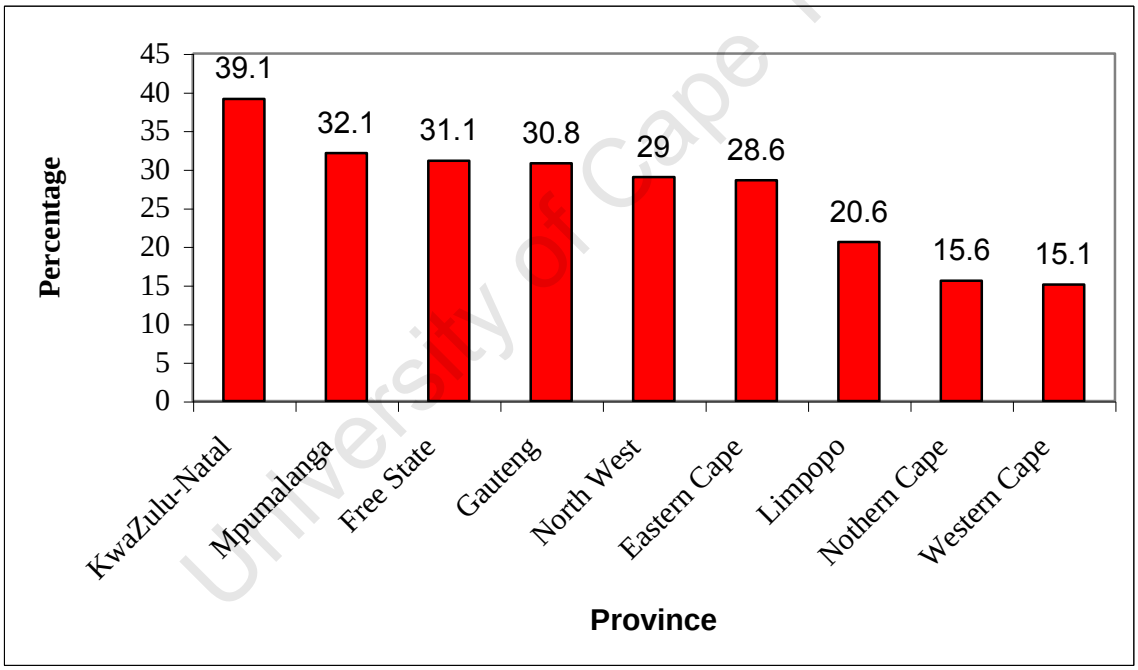
Source: Free State 2005.

There are conflicting reports about the number of people living in poverty in Free State – measured as a household living on less than the equivalent of US$1 per person per day. However, studies reveal that between 63 and 53 per cent of people in Free State lived in poverty between 1993 and 2005 (Free State 1999; SAIRR 2001; Free State 2005; Free State 2007)[52].

[52] The Free State Poverty Eradication Strategy (Free State 1999) estimates that in 1998 sixty-three per cent of Free State inhabitants lived in poverty while the South African Institute of Race Relations (SAIRR 2001) estimated that 54 per cent lived in poverty for the same period. The FSDGS puts the number of people living in poverty at 1.7million (56%), in 2004 (Free State 2007: 27). According to the FSDGS (Free State 2005), approximately 53 per cent of people lived in poverty in 2005. The Free State Development Framework Plan for 2005 estimated that 66 per cent of inhabitants live in poverty. The report noted that the number of people living in poverty grew from over one million in 1996 to almost 1.7 million in 2004, representing 56 per cent of the total population of the Province (Free State 2007: 27)

In addition to high levels of poverty, Free State has high levels of HIV/AIDS prevalence. However, there are various estimates of the prevalence of HIV/AIDS in the Free State. The Nelson Mandela/HSRC study on HIV prevalence, found that Free State and Gauteng had the highest HIV prevalence rates of 14.9 per cent and 14.7 per cent, respectively (Shisana & Simbayi 2002). As Figure 4.3 illustrates, the National Department of Health's (DoH) antenatal sero-prevalence survey of pregnant women attending public hospitals found that the Free State had the third highest HIV/AIDS prevalence (31 per cent) in the country (DoH 2006). Preceding studies by the Department of Health have recorded similar trends since the start of the surveillances (see DoH 2002 – 2005).

Figure 4.3 HIV prevalence by province among antenatal clinic attendees, South Africa: 2006

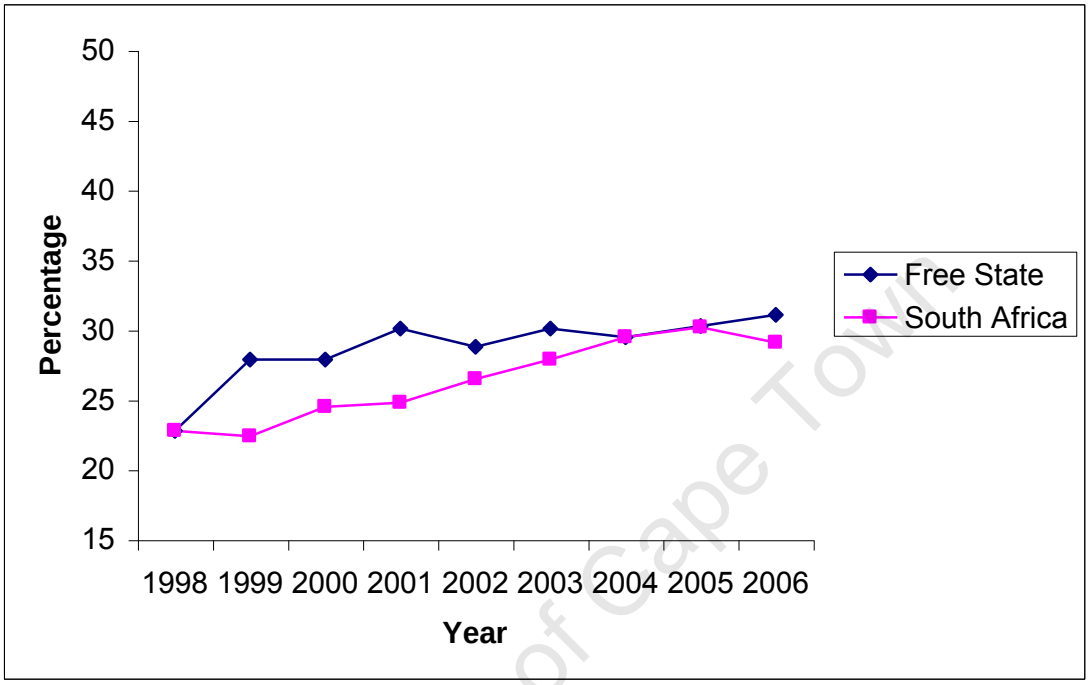


Source: Department of Health (2006)

Moreover, HIV/AIDS incidence in Free State has increased over the last eight years among women attending public sector antenatal clinics. According to the DoH (1999) the HIV incidence rate in 1998 was 22.8 per cent. This figure increased to 30.1 per cent in 2001. The incidence decreased to about 29 per cent in 2002 and 2004 in 2006 there

was a jump to 30.1 per cent. Moreover, as Figure 4.4 illustrates, HIV/AIDS prevalence in Free State is higher than the national average.

Figure 4.4 HIV prevalence in the Free State and South Africa, 1998-2006



Source: National Department of Health (1998-2006)

Areas with high HIV/AIDS prevalence will potentially have highest numbers of orphans and vulnerable children with the consequent problem of placement or care of such children. Thus, along with KwaZulu-Natal and Mpumalanga, it is reasonable to assume that Free State may be regarded as one of the major 'crisis areas' for the placement of orphaned children.

The increase in the HIV/AIDS incidence has also witnessed an increase in the rates of child mortality as well as infections of Tuberculosis (TB). According to the FSGDS (Free State 2007: 45), the Infant Mortality Rate (IMR) increased from 53 per 100 000 live births in 1998 to 62 per 100 000 live births in 2002. The latest estimate from the DoH 60 deaths per 1000 live births (DoH, 2006b). In respect of TB, the FSGDS (Free State 2007: 45) notes that the Province is ranked sixth in the country, accounting for about six per

cent (9 414) of reported cases in 2000. The FSGDS further observes that more than 17 000 people who suffer from TB also suffer from HIV infection.

Xhariep District Municipality

Situated in the southern part of Free State (see Figure 4.1), Xhariep covers the largest area of the province (34 131.55 km2). However, it has the smallest population in Free State (approximately 135 248 see Table 4.1), which makes it the most sparsely populated district in the province. There are three local municipalities falling under Xhariep: Kopanong, Letsemeng and Mohokare.

Table 4.1 Population size per district in 2005

District Municipality	**Population**	**Are in km^2**
Lejweleputswa	657013	31 686.38 km²
Motheo	728263	13 950.18 km²
Fezile Dabi	460316	21 423.14 km²
Thabo Mofutsanyana	725938	28 272.86 km²
Xhariep	*135248*	*34131.55 km^2*
Total	**2706778**	**192 480 km^2**

Source: Free State (2005); IDP Reviewed (2003)

Table 4.2 illustrates distribution of Xhariep District's population per Local Municipality. There are 38 878 households in Xhariep. The total population is estimated at 135 248. Women constitute about 51 per cent of the population while men account for 49 per cent. With a population size of 55 945 people, Kopanong is the largest municipal area in Xhariep.

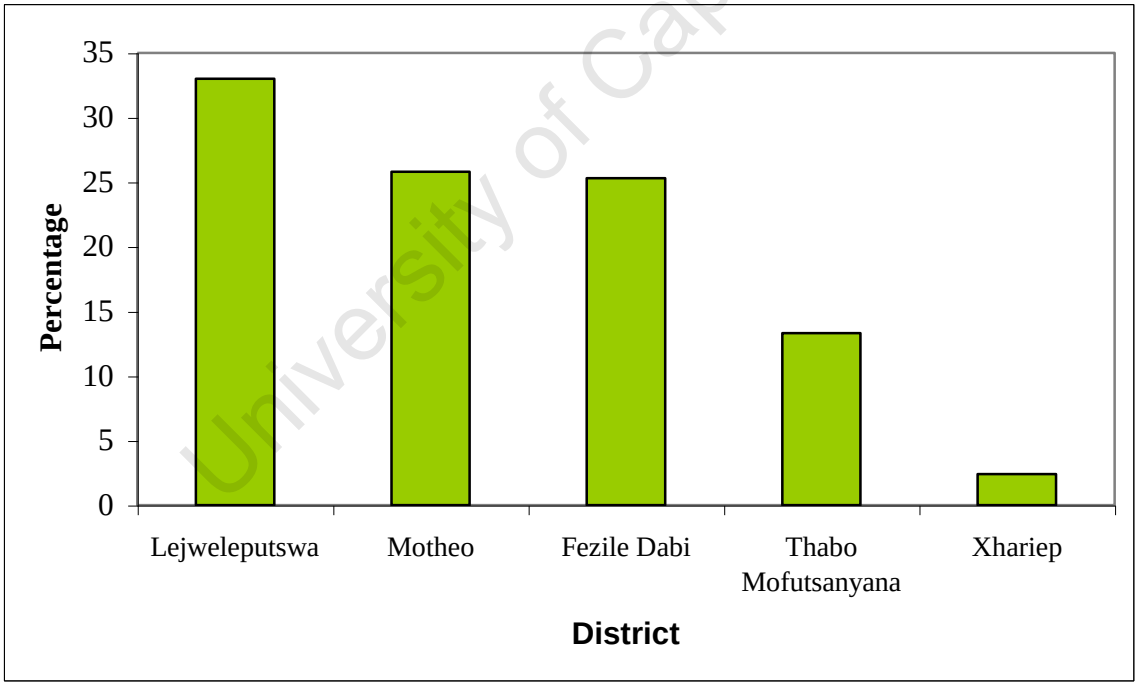
Table 4.2 Population distribution of Xhariep District Municipality, 2001

Area	Total population	Percentage	Density (km²)
Kopanong	*55 945*	*41.37%*	*3.68*
Letsemeng	42 981	31.78%	4.22
Mohokare	36 322	26.85%	4.15
Total / Average	**135 248**	**100.00%**	**3.96**

Source: Stats SA (Census 2001).

Economically, Xhariep is one of the poorest districts. It accounts for less than five per cent of Free State's GGP (see Figure 4.5 below). According to Figure 4.5, Lejweleputswa contributed 34 per cent of the GGP followed by Motheo and Fezile Dabi districts.

Figure 4.5 GGP Contribution per district to the Free State GGP (2001)



Source: Free State Development Plan (2001).

Unemployment in the region more than doubled between 1996 and 2001 from 27 per cent to 63 per cent, respectively (Stats SA 2002). Commercial agriculture is the largest employer at 40 per cent followed by private households (domestic work) at 20 per cent.

These sectors notoriously offer the lowest salaries of all employment sectors (Stats SA 1996; 2002). According to Census 2001 data, more than 90 per cent of the population falls in an income bracket of R1 000, 00 per month or less. The lack of unemployment has led to large-scale exodus from the area as people move to cities to look for jobs with higher wages.

Xhariep has the highest level of illiteracy in the province. As Table 4.3 illustrates, 18 per cent of Xhariep inhabitants had no schooling, compared to 10 per cent in Motheo district. Xhariep's rate of people with no schooling is higher than the national and provincial average rates of 16 per cent and 13 per cent, respectively. Only 20 per cent of Xhariep inhabitants have some secondary education compared to 28 per cent nationally and 26 per cent provincially. Eight per cent of the population had passed Grade 12, compared to 14 per cent and 11 per cent, nationally and provincially, respectively. Three per cent had higher education compared to five per cent for South Africa and four per cent for the Free State.

Table 4.3 Changing Educational Profile by District, 1996- 2001 (Free State)

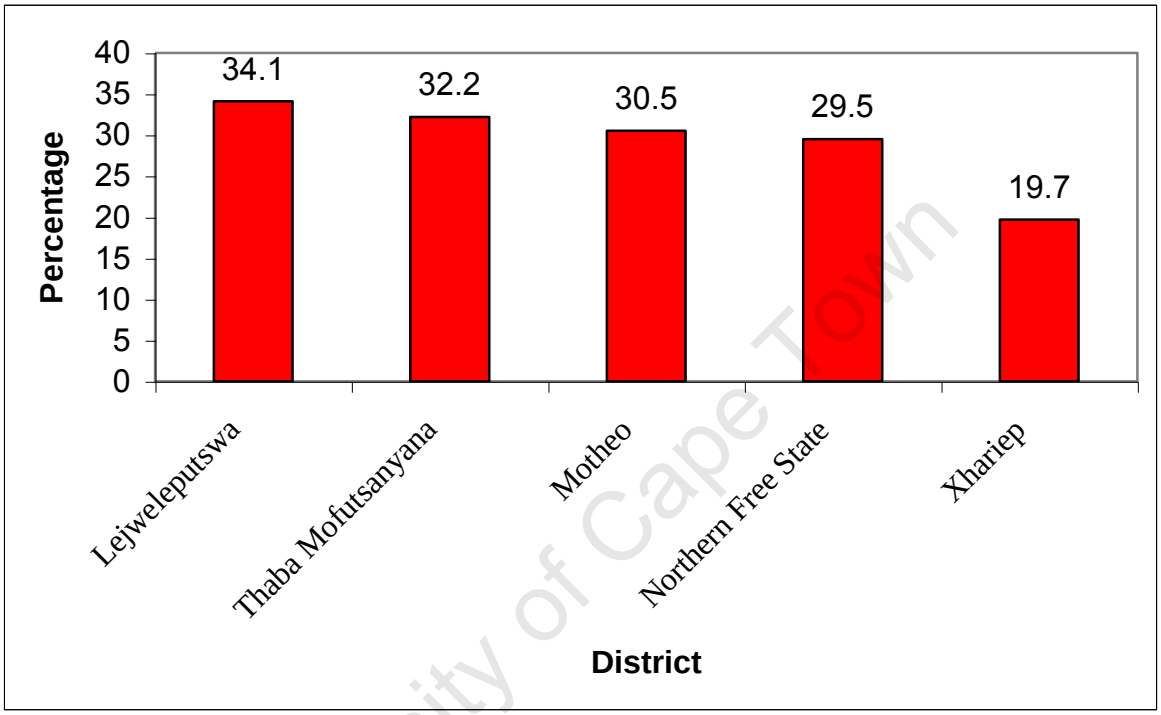
	% No schooling		% Some schooling		% Completed Primary		% Some secondary		% Std10/ Grade 12		% Higher	
Area	1996	2001	1996	2001	1996	2001	1996	2001	1996	2001	1996	2001
Xhariep	23.7	17.5	32.2	35.0	7.4	7.3	18.2	20.4	5.4	7.5	2.5	2.5
Motheo	14.2	10.2	25.5	28.8	7.8	7.1	27.1	26.1	11.4	13.6	4.2	5.4
Lejweleputswa	16.5	13.2	28.3	30.2	8.5	7.8	27.6	26.4	7.5	9.9	2.4	2.9
Thabo Mofutsanyana	20.6	15.7	27.9	31.2	7.5	6.7	24.3	24.1	6.7	9.4	2.4	3.0
Fezile Dabi	16.3	11.9	28.2	29.8	7.6	7.2	27.0	26.8	8.4	11.5	3.2	3.8
Free State	17.3	13.1	27.6	30.3	7.9	7.2	26.1	25.5	8.4	10.9	3.0	3.7
South Africa	22.3	15.8	26.1	29.9	7.5	6.9	28.7	27.9	11.2	13.9	3.9	5.4

Source: Statistics South Africa, 1998; 2003 and FSGDS, 2007

Before, this study, the levels of HIV/ADS incidence and prevalence were not known in Xhariep. South Africa's surveillance system; the annual collation of the incidence of HIV among pregnant women attending public health facilities, did not report the incidence at district level. However, since 2007, the State has begun to report district-level incidence.

According to the latest report DoH (2007) 19.7 per cent of pregnant women attending public sector antenatal were infected with HIV in Xhariep; the lowest incidences of HIV in the province (see Figure 4.6).

Figure 4.6 HIV prevalence according to district, 2007



Source: Department of Health (2007)

Kopanong Municipal Area

Kopanong comprises nine farming towns: Springfontein, Phillipolis, Trompsburg, Jagersfontein, Bethulie, Edenburg, Redersburg, Gariep Dam and Fouriesmith. Table 4.4 provides a brief profile of each town. What is clear is that, firstly, the towns are situated far apart from one another and secondly, the majority of towns are situated far from the provincial capital, Bloemonfontein. This makes access to crucial social services, difficult.

Table 4.4 A brief description of Kopanong towns

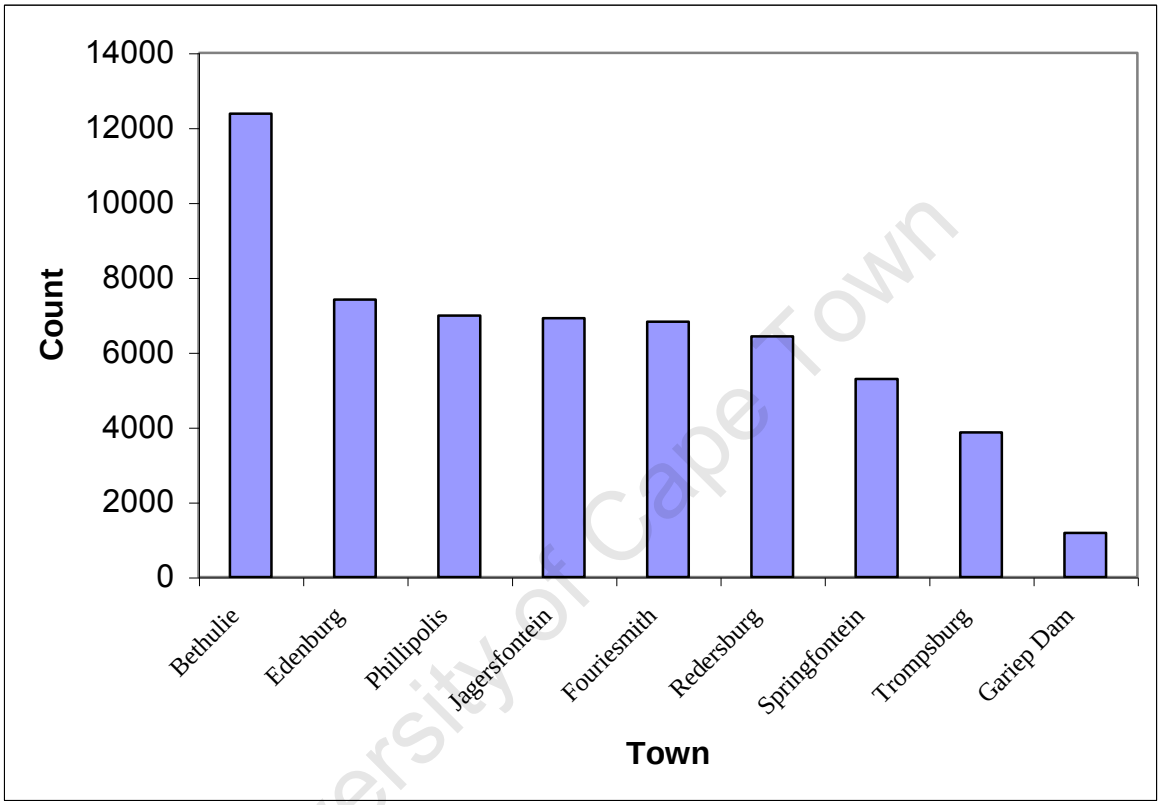
Town	Brief description of the town
Trompsburg	Trompsburg serves as the central town in both Kopanong and Xhariep Municipality with all local district offices situated there. It has a total population of 3860 people who speak mainly Sesotho and isiXhosa. Although it is a central town of the municipality, Trompsburg is among the least developed in Kopanong. Efforts are being made to upgrade it, including the construction of new municipality offices. This construction has resulted in job creation in the local community.
Edenburg	Edenburg is situated about 39 km north of Trompsburg and about 30 km from Reddersburg. It has a total population of 7411. The main languages spoken are Sesotho and Afrikaans;. It is also least developed with few general dealers in town and one filling station.
Reddersburg	Reddersburg is the nearest town to Bloemfontein (37 km), which is the capital of Free State province, and is about 65 km northeast of Trompsburg. The total population size is 6430. The main language spoken is Sesotho, although isiZulu is also spoken by a few. Reddersburg has few shops, and filling stations including a hotel.
Bethulie	Bethulie is the largest town under Kopanong Municipality with a total population of 12 374. It has few shops and filling station. It is fairly well developed compared to other towns in the municipality.
Jagersfontein	Jagersfontein is situated 35 km north of Trompsburg and has a total population of 6913. It is a former mining area, so has many former migrant workers who have since settled there. The main languages spoken are Sesotho and Afrikaans .Compared to other towns in the area, Jagersfontein is better developed; it has more shops and is bigger. There is also a suburban area situated closer to the township, which accommodates people of all races.
Fauresmith	Fauresmith, situated 10 km from Jagersfontein and 47 km north of Trompsburg, also looks better developed. It has a total population of 6822 who reside mainly in the nearest township. As one drives into different areas of Fauresmith social inequalities are evident. One part is developed with access to water and sanitation and clearly marked streets, while nearby there are old squatter houses which do not have access to water and sanitation. Unlike other towns, squatter areas in Fauresmith were occupied by both black and coloured people. Afrikaans is the dominant language, with Sesotho and isiXhosa being secondary languages
Phillipolis	Phillipolis is the third biggest town and comprised 6979 people. It is 55 km south-west of Trompsburg. The main languages are Sesotho and Afrikaans. Phillipolis is a tourist attraction because of its historic value. It claims to be the older town in the Free State and has a number of stately old buildings, and is the birthplace of Sir Lourens van der Post and was the center of Adam Kok Griqua community.
Gariep Dam	With a total population of 1179, Gariep Dam is the smallest town under the Kopanong Municipality, yet the most developed because it is the main tourist attraction. It is situated approximately 62 km from Trompsburg. The main language spoken is Afrikaans, although isiXhosa and Sesotho are spoken by a minority.
Springfontein	Springfontein is the closest to Trompsburg (28 km) and about 3 km away from the N1 route to Bloemfontein. It has a total population of 5289. The main languages spoken are isiXhosa and Sesotho. Due to being close to the N1, the levels of prostitution were said to be very high.

Source: Adapted from Mfecane & Skinner (2005).

As illustrated in Table 4.1 above, Kopanong is the largest of the three municipalities, covering an area of 15 190.54 km^2, with 41 per cent of the district population residing in

the nine (9) towns. Figure 4.7 illustrates the population of Kopanong per town. The total population is estimated at 55945. Women and men constitute approximately 52 per cent and 48 per cent, respectively, of the total population in Kopanong (Stats SA 2002).

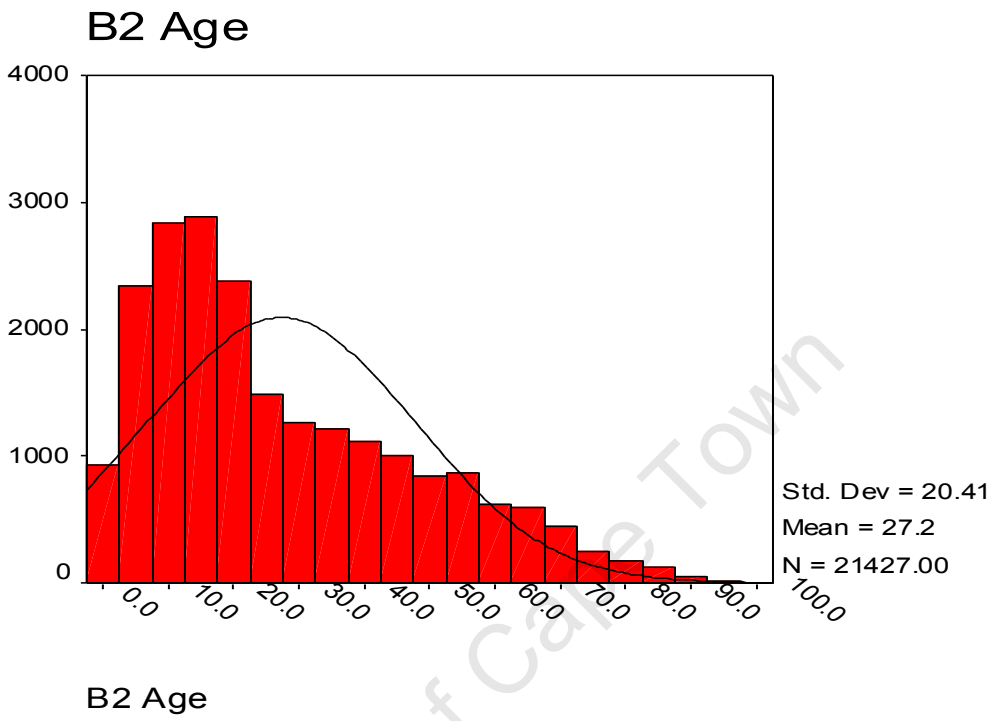
Figure 4.7 Population size for Kopanong Municipality per town, 2001



Source: Stats SA (2001)

As Figure 4.8 indicates below, there are more young people living in Kopanong than adults. This is common in most rural towns. Able-bodied adults often move to urban areas in search of work, as job opportunities in semi-urban towns are scarce. About a third (31%) of the population is between 0-15 years and hence dependant on others for emotional, physical or financial care. The average age is 27 years.

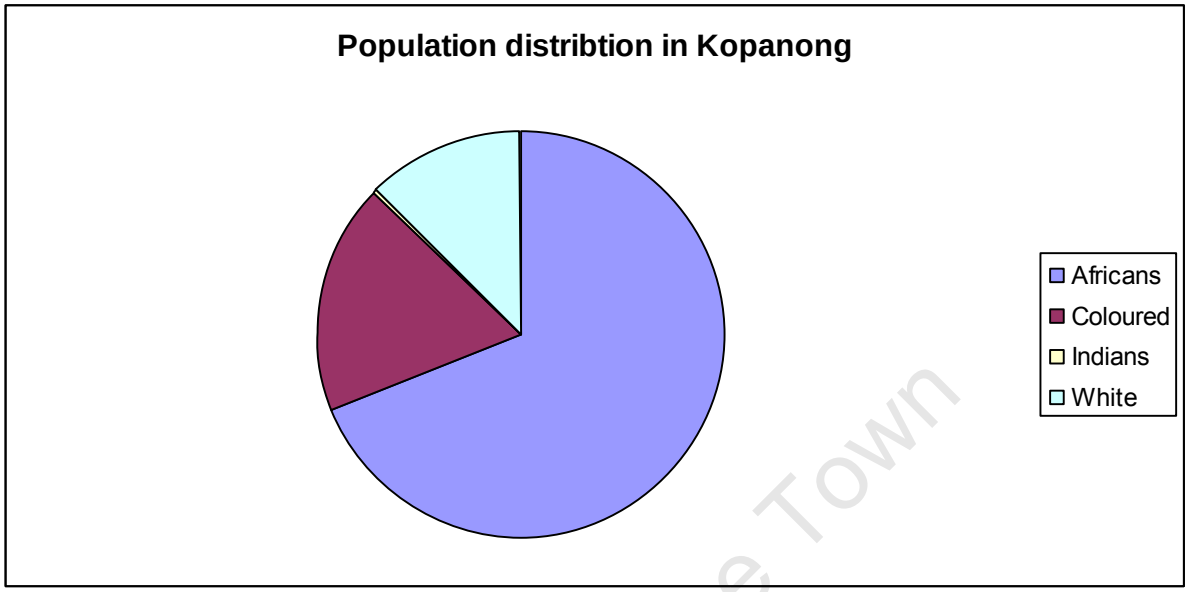
Figure 4.8 Distribution of age in the study population (2004).



Source: HSRC OVC Census (HSRC 2004b)

Kopanong's population is predominantly African (72.5%), followed by Coloured people (17.8%), Whites (9.6%) and Indians at less than one per cent (see Figure 4.9).

Figure 4.9 Population distribution of Kopanong



Source: Free State (2005)

Contrary to expectations, household sizes are relatively small in Kopanong. As Table 4.5 illustrates, 75 per cent of households had from one to four members (a typical nuclear family). Twenty-two per cent of households had only two members. Only two per cent of households had more than ten members.

Table 4.5 Households size in Kopanong, 2001

Number of members in household	2001	%2001
1	3599	20.6
2	3912	22.4
3	3026	17.3
4	2628	15.0
5	1730	9.9
6	1085	6.2
7	596	3.4
8	360	2.1
9	235	1.3
10 and over	309	1.8
Total	17480	100

Source: Census 2001

Like many rural towns of South Africa (with the exception of mining areas), the economic base of the Kopanong Municipality and the District at large is farming and since 1994, tourism. However, commercial farmers are moving into game farming which is less labour intensive than agriculture. Mining operations, once a major source of employment, have since ceased to operate (Lochner & Atkinson 2006), pushing communities further into poverty. Drought has hampered agricultural production in the area and has led to a decline in agricultural activities, thus further reducing employment prospects. This has forced many farm workers to migrate to nearby townships, exacerbating the already dire poverty situation there.

The state of poverty in Kopanong is vividly illustrated by the state of individual income. As Table 4.6 demonstrates, 65 per cent of the adult population recorded no income in 2001. Fourteen per cent of the population were earning less than R500 per month while only 12 per cent earned between R400 and R800 per month.

Table 4.6 Individual monthly income in Kopanong in 2001

Persons	2001	%2001
None	36387	65.0
R1 – 400	7781	13.9
R401 – 800	6733	12.0
R801 - 1600	1574	2.8
R1601 - 3200	1666	3.0
R3201 - 6400	1162	2.1
R6401 - 12800	362	0.6
R12801 - 25600	155	0.3
R25601 - 51200	57	0.1
R51201 - 102400	42	0.1
R102401 - 204800	21	0.0
Over R204801	5	0.0
Total	55945	100

Source: Census 2001

Levels of income poverty are therefore, very high in the Kopanong, which in turn means that many children will be poor, and hence vulnerable. However, in terms of social wage Kopanong fares better. Clean water is available to 91 per cent of residents of Kopanong (IDP Xhariep 2003; Mfecane & Skinner 2005), although water shortages are experienced in summer due to lack of rainfall (Xhariep IDP 2003). The main sources of water in townships are communal taps and taps inside their properties but outside the house. The communal taps are less than 500 m from any household (Mfecane & Skinner 2005).

Housing arrangements exhibit the national trend; whites predominantly occupy the centre of the towns which have the entire infrastructure associated with built-up areas, while African and coloured people mainly dominate townships. Coloured residential areas are also separated from the blacks', though the distance between them is not far. Among township dwellers some reside in formal houses and some in shacks, while others stay in the newly built Reconstruction and Development Programme (RDP) houses. According to the 2001 Census, 86 per cent of inhabitants lived in formal houses, compared to ten per

cent and four per cent who lived in informal and traditional dwellings, respectively (Stats SA 2002).

Other important parts of social wage are the provision of water, sanitation and electricity. According to a review of levels of satisfaction with the level of service delivery, the Municipality registered 89 per cent, 92 per cent and 85 per cent for water, sanitation and electricity, respectively (Free State Province 2004).

Kopanong is, then, an area that exhibits very high levels of poverty, a very young population, but one where housing and sanitation services are better than average.

Research methodology and data sources

As explained above, this study drew from a series of baseline studies conducted by the HSRC in Kopanong, in preparation for the implementation of an intervention programme that is aimed at strengthening families that provide care and support to orphans and other vulnerable children. The specific goals of the project were to: firstly, improve the social conditions, health, development and quality of life of vulnerable children and orphans, secondly, support families and households coping with an increased burden of care for affected and vulnerable children, thirdly, strengthen community-based support systems as an indirect means to assist vulnerable children, and fourthly, build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term (HSRC 2004b). For the purposes of benchmarking, monitoring and evaluation, the HSRC conducted a baseline study at both of the intervention sites in the form of a Census referred to here as *OVC Census* (HSRC 2003).

In addition, the HSRC further undertook a representative survey of vulnerable households, referred to here as the *OVC PSS* (HSRC 2004c), and a qualitative study referred to here as the S*ituational Analysis Report*. The aim of the *OVC Census* (HSRC 2003) was to obtain the number of all orphans and vulnerable children in all eligible households in Kopanong and Kanana (Jooste, Managa & Simbayi 2006). The *OVC PSS*

(HSRC 2004c) was a follow-up study which aimed to investigate the situation of orphans and vulnerable children in these households, and the views of their carers regarding their needs and living circumstances in Kopanong (and Kanana) (Simbayi et al.. 2006). The *Situational Analysis Report* served two purposes: firstly, to collect information on conditions of orphans and vulnerable children in Kopanong and on general living circumstances of people, and secondly, to introduce the intervention and role players to the targeted communities (Skinner & Davids 2006a, 2006b).

Both the *OVC Census* (HSRC 2003) and *OVC PSS* (HSRC 2004c) studies were particularly important for this research. The *OVC Census* (HSRC 2003) provides a general overview of the prevalence of orphans in Kopanong, household conditions, and access to government services. The *OVC PSS* (HSRC 2004c) investigated carers of orphans and their socio-economic status. Information about the views of orphan carers, particularly around care arrangements and support from the community and the state, was collected through a qualitative study that was carried out by this author early in 2005.

The HSRC has produced clients' reports based on the three studies they conducted (Jooste, Managa & Simbayi 2006; Simbayi et al. 2006; Skinner & Davids 2006a, 2006b). Their raw data were then reanalysed by this author to try to answer the questions that the author wanted to investigate. The analysis focussed on, firstly, issues of care: who are the carers? Secondly, poverty: how does it affect the lives of orphans and their carers? Thirdly, access to services: how many carers have access to social grants? In relation to care, the central questions were; who is likely to look after orphans? What motivates them to do so? What is the profile of the carers (age, sex, relation or not to orphan, assets). Orphans and their carers' living conditions were also investigated. These were compared with those of non-orphans to determine whether orphans were more severely impacted upon by poverty than non-orphans. The review of access to services looked at the extent to which needy children (whether orphaned or not by AIDS) are reached by welfare services. In addition, a limited analysis of Stats SA's annual General Household Surveys (GHS) (from 2002 to 2006), and the Stats SA's Community Survey of 2007 datasets, was conducted to corroborate the findings. The analysis focussed mostly on

orphan prevalence, care arrangements and access to services including social grants. The research methodology of each design is discussed below.

The quantitative research designs

This section discusses the research design of this study in detail. As outlined above, the study employed a combination of quantitative and qualitative methods. The combined use of qualitative and quantitative methods serves as a crosscheck regarding the accuracy of information as well as a means of generating further questions and hence deepening the researcher's understanding of the subject of study (Rossman & Wilson 1984, 1991; Croke 2003).

A quantitative study is "an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true (Creswell 1994: 1-2)." Its methods include the random sampling for survey research, structured individual interviews for data collection and the statistical analyses generated thereby (Krishna & Shrader, 1999:10). Quantitative researchers (depending on what they are investigating) may also undertake experiments, analyse official statistics, make structured observations and employ the methods of content analysis (Silverman 2001)[53]. Surveys include cross-sectional and longitudinal studies using questionnaires or structured interviews for data collection with the intent of generalising from a sample to a population. The advantage of the census is that it investigates a whole population, rather than a representative sample, provided the response rate is satisfactory.

However, the survey-style interviews are limited by the fact that they fail to explain the intended meaning of the findings from the respondent's viewpoint. The emphasis on pre-coded data collection schemes sometimes comes at the cost of neglecting the depth and complexity of the research participants' experiences (Marvasti 2004). The combined use

[53] Its main preoccupation is methods that maximise representativity and generalisability to the larger study population. The quantitative research strategy is often referred to as traditional, positivist, experimental, or empiricist. The basic assumption is that the methodological techniques of the physical sciences are the ideal model for exploring the social world (Hamersley & Atkinson 1983; Silverman 2001).

of quantitative and qualitative research techniques – otherwise referred to as methodological triangulation – becomes highly beneficial. The *OVC Census*, *OVC PSS* and the Stats SA's *General Household Surveys* represent the quantitative part of this study.

Orphans and Vulnerable Children Census

The aim of the *OVC Census* (HSRC 2003) study was to obtain a count of all the orphans and vulnerable children in the households in each of the two sites. The objectives were to determine exactly how many orphans and vulnerable children there were in Kopanong (and Kanana) and to obtain information about their carers, the number of other children being cared for, the nature of their accommodation and the household economic situation (Jooste, Managa & Simbayi 2006).

A two-page census record sheet was used to obtain information about all the occupants of the household (see Annexure A). This included the number and types of orphans and disabled people as well as various socio-economic status indicators such as the type of dwelling, access to water for drinking and cooking, the household's main source of energy, main type of toilet facility, income, and average monthly expenditure. This data was used in this thesis to compute the overall prevalence of orphanhood in Kopanong, the level of access to services such as welfare, education, health, housing, water and income, and the vulnerability status of orphans. It also reviewed the care arrangements made for them, as well as non-orphans. Throughout the period in which these studies were conducted by the HSRC, this author was attached to the HSRC as a PhD Research-Fellow. This position facilitated easy access to the dataset and enhanced the interaction between the research coordinators within the HSRC and the author.

The *OVC Census* (HSRC 2003) targeted the entire population found in all households among the previously disadvantaged communities in the nine towns of Kopanong Municipality. The HSRC spent about two months negotiating community entry with community structures and community-based organisations working with orphans and

vulnerable children in the area before the commencement of the census. Once the community approval was obtained, the heads of each household were approached for interviews by an enumerator who was a member of a team of fieldworkers.

Field workers were drawn from local communities. All members of the research team had completed high school education and matriculated. Most field workers had participated in the national census that was conducted in 2001. Therefore, the majority had some experience in data collection as enumerators (see Jooste, Managa & Simbayi 2006). Enumerators were trained for two days on how to use the census record sheet. Each fieldwork team was led by a supervisor who checked each questionnaire at the end of each day. Interviews were conducted in Nov 2003. The field work lasted nearly three weeks.

Ethical approval for the entire study, as well as the *OVC PSS*, was obtained from the HSRC's Ethics Committee, and informed consent was sought from every head of the household using an informed consent form (see Annexure B). The response rate was good at 98 per cent (see Table 4.7). Only one per cent of the questionnaires were not completed. Less than one per cent of respondents refused to participate in the study.

Table 4.7 Response rate among households in Kopanong

Activity: questionnaire	Frequency (n)	Percent (%)
Completed	5188	98.6
Incomplete	37	0.7
Refusal	6	0.1
No one present	18	0.3
Abandoned	5	0.0
Total	5254	100

Source: Jooste, Managa & Simbayi (2006)

The census provided a useful broad picture of Kopanong regarding the prevalence of orphans, their living conditions and access to government services. However, it failed to

unambiguously identify orphan carers. The Orphans and Vulnerable Children Psychosocial Survey was important in this regard.

The Orphans and Vulnerable Children Psychosocial Issues

The main aim of the *OVC PSS* (HSRC 2004c) survey was to investigate the situation of orphans and vulnerable children in their households and to gather the views of their carers regarding their needs and living circumstances in Kopanong (and Kanana) (Simbayi et al. 2006). The survey obtained information about their biographical characteristics, including orphan status, food intake, psychosocial issues, household relationships, risk taking, decision-making and emotional well-being. A detailed discussion of the research methodology can be found in Simbayi et al. (2006). To summarise, three surveys were conducted among orphans and vulnerable children (6-14 years old and 15-18 years old) and their carers. Since this study focuses on care for orphans, the discussion on research methodology, which follows, will be confined to the survey of the carers.

A systematic probability sample of 1000 households was drawn from a sampling frame developed from the *OVC Census* (HSRC 2003). The sampling frame consisted of a list of all houses in Kopanong which either had some children orphaned or which were classified as vulnerable, or both. The following criteria were used to determine vulnerability: access to medical facilities, adequacy of clothing, serious illness in the household, adequacy of uniforms for school-going children, and disability in the household (see Jooste, Managa & Simbayi 2006). The households which participated were all vulnerable – using the above-stated criteria.

According to Simbayi et al. (2005), the households were selected using a computer programme that was developed for this purpose by the project's statistical consultant. In each household, one parent/guardian who was willing to participate in the study was interviewed (the questionnaire is attached in Appendix C). Seven hundred and ninety one guardians were selected in Kopanong and 91 per cent, (718) guardians agreed to

participate in the study. Ethical approval was sought from, and granted by, the HSRC's Research Ethics Committee in 2003. Informed consent was sought from parents/guardian of orphans and vulnerable children. They indicated their consent by signing the consent form (see Appendix D). The research team comprised of one fieldwork coordinator, nine supervisors and 27 fieldworkers.

The software package *Statistical Package for Social Scientists (SPSS)* was used to analyse all the data. Frequencies and descriptive statistics were used throughout the analysis. Cross-tabulations, graphs, figures and charts were used to present the data.

A number of problems emerged when re-analyses of the raw survey data began. One problem was the question of the relationship between the child/orphan and the head of the household. These relationships were not clearly defined. For example, a distinction was made between Grandpa (Grandfather) - Maternal and Grandpa (Grandfather) - Paternal in the questionnaire but Grandma (Grandmother) - Maternal and Grandma (Grandmother) - Paternal were not distinguished. Differences between types of non-related carers were also not clearly defined. It was not possible to distinguish between adoptive parents, foster parents and informal non-family carers. There were also gaps in some of the responses to the questionnaires. Carers were asked how many meals the child ate per day. The respondent was not asked to specify what foodstuffs the meals contained. There is a wealth of difference between an evening meal of maize porridge with a meat sauce and a cup of sweet tea and a slice of bread. Nevertheless, in general these two studies addressed pertinent issues that related to orphans and vulnerable children and they drew on representative samples. Moreover problems in one of the surveys could often be resolved by referring to the other survey. Thus, despite some problems of data analysis the two quantitative surveys – the census and the survey - yielded rich information. The findings were further enhanced by the analysis of the Stats SA's GHS (Stats SA 2002; 2003; 2004; 2005; 2006) and the Community Survey of 2007 (Stats SA 2008). The primary purpose of the latter analysis was to observe trends over time and to compare the HSRC studies' findings with other credible and comparable studies.

The *OVC PPS* survey addressed the problem of identifying the real carers of the children. However, like the *OVC Census*, it could not capture the personal feelings and emotions of the carers and the understandings of teachers, nurses, welfare agency representatives, municipal councillors and others who in different ways are involved in the problem of orphans and their care. It was for this reason that a series of interviews with carers and other key informants were also conducted.

The qualitative research design

The qualitative paradigm, often described as a constructivist approach or a naturalistic, interpretativist or post-modern approach (Groenewald 1986; Creswell 1994; Marvasti 2004), is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting (Creswell 1994: 1-2). Essentially, qualitative research, or the constructivist approach, is concerned with how human interaction helps to create social reality, and how individuals interpret it.

As Chambers (1997) and Payne & Payne (2004: 176) note, the aim of qualitative research is to encounter social phenomenon as they naturally occur and seek out and interpret the meanings that people bring to their own actions. In some qualitative research, researchers interact with those they study, whether this interaction assumes the form of living with or observing informants over a prolonged period of time, or actual collaboration (Creswell 1994; Morgan 1997). Other qualitative research is more limited and will involved one or more interviews with a respondent. In both types of research the researcher tries to minimize the distance between him- or her self and those being researched.

The qualitative research design uses a number of research techniques: observation, participant observation, life histories, in-depth interviews, focus group research, ethnographies and biographic narratives. These methods allow more fluid interviews, and more interaction between the researcher and the respondent, which in turn makes for flexibility around the questions and areas to be explored. The researcher can pursue ideas

and thoughts which are more important than s/he originally thought. It also allows for answers to be elaborated (Marvasti 2004; Payne & Payne 2004: 131).

In-depth interviewing allows researchers to probe the deeper perceptions of their subjects and provides more than one understanding of the topic (May 1993; Marvasti 2004: 22-3). In focus groups the researcher asks questions from a number of respondents at the same time to stimulate discussions (Morgan 1997: 2). The aim is to understand the meanings and norms which underlie those group answers. The format ranges from very structured discussions with respondents taking turns to answer each and every question to a more flexible brainstorming session where participants voice their opinions at will. Both methods of data collection were used to collect the qualitative data for this study.

The choice of informants in qualitative research design is different from the one used in quantitative studies. For quantitative researchers, the preconditions of statistical analysis require that respondents be selected randomly from the study population. Further, the study population must be representative of the wider population in order to allow for generalisation. Sample size will depend on the size of the study population. Qualitative research often uses the sampling procedure that is referred to as *purposive sampling*, meaning that the theoretical purpose of the project, rather than a strict methodological mandate, determines the selection process (Miles & Huberman 1994). It means, for example, that respondents with professional knowledge about the topic, referred to above as key informants, are targeted.

For the qualitative design of this study, purposive sampling was used to target particular people with expert knowledge and/or a comprehensive understanding of the issues. They included seven key informants from the DoSD (i.e. social workers), five from the DoH (i.e. nurses) and 12 from Department of Education (teachers) as well as three municipal councillors and three municipal officials (See Table 4.8 and Appendix A).

Teachers play a crucial role in African communities. In addition to providing academic tuition to children, they are often consulted to offer advice on a range of issues, including

advice on dealing with children with problems. Teachers, then, are in touch with the daily affairs of communities which they serve. Their daily contact with children also made them ideal informants for this study. They were able to provide information on the number of orphans or vulnerable children in their school, and to generally offer informed opinions on conditions of children at home and to suggest possible solutions to these problems. In addition teachers liaise with DoH which provides some poverty relief services. Teachers are a central point of contact for these services. Interviews were conducted with 12 teachers at different primary and secondary schools in Bethulie, Springfontein and Jagersfontein.

Nurses are also a good source of information. They are in the frontline of the health service and are in daily contact with local people. They are also usually respected members of their communities. Nurses attend to the physical and psychological well-being of the community and are therefore, in a good position to comment on both health and social-related problems afflicting the community. They therefore, made a meaningful contribution to the study by discussing issues around the well-being of orphans, other vulnerable children and their caregivers. Five nurses (sisters in charge) were interviewed from 3 clinics – each located in either Bethulie, Springfontein or Jagersfontein.

Table 4.8 Type and number of informants interviewed

Type of informant and organisation/department	**No. of informants**
Department of Welfare officials – social workers and District Manager	7
Department of Health officials – nurses	5
Department of Justice – Magistrate	1
Department of Education – teachers	12
NGO (Hospice) – leaders	1
CBO (Home-based care) – leaders	1
Municipal officials (Kopanong and Xhariep)	3
Kopanong Local Government Councillors	3
Guardians – related (focus groups)	12
Guardians – unrelated (focus groups)	11
Total	**51**

Like teachers and nurses, social workers are a contact point for the DoSD. The DoSD is central in the provision of welfare services to the poor and vulnerable. Its mandate is to promote the welfare of South African citizens. Social workers play a critical role of identifying and assisting poor and vulnerable people in Kopanong. They keep records and statistics of such individuals. They are in contact with them on a daily basis and understand their problems. Social workers provided useful insights into problems that concern the extended family care and support for orphans, the role of other caregivers, and the role of the state and up-take of government-provided services, especially social grants. They highlighted the problem of limited access to birth certificates which are pre-requisites for accessing social assistance, and the impact of social assistance in strengthening social networks of social support for orphans and other vulnerable children. The seven social workers interviewed were therefore, a key group.

Interviews were also conducted with three municipal councillors, and three municipal officials. As a sphere of governance on its own, municipalities, both district and local are expected to produce a business plan, called the *Integrated Development Plan*, every five years[54]. A representative from the Department of Justice was also interviewed. This was because magistrates handle foster care cases. It was therefore, necessary to understand the challenges which communities providing care for orphans face and how the Justice Department addresses them.

A total of six focus-group interviews were held with orphan caregivers in Jagersfontein, Springfontein and Bethulie. These towns have been selected because of the common challenges of HIV/AIDS and poverty. Bethulie is the biggest town in the district and faces high levels of unemployment. Jagersfontein is a former mining town and used to have a high number of migrant workers. Mines have proved to have high HIV and AIDS prevalence rates in South Africa. Springfontein is adjacent to the N1 Road with heavy volumes of transport trucks. Long distance truck drivers are a high risk group in South Africa.

[54] In principle, such plans should include strategies to deal with vulnerable sections of the population such as orphans. Due lack to the lack of resources and capacity, the Kopanong Local Municipality had no plans for orphans and vulnerable children.

Therefore, two focus-group interviews per town were conducted; one set of focus-group interviews was conducted with related caregivers and another with non-relatives, (see Annexure G and Annexure H for the interview guides for related caregivers and non-relative caregivers, respectively). Half of the respondents represented biologically related caregivers and the other half, non-relatives. Each focus-group session included twelve participants. Focus-group sessions were conducted in local clinics or in the offices of the DoH. Each session lasted for about one-and-half to two hours.

In her book *Steering By the Stars*, Ramphele (2002: 22) notes that there are very few African researchers able to investigate "the enormous problems affecting black communities. Knowledge of language, idiom, customs and traditions and their distortions, is an essential tool in tackling social questions which leaves white social scientists, generally unfamiliar with black South African languages at a disadvantage." Being from this area, and a native language speaker, gave the author a rare insight into and empathy with the lives of the people who were investigated. Furthermore, the author was able to pick up nuances in conversation that would have been lost in translation. Discussions were held in *Sesotho* as this was the mother tongue of all the participants or English if the respondent chose this medium of communication. The discussions centred on care for orphans and vulnerable children, access to key services and the role of the extended family as well as the broader community.

The author was fortunate in being able to draw on the contacts previously established by the researchers on the *OVC Census* (HSRC 2003), the *OVC PSS* (HSRC 2004c) survey, and the qualitative study that was conducted to compile the background report to the community. Through these contacts the author met various role players, such as key officials of relevant government departments, non-governmental, not-for-profit, community-based and faith-based organisations and members of the community. In addition the author had personal contacts in the area, especially within the DoSD.[55]

[55] The author had previously worked with the Officials in the DoSD while employed by a research firm based in the Free State Province's capital city, Bloemfontein.

Access to communities was facilitated mostly by social workers. Social workers were instrumental in mobilising participants and introducing the author into the area. Prior to the commencement of the research exercise, ethical clearance was sought from the HSRC's Research Ethics Committee.[56] All research participants were asked to sign a consent form before commencement of an interview session (see Appendixes I, J & K). Consent forms served to affirm that participants participated in the study voluntarily. They were assured that they could withdraw from the study at any point without repercussions. The forms also provided assurance to the participants that individual identities would not be revealed, although the research findings would be made publicly available.

In addition to interviewing key stakeholders, that is, caregivers and service providers, the study reviewed documents and policies that relate to care and support for orphans and other vulnerable children. A review of government legislation on welfare policies, social workers' records and municipal development plans was conducted. The Child Care Act No 74 of 1983 and Children Act No. 38 of 2005, and related documents, were consulted to understand the terms, criteria and conditions within which support is made available to the carers of orphaned children. Both the Xhariep and Kopanong Integrated Development Plans were consulted to understand the mainstreaming of care and support for vulnerable sections of the population in the Kopanong Municipal Council's development plans[57].

Conclusion

This study used quantitative and qualitative research techniques. The strength of this approach lies in its ability to corroborate the information gathered through triangulation. The HSRC *OVC Census* targeted every household in Kopanong. It therefore provides a very rich source of information about people in the area and their living standards. It also yielded useful information for understanding the level of orphan prevalence and their

[56] This was granted on 9 March 2005.
[57] However, no plans were in place to mainstream care for orphans and vulnerable children in broader development agenda.

living conditions. The study conducted by the HSRC facilitated this study. The author was able to contact officials and respondents who had assisted in the first two studies. This eased the author's entry into this community, and the process of data collection. The qualitative approach helped to fill out the gaps of the Census study. It allowed the research participants to express their views about the subject of the extended family care and support for orphans without constraining them to pre-determined response codes.

The profile of Kopanong indicates that, like many rural/semi-rural towns of South Africa, the nine-towns comprising Kopanong, are characterised by high levels of poverty, unemployment and absence of adult members who go to cities where the prospects of employment are thought to be better. The area has a disproportionately high number of younger and old members of the society, who are by definition economically inactive.

The bulk of those employed are farm labourers and domestic workers. Because, 55 per cent of economically active people in Kopanong are unemployed and over 90 per cent have income of less than R800 per month, local families have become increasingly vulnerable. Having no security or sustainable livelihoods, they turn to the welfare system for income, maintenance and social support.

Chapter 5 Is there a crisis of care for orphans? Family care in the context of AIDS and poverty in South Africa: the case of Kopanong Municipality

Introduction

As pointed out in Chapters 1 & 2, the literature shows that there has been a large increase in the number of orphaned children in South Africa due to the HIV/AIDS epidemic, especially amongst African South Africans (UNAIDS 2002, 2004, 2005; Bicego, Rustein & Johnson 2003; Bhargava & Bigombe 2003; Giese et al. 2003). The literature suggests that this increase poses a crisis of care. This is because the institution of the extended family is declining and, extended families will not be able to cope due to the magnitude of the problem (Foster 1996; Mutangadura 2000; Ndlovu & Ngwenya 2001; Booysen & Arntz 2002; Smart 2003; Freeman, Nkomo & Meintjies 2004; Marais 2005; Whiteside 2007).

However other scholars (Nzimande 1996; Kanyogo-Male 1984; Murray 1980; Smit 1998; Spiegel, Watson, & Wilkinson 1996a, 1996b; Steyn 1995; Wallerstein & Smith 1992; Broodryk 2002; Ziehl 2001, 2002, 2003; Nyamukapa & Gregson 2005), argue that the extended family is still strong and continues to shape the lives of its members. While it is acknowledged that the 'traditional' South African extended family has taken different forms over time in response to the challenges of colonialism, globalisation, endemic poverty and disease, it is argued that the intricate web of networks of social support is still very much a common feature of the African family. The experience and practices of other African countries affected by the HIV/AIDS pandemic, such as Uganda (Ankrah 2003; Seeley 2003), Zimbabwe (Mutangadura 2000; Foster 2001; Foster et al. 2001; 2002) and Tanzania (Nnko et al. 2000) have demonstrated the indispensable role of extended families in providing care to children orphaned by AIDS.

This is facilitated by the fact that Africans in South Africa do not define *family* exclusively in biological terms**,** but rather in terms of shared interest in one another's well-being. It is still common for three generations of relatives to dwell together. This way of living creates a pool of resources from which family members can draw. Care is embedded in the cultural norms and traditions that regulate interactions among members of the family, and the entire kinship, including fictional kinship, that is, those that are not related by blood, but by mutual assistance and obligations. Notions of trust, obligation and reciprocity constitute the central tenets of this interaction.

Within the extended family a child has many fathers and mothers. The brothers of his natural father are also regarded and respected as his fathers and the sisters of his mother as his mothers (Broodryk, 2002: 78). Thus, there were no orphans in pre-colonial South Africa. If the natural parents of a child died, the other fathers and mothers in the extended family automatically took over custody of the child. The majority of children who had lost their biological parents found themselves in changed but not isolated circumstances. There was continuity in their lives through the presence of close relatives. Therefore, as Bray (2003) and Meintjies & Giese (2006) have observed, the interpretation of the repercussions of children's loss of their biological parents in a way that does not recognise the critical role of the extended family risks propagating stereotypes of orphans as being susceptible to antisocial behaviour and criminality.

It is within this context that this study, among other issues, sought to investigate whether there is a *crisis of care* for orphans in South Africa. The literature defines the crisis of care for orphans as two-fold. Firstly, because of the assaults it has suffered, from poverty and apartheid, the extended family is no longer able to provide care for orphans. Secondly, the quality of care which orphans receive from their carers, the majority of whom are grandmothers, will not be adequate. Grandmothers are often assumed to be in need of care themselves. This chapter addresses the first dimension of care for orphans; that is, the lack of carers, and asks whether extended families are failing to care for orphans, as suggested by the literature. It also looks at the role of non-relatives in providing care for orphans.

Orphan prevalence in Kopanong

According to the Human Science Research Council's (HSRC) Census of orphans and vulnerable children in Kopanong, (*OVC Census)* which had a response rate of more than 90 per cent, nearly a third (34 per cent) of children in Kopanong were orphans[58]. As Table 5.1, illustrates, of the 8163 children under the age of 18-years who were reached by the *OVC Census*, 19 per cent had lost a father while seven per cent had lost a mother. Double orphans, that is, children who had lost both parents, accounted for eight per cent.

Table 5.1 Number of children <18 years and their status in Kopanong (2003)

Child status	Frequency	Valid Percent
Non-orphans	5440	66.6
Lost mother only	528	6.5
Lost father only	1546	18.9
Lost both parents	649	8.0
Total	8163	100.0

Source: OVC Census (HSRC 2003)

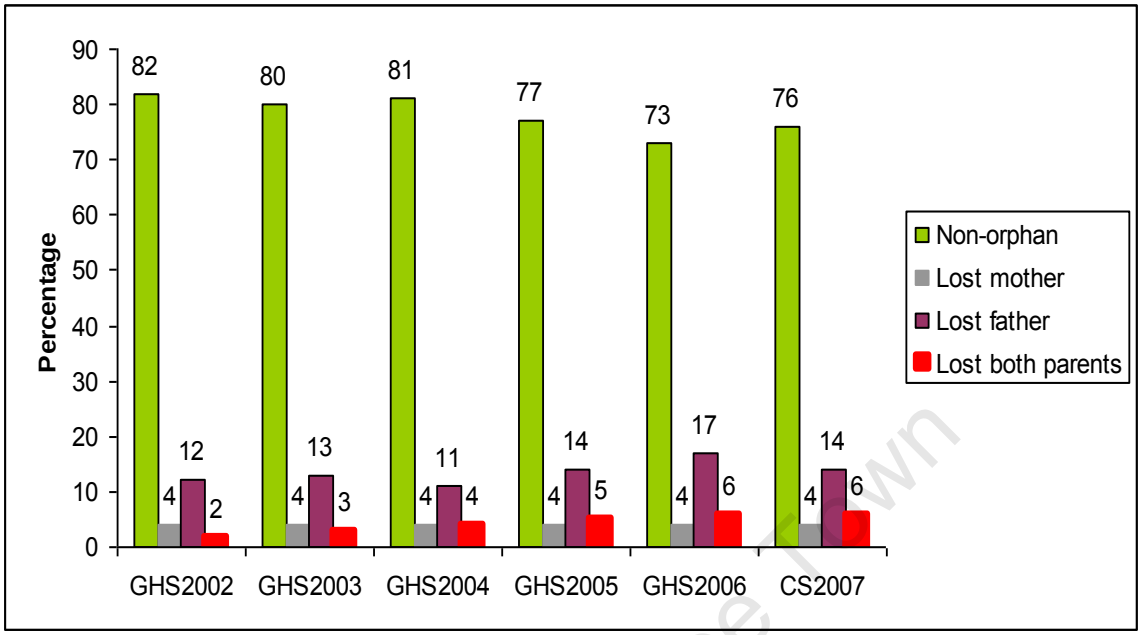
The Kopanong situation was slightly different from the provincial situation. Using the General Household Surveys (GSH) of 2002 to 2006 (Stats SA 2002, 2003, 2004, 2005, 2006), and the Community Survey of 2007 (Stats SA 2008), the analysis found a lower rate of orphan prevalence in the Free State as a whole than in Kopanong.

According to Figure 5.1, the increase in orphanhood rose from two percent of all children in 2002 to six per cent in 2006 in Free State[59]. Crucially, the findings from the GHS corroborate findings from the study carried out in Kopanong, which found eight per cent of children under 18 years old to have lost both parents – that is, double orphans.

[58] According to South African government definition of children under the age of 18-years who have lost one or both parents due to death or permanent desertion.

[59] In terms of numbers this represented an increase from 19020 double orphans in 2002 to 55479 double orphans in 2006. This finding represents an increase of almost 300 per cent, which may have serious implications for the physical care of orphans and the related costs.

Figure 5.1. Prevalence of orphanhood in Free State using the GHS 2002-2003 and the (Stats SA) Community Survey of 2007.



Source: Stats SA (2002, 2003, 2004, 2005, 2006, 2007)

Both the *OVC Census* and the GHS datasets confirm one critical issue, that is, that there is generally a high level of absent fathers in Free State, and Kopanong, due to death or permanent desertion. This observation has led some researchers to question the exclusion of children who have lost a father from the definitions of orphanhood (Skinner et al. 2005). These authors point out that due to the nature of skewed economic development, and the nature of the labour market (and accompanying industrial policies) in South Africa, most fathers migrate to developed areas of the country where employment prospects are considered better (see Chapters 2, 3 and 4).

The high rates of absent fathers has led UNAIDS/UNICEF (1999) to leave out fathers in its definition of an orphan; a child under the age of 15-years who has lost a mother or both parents. But, as argued above, since family is more than biological kinship, orphanhood is also more than just the loss of biological parents, especially in the African context. The living conditions of a child are crucially important in its welfare. The absence of fathers in particular, could expose children to vulnerability as fathers are often the main breadwinners. In the current era of high HIV/AIDS prevalence juxtaposed on

poverty, we cannot afford to exclude paternal orphans, particularly if they live in conditions of severe poverty. Further, some researchers have suggested that mortality rates among fathers in South Africa are disproportionately higher than among mothers (Meintjies, John-Langba & Berry 2008: 66).

For these reasons, this study has sought to disaggregate the total figures for paternal, maternal and double orphans to illustrate the extent of vulnerability among these orphan categories, as well as amongst non-orphans. This has been done for two related reasons. Firstly, the study seeks to address the weakness of excluding paternal orphans in the definitions of orphanhood. Secondly, it compares the three categories of orphanhood against each other, and against non-orphans.

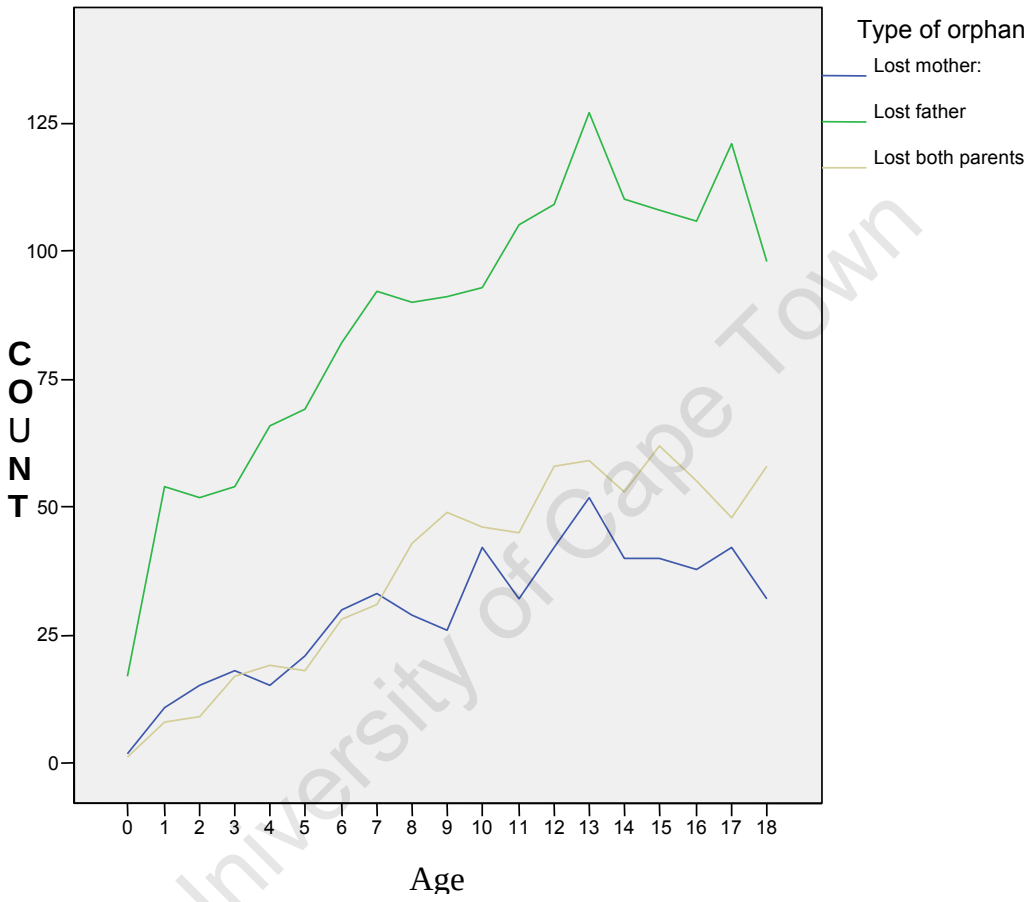
The *OVC Census* (HSRC 2003) study found no significant relationship between sex and orphan status. The gender ratio was 52 per cent for females and 48 per cent for males. The tests for the level of significance reveal that this difference is not statistically significant – Pearson Chi-square=1.015(a) df.2 p>.602. This is generally in line with the population distribution of South Africa which reflects a similar pattern as reported in national censuses of 1996 and 2001 (Stats SA 1999, 2002) as well as in Kopanong where the sex ratio is also forty eight to fifty two.

However, there does seem to be a positive correlation between age and orphan status – the Pearson correlation coefficient is significant at 0.045. This study found that older children are more likely to be orphaned. According to Figure 5.2, the highest number of orphans is found amongst 13-years olds. In this age cohort, the numbers of paternal orphans is higher than that of other orphans, followed by double and maternal orphans. While the number of paternal and maternal orphans drops sharply at the age of 18, the number of double orphans, which peaks at age 15, increases sharply again at age eighteen.

The graph of orphan prevalence shows three clear peaks for maternal orphans at ages 10, 13 and seventeen, while for paternal orphans there are two at 13 and 17. It is tempting to

speculate that the reason for this is related to the spread of the epidemic and the average of ten years between infection and death, but without knowing when parents were infected, and indeed whether they died of AIDS, this remains speculation.

Figure 5.2 Orphan prevalence by age in Kopanong (2003)



Source: OVC Census (HSRC 2003)

To further illustrate the distribution of orphanhood by age, children and orphans have been grouped according to age categories; 0-4, 5-9, 10-14 and 15-18. Table 5.2 indicates that the highest number of orphans is found in the age cohort 15-18 years. Double orphans registered the highest level of prevalence, 40.2 per cent. Maternal orphans, 39.3 per cent, follow them. The next dominant age cohort is 5-9, 27.1 per cent for those who have lost a father and 26 per cent of maternal as well as double orphans. The situation is similar across the country and the Free State province as will be illustrated below.

Table 5.2 Number and percentage of non-orphaned and orphaned children by age categories in Kopanong (2003)

Children's statuses	Age categories of children			
	0-4	**5-9**	**10-14**	**15-18**
Both parents alive and present	1218 (77.3)	1637 (69.1)	1719 (62.9)	866 (58.3)
Lost mother	61 (3.9)	139 (5.9)	208 (7.6)	120 (8.1)
Lost father	243 (15.4)	424 (17.9)	544 (19.9)	335 (22.5)
Lost both parents	54 (3.4)	169 (7.1)	261 (9.6)	165 (11.1)
Total	**1576 (100)**	**2369 (100)**	**2732 (100)**	**1486 (100)**

Source: OVC Census (HSRC 2003)

The findings from qualitative interviews and focus groups discussions confirmed the observed prevalence rate of orphans in Kopanong. The Social workers, nurses, teachers, councillors, and members of non-governmental organisations (NGOs) and community-based organisations (CBOs) who were interviewed corroborated the finding that there are many orphans in Kopanong. These informants were asked whether they thought there was a crisis of orphaned children in Kopanong, and where possible to produce evidence to support their view. The question was phrased as follows: *Do you think there is a problem of orphanhood in this community?*

Overall, respondents felt that there were 'too many' orphans in their respective communities.[60] What has been considered by members of the community as a high prevalence of orphanhood was attributed to the high levels of HIV/AIDS in these

[60] Those with records, such as social workers, members of community-based organisations, nurse and teachers provided figures. The Hospice manager in Bethulie indicated that they had 260 "orphaned" children in their books. This category of orphans is put in inverted commas because respondents were not asked how they defined an orphan. So orphans here could be children who had lost either parent or both. According to social workers' records, there were 164 orphans in Jagersfontein, 183 in Springfontein and 206 in Bethulie, in May 2005. In one of the primary schools in Jagersfontein, 16 children were orphaned (according to the school's Principal – this record is kept to identify children who qualify for food parcels at a particular school). An adjacent combined school (in Jagersfontein) had 70 orphans on its records. At a secondary school in Bethulie, 63 children (up from 52 in 2004) were recorded as either orphans or vulnerable children. A primary school in Springfontein had 11 orphans. These numbers are relatively high considering the fact that the population of towns mentioned are very small. Jagersfontein had a total population size of 6913, Springfontein and Bethulie had a total population size of 5289 and 12 374 respectively.

communities and the widespread migration by young adults to bigger cities in search of employment. A nursing sister in Bethulie clinic pointed out:

> There are many orphans in the community, because of HIV/AIDS-related deaths. Also, many young people leave our small town to big cities in search of work, leaving their children with their parents. Some never come back home, others lose contact with parents and relatives, some sadly die there or just come home to die. There are many children who are without parents as a result of this state of affairs (Interview was conducted on the 05th Apr 2005).

These views were echoed by over 90 per cent of the key informants interviewed. The problem of labour migration was also linked to the high rate of orphaned children by several respondents. A councillor in Springfontein explained;

> Yes, there are many children without parents in this area. Some parents' have died; others have left for a long time without trace. You see; our town is very small and job opportunities are limited. Young people are then forced to go to bigger cities where prospects of finding jobs are greater. Some never come back. Others come back after a very long time and when they are seriously ill. They just come home to die (Interview conducted on the 06th Apr 2005).

Related to the above, is the observation by Simbayi et al.. (2006: 56) that to the majority of residents in Kopanong, poverty was the largest contributor of orphanhood and vulnerability. They note that 65 per cent of the respondents said they have noticed an increase of orphaned children in their respective communities. Nearly half of them (49 per cent) said the rise in the number of orphaned children was due to poverty (parents migrating away from Kopanong) while 40 per cent and 22 per cent of the respondents attributed the increase of orphanhood to HIV/AIDS and accidental deaths, respectively. Similarly, 60 per cent said the main reason why children were vulnerable was due to poverty, compared to 30 per cent and 23 per cent for HIV/AIDS and abuse and violence, respectively. Therefore, poverty is seemingly central to communities' perceptions of the causes and conceptualisation of orphanhood and vulnerability among children.

Care arrangements for orphans in Kopanong

Extended family care for orphans

The interventions of the small number of CBOs and NGOs working in this field in Kopanong is important, however, of far greater importance is the support offered by the wider families of children who have been orphaned. A distinction is often made between a *carer* and the *head of the household*. The latter refers to that usual member of the household who manages the day-to-day running of the household activities and its members and is regarded as such by other usual members. He/she could be a carer at the same time, but is not necessarily always the carer. The *carer* is any person who takes full responsibility for a child. The carer is also referred to as the *guardian*.

In the South African situation, this distinction is important, since in some cases family sizes are large, and therefore, the head of the household may not necessarily be a carer of a specific child who resides in the household he/she is heading. In some cases, the head of the household may even be someone who is cared for by someone else in the household – that is, where an adult child stays with his/her parent who is regarded as the head of the household by virtue of age, yet could be in the care of his/her adult child. In the case of minor children, while the chances are high that the head of the household is the likely carer this assumption was only made in the analysis of the data where the guardianship was positively confirmed as in the case of *OVC PSS* study (HSRC 2004c).

The findings of this research confirm findings of other research studies which show that the majority of orphans are supported by members of their extended families. Table 5.3 shows that 67 per cent of double orphans lived in households that were headed by grandparents. Fourteen per cent lived in households that were headed by other relatives. Six per cent of double orphans lived in households that were headed by a sister or a brother. This implies that 87 per cent of double orphans lived in households that were headed by members of the extended family.

The majority of maternal orphans (57%) also lived in households that were headed by grandparents, while only 21 per cent lived in households that were headed by biological fathers. This contrasts sharply with paternal orphans. Two-thirds of paternal orphans lived in households that were headed by their biological mothers.

Forty nine per cent of non-orphans also lived with members of the extended family. (Only one per cent lived in households that were headed by non-relatives). Almost 40 per cent of non-orphans lived in households that were headed by grandparents. Seven per cent lived in households that were headed by other relatives while about two per cent lived in households that were headed by a brother or sister.

What is clear from the above findings is that the extended family still plays an important role in providing care for children, whether orphaned or not. However, little is understood about the financial implications for carers of orphans who are forced by circumstances to take them into their households. Moreover, the situation of caring for orphans may be different to caring for other children whose parents are still alive as they may continue make to financial contributions towards their upbringing. In addition to the likely financial costs to carers of orphans, there is a question of emotional support for orphans. Unlike other children cared for by other relatives, and can still draw emotional support from their parents, orphans may lack such support. This is an area that needs much more detailed research.

Table 5.3 Relationship between children <18 years and the head of the households in Kopanong (2003)

Relationship with the head of household	Type of orphan			
	Non-orphan N (%)	Lost mother only N (%)	Lost father only N (%)	Lost both parents N (%)
Biological Child	2632 (49.7)	108 (20.8)	534 (35.3)	0 (0.0)
Sister/brother	79 (1.5)	14 (2.7)	29 (1.9)	34 (5.6)
Grandchild	2069 (39.1)	296 (57.0)	760 (50.3)	404 (66.7)
Other relative	448 (8.5)	77 (14.8)	170 (11.2)	87 (14.4)
Not Related	49 (0.9)	22 (4.2)	15 (1.0)	79 (13.0)
Head	20 (0.4)	2 (0.4)	4 (0.3)	2 (0.3)
Total	5297 (100)	519 (100)	1512 (100)	606 (100)

Source: OVC Census (HSRC 2003)

What is very clear is that households are multi-generational and grandparents in particular are heads of households in which their grandchildren live. When a child is orphaned it is grandparents who bear the major burden of care followed by other relatives. Similar trends could be observed with a smaller survey, *OVC PSS*, which specifically asked whether the respondent was a guardian of a particular orphan. As Table 5.4 illustrates, 45 per cent of orphans lived with their grandparents and 19 per cent with other relatives. Altogether 65 per cent lived with relatives other than their remaining biological parent.

Table 5.4 Relationship between orphaned and non-orphaned children and their carers (2004)*.

Relationship to the child	Type of orphan			
	Non-orphan N (%)	Lost mother only N (%)	Lost father only N (%)	Double orphan N (%)
Biological parent	162 (63.5)	9 (11.8)	55 (60.4)	0 (0.0)
Grandparent	63 (24.7)	44 (57.9)	27 (29.7)	19 (61.3)
Other relative	28 (11.0)	18 (23.7)	8 (8.8)	12 (38.7)
Non-relative	2 (0.8)	5 (6.6)	1 (1.1)	0 (0.0)
Total	255 (100)	76 (100)	91 (100)	31 (100)

Source: OVC PSS (HSRC 2004c)

* Of the 791 guardians who were sampled for the HSRC OVC Psychosocial Issues, 567 were Africans. Of this 567, 502 could confirm whether children they were providing care for were orphaned or not, and whether they had lost a father or mother or both parents. Of the 502, 453 confirmed their relationship with the children who were in their care.

The role of extended family in providing care or support for orphans and vulnerable children is further illustrated by the analysis of GHS, 2002 to 2006 and the Census 2001. The former analysis looks at care arrangements for orphans and other children over time while the latter compares care arrangements in semi-rural (Kopanong) and urban areas (Johannesburg).

The analysis of GHS data reveals that orphans are more likely to be accommodated in relatives' households. Between 2002 and 2006, nearly all orphans were accommodated in extended families' households. Non-relatives supported less than two per cent of children who had lost both parents – that is, double orphans. This analysis corroborates the Kopanong findings which indicate that a large proportion of non-orphaned children also live in extended families. On average, a third of children whose biological parents (both parents) were alive, lived in households that were headed by either grandparents or other relatives. Lastly, the analysis confirms the observation above that grandparents bear the greatest responsibility of providing care for children, orphans included. Nearly, two-thirds of double orphans, on average, were supported by families that were headed by grandparents.

Overall, the findings highlight the strength of extended family ties that facilitate care for orphans in the face of ubiquitous poverty. Poverty notwithstanding, orphans are likely to be accommodated in relative's households. As will be illustrated this is facilitated by normative feelings of trust, obligation and reciprocity which constitute social capital.

This observation is further reinforced by the analysis of the Census 2001. This analysis reveals similar trends in care arrangements at the district (Xhariep) and metro (Johannesburg) levels in South Africa. As Table 5.5 illustrates, nearly all orphaned children, 98 per cent, lived in households that were headed by relatives in Xhariep District. Sixty-two per cent of these orphans lived in households that were headed by grandparents. Similar observations were made in an urban area of South Africa, Johannesburg Metropolitan Municipality. According to Census 2001, 96 per cent of orphaned children were cared for by relatives in Johannesburg. However, the proportion of orphans who lived in households that were headed by grandparents was less in Johannesburg compared to Xhariep, 46 per cent. The role of members of extended families is not confined to semi-rural areas such as Kopanong. But, clearly there is less reliance on grandparents in the urban areas if the Johannesburg case is representative of the country as a whole.

Table 5.5 Relationship between orphaned children and head of households in Xhariep District and Johannesburg Metro in 2001*

Relationship to head of household	Xhariep District (%)	Johannesburg Metro (%)
Head/acting head	-	1
Husband/wife/partner	1	0
Son/daughter	-	-
Adopted child	9	13
Stepchild	3	1
Brother/sister	8	13
Parent	-	-
Parent-in-law	-	-
Grand/greatgrand child	*62*	*46*
Son/daughter-in-law	1	0
Brother/sister-in-law	2	2
Other relative	*14*	*20*
Non-related person	1	2
Not applicable (collective living quarters)	1	2
Total	100	100

Source: Census 2001 (Stats SA 2002).
*This figures include a weighted percentage of African orphaned children in Xhariep District and Johannesburg Metro.

During the qualitative inquiry key informants confirmed what the surveys reveal, namely that orphans are often accommodated in the relative's households even before the death of a parent. A 74-years old grandmother in Jagersfontein illustrated:

> I live with a 15 year old child who is my granddaughter. I have been living with her since her birth. Her mother left her with me when she was very young. I also live with an 18 year old grandson…. (Interview was conducted on the 07th Apr 2005).

These explanations were very common amongst all related-carers who were interviewed. Nurses, teachers, social workers and community workers all mentioned that there is a huge exodus by young adults to big cities with better employment prospects, who often

leave their dependant children with their mothers or other relatives. In Chapter 4 we saw that Kopanong's population consists of a disproportionately high number of very young and old inhabitants. It is therefore, not surprising that many children in Kopanong were cared for by someone other than their biological parents, the majority of whom were other relatives, especially grandparents.

While these findings refute claims of a crisis of the lack of adequate numbers of carers, they confirm other findings which attest to the central role of extended families, and especially grandparents in providing care for orphans.

However, as pointed out above, some researchers question the quality of care provided by grandparents. Others suggest that grandparents are more likely to care for older orphans, who in turn become a source of support for their carers. This study found a relationship between the head of the household and the age of an orphan. Even though it is difficult to run statistical tests due to the fact that too many cells have 0 values, a comparison of the distribution of proportions of orphans' ages and the type of the carer points to this fact. The remaining biological parent, where one parent had died/was permanently absent, and grandparents were more likely to care for older orphans; 39 per cent and 28 per cent were caring for children aged 15-18 years respectively (see Table 5.6). Non-relatives were more likely to live with orphans aged 5-9 years old.

Table 5.6 Relationship between orphans and theirs carer according to age in Kopanong (2003)*

Age categories of children	Relationship of the carer to the orphan			
	Biological parent N (%)	Grandparent N (%)	Other relative N (%)	Non-relative N (%)
0-4 yrs	2 (3.0)	2 (2.2)	0 (0.0)	0 (0.0)
5-9 yrs	13 (19.7)	20 (22.2)	10 (25.6)	2 (33.3)
10-14 yrs	25 (37.9)	43 (47.8)	20 (51.3)	3 (50.0)
15-18 yrs	26 (39.4)	25 (27.8)	9 (23.1)	1 (16.7)
Total	66 (100)	90 (100)	39 (100)	6 (100)

Source: OVC PSS (HSRC 2004c)
*Figures in this table consist of maternal, paternal and double orphans who were sampled for the OVC Psychosocial Issues survey.

Moser (1999) has suggested that orphaned girls are more likely to live in households that are headed by grandparents since they provide a labour resource. However, in the *OVC Census* (HSRC 2003) the relationship between the head of the household and the sex of an orphan was not statistically significant. As Table 5.7 illustrates, only 44 per cent of orphans who were cared for by grandparents were females, compared to 56 per cent of boys. This may suggest that carers do not consider the sex of an orphan when making decisions regarding care provision. This study suggests that, at least in Kopanong, there is no evidence to suggest that grandparents are keen to adopt girls who will be able to assist them more than boys.

Table 5.7 Relationship between orphaned and non-orphaned and their carers according to their sex in Kopanong (2003)*

Sex of an orphan	Relationship of the carer to the child			
	Biological parent N (%)	Grandparent N (%)	Other relative N (%)	Non-relative N (%)
Male	30 (45.5)	40 (44.4)	16 (41.0)	4 (66.7)
Female	36 (54.5)	50 (55.6)	23 (59.0)	2 (33.3)
Total	66 (100)	90 (100)	39 (100)	6 (100)

Source: OVC PSS (HSRC 2004c)
*Figures in this table consist of maternal, paternal and double orphans.
Pearson Chi-square=1.401(a) df.3 p>.705 (This test should be treated with caution since two cells have figures less than 5 which may affect the validity of the test.

The centrality of extended family care for orphans is further demonstrated by the low rate of what has been termed 'orphan-headed households'[61]. Barnett & Whiteside (2002) and Whiteside (2000, 2007) suggest that as a result of the high prevalence rate of orphans and the weakened role of extended families, orphans are likely to exacerbate the phenomenon of 'child-headed households'. They suggest that this phenomenon will become common as a result of the dramatic increase in adult deaths due to AIDS, especially if members of extended families failed to intervene as was predicted. However, this study found little evidence to support this claim.

As Table 5.3 above illustrates, less than one per cent of children, irrespective of their status (orphan or non-orphan), lived in households that were headed by other children under the age of 18-years in Kopanong. Even where this did occur the children had not been abandoned. Jooste, Managa & Simbayi (2006: 14) note that 60 per cent of the children-headed households in Kopanong said they had a caretaker and a similar proportion said they had someone with whom to discuss their problems. Key informants argued that there were in fact no orphan-headed households, except for households that

[61] Child-headed households have been defined as children, aged 15-18 years old, whose parents have died or abandoned them and who are living alone, and children whose parents are present but are too ill to look after them.

are headed by children of farm workers who live in these towns in term-time so they can be closer to schools. As a school Principal in Jagersfontein explained:

> The majority of [orphans] are looked after by relatives especially grandparents…. In my knowledge there are no orphan-headed households. Perhaps the community is quite vigilant and caring (Interview conducted on the 31st Mar 2005).

Another school Principal, from Bethulie, added:

> There are very few cases of child-headed households. These are mostly children of nearby farm workers who go to their respective homes every weekend. Orphans are usually accommodated within communities, especially extended families (Interview conducted on the 29th Mar 2005).

This point was further emphasised by a senior manager in the in the Free State. He explained:

> Reports indicate that there is an increase of orphans in the area. You see I read in a report … saying that people do not care. It is not true to say that people do not care. Most orphans are accommodated elsewhere, either with relatives or non-relatives, even neighbours. There has never been a single case where orphans are left alone to suffer (Interview was conducted on the 30th Mar 2005).

This finding has also been confirmed by the recent GHS of 2006 (Stats SA 2006). The Survey indicates that less than one per cent of children under the age of 18-years were heads of households. Meintjies, John-Langba & Berry's (2008: 68) study further indicates that there has not been an increase in the number of child-headed households in the period between 2002 and 2006. This study confirmed the remarks of the key informants. Either extended family members or community volunteers, who work for community-based organisations, provided supervision and support on a regular basis for older teenage children living alone.

These findings, then, contradict the belief that orphans face the damaging prospects of separation from families, separation and/or isolation from a home environment, and the

absence of adults in their socialisation. Moreover, this study, and the others cited, do not support the suggestion that there is a crisis of child-headed households in South Africa due to HIV/AIDS. Significantly, these findings do not support the belief that orphans are likely to end up on the streets, in orphanages or with non-relatives because of the weakened role of extended families.

The significance of kinship ties – implications for theory

As discussed in Chapter 3, critical to the concept of social capital, as espoused by James Coleman, are the notions of trust, obligations and reciprocity. These notions are embedded in extended family ties or more appropriately, kinship ties. Kinship, was defined as social relationships between those related by blood, marriage, or self-ascribed association that extends beyond the marital dyad, the nuclear family of parents and dependant children, or one parent. In Sesotho kinship means *leloko*, whereas family means *lelapa*. The same term, *lelapa*, is also used to refer to extended family. *Leloko* encompasses people to whom one is even remotely connected to through shared lineage. Members of *leloko* (as well as their children) are treated as any other member of the closer family/household. As such kinship ties play a crucial role in African customs; most importantly, they facilitate care and support for one another. In particular, norms of trust, obligations and reciprocity facilitate care by other members of the collective (family), and therefore could be a motivating factor for relatives to take in orphaned relatives' children.

Kinship or extended family ties were found to be critical in facilitating care for orphans in Kopanong. During interviews with key informants, there was a general agreement, and in fact endorsement of the view, that orphans were more likely to, or should, be cared for by relatives. Interviewees were asked who they thought should care for orphans and are more likely to care for orphans. All the respondents, but one (a nurse at Bethulie clinic), said orphans are more likely to be cared for by relatives, while noting that there were instances where orphans were cared for by non-relatives.

A primary school principal in Bethulie argued that "Most of these children [orphans] live with extended families; grandparents, relatives and/or guardians" (Interview conducted

on the 5th Apr 2005), when asked what form of social support exists for orphans in Bethulie. The magistrate for Bethulie, Springfontein and Gariep Dam further explained that:

> Children adapt better if they are placed with their extended families. We try hard to first find a placement with the extended family and if all fails, we consider non-related guardians (Interview was conducted on the 5th Apr 2005).

In order to ascertain the centrality of relatedness, especially the feeling of obligation, in making decisions regarding care for related orphans, key informants were asked whether they thought the notion of kinship ties plays any major role in determining care arrangements for orphans. The question was framed as follows; *what do you think motivates relatives to look after orphaned children?* This question was asked after establishing whether respondents felt that there was an unusual increase of orphaned children in their respective communities.

The majority of carers, especially carers who were relatives, felt a sense of *obligation* towards orphaned children. For example, a nurse in Jagersfontein explained that:

> Extended families still play an important role in our communities. *Relatives are expected to take in orphaned relatives*. I am one of such people. I am looking after my late sister's children (Interview was conducted on the 31st Mar 2005) (author's emphasis).

She further explained that she knew before that it was her *responsibility* to do so;

> …after my sister's funeral *I knew that it was my responsibility to look after her children* as I am the only member of the family who works. I have in fact been looking after them as soon as she became incapacitated by her illness[62] (Interview was conducted on the 31st Mar 2005) (author's emphasis).

A senior manager in the DoSD stated that kinship ties are very central in influencing the decisions that go with the care arrangements for orphans.

[62] The nursing sister revealed that her sister died due to HIV/AIDS-related illness.

> Yes. Kinship ties do play a crucial role in motivating relative carers to take in orphans that belong to their children or relatives. Kinship issues still play an important role in many African communities. There is also a question of pride. *People do not want to see their next of kin suffer while they are still alive*. In the majority of adoption and foster care cases, children have been placed with relatives. The only problem is when children are separated in order to share the burden of their care and support among relatives (Interview was conducted on the 30th Mar 2005) (author's emphasis).

In highlighting the significance of kinship ties, this manager went further to give a personal account of how he and other male members of his family decided to support a younger male relative (brother) who could not financially support a child he had fathered. He explained that this was done to ensure that their brother's child did not suffer while they were still alive.

The embedded nature of obligatory feelings to look after one's relatives was further highlighted by a primary school principal in Springfontein when she explained:

> It is mostly only relatives that take in orphans. Some of them do not even get welfare grants for their grandchildren…. As Black people, *our customs have always taught us to look after our own, our extended family members*. Nearly all Blacks still practice this custom (Interview was conducted on the 06th Apr 2005) (author's emphasis).

A high school teacher in Bethulie echoed similar views. A community councillor in Jagersfontein) added that care for relatives' orphans is also motivated by the desire to keep the family name. She explained:

> Both related and not-related members of the community have the interest of orphans (and vulnerable children) at heart. Of course *relatives are driven by the desire to keep the family name and to look after their own blood*. Members of the community act out of a concern that their children or relatives' children would one day be in the same predicament (Interview was conducted on the 31st Mar 2005) (author's emphasis).

However, most of the social workers interviewed said they do not take blood relationship as a priority when they decide on the care arrangements of orphans, and other vulnerable

children. Their main concern was the welfare of the child. When asked whether kinship connections are taken into account when applications for foster parents are considered, a social worker in Jagersfontein argued:

> Not really. Kinship ties are never a priority. Our main concern is the wellbeing of the child. We want to place the child where we think he/she will receive the best care. However, in the majority of cases, relatives are the guardians/carers…. I think generally people prefer it when children are cared for by relatives, because it is people they know, anyway (Interview was conducted on the 31st Mar 2005).

The 'welfare of the child' is often measured in material terms, that is, whether a particular carer has additional source of income other than the children's grants. The screening process – to establish the suitability of the carer – involves looking at life style, size of the family, stability within the family, income, and whether the children of a particular family are willing to accept other children into their family. A social worker in Jagersfontein explained:

> …. We screen them. We look at their lifestyle, size of the family, stability within the family, income, and whether children of that family are willing to accept other children in their homes. We then prepare them. We also find out from orphans themselves who they would prefer to stay with. That is also what guides us. If the child is too young to make such a decision, we make the decision as social workers, taking the child's best interest into account. We investigate the applicant thoroughly, checking on the background, his/her children, interviewing neighbours and friends (Interview was conducted on the 7th Apr 2005).

All the same, social workers, nevertheless, conceded that the majority of carers are relatives, mostly grandmothers.

However, while the role of extended families in providing care for orphans has been confirmed, the quality of the care offered by relatives was another matter. Relatives are accused of disregarding the well-being of orphans while using the state cash grants, meant for their welfare, for personal gain. A community leader (a municipal councillor) in Jagersfontein explained:

> Some of them [orphans] have been taken in by foster parents, relatives and grandparents. But as I said earlier their living conditions are worrying, they have little to eat. Some of them get their meals at schools only. When they get home they have nothing to eat. Many orphans prefer to live on their own as they feel they do not get good treatment from relatives. The problem is the lack of food since they do not have any means of income. Many cannot access welfare services directly as they are under-age [less than 18 years] and have no one to receive foster care grants on their behalf (Interview was conducted on the 31st Mar 2005).

She felt orphanages were better suited to care for the needs of orphans. She explained further as follows:

> Although members of the community are helpful in this fashion, I still maintain that orphan centres are the way to go [viable alternative]. Such centres should accommodate both orphans and vulnerable children, to avoid discrimination against orphans, but to also assist children who come from poor backgrounds (Interview was conducted on the 31st Mar 2005).

Her feelings were shared by two other councillors interviewed, both women. However, only a minority of those interviewed, (four out of 37) expressed these views. The fourth respondent was a member of a local community-based organisation. The survey material confirmed that these views were very much minority views and did not describe the dominant reality. That is, as pointed out above, the overwhelming majority of orphans are cared for in a family context. Only 23 out of 7934 children under the age of 18-years were themselves the head of the household. Of these, 20 were not orphans at all, but were school-going children from nearby farms.

Care by non-family carers

While extended family and kinship ties play a central role in the life of African communities, care by non-relatives has been practiced, on a very small scale, as well (see chapter 2). According to the *OVC PSS* study (HSRC 2004c), about one per cent of orphans were cared for by non-relatives (see Table 5.6), while according to the *OVC Census* (HSRC 2003)*;* two per cent of orphans lived in a household that was headed by a

non-relative (see Table 5.3). Other studies, too, attest to the role of non-relatives in providing care for orphans (Kuo & Operario 2007).

Kuo & Operario's 2007 study called into question the assumption that non-kin carers are inferior care providers due to their lack of family connection with the child. The study suggested that what matters for child development is not whether kin or non-kin cared for children, but that the children remain in their community. Interviews with key informants and carers confirmed Kuo and Operario's (2007) views. They revealed that non-relatives are playing an active role in providing care and support for orphans in Kopanong, a role that they take very seriously. In Jagersfontein, a non-relative carer explained in detail how she has been looking after children with whom she had no kinship ties over many years, although they were not necessarily orphans. Some of the children she brought up are now adults. She explained: "I have in total permanently raised up three boys. They now have their own families. They still visit us regularly." (Interview was conducted on the 07th Apr 2005). She has been performing these tasks despite not receiving any financial support from the state. For example, at the time of research she was looking after three orphans. She was not receiving a grant for any of them.

In another case, in Springfontein, a non-relative carer was looking after four orphans. She explained that, in addition to caring for her own children - who are now independent adults - she has been looking after two other children who were not hers. They are now both independent parents. Given this history, she was approached by a local social worker to provide care for the four orphans. She explained her reaction in the following terms; "I just took them in, because they had nobody to turn to. I just took it upon myself to do so." (Interview was conducted on the 07th Apr 2005)

By the time of the research, she had been staying with these children for over a year. All this time, she was not receiving any financial assistance from the state. She claimed that the social worker responsible was still working on her case. When asked how she is coping, since she is unemployed, she said she survives on remittances from her working children, who are now adults.

Cases of a child's vulnerability are usually reported by community-based organisations, government officials from other departments or the broader community to social workers. Social workers then place these children with foster parents. During the qualitative data collection process, the majority (10 out of 12 cases) of orphans (or vulnerable children) who lived with non-relative carers had been placed with these guardians by social workers. It was observed during this study that these children are often taken to far-away towns, as taking them to neighbours within the same town has proved to be a cause of friction between foster parents and biological parents (in the case of vulnerable children) or blood-relatives (in the case of orphans) of such children.

Services provided by Government departments

Besides the care provided by their families, the government and the NGO sector also provide support for orphans. These will be considered in turn.

Department of Social Development

As discussed in Chapter 3, the Department of Social Development (DoSD) is responsible for welfare and poverty alleviation services in South Africa. Orphan-related services provided by DoSD are child grants (Child Support Grant and Foster Child Grant – Table 3.4 lists types of grants offered by DoSD), food parcels and allocation of children to foster homes. In principle, families who have legally adopted/fostered a child receive a Foster Child Grant (FCG) of R650 a month (as of April 2008) that is meant to meet the requirements of a child, such as school uniform, clothes, and food.

In addition to these various social assistance transfers, the DoSD runs a Poverty Relief Programme, which adopts a community-based approach to poverty alleviation. These include income-generating projects for unemployed women. The DoSD also provides funding to youth organisations in the district. However, as the HSRC OVC study (*Situational Analysis*) notes this service was not well used among the community (see Mfecane & Skinner 2005; Skinner & Davids 2006). Currently the DoSD also funds two

organisations that co-ordinate services of NGOs in Kopanong that deal with Orphans and Vulnerable Children (OVC). The consortiums also distribute food parcels. Their role is discussed in detail in the next section.

Department of Health

Access to health services is relatively easy for the majority of residents of Kopanong since there is a clinic in every town and virtually all residents of the towns are within 5 km of a facility. All the clinics offer a 24-hour call service, meaning that although they close at 16h00, if someone needs a nurse after working hours, assistance will be available.

Out of 17 clinics, nine have established voluntary counselling and testing for HIV volunteer groups (VCT). Nevirapine for prevention of mother to child transmission (PMTCT) of the HI-virus at the time of the study was available in the district hospital at Jagersfontein, but not elsewhere.

The home-based care service is a key intervention of the DoH aimed at increasing access to health services. DoH contracts several volunteers from local NGOs and CBOs to deliver services to people including the provision of medicine, assisting with domestic chores, washing and dressing patients and health education. In return for their services they receive stipends of R500 per month as of May 2005.

Through the home-based care programme, the DoH also identifies orphans (and vulnerable children) in the community. Once they have been identified their files are handed over to the DoSD to provide the necessary assistance for them.

Department of Education

A key intervention of the Department of Education (DoE) in relation to material support for orphans and other vulnerable children is the school feeding programme. Primary schools provide lunch to all children three or five times a week, consisting of four slices of bread and peanut butter, and some times bread and milk. High schools distribute food parcels bi-monthly. This is done with the support of the teachers. Moreover, the DoE (through the teachers) is involved in the identification of OVC at schools in an attempt to assist them with various needs. The DoE also contributes towards the education of learners who come from impoverished families by exempting them from paying school fees.

Department of Agriculture

The *HSRC Situational Analysis* of Kopanong (Mfecane and Skinner 2006) indicates that a key intervention by the Department of Agriculture (DoA) aimed at children is a Youth Programme for Grade 3 to Grade 10 children. The main aim of this programme is to encourage children to develop an interest in agriculture through the formation of youth clubs. Reportedly there were two clubs in Petrusburg, two in Koffiefontein, and one in Springfontein at the time of the research, in 2004. Due to financial constraints this programme cannot be extended to all towns; in addition, there is no budget for the programme so it is difficult to maintain it.

Another intervention of DoA is through a food security programme. Conducted in collaboration with DoSD, the aim of this programme is to assist poor people to develop vegetable gardens in their own backyards. The DoA provides seeds to people to facilitate this programme.

Local municipalities

Interviews with local government officials and councillors revealed that Kopanong local municipality has no services targeting the orphans in particular. This is attributed to the lack of funding. A councillor in Jagersfontein explained:

> The Council and the Municipality do not have a specific programme for orphans and vulnerable children. You see our Municipality is very small with limited funds. So we are unable to initiate a specific programme. But we deal with social workers and the Department of Social Development. We normally refer cases of vulnerable children to the Department of Social Development through social workers. We help the community and social workers in that regard. We also facilitate the distribution of food parcels that are sent by the Department of Social Development. We are currently running workshops for local women whereby we are training them in home-based care. We are also planning to establish a committee that deals with cases of orphans and vulnerable children (Interview was conducted on 29th May 2007).

All senior managers representing the local and district municipalities confirmed that there were no specific orphan programmes that are run or funded by their respective municipalities. They cited the lack of funding as the main problem.

Services of Non-Governmental Organisations

There are a few Non-governmental organisations (NGOs) that exist in Kopanong. Only two could be identified during the research exercise. Even where there are some, they tend to lack many resources and are often not well supported financially.

A system of social support is often provided or facilitated by Community Based Organisations (CBO) and/or NGOs. According to a senior district manager for the DoSD in the Free State CBOs are a crucial link between the Government and the community. He explained:

> The strength of CBOs is that they are closer to communities, therefore they are easily accessible, and are able to monitor developments continuously. All members of a CBO are not qualified professionals, as is the case with NGOs.

> Therefore, the money is spent directly on people who are doing the actual work. Yet, we continue to deny them training. In this way, we are killing them (Interview was conducted on the 30th Mar 2005).

He added:

> CBOs have information about what all stakeholders (service providers) do, including the government. They accompany the client from the first to the last point. For example, when they assist families to apply for social grants, they accompany them to the Department of Home Affairs offices where they would apply for relevant identity documents, and accompany them to Department of Social Development offices where application for relevant grants are provided (Interview was conducted on the 30th Mar 2005).

However, despite the up-beat mood by DoSD officials, there is very little 'organised' community effort to care for orphans and vulnerable children. In comparison with health care that is provided mostly by women's organisations, there is no organised community drive to directly address the plight of orphans and vulnerable children. Most of interventions are based on individuals' efforts. The main preoccupation of community-based organisations attached to the three towns visited is the provision of care for terminally ill patients and the elderly. The type of training that they have, has concentrated on home-based care. A member of a community-based organisation described their role as follows:

> We identify children who have lost parents. We report them to the social workers to apply for welfare care grants. If they do not have relevant documents we take them to the Department of Home Affairs and apply for birth certificates…. We also assist them to apply for welfare grants. We try to identify relatives, and try to see if they can stay together. If they can't, and children do not want to stay with relatives, we identify closer neighbours among ourselves who would check on them on a regular basis. We also make sure that they access social grants…. These children have many basic needs. We take them to clinics when they are sick (Interview was conducted on the 29th Mar 2005).

The work of the CBOs is constrained by lack of financial resources. Due to limited funds, CBOs are not able to attract the services of professional social workers. They are not able to recruit enough men and women to volunteer their services and are not able to offer

tangible assistance like food or clothes to the needy. These challenges undermine both the efficiency and sustainability of CBOs. A senior manager in the DoSD explained funding challenges in the following terms:

> The type of funding that the government provides [to CBOs] is never adequate, yet they continue to work on their own. Who knows for how long? Because members have families to look after, therefore they cannot afford to volunteer their time indefinitely. This also affects the labour turnover of these organisations. Funding mechanism, too, needs to change. We normally refuse grants without discussing the figures with them. I am sure that if we discussed the figures with them, they may reduce the amounts, and get the much-needed cash. We should also not dictate to them how they should use the allocated money. Yes, we must have auditing and accounting mechanisms, but we should not be too prescriptive when auditing CBOs. We should not control them. I have seen this sort of thing [controlling] happen a lot, especially by our officials. They become unreasonably strict when it comes to auditing CBOs. This attitude affects the morale of CBO members. The Department of Social Development should try it's best to empower CBOs…. CBOs should move to a point where they can employ professional people (such as qualified social workers or nurses). What we give them presently does not allow them to grow (Interview was conducted on the 30th Mar 2005).

It was established that community-based care workers (CBCW) exist in all towns. Their main services are home-based care, HIV/AIDS/Prevention of Mother to Child Transmission/Voluntary Counselling and Testing education, supporting HIV-positive people, identification of OVC through home-based care, directly observed tuberculosis treatment (DOTS) and distribution of food parcels. Most community-based health care workers are contracted by the DoH and are reimbursed a stipend of R500 a month. They tend to be based in clinics in towns. They also work closely with DoSD in delivering services to the people, assisting with the identification of OVC through home-based care and the distribution of food parcels.

Lekomo HIV/AIDS Consortium was the CBO identified during the situational analysis by the HSRC research team (see Mfecane & Skinner 2005). The Lekomo HIV/AIDS Consortium is an umbrella body of clusters of NGOs based in the Xhariep district. As the HSRC OVC study found, initially the Consortium was composed of NGOs in all towns under the Xhariep district, but due to the vastness of the district it was broken down into

two consortiums (Mfecane & Skinner 2005). The new consortium is called Bokomoso. This offers similar services to those of Lekomo Consortium and has the same structure. The formation of the Consortium was facilitated by the DoSD in recognition of a need to (i) co-ordinate the activities of the NGOs in the Xhariep district; (ii) avoid duplication of services; and (iii) ensure quicker delivery of services (Mfecane & Skinner 2005).

According to the Consortium's constitution, it has four focus areas, namely; home-based care, information, education and communication on HIV/AIDS, distribution of food parcels and identification of OVC (see Mfecane & Skinner 2005). The Consortium's activities include support for the terminally ill; support for HIV/AIDS orphans; promotion of VCT in the community; educating the community about HIV/AIDS; education of persons living with AIDS about their constitutional rights; encouraging disclosure; facilitating the identification of orphans and child-headed households; and encouraging those living with HIV to remain within their communities. The Consortium works in partnership with other not-for-profit organisations operating in the area.

Conclusion

This chapter has noted the high increase of orphaned children linked to the HIV/AIDS epidemic in South Africa, especially amongst Africans. This noticeable increase has given rise to concerns about the implication for their care and the impact thereof on the extended family system of care, as pointed out above. However, the research in Kopanong indicates that there is not sufficient evidence to suggest a crisis of care for orphaned children in this community, as measured by the failure of extended families to accommodate them. This research revealed that 96 per cent of orphans were cared for by relatives. This state of affairs indicates that the traditional African extended family may still be strong. The traditional African extended family care system is further demonstrated by the fact that almost half of all children whose biological parents were alive and present also lived with other relatives. The role of non-family carers is very limited in Kopanong. Only 79 out of 527 (15%) orphaned children were placed with

carers other than their family. Less than one per cent of all children, orphans and non-orphans combined, lived in a child-headed household.

Drawing on Coleman's analysis of the concept of social capital this chapter has argued that norms of obligations, expectation and reciprocity that govern behaviour (actions) of family members (actors within in a social structure) facilitate an extended family social safety net. These norms guide members to act in the interests of the collective – extended families – because, firstly, it is expected of them. Members of extended families who were interviewed in Kopanong felt *obliged* to look after their orphaned relatives. When asked in the interviews the majority of carers said that for them providing care for orphaned relatives was an *obligation*. These views were supported by important informants such as community leaders, teachers and senior managers in the relevant government departments. Secondly, helping family members is seen as the right thing to do. Lastly, the actions of those who help their relatives, including orphans, will be rewarded, either directly by providing help in times of need or indirectly by family help for their children.

It could be argued that the crisis of care for orphans, in this context of high HIV/AIDS prevalence and widespread poverty, is lessened by the expressed sense of familial ties which are reinforced by mutual feelings of obligations. However, the financial implications of looking after orphans and the ability of the extended family to cope economically with additional members are less understood and as a result the situation may in fact be dire. The next chapter looks at other factors that are associated with the crisis of care for orphans, namely; the socio-economic conditions of orphans, and other vulnerable children and the quality of care provided by their carers.

Chapter 6 The socio-economic conditions of orphans and vulnerable children, and the quality of care provided by their carers – especially grandparents

Introduction

As discussed in the last chapter, the notion of care for orphans is conceptualised in two ways. The first has to do with the alleged lack of an adequate number of orphan carers due to the perceived declining role of extended families. In the second place, the quality of care which orphans receive is questioned since it is known that the majority of carers are grandmothers. They are perceived to be vulnerable themselves due primarily to old-age. The previous chapter addressed the first level of the conceptualisation of care, namely; the lack of adequate numbers of carers. It documented the continuing central role of extended families in providing support and care for orphans in Kopanong. Foster parents, that is, non-relatives, play a very minor role. This chapter will examine the second question – the quality of care orphans receive within the extended family.

The dominant view is that the quality of care for orphans is not good because of generalised poverty and the fact that many are taken in by grandmothers who are elderly, and very poor. As a result of this view the government's and aid agencies' support is being channelled to 'AIDS orphans' to the neglect of other poor children. Some researchers argue that this is causing rifts in poor communities where most children are desperately poor.

This chapter reviews these debates in the light of the evidence from Kopanong. It first compares income levels of households with and without orphans. It then looks at another indicator of poverty: fuel used for cooking by households with and without orphans. This is followed by a review of state grants and the distribution of grants between households with and without orphans. Finally, the chapter looks at the question of grandmothers as carers. It will suggest, based on the evidence from the Kopanong study, that orphans and

non-orphans are in very similar situations as regards poverty; that the uptake of social grants is very low among both groups and that grandmothers are good carers.

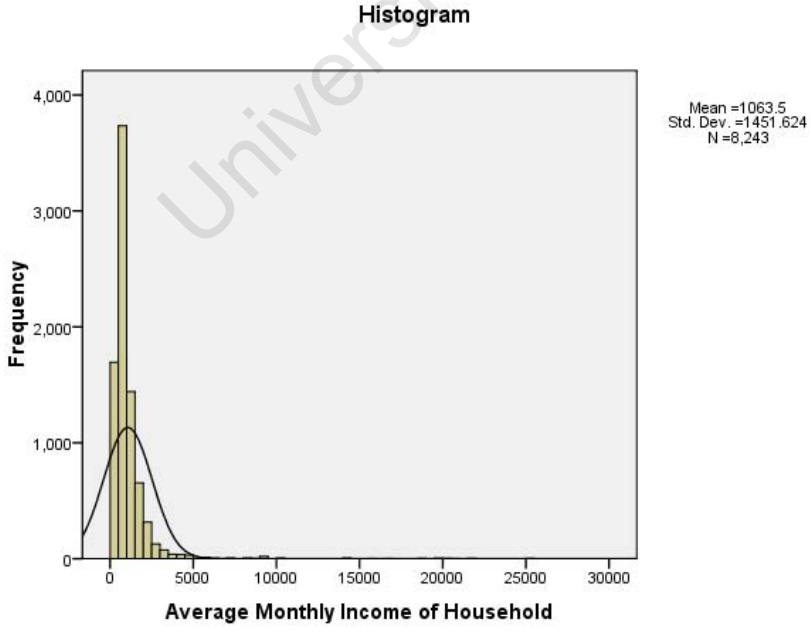
Poverty, orphanhood and child vulnerability in Kopanong

The situation at the household level

In Kopanong, income poverty was the most common form of poverty amongst the majority of households. According to the national census of 2001 (Stats SA 2002), 65 per cent of residents in Kopanong recorded no income while 14 per cent earned between R401-R800 per month. Twelve per cent earned between R801-R1600 (Stats SA 2002).

These findings have been confirmed in this study. The *OVC Census* (HSRC 3004c) data also recorded a high level of income poverty in Kopanong. As Figure 6.1 indicates, the average household monthly income for households with children under the age of 18 years was R1064 in 2003.

Figure 6.1 Income of households with children aged <18 in Kopanong (2003)



Source: OVC Census (HSRC 2003)

Table 6.1 further illustrates that, in 2003, 97 per cent of households in Kopanong had a monthly income of R3000 or less. The majority of these households (68%) had a monthly income of R1000 and less. The situation of non-orphans was no different from that of orphans.

Table 6.1 Monthly household income in Kopanong (2003)*

	Children's orphan status			
Household income category	**Non-orphans N (%)**	**Lost mother N (%)**	**Lost father N (%)**	**Lost both parents N (%)**
R1-R1000	3358 (66.8)	302 (63.4)	971 (68.9)	371 (63.3)
R1001-R3000	1487 (29.6)	160 (33.6)	421 (29.9)	204 (34.8)
R3001-R5000	110 (2.2)	4 (0.8)	12 (0.9)	9 (1.5)
R5001-R10 000	37 (0.7)	8 (1.7)	4 (0.3)	0 (0.0)
R10 001>	33 (0.7)	2 (0.4)	1 (0.1)	2 (0.3)
Total	5025 (100)	476 (100)	1409 (100)	586 (100)

Source: OVC Census (HSRC 2003)
*This figure includes all households in Kopanong that were reached by the study and gave details about their household's average monthly income.

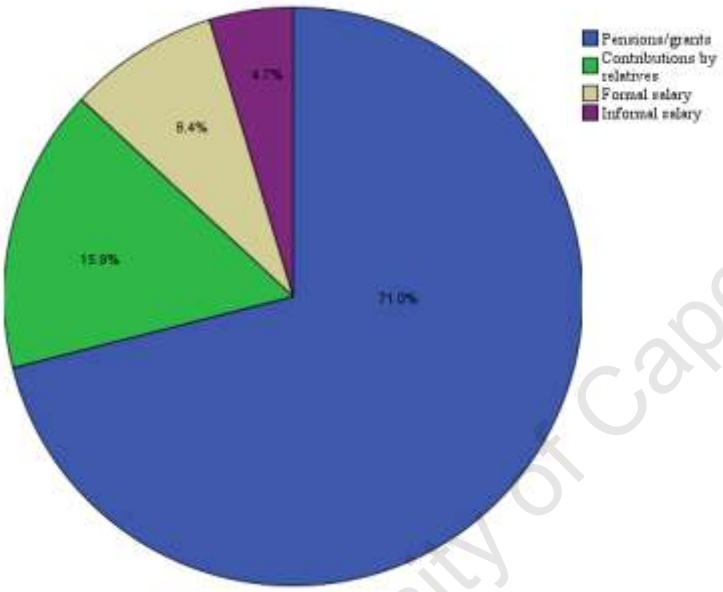
The economic situation of carers is as bleak as that of their households. A great majority of carers are unemployed, and therefore face income-related poverty. Half of them are pensioners while nearly a third has no jobs. Only 19 per cent is employed on either full- or part-time basis. Over half of the carers were pensioners or unable to work due to disabilities.

The gravity of the problem of poverty is illustrated by the way carers described their households' economic situation. The respondents were given three options that could best describe their household situation; 'Not enough money for basic things like food and clothes', 'Have enough money for food and clothes, but short on other things' and 'Have some money for extra things such as going away for holidays'.

Two-thirds of the respondents said they did not have enough money for basic things like food and clothes while just only over a quarter said they had enough money for food and

clothes, but went short on other things. The main sources of income are pensions or grants from the state or private welfare organizations (71 per cent), contributions by relatives (16 per cent), formal (8 per cent) and informal employment (5 per cent), (see Figure 6.2). The majority (70%) of those who were helped by relatives said they receive such support every month.

Figure 6.2 Source of income for orphan carers in Kopanong (2003)



Source: OVC PSS (HSRC 2004c)

The gravity of household poverty is further highlighted by the analysis of the socio-economic situation of carers. In the first, place, the majority (84%) of carers are women and many (more than 60%) are grandmothers. As pointed out above, women are disproportionately affected by poverty relative to men[63].

The lack of cash income is best illustrated by the choices people make about how to spend the little money they had. In semi-rural areas such as Kopanong, households use

[63] Nevertheless, despite the high level of income poverty, the provision of basic services in Xhariep District Municipality (under which Kopanong falls) is relatively high. The same observation was made in Kopanong during this study. Ninety-nine per cent of residents in Kopanong lived in households whose main dwelling type was a brick house. This is because the province undertook a massive re-housing project after 1994, RDP (Reconstruction and Development Programme) Housing Project. But, while residents have houses, they do not have money, as pointed out above.

different sources of energy for cooking and lighting, depending on affordability. Some households use electricity for both, while others use electricity for lighting, and paraffin or wood for cooking. In some instances some households use gas for cooking. Electricity and gas are considered expensive and therefore used sparingly. For these reasons, the use of electricity and/or gas for cooking can be used as a proxy indicator of the household's income situation.

While 90 per cent of households had connection to electricity, few could afford to use it for cooking. As Table 6.2 illustrates, 58 per cent of households used paraffin as the main source of energy for cooking. On average, only a third (34 per cent) of households used electricity for cooking. Gas is the third most popular source of energy for cooking followed by wood. Among households that were housing double orphans and maternal orphans, 61 per cent used paraffin for cooking. This was only slightly different from the percentage of households accommodating non-orphans that were using paraffin.

Table 6.2 Main source of energy for cooking in households with children <18 years in Kopanong, (2003)*

	Type of child			
Main Source of Energy for Cooking	**Non-orphans N (%)**	**Lost mother N (%)**	**Lost father N (%)**	**Lost both parents N (%)**
Wood	144 (2.7)	13 (2.5)	40 (2.6)	27 (4.2)
Paraffin	3027 (56.9)	316 (60.7)	926 (60.4)	391 (60.7)
Electricity	1887 (35.5)	162 (31.1)	511 (33.3)	192 (29.8)
Gas	224 (4.2)	24 (4.6)	46 (3.0)	25 (3.9)
Coal	31 (0.6)	4 (0.8)	6 (0.4)	7 (1.1)
Solar	1 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)
Other	8 (0.2)	2 (0.4)	3 (0.2)	2 (0.3)
Total	5322 (100)	521 (100)	1533 (100)	644 (100)

Source: OVC Census (HSRC 2003)

*This figure includes all households in Kopanong that were reached by the study and gave details about their household's use of different sources of energy.

On the set two measures then, there was very little difference between orphan households and non-orphan households. Were there any differences between them in terms of access to welfare grants?

Access to welfare services

Access to social grants

Estimates of the uptake of social grants vary, but overall, most studies estimate the uptake of social grants by carers of eligible children to be above 80 per cent, in South Africa (Budlunder et al, 2005; Leatt 2006; Noble et al. 2005a, 2005b; Wright 2006). Therefore, given the high numbers of orphans, and high levels of unemployment and poverty, it is expected that social grants constitute the backbone of income for many families in

Kopanong[64]. In particular, it is reasonable to expect the high uptake rate of the Foster Child Grant (FGC) amongst orphans, especially double orphans, and orphans who are cared for by grandparents.

Contrary to the national and provincial estimates of eligibility and uptake rates, Kopanong recorded a low level of uptake. According to Table 6.3 only 20 per cent of double orphan carers received social grants on behalf of orphans for whom they were caring – eight per cent and 12 per cent, received the CSG and the FCG, respectively.

A further surprising finding is that the uptake of child support grants was higher among families with non-orphans (21%) than those with maternal orphans (11%), and double orphans (8%). Only the uptake of those caring for paternal orphans (19%) reached the levels of non-orphan families.

Table 6.3 Uptake of social grants by carers of children <18 years in Kopanong (2003)*

Type of a grant	Child Status			
	Non-orphan N (%)	**Maternal orphan N (%)**	**Paternal orphan N (%)**	**Double orphan N (%)**
Child Support	1112 (20.6)	59 (11.4)	288 (18.7)	54 (8.4)
Foster Child	37 (0.7)	27 (5.2)	22 (1.4)	76 (11.8)
No Grant	4260 (78.8)	432 (83.4)	1229 (79.9)	514 (79.8)
Total	**5409**	**518**	**1539**	**644**

Source: OVC Census (HSRC 2003)
This figure represents all children <18 years in Kopanong who were reached by the census.

The relationship between the sex of children and the receipt of a grant is not statistically significant – the Pearson Chi-Square=.332 df.1 p>.564. Incidentally, the CSG is the most commonly accessed social grant. In the light of the above observation, if the main source of income for a particular household where an orphan or a vulnerable child stays is a state cash grant, it matters a great deal which type of a grant a child gets. According to Table

[64] It should be remembered that Xhariep has one of the highest levels of unemployment in the Free State, with the highest number of people living below the poverty line.

6.4, of the 634 orphans who stayed with a biological parent (that is, either maternal or paternal orphan), 17 per cent were receiving the CSG. However, contrary to many expectations the majority of orphan carers who lived in households that were headed by grandparents or other relatives received the CSG as well.

Sixteen per cent and 14 per cent of orphan carers who lived in households that were headed by grandparents and other relatives, respectively, received the CSG. This contrasts markedly with five per cent and six per cent uptake of FCG by orphan carers who lived in households that were headed by grandparents and other relatives, respectively. The uptake rate of the FCG was modestly higher amongst orphan carers who lived in households that were headed by non-relative carers at 18 per cent.

Table 6.4 Access to social grants by orphans according to the type of household head in Kopanong (2003)*

	Relation to the head of household			
Type of grant received by carers	**Biological Child N (%)**	**Grandchild N (%)**	**Other relative N (%)**	**Not related N (%)**
Child Support	107 (17)	230 (15.8)	47 (13.7)	13 (11.4)
Foster Child	0 (0)	79 (5.4)	21 (6.1)	19 (16.7)
No Grant	524 (83)	1143 (78.7)	276 (80.2)	82 (71.9)
Total	631 (100)	1452 (100)	344 (100)	114 (100)

Source: OVC Census (HSRC 2003)

*This figure represents all orphaned children whose carers provide detail about whether they receive grants on their behalf or not.

Overall, there is a very low uptake of both the FCG and the CSG even though all orphan carers are entitled to one of the other.

Access to birth certificates has a definite bearing on the uptake of social grants. Without valid identity documentations such as a birth certificate of an orphan or vulnerable child, carers are unable to access social grants on their behalf. We looked at whether the lack of documentation can explain the very low levels of grant up-take.

Access to birth certificates

Orphan carers are unable to access any form of welfare grants if the orphan does not have a birth certificate. More than 85 per cent of children under the age of 18-years had birth certificates in Kopanong – non-orphans (87%) and orphans (80%) (see Table 6.5). Access to birth certificates is lowest among older orphans, 15-18 years old. Only 76 per cent of orphans aged 15-18 years have birth certificates, compared to 82 per cent of orphans aged 5-14 and 80 per cent of orphans aged 0-4 years-olds.

Table 6.5 Access to birth certificates by orphans and non-orphans in Kopanong (2003)*

	Orphan or not orphan	
Has birth certificate	**Non-orphan N (%)**	**Orphan N (%)**
Yes	4373 (87.4)	1980 (80.2)
No	633 (12.6)	488 (19.8)
Total	5006 (100)	2468 (100)

Source: OVC Census (HSRC 2003)

*This figure includes all households in Kopanong that were reached by the study and indicated whether they have a birth certificate or not.

The relationship between access to birth certificates and the relationship to the head of the household was not statistically significant. About 83 per cent of orphans cared for by a biological parent had birth certificates, while 80 per cent of orphans who lived in households that were headed by grandparents and 79 per cent of those who lived in households that were headed by non-relatives had birth certificates, respectively.

Despite this finding, key informants maintained that access to birth certificates was the largest impediment to the uptake of social grants. During interviews with key informants, it was constantly pointed out that the low uptake of social grants was related to the lack of access to birth certificates. The social workers, teachers and nurses blamed the lack of access to social grants on the lack of birth certificate. For example, a social worker based in Bethulie and Springfontein explained:

> It will amaze you to find how many children do not have birth certificates. In some cases even their mothers do not have identity documents. This makes it even harder to apply for late birth registration (Interview was conducted on the 29th Mar 2005).

A local clinic sister in Springfontein added:

> Orphans face many challenges when applying for social grants due to the lack of relevant documents. Often grandparents fetch some of the orphans and vulnerable children from other towns, thus making it logistically difficult to trace them while trying to apply for late birth registration. Some are handed over to grandparents by relatives (Interview was conducted on the 29th Mar 2005).

A magistrate serving Bethulie, Springfontein and Xhariep Dam explained the urgency of the situation in the following terms:

> We need birth certificates to process placement for orphans and other vulnerable children. When children do not have birth certificates, it takes a lot longer to process applications for placement. The problem is that; you will find that these children need placement, now! (Interview was conducted on the 29th Mar 2005).

The lack of access to birth certificates was attributed to the poor quality of service by the Department of Home Affairs (DoHA). The DoHA is responsible for the registration of birth details of all citizens of the Republic of South Africa. Access to DoHA is reportedly erratic. One social worker from the Department of Social Development (DoSD) indicated thus: "…officials from the Department Home Affairs visit small towns once a month, further delaying the process. The process of applying for birth certificates is also very complex…." (Interview was conducted on the 29th Mar 2005).

The DoHA was also accused of being inflexible. A frustrated social worker in Bethulie explained:

> There is quite a healthy relationship between the Department of Social Development and the Department of Justice, but the Department of Home Affairs is inflexible. The process of verification is very difficult. You find

> children do not have clinic cards or birth certificates, and you also find that the deceased mother did not have a birth certificate. Where do you start? (Interview was conducted on the 29th Mar 2005).

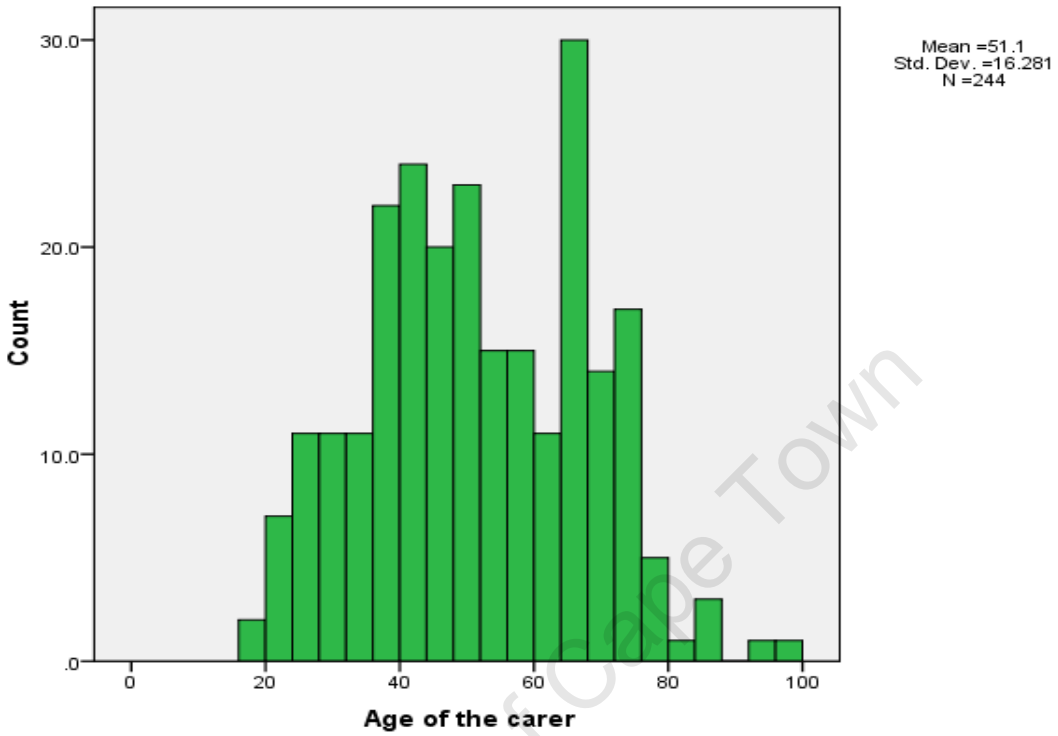
The perceptions of the people interviewed were not confirmed by the findings that the majority of the children, orphans and non-orphans alike, have birth certificates. The reason behind this disjuncture is an important research question and will be revisited in the next chapter.

The quality of care for orphans and vulnerable children

Grandparents as carers

In the literature, there is a concern regarding reliance on grandparents as the main providers of care for orphans. It is usually assumed that grandparents are octogenarians who are incapable of looking after their grandchildren (Booysen & Arntz 2002; Croke 2003; Whiteside 2007). Croke (2003: 95) for example, notes that "AIDS has presented a situation whereby the old are increasingly supporting the very young or are being supported themselves by teenage grandchildren. Grandmothers face greater challenges when orphan children in their care are younger. It is households where grandmothers care for very young children that are most vulnerable". However, this study found that grandparent carers are not as very old as suggested by the literature. While the age of *all* carers (including non-grandparents) ranged from 18-99 years, the mean age is 52 years. According to Figure 6.3, the highest concentration is in the 40-70 years. This suggests that carers are on the whole not as very old as suggested by some.

Figure 6.3 Age profile of orphan carers in Kopanong (2004)



Source: OVC PSS (HSRC 2004c)

Significantly, the survey indicates that carers who identified themselves as grandparents of orphans were much younger than it is usually thought. The minimum age of grandparents was 36 years. The mean age was 62. The majority of grandparent-carers were in the age range 47-74 years. The peak was at age 64. There were very few cases of grandparents older than 75 years old who were looking after orphans. This observation has been confirmed by Jooste, Managa & Simbayi (2006: 13) who found that while more than half of household heads were over 51 years old in Kopanong, only 14 per cent were over 65 years old. Therefore, all-in-all, grandparents are seldom octogenarians as is often claimed. Nevertheless, the threat of income poverty is exacerbated by poor access to welfare grants by all types of orphan carers alike as illustrated above.

School attendance as a dimension of the quality of care for orphans

School attendance has been widely used as the measure of vulnerability among orphans. This study reveals that overall, school attendance by children aged 7-17 years is good, widespread poverty notwithstanding. As Table 6.6 illustrates, about 95 per cent of all children attended school. Significantly, the difference in school attendance between orphans and non-orphans is not statistically significant (Pearson Chi-square=.10-64(a) df.6 p>.122)[65]. Ninety-six per cent of children who had lost both parents were attending school compared to 95 per cent of non-orphans. This finding contradicts commonly-held beliefs that orphans are likely to miss school due to poverty and the other vulnerabilities that are associated with being an orphan.

Table 6.6 School attendance by children aged 7-17 in Kopanong (2003)*

Attend school or ever been to school	**Type of orphan**			
	Non-orphan N (%)	**Lost mother N (%)**	**Lost father N (%)**	**Lost both parents N (%)**
Yes	3287 (95.4)	374 (93.7)	1084 (96.8)	519 (96.1)
Attended but stopped	122 (3.5)	20 (5.0)	32 (2.9)	16 (3.0)
Never been to schools	37 (1.1)	5 (1.3)	4 (0.4)	5 (0.9)
Total	**3446 (100)**	**399 (100)**	**1120 (100)**	**540 (100)**

Source: OVC Census (HSRC 2003)

*The age category 7-17 has been used, because children start school at 7-years and are expected to complete before they turn 18-years-old. Therefore, the figures in this table represent the number of school-going children in Kopanong who were reached by this study.

There appears to be a strong relationship between school attendance and age. According to Table 6.7, there is low rate of school attendance among older orphans, aged 15-17 years compared to other age categories. Only 90 per cent of these children were attending school compared to 99 per cent of those aged 10-14 years. Nearly two-thirds of orphans aged 15-17-years-old were not attending school due to reasons that relate to financial constraints (see Table 6.7). This table shows that most parents and carers sent their children to school. The number of non-attendance after age 15 is nine per cent. This is consistent with the national data.

[65] The Pearson Chi-square value should be treated with caution since some rows had cases that were lower than five, see also Jooste, Managa & Simbayi 2006.

Table 6.7 School attendance by orphans according to age categories in Kopanong (2003)*

Attend school or ever been to school	Age category		
	7-9 N (%)	10-14 N (%)	15-17 N (%)
Yes	455 (97.8)	976 (98.6)	546 (90.4)
Attended before but stopped	5 (1.1)	7 (0.7)	56 (9.3)
Never been to school	5 (1.1)	7 (0.7)	2 (0.3)
Total	465 (100)	990 (100)	604 (100)

Source: OVC Census (HSRC 2003)
Pearson Chi-square=1.150E2 df.4 p>.000
*The figures in this table include orphaned children aged 7-17 years old whose answers were recorded.

This study found no difference in the rate of school attendance between orphaned girls and orphaned boys. About, 96 per cent of both boys and girls were attending school.

Further, there was no clearly visible difference in school attendance by orphans who lived in households that were headed by biological parents, grandparents, other relatives or non-relatives. Approximately, 98 per cent and 95 per cent of orphans who lived in households that were headed by grandparents and those who lived in households that were headed by biological parents, respectively, were attending school. At the same time, 97 per cent of orphans who were cared for by non-relatives were also attending school. This suggests that there is no difference in the quality of care between related and non-related carers or orphans. Neither is there any difference in the quality of care between other relatives and grandparents. This finding therefore, contradicts the belief that the quality of care by grandparents is inferior, and that grandparents are less likely to motivate children to attend school.

There was no difference in school attendance between orphans whose carers were receiving a CSG and those whose carers were receiving FCG. Ninety-nine per cent of orphans whose carers were receiving the latter grant were attending school while 98 of those whose carers were receiving the former grant were attending school. Very few orphans (less than one per cent) aged 7-17 years had never been to school.

Financial constraints were the main reason why 43 per cent of non-orphans were not attending school (see Table 6.8). Numbers of orphans not attending school were too small to make a meaningful analysis. Nevertheless, it is evident from the data that financial constraint was the main reason. The second common reason for children not to attend school was illness. It is not clear if this observation bears any relationship to the spread of HIV/AIDS in the area as the causes of illness were not known.

Table 6.8 The main reason why children were not in school in Kopanong (2003)

Main reason for not attending school	**Type of orphan**			
	Non-orphan N (%)	**Lost mother N (%)**	**Lost father N (%)**	**Lost both parents N (%)**
Financial constraints	53 (43.4)	12 (92.3)	25 (61.0)	12 (57.1)
School too far away	11 (9.0)	1 (7.7)	11 (26.8)	3 (14.3)
Ill/Sick	35 (28.7)	0 (0.0)	0 (0.0)	2 (9.5)
Pregnancy related	12 (9.8)	0 (0.0)	3 (7.3)	2 (9.5)
Completed	6 (4.9)	0 (0.0)	1 (2.4)	1 (4.8)
Other	5 (4.1)	0 (0.0)	1 (2.4)	1 (4.8)
Total	122 (100)	13 (100)	41 (100)	21 (100)

Source: OVC Census (2003)
*The figures in this table include orphaned children aged 7-17 years old whose answers were recorded.

These tables show reveal that is no statistically significant difference in school attendance between orphans and non-orphans. There is also no statistically significant difference in school attendance between orphans who are cared for by grandparents and those who are cared for by other relatives and non-relatives.

Food intake as a dimension of the quality of care for orphans

Food intake is another indicator of child vulnerability. This study found little evidence of vulnerability amongst children less than 18 years old as measured by food intake. As Table 6.9 illustrates, more than 90 per cent of children had two or more meals per day. There is no major difference between orphans and non-orphans. No relationships between sex and food intake, and age and food intake were observed.

Table 6.9 Food intake by children in Kopanong (2003)*

Meals per day	Type of child			
	Non-orphans N (%)	Lost mother N (%)	Lost father N (%)	Lost both parents N (%)
One	164 (3.1)	5 (1.0)	35 (2.3)	16 (2.6)
Two or more	5120 (96.9)	512 (99.0)	1488 (97.7)	607 (97.4)
Total	5284 (100)	517 (100)	1523 (100)	623 (100)

Source: OVC Census (HSRC 2003)

*This figure includes all households in Kopanong that were reached by the study and indicated whether how many meals they can afford to eat per day.

It is surprising that, despite the high level of income poverty in Kopanong, there is no evidence of severe vulnerability among orphans as illustrated by school attendance and meals intake. All children are affected in the same way, regardless of orphan status. This was not the perception of the principal of Springfontein High School. He suggested that non-orphaned children were more vulnerable than orphans;

> There are many children who have no parents in my school, but I do not have any major problems with them…you can see they eat OK and dress well. My biggest problem is of children who have both parents alive, but are unemployed. There are just too many of them. They are struggling to even pay school fees and come to school on empty stomachs. This often leads to young children involving themselves in prostitution. Another major problem in this town (Springfontein) is alcohol abuse.

This observation calls into question the assumption that orphans are more vulnerable due to poverty. As illustrated above, in the African context, orphanhood is more than the loss of biological parents. It has more to do with the living conditions. Children who live in poverty are considered orphans, even if their biological parents are alive and present. The conclusion we draw is that in this desperately poor community orphans do not fare any worse than non-orphans.

Conclusion

This chapter has discussed the most critical aspect of the dimension of care for orphans; namely, the quality of care. It drew on data on the socio-economic status of households and carers in Kopanong, and the impact of this situation on their wellbeing as measured by school attendance and meals intake. A close comparison was drawn between orphans and non-orphans.

The analysis revealed there is no difference between the poverty levels of households that accommodate orphan and those that accommodated non-orphans. The study also found that while the burden of care rests with grandmothers, they are not as old as is often assumed. The evidence of school attendance, and number of meals eaten per day, suggests that they are as caring as biological parents.

What does jump out from the empirical material is that, firstly, carers, related and non-related, were motivated by altruism. Secondly, since so few people access the CSGs to which they are entitled, children placed with grandmothers may be better-off than others because the OAP is much higher than the CSG. This leads to two critical observations about the welfare system; firstly, pensioners have to subsidise the care of their grandchildren from the pension which was intended for them. Secondly, there is an urgent need to find out why many more people are not getting the CSGs to which they are entitled. Despite its limitations this welfare benefit could make a big difference to both orphans and other vulnerable children if people were accessing it.

The question that this study asks is whether the HIV/AIDS epidemic is having the disastrous impact often suggested. In Kopanong at least families seem to be coping in the ways they have for over a hundred years. Three generational groups live together and when sons or daughters migrate or die their parents, particularly mothers, take over the care of their grandchildren. However, there is no cause for complacency. All families in Kopanong are desperately, heart-wrenchingly, poor. Making sure that the carer of every child who is eligible receives the CSG would make an important contribution to alleviating this poverty. It is to this issue that we now turn.

Chapter 7 Welfare policies and extended family care for orphans and vulnerable children

Introduction

This study has so far shown that orphans are mostly cared for by relatives in Kopanong. It has been established that extended family members continue to provide care for orphans, as has always been the case. However, this does not meant that everything is alright either. We have seen that the biggest challenge facing carers of orphans and non-orphans alike is the lack of cash. Welfare grants in Kopanong are not reaching those who need and are entitled to them. Why is this? It is this question that this chapter will attempt to answer. It will begin by very briefly outlining Esping-Andersen's (1990) typology of welfare capitalism.

In his analysis of the relationship between the state, market and family, and social rights, Esping-Andersen identified three distinct patterns of state intervention in welfare policies in advanced capitalist countries. He identified three patterns; liberal, conservative and social welfare capitalism.

In a liberal welfare state means-tested social assistance, modest universal transfers or modest social insurance are provided. Social insurance is facilitated through private savings. Social assistance provision is limited in order not to discourage people from looking for work. As a result, entitlement rules are very strict and often associated with stigma.

The conservative welfare state is characterized by a dominant state role in the provision of social assistance. Private insurance play a marginal role. Welfare services are provided mainly through religiously-linked organisations; the church, as such it is committed to the traditional familyhood with family benefits encouraging motherhood. The state only intervenes when the family's capacity to service its members is exhausted.

The social democratic welfare state, on the other hand, pursues a welfare state that seeks to reduce inequality through improved living conditions, protection of labour and guaranteeing employment. It addresses both the market and the family. The principle is not to wait until the family's capacity to aid is exhausted, but to socialize the cost of family by maximising individual's independence capacity rather than maximising family dependence.

The first democratic government in South Africa (ushered in, in 1994) inherited a liberal welfare regime model (see Harris 1993; Adams 1997; Terreblanche 2002; Seekings & Nattrass 2005; Bond 2006; Bhorat & Oosthuizen 2006; Makgetla 2006; Ntsebeza 2006). It remains committed to interventions at certain groups and neglects the very high rates of unemployment and the generalised poverty that means that most South Africans need support from the state. The application of a model designed for a very different situation, has led to certain anomalies that affect its capacity to deliver.

Anomalies of the grants system

Firstly, there is the disparity between the Foster Child Grant (FCG) and the CSG; the former being three times higher than the latter. In a situation of very high unemployment and deep poverty it is not clear what the difference is in material terms between raising an orphaned child and raising a child in a family where the biological parents are still alive. This discrepancy breeds fertile grounds for discord among carers - relatives and non-relatives.

The second area of concern was that many carers felt that the amounts payable were simply not adequate. One of the carers in Bethulie explained:

> I want to know how the government can help me financially, since I have my mother, my children and fostered children to look after. I can't go around and look for work as a result of these obligations. I just have no time (Interview was conducted on the 05th Apr 2005).

Another carer in Bethulie complained in frustration:

> We are told we should spend the grant money exclusively for the orphan's benefit. That is fine, but how can I discriminate against others in the house? When I cook food, it is for everybody. How do I say this child can eat this and that child cannot eat while they both need food and live in the same house? (Interview was conducted on the 05th Apr 2005).

A nursery school teacher came to her support emphasising that it is impossible to discriminate against non-orphans living in the same household as orphans. She explained:

> There are cases where welfare grants are being abused. But generally, they are used to support children [orphans] and their relatives. When you cook, you can't cook for the orphaned child only. You cook for the whole family (Interview was conducted on the 29th Mar 2005).

A third issue was the impact of differential welfare payments on community cohesion. The current situation of widespread unemployment and poverty and the limited, and differentiated social assistance available, leads to feuds in the community as poor people jostle for access to social assistance. There have been accusations and counter-accusations regarding carers' motives. Some social workers and non-relative carers accused members of extended families of being driven by the desire to access social grants. A non-relative carer in Jagersfontein pointed out;

> Many members of the community have taken in foster children, both orphans and vulnerable children. The problem emerges when the foster parents receive welfare grants. You find relatives coming from all sorts of directions claiming custodianship over children. This indicates that they do not have children's interests at heart. They are only interested in the welfare grants…. Usually, before we decide on the placement of children, we try by all means to trace their relatives. They always demonstrate the lack of interest in taking in their relatives' orphans, but once foster parents receive welfare grants, they start to make claims (Interview was conducted on the 07th Apr 2005).

Foster parents who were interviewed confirmed that relatives often treated them with contempt and often accused them of being ill-intentioned. All foster parents complained about bad comments and accusations from members of the community and the relatives of children in their care. A foster parent in Springfontein complained:

> People say very nasty things about us out there. They say that we are rich because of orphans and vulnerable children. This money [social grant] is not even enough to look after all the needs of the children, yet we are being accused of using them to enrich ourselves. It is truly saddening (Interview was conducted on the 06th Apr 2005).

There is, on the other hand, a generally accepted view that members of extended families act in the best interest of orphans. Numerous examples were cited in Chapter 5 to illustrate that relatives, as well as foster parents, are not primarily motivated by money. A senior manager in the Department of Social Development (DoSD) further explained:

> There may be cases where people are motivated by money, but to a large extent, people act out of genuine concern to look after orphans…. Foster Care Grant applications take time to be approved. You would find people still staying normally with these children despite the long delays (Interview was conducted on the 30th Mar 2005).

His views were echoed by a social worker based in Jagersfontein. She explained:

> I don't think that people have necessarily been influenced by the grants. People, especially relatives, have always been willing to look after orphans and vulnerable children (Interview was conducted on the 30th Mar 2005).

Indeed, even the accusations levelled against non-relatives are not backed up by any evidence. On the contrary, as chapter 6 showed, very few (18 per cent) non-related carers were receiving the FCG and some were bringing up children who were not related to them without any support from the state.

A fourth issue is that the CSG is means-tested, while the FCG is not. As pointed out above, applicants for the CSG – which is intended to support parents of children from poor families – must prove that they are poor, by passing the means-test. The purpose of the means-test exercise is to ensure that the neediest families benefit from this intervention. However, the fact that the FCG is not means-tested in the same way as the CSG – and in fact preference is given to foster parents with better earning potential –

appears to discriminate unfairly against poor children and their families. In terms of the Child Care Act No. 57 of 1983, a potential foster parent must prove financial ability to care for orphans. This clause is intended to ensure that the FCG will be used to the benefit of the fostered child alone. However, this may have the unintended consequence of excluding people who matter most to the care for orphans – their extended family members – because they do not have sufficient money.

The means-test for the CSG also has problems. The bureaucracy involved in trying to access the grant has resulted in a low uptake of social grants in Kopanong where only 20 per cent of those eligible for the grant were receiving it. A further problem is that the means-test system distinguishes between the supposed differences in the cost of living between rural and urban areas. The threshold for urban areas is a family income of R1100 per month. For rural areas the threshold for a rural family is income of R800 per month. These thresholds have not kept pace with the cost of living. Rural people are disadvantaged compared with those living in urban areas because their income threshold is lower than that of the urban dwellers. Since a significant proportion in both groups' lives below the poverty line it is difficult to see how this distinction can continue to be justified. Further, the complex urban/rural distinction challenges the already weak administrative capacity of the DoSD to administer the grant system.

One consequence of this state of affairs is that many very poor families are unable to claim the grant because their cash income is above the threshold. Needy children are excluded *en masse* (Samson et al. 2007). It is estimated that if the cash thresholds were revised upwards to account for inflation, and the urban/rural distinction was abolished 27 per cent more children would have been eligible to receive the grant in 2005 (Samson et al. 2007).

The CSG expires on the 14th birthday of the child while the FCG expires on the 18th birthday of the child. Again, in a situation of ubiquitous unemployment and poverty, it is not clear what the difference is, in terms of costs, of raising a vulnerable child or an orphan. Yet poor families raising their own children lose state support four years before

foster families bringing up orphans, who already receive three times as much as biological parents.

An effect of the differentiated grant system is that the processes involved in accessing the FCG are more complex than those for the CSG. In addition to the financial scrutiny to which foster care applicants are subjected, social workers have to make a thorough investigation of the individual applicant and his/her family to determine his/her suitability as a carer. Moreover, foster care placements require a court-order. The complex and lengthy admin process maybe on reason why more carers are not applying for it.

Targeted interventions

In its well-intended approach to alleviate poverty among the poor, the government implements a policy of 'targeted intervention'. The claim of this targeted intervention is to provide some relief to unproductive labour. This category includes children, the elderly and those who are unable to work due to their disabilities. Implicitly, this approach still assumes full employment. The reality of contemporary South Africa, as we have seen, is very different.

In relation to orphaned and vulnerable children, this targeted intervention assumes that some social categories are doing better than others. It is taken as given that orphans are more vulnerable than other children by virtue of having lost either or both biological parents. Earlier we saw that over 70 per cent of children in South Africa are considered to be living in conditions of poverty, irrespective of orphan status. This study has shown that both orphans and non-orphans are affected by problems associated with poverty. While acknowledging the emotional trauma of losing biological parents, if the data from Kopanong is typical of other parts of the country with a similar socio-economic profile, orphans are not more vulnerable economically than non-orphans. Indeed, it might be the case, and this topic merits serious study, that those who live with (a) relatively young grandparent(s) are better off than other children because the value of OAP is so much greater than the CSG. Therefore, if orphans are no worse or better off than non-orphans of similar socio-economic status, singling them out for support is inappropriate. Relief

and support should be given to all poor children, irrespective of whether or not they are living with their biological parents.

Based on this analysis it can, therefore, be concluded that the South African welfare system is designed in such a way that it denies financial support to the majority of desperately poor people. As Lund (2007) observes, a society warped by such withering impoverishment and inequality largely needs radical, redistributive change. In particular calls have been made for the introduction of a universal grant for all families in South Africa. At the current levels of poverty, the means-test does not make sense, morally, socially, politically or economically. Samson et al. (2007) estimate that with the inflation adjustment and elimination of the rural/urban distinction, more than three out of four children in South Africa would qualify for the CSG.

We have already seen that the practice of distributing and/or circulating children amongst relatives is still common in South Africa (Ramphele 2002). In the current context of high levels of poverty and continuing labour migration, such a practice frees young adults to migrate to cities and look for work. Absent parents are expected to contribute to the child's upbringing. Recent research shows that, in rural areas, young adults move out of the household once a grandmother starts to receive an OAP (Samson et al. 2007).

Using the September 2004 Labour Force Survey, Samson et al. (2007) found that working age adults in poor households where there is an OAP are more likely to look for work and more likely to find employment than comparable adults in households that do not receive the pension. The CSG demonstrates a similar effect (Samson et al. 2007). The conclusion they draw is that access to a grant allows space for parents to move away in search of jobs elsewhere[66].

To compound the difficulties very poor, unemployed families face, a number of researchers have argued that post-apartheid housing policy has unwittingly undermined

[66] This finding contradicts the widely-held belief that social grants discourage people from looking for employment.

the foundation of the family social safety net by making it very difficult for extended families to continue to live together (Spiegel, Watson & Wilkinson 1996b). The Reconstruction and Development Programme's (RDP) housing programme, introduced in 1995, while providing better houses than self-constructed shacks, and providing electricity and clean running water, are very small. Overcrowding is common. According to Hall and Berry (2006) more than a quarter of all children in South Africa lived in overcrowded households (more than two people per room, excluding bathrooms but including kitchens and living rooms) in 2005. Spiegel, Watson & Wilkinson (1996b) observe that housing policy makers do not appear to view this as problematic, possibly because they have adopted the idea that the occupants of these sites are nuclear family households with growing children, having primary need for the basic elements of suburban life – usually identified as space, privacy and access to basic community facilities.

However, as Spiegel, Watson & Wilkinson (1996b) further point out, the delivery of a standard, limited form of accommodation to households is not simply causing a measure of inconvenience. It is fundamentally undermining the ability of some households and individuals to survive. One aspect of this is the limits on a household's ability to take in additional members for shorter or longer periods, a measure which is frequently based on the assumption that this can be reciprocated in times of distress. This may be contributing to the declining size of households in South Africa. According to the Children's Institute (2007), the average household size has gradually decreased from 4.5 in 1996 to 3.8 in 2004. In addition, new housing developments for the poor are often located far from places of work, economic activities and other essential services, particularly government services.

The implementation of welfare policies

Chapter 3 argued that the sociology *of* welfare (as opposed to sociology *for* welfare) dictates that we ask hard questions that relate to the unintended consequences of welfare interventions, especially the impact of welfare policies on the institution of the family. In particular, we need to look at how effectively these policies redistribute wealth and social advantages, and the nature of the interaction between welfare policy agencies (government officials) and their clients.

In their studies, Meintjies et al. (2003, 2004) have identified poor access to social grants, especially in the rural areas of Limpopo and the Eastern Cape provinces. In Limpopo, for example, they found that only 40 per cent of the study population had access to social grants. This poor access was attributed to the lack of correct documentation, and the attitude of social workers and other welfare officials charged with the responsibility of disbursing social grants. These factors constitute the core set of administrative barriers of access to social services. While this study found a low uptake of social grants in Kopanong, access to birth certificate was high. This suggests that there is no correlation between access to birth certificates and the uptake of social grants in Kopanong. However, the attitude of social workers and the critical shortage of staff were identified as central to the poor uptake of social grants in Kopanong.

The role of welfare officials

Welfare agencies have a tendency to obstruct access to welfare services, mainly through policing attitudes (see Mishra 1993; Peillon 1998). Meintjies et al. (2003, 2004) observed social workers' attitudes in their Limpopo and Eastern Cape provinces' studies. They noted that social workers imposed arbitrary pre-requisites such as death and/or divorce certificates, and police affidavits on of orphan carers and vulnerable biological parents, before granting social assistance.

Interviews with welfare officials in Kopanong revealed similar attitudes and lack of trust in orphan carers, especially relatives. Social workers, in particular, accused relatives of lying in order to gain access to welfare grants. A social worker in Bethulie argued:

> People are just after money. They even fight over the right to foster children, whenever a relative dies, even when they have never been looking after the child's parents when they were terminally ill. It's saddening (Interview was conducted on the 29th Mar 2005).

Another visibly incensed social worker elaborated:

> Communities like orphans [like to use orphans as a means of accessing welfare grants]. They even fight over them. They [orphans] are seen as a means of accessing the foster care grants. You find some families looking after up to four (4) orphaned children. This easily guarantees them R2000.00 every month. You can never find a child without care for as long as the Department of Social Development provides foster care grants to foster parents. As you can see they do not necessarily like them [care about their well-being]. They only use them to access foster care grants. Foster care grants promotes greediness among members of the community. People are just desperate to get foster care grants (Interview was conducted on the 29th Mar 2005).

In response to this 'crisis' welfare officials resort to strict adherence to rules regulating access to welfare grants, as another social worker highlighted:

> That is why screening plays an important part. Members of the community usually lie to us. Sometimes they just make up stories and expect us to act on them without first verifying them. You find them declaring that their [grown up] children [parents of the 'orphan'] have gone missing, while in fact they are making up such stories. It's probably because of poverty (Interview was conducted on the 29th Mar 2005).

Another social worker, based in Bethulie, added:

> You know what I do? I ask them to report that person missing to the police so that the police can investigate. They never come back to me about that. Then you know they were lying to you (Interview was conducted on the 29th Mar 2005).

The social workers who were interviewed also treated poor and rural men, women and youth with suspicion. Young women were accused of falling pregnant deliberately in order to gain access to social grants which they allegedly spend on themselves rather than their children. Men and women were accused of dependency on welfare grants, as if this was shameful, notwithstanding the high levels of unemployment. Such moralism and judgemental attitudes may well contribute to the low uptake of the FCG and fuel resentment towards foster parents by relatives of fostered children.

We have already seen that social workers were more inclined to work with non-kin foster parents, without relatives' involvement. This practice tends to undermine extended family mechanisms of care for orphans, and community cooperation. Social workers also appeared to prefer to work with non-kin foster parents who were often from a different locality, thus cutting off the child's important family links, with potentially serious repercussions for affected children. For example, if orphans are placed with foster parents elsewhere and family links are severed, what will happen to orphans when they reach 18 years of age and therefore no longer qualify for the grant? Will foster parents be willing to care for them without further state financial support? If not, will relatives now be required to intervene? Would they be prepared to do so, after all? Also, what will happen to foster children – orphans – when foster parents die? Will the relatives of foster parents be willing to take them in as part of the family?

Already there are reports of foster parents throwing foster children out upon the expiry of the FCG. In their study of homeless children in Johannesburg City Centre, Tamasane & Seager (2006) reported this phenomenon. Care workers attached to Shelters for the homeless mentioned that some of the children who are or have been in their care are children who have been fostered before, but have been driven out when the grant expired. Subsequently, many moved into the inner city of Johannesburg to look for work. Since they do not have qualifications, most, ultimately ended up living on the streets of Johannesburg. Some found accommodation in shelters for homeless people, according to care workers' testimonies. This highlights the importance of building family support

structures for orphans, in practice and not just in the written legislation. For, as explained, government is committed to strengthening family care for orphans and vulnerable children, but the designs of interventions, as embodied in welfare policies do not create a favourable environment for this to develop.

Shortage of staff

The acute shortage of the suitably qualified personnel such as social workers, auxiliary social workers, and child and youth care workers has been identified as a central barrier to the provision of efficient *social services* in Kopanong. Social workers complained that they were not spending enough time with the communities they were serving, as they were each responsible for at least two towns at a time. Some social workers pointed out that they did not have enough time to do *social work*; casework. Instead, the bulk of their work included processing applications for social grants.

This situation is complicated by the fact that the foster care arrangement is renewable every two years, based on the assessment report of a qualified social worker. The renewal process increases the work load of social workers, leading to further delays in the processing of new applications and the provision of social services.

Welfare capitalism in post-apartheid South Africa

The ambiguities of the welfare system discussed above should be understood in the context of the current model of welfare in the post-apartheid South African. While there is an emphasis on the role of the extended family in the provision of welfare services, a survey of policy documents and available literature indicates the dearth of policy mechanisms to drive the process. Essentially, the government relies on the apartheid-era policy framework. The only modifications have been the removal of discriminatory clauses. Indeed, the present government has merely *reformed* rather than *transforming* the apartheid welfare policies as Seekings & Nattrass (1997; 2006) point out. As a result, the ethos of the colonial and apartheid welfare policies still find their way into the present welfare dispensation.

The apparent lack of tangible welfare reform is the result of the dominant politico-economic ideological framework regulating the relationship between the state, market and the family. The South African welfare system has been characterised as liberal welfare capitalism. In a liberal welfare capitalism the government relies on market expansion for economic growth in order to realise the equitable redistribution of resources; the trickle-down effect. In order to attract foreign direct investment that is pivotal to economic growth, the government adheres to tight fiscal discipline, tax concessions for big businesses, inflation targeting, and investment in private-business-oriented infrastructure. Fiscal discipline entails downsizing the government bureaucracy, and reducing spending on welfare, education and health services.

In a liberal welfare capitalist state, limited social assistance is provided to target groups, such as the elderly, and disabled. In addition to being targeted at particular groups, social assistance is means-tested. Critics of this practice argue that the means-test is a form of exclusion. The means-test is aimed at ridding the welfare system of those deemed a public burden, and to indirectly force them to seek employment in the free market. Employed individuals are encouraged, often forced, to take out private social insurance in order to reduce their reliance on the state when their labour has become obsolete at the age of retirement.

The wisdom of a means-test in South Africa, given the high level of dependency on social grants is indeed questionable. It is for these reasons that some have proposed that the grant should become universal with a possible 'claw-back' through the tax system from those who are not poor (Wright 2006). This has led to calls for the introduction of the *Basic Income Grant* by civil society, trade unions, and opposition parties. However, the Minister of Finance, Mr. Trevor Manual[67], has resisted calls for the implementation of this recommendation on the grounds that it is unaffordable and the introduction of such a grant will create perverse incentives to remain unemployed. This study asks whether the time is not ripe for this topic to be revisited.

[67] Mr. Manuel repeated his rejection of the call for Basic Income Grant in his latest budget speech (2008), once again citing budget constraints.

Conclusion

The review of post-apartheid welfare legislation, which has been the theme of this chapter, has shown that not enough has been done to adequately strengthen extended family care for orphans and vulnerable children. The problem lies with the design and ethos of welfare services, especially social assistance. The first way in which current welfare provisions fail families looking after orphans and other vulnerable children, is access to welfare services, especially grants. The fact that a mere 20 per cent of children regarded as orphans in Kopanong have access to welfare grants is a serious indictment of the state of welfare in South Africa, and a heavy blow to the needy children and their carers. This state of affairs is attributable to the lack of relevant documentation such as parents' death certificates, identity documents, orphans' birth certificates, clinic cards or school progress reports.

The 'policing' attitude of the DoSD officials may be contributing to the low uptake of social grants. Social workers treat applicants with a great deal of suspicion. They suspect that applicants are just after money and in the process lie to them. They accused applicants of taking their relative's children and then falsely claiming that they have no parents. They therefore adopt a strict approach towards them. This attitude is likely to exclude key family members from providing care and support for orphans. At the same time, the DoSD in Xhariep District is very understaffed, according to social workers' and senior managers' accounts.

The design of the welfare policy is also not in harmony with the African extended family ethos. Certain provisions were made to cater for the needs of the privileged White community under apartheid, especially the protection of vulnerable children due to neglect. The same laws are used to regulate care of orphans in the current context, with undesirable consequences. It is difficult for carers who are related to the orphans, most of whom are grandmothers, to access services and negotiate the daunting bureaucracy involved.

The disparity in the value of the two different grants creates tensions among relatives, and other non-relative carers. The court-ordered nature of the formal foster care arrangement which would lead to a grant being paid, delays the disbursement of social grants, and makes it difficult for relatives to circulate children amongst themselves. Housing policies further hamper extended family care of orphans as housing units are too small to accommodate large numbers of people.

The targeted nature of state assistance leaves other vulnerable sections of the population falling through the cracks of the social safety net. The state targets orphans while ignoring other children from poor backgrounds or discriminating against them by offering their carers inferior amounts of social assistance.

The dual system of child support through the FCG and the CSG is flawed. The amounts payable are not the same, applicable means-tests are not similar and ages of eligibility are different. In addition, carers of poor, non-orphaned children are subjected to a means-test based on an arbitrary maximum threshold of earnings. This threshold has not been revised since its inception in 1998 and the means test does not take the number of dependants being cared for by a particular carer.

Welfare grants play an important role in alleviating poverty among the poor and therefore in enhancing the family social safety net in South African townships. As Marais (2005) points out, people in rural areas talk of 'pension day' because it is the day when most expect to receive some money. This illustrates how important welfare grants have become, to many poor households in South Africa. In Kopanong it was found that less than a quarter of carers were receiving grants on behalf of the children they were looking after, in spite of the fact that more than 70 per cent of children lived in poverty. It is therefore, important that the welfare net is stretched wider to include as many needy and deserving families as possible. It also needs to be considered whether the criteria for intervention should be based on the child's vulnerability, as is the case now, or on the family's vulnerability.

One powerful conclusion that can be drawn is that while the intention of government policies and processes was not to weaken extended families, they have, in fact, negatively affected extended family members' and non-relative carers' morale. Indeed, a social security system that provides grants to orphans younger than 18-years old, without providing adequate and equal support to the many other impoverished children is discriminatory (Meintjies & van Niekerk 2005:4).

Chapter 8 Conclusion

This study investigated the role of the current welfare regime in strengthening family care for orphans in the context of HIV/AIDS and ubiquitous poverty in South Africa. It was based on empirical research among African communities in the Kopanong municipality of Xhariep district in Free State. This municipality was chosen because like most small-towns municipalities, Kopanong has high levels of poverty. Moreover, Free State has one of the highest HIV/AIDS prevalence in the country, third after KwaZulu-Natal and Mpumalanga. It is therefore reasonable to assume that extended family networks of social support might be experiencing a heightened burden.

The aim of the research was to ask six fundamental and interlinked questions. Firstly, it asked whether there is a crisis of orphan-care as a result of HIV/AIDS, as is asserted in much of the literature. Secondly, it looked at the quality of care for orphans and asked whether orphans are especially vulnerable given the widespread nature of poverty in South Africa. In doing so, thirdly, it looked at the material conditions of orphans, as well as non-orphans and their carers, and fourthly addressed the question of the role of the extended family in the care of orphans. It then, fifthly, examined the role of post-apartheid welfare policies in strengthening, or not, extended family care for orphans. Finally, following from this it asked whether resources should be prioritised for orphans, which is the policy pursued and promoted by many international organisations and Non-Governmental Organisations (NGOs).

The research design involved a methodological triangulation that included the quantitative and qualitative approaches. The quantitative design involved analysis of the data from an *Orphans and Vulnerable Children Census* study conducted by the Human Sciences Research Council (HSRC) in Kopanong in 2003, to which the author was given access. The *OVC Census* was aimed at finding the actual number of orphans and vulnerable children living in Kopanong, their living conditions and access to welfare services. A major strength of the *OVC Census* is its focus on the local level. Many studies have attempted to record the number of orphans and vulnerable children before (see

UNAIDS 1999; 2000; 2002; UNICEF 1999; 2003; Stats SA 2004, 2005; HSRC 2005)[68]. The challenge with these studies is that they are extrapolations from large samples, thus, missing the local specificity.

The *OVC Census* provides a more detailed understanding of the conditions confronting orphans, and other vulnerable children in South Africa. Moreover, the *OVC Census* study is the first sub-district-level count of orphans and their living conditions done in South Africa. Therefore, its findings provide fresh insights into the prevalence of orphans, care arrangements, living conditions, and those of other vulnerable children in Kopanong. The census suffered from an assumption that heads of household were the *de facto* carers of orphaned and other vulnerable children. However, the complimentary *Orphans and Vulnerable Children Psychosocial Survey (OVC PSS),* carried out by the HSRC in 2004, to which the author was also given access, was helpful in correcting this assumption.

The *OVC PSS* was a survey of a representative sample of the population included in the earlier census. This was conducted to understand the psychosocial issues affecting orphans and other vulnerable children, and their carers. This study has been referred to as the *OVC PSS*. The *OVC PSS* survey provided information on specific issues pertaining to orphans and their carers. The use of these two data sets allowed this study to move from the general observations to specific issues pertaining to establishing the identity of orphan carers, their relationship with orphans, and their socio-economic profile.

The data from the two Kopanong studies was compared with an analysis of the relevant data from the National Census of 2001 (Stats SA 2002) and the General Household Surveys of 2003 to 2006 (Stats SA 2003; 2004; 2005; 2006). These provided a national and provincial picture of orphan prevalence, care arrangements, access to social grants and school attendance.

A qualitative study was undertaken by the author, to probe some questions further, especially ideas about the role of kin in the care of orphans as well as their views

[68] Giese et al. (2003), Meintjies et al. (2003) and Bray (2004) challenge these extrapolations.

concerning the nature of the State's support. Therefore, in addition to corroborating the quantitative studies' findings, the qualitative study provided sociological depth regarding care for orphans and vulnerable children by soliciting opinions of carers and key informants. It also provided an overview of different agencies that provide support to orphans and their carers, and their effectiveness.

The qualitative research design involved in-depth interviews with key informants, and the carers of orphans and vulnerable children. Interviews sought to ascertain the extent of family care for orphans. Interviews were conducted in the towns of Bethulie, Jagersfontein and Springfontein in the Kopanong Municipality. Interviews were held in Sesotho or English according to the preference of the respondent.

The conceptual framework of social capital was useful in elucidating the normative values that facilitate care for orphans. The communities' definition of orphanhood differed from that adopted by government and international development agencies. In Kopanong 'orphan' does not merely imply the loss of biological parents, but rather is used to refer to any child who lives in poverty.

In the policy discourse child vulnerability is still defined in the language of the HIV/AIDS-related vulnerability. These children are conceptualised as those living with sick and dying parents, or children who receive precarious care because they depend on grandmothers, frail or disabled carers. Little reference is made to children who live with unemployed parents, despite the very high levels of unemployment and consequent poverty in South Africa.

Summary of findings

The literature indicates a rapid increase in the number of orphaned children that has coincided with the HIV/AIDS epidemic. It is predicted that the numbers are likely to increase over time. Such observations have raised concerns about care for orphans. The debates on care centre around, first, the declining ability of extended family on whom care has always rested to fulfil this role. Secondly, concerns have been raised about the quality of care of orphans. It is known that many orphans are cared for by grandmothers who are assumed to be old, frail and semi-destitute and hence unable to provide the care their grandchild(ren)'s need. However, this study found that most grandparents were not necessarily octogenarians. A majority of grandparents were between 50-70 years-olds, with a mean age of 62. In some cases, grandparents were as young as 40 years old.

The study did not find any evidence of a 'crisis of care'. Over 90 per cent of orphans were cared for by relatives. Of vital significance, more than half of non-orphaned children were also cared for by someone other than their biological parents, while over two-thirds of children knew their carer before the death of their parents. The same proportion lived in the same house as they had lived in with their parents. There was, therefore, a very high degree of continuity of care of orphans in terms of their household/extended family location. And this did not differ from the care arrangements for other vulnerable children. Of equal importance, there were very few cases of orphan-headed households – less than one per cent. This further confirms the finding that extended family support for orphans is the main form of care that exists.

The strength of extended family is further highlighted by the finding, mentioned above that almost half of non-orphaned children were cared for by relatives. Young adults leave their children in the care of their parents when they leave to look for work in bigger towns or cities. This suggests that an income through the state pension provides a window of opportunity for young people to move away in search of work. It provides them with

transport money, but it also serves as an assurance that their children won't go hungry in their absence.

The concept of social capital has been key to explaining the relationship between the state and the family, and the networks of relations between members of the extended family that constitute a bastion of social support for orphans. It emphasises trust, mutual obligation and reciprocity, which inhere in family relations, as prompting family members to act in the interests of each other. To many carers, looking after orphans was a duty; an obligation. Moreover, children have a special place in this relationship; they perpetuate the family and build relations amongst families. This has been referred to as *bridging social capital*. A key implication for policy is that the placement of orphans with relatives has tremendous benefits for the child and the family. The child will often remain in the home where he/she has always lived, or in another familiar environment, and family relations will be maintained.

The fact that extended family, and particularly grandmothers, provides most care for their children's children should not be interpreted to mean that all is well with these families. These households are desperately poor by any standards. It is a testimony to their generosity and humanity that they take on this additional burden when they themselves have so little. Nor is it just a single child that the grandmother raises. One third of carers had more than three children in their care. The reliance on grandparents as carers may present another challenge: who will look after orphans when grandparents die themselves? In the absence of a longitudinal study data it is difficult to conclusively answer this question. Further research is required.

Yet the uptake of social grants meant for orphans and children from poor families is very low in Kopanong. Only 20 per cent of those entitled to grants actually receive them. Various explanations were offered. The most plausible seems to be the understaffing of the relevant offices and the bureaucratic hurdles that carers have to cross. Social workers dealt with social grants applicants with a great deal of suspicion and became intransigent, to the point of being 'gate keepers' and deciding who should or should not receive the grant. They seemed to think their role was to block rather than facilitate the uptake of

grants. The acute shortage of welfare staff compounded the problems of accessing social grants, since social workers facilitate the processes by completing the necessary paper work.

Surprisingly, despite the high level of income poverty, and limited access to social grants, there were no severe cases of vulnerability, or 'crisis' of care. On average, 96 per cent of all children of school-going age attended school in Kopanong. There was no difference in school attendance between orphans and non-orphans ate daily. A second measure of well-being or deprivation, the number of meals a child receives, also suggested that orphans do not fare worse that other children.

What is obvious from the above analysis is that poverty affects orphans and non-orphans alike, and that poverty has no direct bearing on decisions regarding care for orphans. For, despite widespread poverty, extended families continue to care for orphans.

Based on these observations, it can be concluded that the targeted intervention approach of the Department of Social Development that fails to address poverty holistically, risks undermining family social safety nets and creating divisions within very poor communities.

The Child Support Grant is means-tested while the Foster Care Grant is not. Furthermore, the Child Support Grant expires at the 14th birthday of the child, while the Foster Care Grant expires at the 18th birthday of the child, and can be extended to the 21st birthday if the child is still at an institution of higher learning. In addition, the value of the FCG is three times that the CSG. This fuels discord among potential carers. Caregivers were accusing each other of being solely interested in getting their hands on social grants. Non-relative carers were particularly vulnerable to such accusations, despite the lack of evidence to substantiate such accusations.

A further problem of the welfare system is that many families rely entirely on the OAP for their survival. A grant intended to support a single elderly person, instead supports the whole family. It is clear that while welfare policies have the potential to strengthen

extended family support for orphans and other vulnerable children by alleviating poverty, they can also weaken it. This is fundamentally a problem arising from the untransformed nature of welfare provisions in South Africa. The provisions offered under the old apartheid model have been equalised across the 'races' and dramatically extended to more people since 1994. However, the rationale of the system – temporary support for families experiencing temporary difficulties in a situation of full employment – has not changed. The reality is that the population previously excluded from the welfare regime – the majority of South Africa's people – experience very high levels of enduring structural unemployment and lifelong poverty. The current welfare system offers two forms of child support; the CSG and FCG.

This study has shown then, that while there is not a crisis of orphan care, in the sense that orphaned children have no carers and/or are reduced to much greater poverty than their neighbours, there is urgent need for state support to all poor families with children. Contrary to dominant thinking, it may well be that orphans care for by a grand parent are better off materially than many children whose parents raise them.

Recommendations

It is clear that the crisis facing orphans and their carers is income poverty. However, this is a crisis that faces all poor children and their families. The need to lift families looking after children – orphans and non-orphans alike - out of poverty cannot therefore be overstated. Long-term sustainable initiatives are needed. Under normal circumstances, creating employment on a large scale would be a long-lasting solution. However, in South Africa, unemployment is driven by structural conditions of the economy. For this reason, many have argued for the introduction of a Basic Income Grant which would be offered to every South African, child and adult alike. It would be taken back from those who did not need it through the taxation system. Such a grant would significantly alleviate poverty in the short-term. It would generate demand and thus stimulate the growth of the internal market and it could be phased out in the longer term as jobs are created.

However, such support should not discriminate between children and their carers. The CSG and the FCG should be equalised and made available to every child in need. The reasons that there is such a low uptake of social grants in Kopanong urgently need investigating, followed by measures to increase the uptake. This will involve reducing the administration involved and increasing the number of social workers. If the 80 per cent of carers who currently do not receive the grant were to receive it, the situation among the very poor of Kopanong will significantly improve.

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Annexures

Annexure: A. Interviewee list for orphans project

Organisation	Position	Area	Date
Department of Social Development (Free State)	Social Worker	Springfontein/ Bethulie	29 Mar 05
Department of Social Development (Free State)	Social Worker	Bethulie	29 Mar 05
Department of Social Development (Free State)	Social Worker	Trompsburg/ Jagersfontein	07 Apr 05
Department of Social Development (Free State)	Social Worker	Jagersfontein	07 Apr 05
Department of Social Development (Free State)	Parole Officer	Smithfield Region	29 Mar 05
Department of Social Development (Free State)	Director	Xhariep District	30 Mar 05
Kopanong Local Municipality	Local Councillor	Springfontein	06 Apr 05
Kopanong Local Municipality	Local Councillor	Bethulie	05 Apr 05
Kopanong Local Municipality	Local Councillor	Jagersfontein	31 Mar 05
St Laurence Primary School	Principal	Jagersfontein	31 Mar 05
Bosabelo Combined School	Teacher	Jagersfontein	31 Mar 05
Bosabelo Combined School	Teacher	Jagersfontein	31 Mar 05
Maphoi Primary School	Principal	Springfontein	06 Apr 05
Springfontein Secondary School	Principal	Springfontein	06 Apr 05
Lephoi Primary School	Principal	Bethulie	29 Mar 05
Wongalethu	Principal	Bethulie	29 Mar 05

Secondary School			
Lehlaseli Edu Centre	Principal	Bethulie	29 Mar 05
Department of Social Development (Free State)	Community Liaison Officer	Jagersfontein	07 Apr 05
Department of Health	Nurse	Springfontein	06 Apr 05
Department of Health	Nurse	Bethulie	04 Apr 05
Department of Health	Nurse	Jagersfontein	31 Mar 05
Hospice	Manager	Bethulie	05 Apr 05
Kopanong Local Municipality	Manager	Trompsburg	08 Apr 05
Kopanong Local Municipality	Community Liaison Officer	Trompsburg	08 Apr 05
Xhariep District Municilaity	PIMS Manager	Trompsburg	08 Apr 05

Annexure: B. Kopanong OVC Census questionnaire

Location of home										**Interview visits**	**1**	**1**
A1	Physical address/village Name									**Date**		
A2	Additional contact details (nearest feature, e.g., school									**Result***		
Star indicates codes to be used available in code list **B list of members in household** *(those who normally live here)* **and fill in the following information**												
B1	B2	B3	B4	B5	B6	B7		B8	B9	B10	B11	
Full name (Mark the head of household with a cross)	Age Write age	Gender 1. Male 2. Female	Relationship to head of household* Enter the code	Type of orphan* Above 18 years, don't ask orphan status	Nature of grant received by the person 1. Child 2. Foster 3. Disability 4. Old age 5. UIF 6. other, specify	Does this household member have a birth certificate (1st column) and an ID (2nd column)? 1. Yes 2. No		Does this person attend school? If no, have they ever been to school? Up to the age of 25 1. Yes 2. No, attended before 3. No, never attended school If No, go to B10	Highest level of education completed 1. Pre-school 2. Primary 3. Secondary 4. High school 5. Tertiary (Not Degreed) 6. Tertiary (Degreed)	If (name) is not at school, what is the main reason? 1. Financial constraints 2. School too far away 3. Ill/sick 4. Pregnancy related 5. Completed	Indicator of food intake. 2 questions. 1st column How many meals do you have per day? 2nd column. Is there one day a week where you normally do not have any food? 1. Yes 2. No	
1		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
2		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
3		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
4		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
5		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
6		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
7		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
8		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
9		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
10		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
11		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
12		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2

13		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
14		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
15		1 2		0 1 2 3		1 2	1 2		1 2 3 4 5 6	1 2 3 4 5	1 2 3 4	1 2
Enter the chief respondent's line number				**If number in B1 continues tick in the box below and use another sheet**								

C Household's Living Conditions								
Main Dwelling Units Type	1. Traditional	2. Bricks	3. Room a back of house	4. Flat	5. Hostel	6. Shack	7. Other (specify)	
C1. Enter number of structures								
C2. Enter number of rooms								
C3. Water for drinking and cooling		C4. What is the household's main source of energy		C5. What main type of toilet facility is used by this household? Tick one				
Main water*	Distance from water source	Cooking*	Lighting*	Flush	Pit	Improved pit	Bucket	Nil
C6. Average monthly expenditure on?		Food	Clothing	Education	Health	Other	Total	
Enter amount in local currency								
C7. What is the household's average monthly income (enter number)								
C8. Household income (annual)								
1. Remittances	2. Farming	3. Wages	4. Pension	5. Grants	6. Own business	7. Own Labour	8. Other	
H/H income per annum								
C9. Other income Indicators – They must be functioning (as observed, or asked) Tick appropriate response								
Television	Radio	Elective stove	Phone	Car	Manufacturing equipment	Farming animals	Farm equipment	
C10. External material assistance		Type*						
		Source*						

Annexure: C. Consent form for Carers of OVC

THE KELLOGG FOUNDATION'S ORPHANS AND VULNERABLE CHILDREN (OVC) CARE INTERVENTIONS PROJECT

INFORMED CONSENT FORM

The Human Sciences Research Council (HSRC) have been commissioned by the WK Kellogg Foundation (WKKF) to develop and implement a 5-year intervention project on orphans and vulnerable children (OVC) as well as families and households coping with an increased burden of care for affected children in *South Africa*.

The goals of the project are to:

- Improve the social conditions, health, development, and quality of life of vulnerable children and orphans.
- Support families and households coping with an increased burden of care for affected and vulnerable children.
- Strengthen community-based support systems as an indirect means of assisting vulnerable children.
- Build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term.

The main aims of the project are to develop, implement and evaluate some existing and/or new OVC intervention programmes that address the following issues:

- Home-based child-centred health, development, education and support
- Family and household support
- Strengthening community-support systems
- Building HIV/AIDS awareness, advocacy and policy to benefit OVC

We're talking **with carers of orphans and vulnerable children** in your community to find out their experiences as carers. We invite you to participate in this important study. We would like to interview you. The interview will take approximately one and a half hours of

your time. You will either be interviewed individually or as part of a group with other people from your community.

The interview will be tape-recorded and later transcribed. This helps us to keep note of everything that you have said. Your name will not appear on these transcripts and there will be nothing to identify you in these transcripts. If you want the tape recorder turned off at any point, or want something that you said erased, then we will do that.

I'm going to ask you some very personal questions that you could find difficult to answer. I am not going to talk to anyone about what you tell me. Your name will not be written down, and will never be used in connection with any of the information you tell me. You do not have to talk about anything that you do not feel comfortable with, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about orphans and vulnerable children.

There might not be a direct benefit for you as an individual, but the information that you will share will be useful in our understanding of the situation of orphans and vulnerable children and their families; and will help HSRC and other organisations to implement interventions that are socially and culturally relevant. One possible limitation of participating in the interview or focus group is that you may experience intense emotions due to recalling difficult experiences in your life. In the event that this should happen we have a trained counsellor who is available to connect you to an organisation that can offer you assistance and support if necesssary.

If you do not want to talk about your experiences you can say no to doing the interview. You have the right to decide whether or not to participate in this study and to withdraw your consent or to leave the research at any time without negative consequences to you.
We would greatly appreciate your help in responding to this interview. Would you be willing to participate in this study?

_____

Signature of the respondent. (*If the respondent refuses to sign but consents to participate in the project, the interviewer must sign on behalf of the respondent certifying that informed consent has been given verbally by the respondent*)

_____

(*Signature of witness certifying that informed consent has been given verbally by respondent*)

If you have any questions about your rights as a study participant, or are dissatisfied at any time with any aspect of the study, you may contact – anonymously, if you wish – Dr Donald Skinner or Mr Sakhumzi Mfecane at the HSRC on Tel: 021 467 4420 or Fax: 021 467 4424.

Annexure: D. Questionnaire for orphan guardians

KELLOGG'S OVC CARE INTERVENTIONS PROJECT

Orphans and Vulnerable Children (OVC) Psycho-Social Issues Questionnaire

Logos of each country's M & E Research Team(s) and Grant Maker

Project number	P	B	E	L	A	A
Province						
Municipal area						
Enumerator area (EA)						
Visiting point number						
Person number						
Interview number						
Interviewer team						
Interviewer number						

INTERVIEW DETAILS

	Year		**Month**		**Day**		**Start Time**[69]					**End Time**					**Response****
First visit	0	4	0	2					:					:			
Second visit	0	4	0	2					:					:			
Third visit	0	4	0	2					:					:			

Interviewer's Name .....

Have You Obtained Written Consent?

Yes	No
1	**2**

REFUSAL PARTICULARS IF NO WRITTEN CONSENT OBTAINED

a. At what point did the respondent refuse?

SPECIFY ..... ☐

You do not have to give any reasons but if you would like to tell us it will help us.

b. What was the reason for the refusal?

SPECIFY…… ☐☐

****Response Codes** 1 = Interview completed 2 = Interview not completed 3 = Appointment made for interview 4 = Selected respondent not at home 5 = Refusal by head of household 6 = Refusal by respondent 7 = Other	**Refusal Codes:** 1 = At the gate or door 2 = After explanation of the survey and the process 3 = After the first respondent has been identified (before interview) 4 = During the individual interview 5 = After individual interview 6 = Other (detailed codes to be provided later)
Reason Codes: <u>Upfront refusals</u> 01 = Too busy to grant interview 02 = Not available now 03 = Too late in the evening 04 = Not willing to participate in any survey/interview 05 = Objected to the topic of the survey (HIV/AIDS)	**Refusals during individual interview:** 20 = Objected to provide any/some information on the topic 21 = Objected to provide personal/confidential information 22 = Unable to provide requested information 23 = Refused to continue because he/she got irritated/bored 24 = Refused to continue because he/she got angry

Supervisor's Full Name

Signature

Date

***CIRCLE THE CODE NEXT TO THE APPROPRIATE ANSWER,IF INDICATED,READ THE ANSWER OPTIONS.**

SECTION 1: BIOGRAPHICAL DETAILS OF THE CHILD

1.1 How old is the child (completed years)

		Years

1.2 Is the child a boy or a girl?

Male	**Female**
1	**2**

1.3 Race group of the child.

African	White	Coloured	Asian	**Other**
1	**2**	**3**	**4**	**5**

1.4 What is the nationality of the child?

South African	**Zimbabwean**	**Botswana**	**Other (Specify)**
1	**2**	**3**	**4**

1.5 What is the child's highest educational qualification? *Circle one answer only*

No Schooling	**Grade**											
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

1.6 Is the child's biological mother alive?

Yes	**No**	Don't know
1	**2**	**3**

Go to 1.8

1.7 **(If No)**, how old was the child when the mother passed away?

		Years

1.8 Is the child's biological father alive?

Yes	**No**	Don't know
1	**2**	**3**

Go to 2.1

1.9 **(If No)**, how old was the child when the father passed away?

		Years

SECTION 2: PARENT/GUARDIAN'S BIOGRAPHICAL DATA

2.1 **Just to confirm**. Are you the parent/guardian of this child? (i.e. taking care of/take responsibility for this child).

Yes	No
1	**2**

Go to 2.3 ←

2.2 **(If Yes)**, what is your relationship to this child?

1	**Biological parent**		**2**	**Adoptive parent**	
3	**Step parent**		**4**	**Grand parent (maternal)**	
5	**Grand parent (paternal)**		**6**	**Sister/brother**	
7	**Other family relative (e.g. aunt) maternal**		**8**	**Other family relative (e.g. aunt) paternal**	
9	**Unrelated guardian**		**10**	**Other unrelated (specify)**	

2.3 **(If No to Qn 2.1)**, where is the parent or guardian of this child?

a	Unavailable for interview because at work	1
b	Unavailable because of another commitment	2
c	Too ill to participate	3
d	Not living in the same house, but living in the same area	4
e	Living in another area	5
f	Deceased	6
g	Alive, but we don't know where he/she is	7
h	Other (specify)	8

Questions 2.4 to 2.7 deleted (Not Applicable)

2.8 What is your age (parent/guardian)?

		years

2.9 Sex of the respondent (parent/guardian).

Male	**Female**
1	**2**

2.10 Race of the parent or guardian.

African	White	Coloured	Asian	**Other**
1	**2**	**3**	**4**	**5**

2.11 What is your nationality?

South African	Zimbabwean	Botswana	Other (Specify)
1	2	3	4

2.12 What is your home language? Language spoken most often at home.

01	Afrikaans	06	Isizulu	11	Xitsonga
02	English	07	Sesotho sa borwa	12	Other african
03	Isindebele	08	Sepedi	13	Other european
04	Isiswati	09	Setswana	14	Indian languages
05	Isixhosa	10	Tshivenda	15	Other (specify)

2.13 What is your highest educational qualification?

No schooling	Primary school	Secondary school	Tertiary non-degreed	Tertiary degreed
1	2	3	4	5

2.14 Are you a member of any faith or religious grouping e.g. Faith Based Organisation or denomination?

Yes	No
1	2

Go to 2.18 ←

2.15 To which Faith Based Organisation/faith/religion do you belong?

Catholic	Protestant	Pentecostal	Apostolic Sects	Moslem	Traditional African	Atheist	Other
1	2	3	4	5	6	7	8

2.16 How important is religion to you?

Not important at all	Slightly important	Important	Very important	Not applicable
1	2	3	4	5

2.17 How often do you go to church or other religious gatherings?

Daily	Twice a week	Once a week	Once in two weeks	More than twice a week	Once a month	Never	Other
1	2	3	4	5	6	7	8

2.18 How many children are dependent on you/ children you are caring for? (aged 18 years and below)

2.19 Of these children, how many are your biological children i.e. by birth? (aged 18 years and below)

2.20 Do you have any other dependants (i.e. you are caring for, e.g. parents or nieces)?

Yes	No
1	**2**

Go to 2.22 ←

2.21 **(If Yes**), how many other dependants do you have?

2.22 How would you describe your present employment situation? *(Do not read)*

01	**Housewife, not looking for work**	**02**	**Unemployed, not looking for work**
03	**Unemployed, looking for work**	**04**	**Housewife, looking for work**
05	**Work in informal sector, not looking for permanent work**	**06**	**Pensioner**
07	**Sick/disabled and unable to work**	**08**	**Student**
09	**Self-employed - full time (5 days or more per week)**	**10**	**Self-employed - part time (less than 5 days per week)**
11	**Employed part time (less than 5 days per week)**	**12**	**Employed full time (5 days or more per week)**
13	**Other (specify)**		

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

A	**Not enough money for basic things like food and clothes**	**1**
B	**Have money for food and clothes, but short on many other things**	**2**
C	**We have most of the important things, but few luxury goods.**	**3**
D	**Some money for extra things such as going away for holidays and luxury goods.**	**4**
E	**None of the above.**	**5**

2.24 What is the main source of your household income?

A	**Formal salary/earnings on which you pay income tax**	**1**
B	**Contributions by <u>adult</u> family members or relatives**	**2**
C	**Contributions by <u>younger</u> family members or relatives (<18 years)**	**3**
D	**Government pensions/Grants (e.g. old age pension, disability grant)**	**4**
E	**Grants/Donations by private welfare organizations**	**5**
F	**Informal income**	**6**
G	**Undisclosed**	**7**
H	**Other sources, specify main source:**	**8**

2.25 How do you manage to make ends meet? *(Multiple responses possible) Do not read or Prompt.*

		Mentioned?	
		Yes	**No**
a	**Self employment.**	**1**	**2**
b	**One of household members working.**	**1**	**2**
c	**Support from relatives.**	**1**	**2**
d	**Support from institutions.**	**1**	**2**
e	**Other (specify)**	**1**	**2**

2.26 **If you receive support** (from relatives/organisation) how regular is the support?

Daily	**Once a week**	**Once in 2 weeks**	**Once a month**	**Once in 3 months**	**Once in more than 3 months**	**No response**	**NA**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**

2.27 What nature of support do you receive?

Financial assistance	**Food Assistance**	**School Fees**	**Medical Fees**	**Other**	**Don't know**	**No response**
1	**2**	**3**	**4**	**5**	**6**	**7**

2.28 What do you see as the greatest challenge of heading a household?

Discipline	**Shortage of**	**Sickness**	**School requirem**	**Adjusting to**	**Lack of**	**Other (spec)**	**None**	**No Respon**

	finances		ents	prevailing situations	food			se	
1	2	3	4	5	6	7	8	9	

2.29 What is your current marital status? *(Only one response required) Read**;***

01	**Married - Civil (magistrate)**		**02**	**Married - Traditional (lobola or dowry)**
03	**Married - Religious**		**04**	**Married - Civil and traditional (lobola or dowry)**
05	**Married - Civil and religious**		**06**	**Married - Traditional and religious**
07	**Single/Never married**		**08**	**Divorced / Separated**
09	**Living together/cohabiting**		**10**	**Widowed**
11	**Other (specify)**			

2.30 Have you been ill during the **past month**?

Yes	No
1	2

Boys		Girls		
				If 00 Go 3.1

2.31 How many children under the age of 18 live (excluding visitors) in this house?
2.32 How many of these children are your biological children?
2.33 How many of these children have you taken in?

2.34 What were the reasons for taking these children? *(Multiple responses possible) Do not read or Prompt.*

		Mentioned?	
		Yes	**No**
a	**Migration**	**1**	**2**
b	**Parents died**	**1**	**2**
c	**Children abused**	**1**	**2**
d	**Children abandoned/neglected**	**1**	**2**
e	**Poverty**	**1**	**2**
f	**Other (specify)**	**1**	**2**

2.35 (Targeted for late entries only. That is eight years and above)
Have any of these children been placed in school for the first time?

Yes	**No**
1	**2**

Go to 2.37 ←

\

2.36 **(If Yes)**, so, by whom? **DK = Don't Know, NR = No Response**

Guardian	**Other relative**	**Parent**	**NGO**	**Church**	**Other (specify)**	**DK**	**NR**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**

2.37 Has the household been impacted in any of the following manner since the child came in?

		Yes	**No**	**Don't Know**	**No Response**
A	**Shortage of food**	**1**	**2**	**8**	**9**
B	**Increased medical spending**	**1**	**2**	**8**	**9**
C	**Shortage of money**	**1**	**2**	**8**	**9**
D	**More money spent on food**	**1**	**2**	**8**	**9**
E	**Not enough time to attend to own kids**	**1**	**2**	**8**	**9**

2.38 Has your own children's behaviour changed for the worst since the child came in?

Yes	No	NA
1	**2**	**3**

Go to 3.1 ←

2.39 How do your own children react to the introduction of the additional child? *(Multiple responses possible) Do not read or Prompt.*

		Mentioned? Yes	No
a	Like the child	1	2
b	Dislike the child	1	2
c	Angry towards you	1	2
d	Angry towards the child	1	2
e	Child is incorporated into the family	1	2
g	Other, Specify _____	1	2

2.40 Do your own children play with the child?

Yes	No	Don't Know	No Response
1	2	3	4

SECTION 3: PERCEPTIONS AND EXPERIENCES OF GUARDIANS REGARDING HIV/AIDS AND RELATED ISSUES

In the past 6 months, have you seen an increase in the number of :-	Yes	No
3.1 Orphans living in your neighbourhood?	1	2
3.2 Families taking care of orphaned children in your neighbourhood?	1	2
3.3 Vulnerable children living in your neighbourhood? *Definition of vulnerable: children in need*	1	2
3.4 Families taking care of vulnerable children in your neighbourhood?	1	2

3.5 In your opinion, what are the main reasons that children are being orphaned in your area? *(Multiple responses possible) Do not read or Prompt.*

		Mentioned? Yes	No
a	Poverty	1	2
b	Accidental deaths	1	2
c	HIV/AIDS	1	2
d	Tuberculosis	1	2
e	Other, Specify _____	1	2

3.6 In your opinion, what are the main reasons that children are becoming vulnerable in your area? *(Multiple responses possible) Do not read or Prompt.*

		Mentioned?	
		Yes	**No**
a	**Poverty**	**1**	**2**
b	**Accidental deaths**	**1**	**2**
c	**HIV/AIDS**	**1**	**2**
d	**Tuberculosis**	**1**	**2**
e	**Migrant Labour**	**1**	**2**
f	**Abuse**	**1**	**2**
g	**Violence**	**1**	**2**
h	**Other, Specify**	**1**	**2**

SECTION 4: HIV RELATED ISSUES

4.1 Have you heard about HIV/AIDS?

Yes	**No**
1	**2**

Go to 4.7 ←

4.2 Can you tell if someone is suffering from HIV/AIDS?

Yes	**No**
1	**2**

Go to 4.4 ←

4.3 **(If Yes)**, how can you tell if someone has HIV/AIDS?

.....

.....

	Yes	No
4.4 Do you have any close friends or relatives that you suspect are living with HIV/AIDS?	**1**	**2**
4.5 Do you have any close friends or relatives that you suspect have died of HIV/AIDS?	**1**	**2**
4.6 In the past 6 months, have you seen an increase in the number of people with HIV/AIDS?	**1**	**2**

	Yes	No	NA
4.7 Have you told the child(ren) the cause of their parents' death?	**1**	**2**	**3**

Go to 4.9 ← → ***Go to 4***

4.8 **(If Yes)**, what did you tell him or her?

	Yes	No
4.9 Has anyone else told the children the cause for their parents' death?	**1**	**2**

Go to 4.11 ←

4.10 Who told the children the cause for their parent/s' death?

a	**Uncle**	**01**		**b**	**Aunt**	**02**
c	**Grand father**	**03**		**d**	**Grand mother**	**04**
e	**Step-Mother**	**05**		**f**	**Step-Father**	**06**
g	**Brother**	**07**		**h**	**Sister**	**08**
i	**Mother**	**09**		**j**	**Father**	**10**
k	**Cousin**	**11**		**l**	**Neighbour**	**12**

m	**Family friend**	**13**	**n**	**Other Specify**	.....	**14**
o	**Don't Know**	**15**	**p**	**No Response**		**16**

4.11 What are the main needs for orphaned and vulnerable children? *(Multiple responses possible) Do not read or Prompt.*

			Mentioned?	
			Yes	**No**
a	**Financial support**		**1**	**2**
b	**Food**		**1**	**2**
c	**Educational support**		**1**	**2**
d	**Skills training**		**1**	**2**
e	**Medical support**		**1**	**2**
f	**Socio-emotional support**		**1**	**2**
g	**Adjustment**		**1**	**2**
h	**Other (specify)**	.....	**1**	**2**

4.12 What are the main concerns that you have for the child(ren) you have taken in? *(Multiple responses possible) Do not read or Prompt.*

			Mentioned?	
			Yes	**No**
a	**Financial support**		**1**	**2**
b	**Food**		**1**	**2**
c	**Educational support**		**1**	**2**
d	**Skills training**		**1**	**2**
e	**Medical support**		**1**	**2**
f	**Socio-emotional support**		**1**	**2**
g	**Adjustment**		**1**	**2**
h	**Other (specify)**	.....	**1**	**2**

4.13 What is the biggest concern facing your community with regards to HIV/AIDS. *(Multiple responses possible) Do not read or Prompt.*

Mentioned?	
Yes	**No**

a	**The problem is getting worse**		**1**	**2**
b	**Not enough is being done**		**1**	**2**
c	**People are too afraid of it**		**1**	**2**
d	**There is a lot of discrimination**		**1**	**2**
e	**There is not enough information**		**1**	**2**
f	**Other (specify)**		**1**	**2**

	Yes	**No**
	1	**2**
4.14 Do you talk to children in your household about sex?	**1**	**2**
4.15 Do you talk to children in your household about HIV/AIDS?	**1**	**2**
4.16 Do you talk about reproductive health issues in your family?		

4.17 Do you believe that your children should know about :-

Sex	**1**	**2**
HIV/AIDS	**1**	**2**
Reproductive health	**1**	**2**

4.18 What particular problems do you think this child may be facing? *(Multiple responses possible) Do not read or Prompt.*	**Mentioned?**	
	Yes	**No**

a	**Financial support**		**1**	**2**
b	**Food**		**1**	**2**
c	**Educational support**		**1**	**2**
d	**Skills training**		**1**	**2**
e	**Medical support**		**1**	**2**
f	**Socio-emotional support**		**1**	**2**
g	**Adjustment**		**1**	**2**
h	**Other (specify)**		**1**	**2**

	Yes	**No**	
4.19 Do you suspect that the child has HIV/AIDS?	**1**	**2**	
4.20 Have you taken the child for an HIV test? **(If Yes)**, did you discuss/consult with the child before taking him/her for a	**1**	**2**	**If 2 Go to 5.1**

4.21 test?	**1**	**2**

SECTION 5: GENERAL LIVELIHOOD ISSUES

Make sure that OVC HHH (i.e. Heads of households aged 18 & below, answer the following question).

5.1 When did you assume the responsibility of being the head of this household? **DK = Don't Know, NR = No Response**

Less than 6 months ago	7 months to 1 year ago	Over 1 to 2 years ago	more than 2 years ago	DK	NR
1	**2**	**3**	**4**	**5**	**6**

5.2 How many biological (they have the same mother or father as you) brothers and sisters are you looking after in this household?

Brothers		
Sisters		

5.3 How many other children (they do not have the same mother or father as you) are you taking care of? *(This can be None or Zero)*

Boys		
Girls		

YOU ARE DOING A REALLY GOOD JOB IN LOOKING AFTER THE HOUSEHOLD. PLEASE KEEP IT UP! DO YOU HAVE ANY QUESTIONS FOR US?

Annexure: E. Consent form for OVC Guardians

THE WK KELLOGG FOUNDATION'S ORPHANS AND VULNERABLE CHILDREN (OVC) CARE INTERVENTIONS PROJECT
INFORMED CONSENT FORM

The Human Sciences Research Council (HSRC) have been commissioned by the WK Kellogg Foundation (WKKF) to develop and implement a 5-year intervention project on orphans and vulnerable children (OVC) as well as families and households coping with an increased burden of care for affected children in *South Africa*.
The goals of the project are to:

- Improve the social conditions, health, development and quality of life of vulnerable children and orphans.
- Support families and households coping with an increased burden of care for affected and vulnerable children.
- Strengthen community-based support systems as an indirect means of assisting vulnerable children.
- Build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term.

The main aims of the project are to develop, implement and evaluate some existing and/or new OVC intervention programmes that address the following issues:

- Home-based child-centred health, development, education and support
- Family and household support
- Strengthening community-support systems
- Building HIV/AIDS awareness, advocacy and policy to benefit OVC

We're talking with **guardians of children** here in **[name of city, region or site]** in order to find out their experiences as guardians of orphans and vulnerable children. We invite you to participate in this important study.

I would like to ask you a few questions about your life and the lives of your children. We are asking these questions so that we can understand the situation better and be able to develop interventions and programs for the community. The questions for you will only take about **20 minutes**.

I will also want to talk to the child alone and she or he can agree or refuse to participate. Also she or he has the option of asking you to be present at anytime during the interview. I'm going to ask the child some personal questions about their feelings and their emotions., that she or he could find difficult to answer, Their answers are completely confidential, their name will not be written on this form, and will never be used in connection with any of the information they tell me. He or she does not have to answer any questions that he or she does not want to answer, and s/he may end this interview at any time. The interview will take about ***20 to 45 minutes, depending on the age group.*** Would you be willing to let one of the children participate?

There will not be a direct benefit for you as an individual, but the information that you will share will be useful in our understanding of the situation of orphans and vulnerable children and their families; and will help HSRC and other organisations to implement interventions that are socially and culturally relevant. One possible limitation of participating in the survey is that you may experience intense emotions due to recalling difficult experiences in your life. The benefit of participating is that we have a trained counsellor who is available to connect you to an organisation that can offer you assistance and support if necessary.

If you are averse to discussing such topics with others, please feel free to decline the interview. You have the right to decide whether or not to participate in this study and to withdraw your consent or to leave the research at any time without negative consequences to you.

We would greatly appreciate your help in responding to this interview. Would you be willing to participate in this study?

_____

Signature of the respondent. (*If the respondent refuses to sign but consents to participate in the project, the interviewer must sign on behalf of the respondent certifying that informed consent has been given verbally by the respondent*)

_____

(*Signature of witness certifying that informed consent has been given verbally by respondent*)

If you have any questions about your rights as a study participant, or are dissatisfied at any time with any aspect of the study, you may contact – anonymously, if you wish – Professor Leickness Simbayi at the HSRC on Tel: 021 467 4420 or Fax: 021 461 0029.

Annexure: F. Interview guide for government officials

Date……

Venue……..

Interviewee's position within the Department

……
……

Name of the government department…….

What type of service does this department provide for orphaned children?
……
……
……

What are the government policies regarding orphans and vulnerable children?.....
.....
.....

What are the government's considerations for placing orphans (i.e., are kinship relations a priority or not)?
……
……
……

What are government's incentives for each type of care (extended family care or foster parents)?

……
……
……

What are their own observation regarding the effectiveness of each and why so?
……
……
……

What are the observation regarding (i) socio-economic conditions or orphans, and (ii) community treatment of orphans?
……
……
……

Annexure: G. Interview guide for relative caregivers

Date…….

Venue……..

Age of respondents …….

Gender of respondents ……

Employment status of respondents …….

What is the relationship with the child being cared for?

……..

Why did they decide to adopt an orphan or orphans?

……

……

……

Was it out of the desire to help, they had no children or to access government grants?

……

……

……

How have children adapted in the new home?

……

……

……

How do your relatives feel about the issue?

……
……
……

How has the community responded so far?

……
……
……

Do they find taking in an orphan putting pressures on their resources (having to feed too many mouths)?

……
……
……

What type assistance do they get from the government? Is it enough?

……
……
……
……

What is the size of the household?

……
……
……

Who is the head of the household?

……
……
……

Whose decision was it to take in an orphan?

……

……

……

What is the monthly income of the household?

……

……

……

What are other sources of income for the household?

……

……

……

Annexure: H. Interview guide for non-relative caregivers

Date…….

Venue……..

Age of respondents …….

Gender of respondents ……

Employment status of respondents …….

Why did they decide to adopt an orphan or orphans (out of the desire to help, they had no children or to access government grants)?

……
……
……

What are the long term plans for the child (e.g., any plans to take him/her to tertiary institution)?

……
……
……

How have children adapted in the new home?

……
……
……

How do relatives of orphans feel about the issue?

……
……
……

Would they allow their fostered/adopted orphans visit their relatives?

……

……

……

How do relatives of the guardian feel about the issue?

……

……

……

How has the community responded so far?

……

……

……

Do they find taking in an orphan putting pressures on their resources (having to feed too many mouths)?

……

……

……

What type assistance do they get from the government? Is it enough?

……

……

……

What is the size of the household?

……

……

……....

Who is the head of the household?

……

……

……

Whose decision was it to take in an orphan?

……

……

……....

What is the monthly income of the household?

……

……

……

What are other sources of income household?

……

……

……

Annexure: I. Interview guide for CBO staff & care givers

Date……..

Venue of interview……

Names of organisation?

……
……
……

Position within the organisation?

……
……

Type of services offered to orphans?

……
……
……

Challenges regarding service provision?

……
……
……

Number of orphans that are being serviced?

……
……
……

What are their own observation regarding the effectiveness of each and why so?

……

……
……

What are the observation regarding (i) socio-economic conditions or orphans, and (ii) community treatment of orphans?

……
……
……

What are the government's considerations for placing orphans (i.e., are kinship relations a priority or not)?

……
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What are government's incentives for each type of care (extended family care or foster parents)?

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What are their own observation regarding the effectiveness of each and why so?

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Annexure: J. Consent Form For Guardians

Hello, I am **Tsiliso Tamasane** I am from the Human Sciences Research Council. Our organisation is asking people from your community to answer a few questions, which we hope will benefit your community and possibly other communities in the future.

The Human Sciences Research Council is a national research organisation, and we are conducting research regarding the care and support for orphans and vulnerable children. We are interested in finding out more about the types of networks of social support that are available for orphans and vulnerable children – either from extended family, fostered parents, members of the community, CBOs, FBOs, NGOs and government departments. We are carrying out this research to help to guide government policy regarding the care and support of orphans and vulnerable children.

We have approached you as guardians of orphans to provide us with the information about the opportunities and challenges regarding access of support for care and support for orphans and vulnerable children, including access to government grants as well support from the broader community which will help us make useful recommendations to the relevant authorities and organisations.

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

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 30 minutes. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about them. When it comes to answering these questions, there are no right and wrong answers. When we ask questions about the future we are NOT interested in what you think the best thing would be to do, but what you think would actually happen.

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

CONSENT

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

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

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

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

……..

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

Annexure: K. Consent Form For CBO, NGO & FBO Leaders

Hello, I am **Tsiliso Tamasane** I am from the Human Sciences Research Council. Our organisation is asking people from your community to answer a few questions, which we hope will benefit your community and possibly other communities in the future.

The Human Sciences Research Council is a national research organisation, and we are conducting research regarding the care and support for orphans and vulnerable children. We are interested in finding out more about the types of networks of social support that are available for orphans and vulnerable children – either from extended family, fostered parents, members of the community, CBOs, FBOs, NGOs and government departments. We are carrying out this research to help to guide government policy regarding the care and support of orphans and vulnerable children.

We have approached you as leaders of NGOs, CBOs and FBOs to provide us with the information about the placement of orphans in foster care, opportunities and challenges which will help us make useful recommendations to the relevant authorities and organisations.

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

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 30 minutes. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about them. When it comes to answering these questions, there are no right and wrong answers. When we ask questions about the future we are NOT interested in what you think the best thing would be to do, but what you think would actually happen.

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

CONSENT

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

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

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

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

……..

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

Annexure: L. Consent Form For Government Officials

Hello, I am **Tsiliso Tamasane** I am from the Human Sciences Research Council. Our organisation is asking people from your community to answer a few questions, which we hope will benefit your community and possibly other communities in the future.

The Human Sciences Research Council is a national research organisation, and we are conducting research regarding the care and support for orphans and vulnerable children. We are interested in finding out more about the types of networks of social support that are available for orphans and vulnerable children – either from extended family, fostered parents, members of the community, CBOs, FBOs, NGOs and government departments. We are carrying out this research to help to guide government policy regarding the care and support of orphans and vulnerable children.

We have approached you as a government official to provide us with the information about the placement of orphans in foster care, opportunities and challenges which will help us make useful recommendations to the relevant authorities and organisations.

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

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 30 minutes. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about them. When it comes to answering these questions, there are no right and wrong answers. When we ask questions about the future we are NOT interested in what you think the best thing would be to do, but what you think would actually happen.

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

CONSENT

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

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

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

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

……..

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