AIDS

Home truths:

The phenomenon of residential care for children in a time of AIDS

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Helen Meintjes, Sue Moses, Lizette Berry and Ruth Mampane

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Abbreviations

ARV	Antiretroviral
ART	Antiretroviral treatment
BQCC	Basic Qualification in Child Care
CBO	Community-based organisation
CPU	Child Protection Unit
ECD	Early child development
FBO	Faith-based organisation
FC/PPOS	Foster care or private place of safety
FCG	Foster Care Grant
IDP	Individual development plans
NACCW	National Association of Child Care Workers
NGO	Non-governmental organisation
NPO	Non-profit organisation
OVC	Orphans and Vulnerable Children
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission
TB	Tuberculosis
UNCRC	United Nations Convention on the Rights of the Child

Executive summary

In the face of the burgeoning AIDS epidemic in sub-Saharan Africa, there is widespread concern that responses to increasing numbers of orphans are resulting in a proliferation of orphanages across the region. This unease emanates from the view that care for children – orphaned or otherwise – in a 'home' and 'community' environment is ideal. Institutions, on the other hand, are noted to impact negatively on children, to operate as 'magnets' for children growing up in poverty-stricken environments, and to be disproportionately costly. Arguing that residential care violates the principles of the UN Convention on the Rights of the Child, the international child welfare sector is united in advocating its use as only a temporary 'last resort' for children. The position is shared by the South African government and other key players in the local child welfare sector.

Two important policy processes that are underway aim (in part) to limit, transform and regulate residential care for children. Globally, a range of international agencies are spearheading a campaign for international standards for 'children without parental care'. In South Africa, the primary piece of children's legislation – which includes all provisions for residential care – is under review, and soon to be replaced by a new Children's Act.

However these policy processes are occurring amidst a dearth of systematic empirical evidence about the phenomenon of residential care in sub-Saharan Africa in general, and in South Africa more specifically. We have little more than an anecdotal picture of how the sector manifests in practice on the ground.   In particular, little is known about less formal residential care provisioning, about residential care settings that do not conform neatly in their origins, form or function to conventional institutions and which tend not to be registered with the State as required by law.

It is within this context of inadequate description and analysis of the phenomenon of residential care – particularly in the context of HIV/AIDS – that this study aims to contribute to policy. It sets out to advance understanding of the complex patterning of residential care in South Africa, as well as how it relates to national policy and law and to international child welfare policy on the issue.

Following a careful examination of international and local policy directives regarding residential care, primary research was conducted in four diverse study sites in four South African provinces: Gauteng, KwaZulu-Natal, Limpopo, and the Western Cape. This included a scoping exercise to identify a broad range of residential care arrangements, interviews in residential care settings and with the providers of social services, as well as an audit of children resident in participating homes. Only those facilities concerned with children 'in need of care' – those which would be technically defined as Children's homes in terms of South African law – were included in the study.

Subsequent to an overview of the study methods (sections 2.1-2.6), the report commences with a description of how the international child welfare sector and the South African government define and conceptualise the role of residential care in the context of the HIV epidemic (section 3). It then provides an analysis of basic characteristics of children found to be resident in the range of settings identified (section 5). The remainder of the report is dedicated to detailed exploration of different aspects of residential care settings in the study sites. Particular attention is paid to examining the complexity that exists in practice regarding the legal status of homes, their models of care, staffing, programme provision, relationships to 'community', and funding (section 6). In addition, the critical issues of children's referral to, and admission into, residential care, and the factors affecting their subsequent exit or otherwise from homes, are examined (section 7). The interface between children's homes and government social services is documented throughout the discussions, with focussed consideration occurring primarily in

sections regarding legal status, funding, referrals, leaving care and – of key importance – registration (sections 6.1, 6.9, 7.3 and 8). A stand-alone section (9) provides a brief analysis of knowledge and practice regarding HIV/AIDS in the homes.

The primary conclusions emerging from the study findings can be grouped into six key areas:

Children in residential care

Contrary to popular perception, the child population in the children's homes in the study was neither disproportionately skewed towards large proportions of very young children, nor predominantly constituted by children who had been orphaned. However homes were providing care to an exceptionally high ratio of HIV-positive children. This feature of the child population in the homes raises important considerations for the provision of adequate and appropriate care, including in relation to caregiver skills, training and continuity; and children's access to health services.

While it is tempting to become pre-occupied with 'categories' of children in homes however, it is important not to conflate these with the reasons for children's admission into them. In this regard, the study suggests widespread abuse, neglect and abandonment of children to be the major reasons for their entry into the residential care settings, and that HIV/AIDS and poverty are part of a complex causal pathway rather than the dominant reasons for admission in and of themselves. If this is indeed the case, the distinction has important implications for the design and delivery of 'prevention' services.

Knowledge and practice regarding HIV/AIDS

Despite the high proportion of HIV-positive children resident in homes, knowledge about HIV and AIDS in the residential care settings was uneven and far from comprehensive. In addition, homes' practices regarding HIV tended to be unsystematic, and to address only limited components of the necessary spectrum of HIV interventions. A number of homes nonetheless demonstrated that administration and management of paediatric antiretroviral therapy is possible in group-care settings, as long as systems for doing so are in place.

Key areas requiring strengthening relate to staff and caregiver HIV literacy, including awareness of the prevention of mother to child transmission, post-exposure prophylaxis, HIV testing and disclosure, and antiretroviral therapy; and relationships between HIV health services and homes. In addition, widespread perceptions that HIV-positive children are not suitable for foster care or adoption are of concern.

Policy discourse

Despite the international drive to limit residential care facilities to small, local homes that minimise the physical and social separation of children, the discourse surrounding residential care throughout both international and South African policy and legislation is anchored in a perception of residential care as that provided by 'conventional' institutions. This institutional discourse represents the practice of residential care as a professionalised, highly structured, service-oriented, formalised intervention. Recommendations and provisions clearly envisage professional interventions designed to provide temporary therapeutic care to children in order to 'return' them to family or community settings.

A clear distinction between residential care and family- or community-based care is inherent throughout policy discourse. At the core of this distinction is a series of overlapping dichotomies: A 'first resort' model of care for children juxtaposed with an explicit 'last resort' model; a context of care in which children's rights are protected juxtaposed with one in which rights are violated; and an existence embedded in everyday community juxtaposed with an existence 'inside' an institution, separate from community.

The complexity of residential care provision 'on the ground'

The situation of residential care 'on the ground' in South Africa is demonstrated to be much more complex than is acknowledged in policy discourse and debate both locally and internationally. Data from the study documents how residential care settings for children vary substantially across multiple axes, and how in many instances negative features associated with residential care settings do not apply. These include concerns about children's routine dislocation from family, community, and cultural background; their marginalisation from everyday society; and the absence of opportunities to develop secure, long-lasting attachments.

Furthermore, given the extent of heterogeneity in the sector, the inherent focus in policy on conventional institutional forms seems misplaced in the South African context. The study findings clearly illustrate the blurring of boundaries between family-based, community-based and residential care, and raise questions about the usefulness of the categorical distinction between the 'first' and 'last resorts'.

Registration

Much of the attention directed at residential care by both the State and non-governmental children's sector in South Africa is preoccupied with the legal status of existing and new residential care settings, with the tendency to characterise unregistered homes in entirely negative terms. However, the study indicates that the legal categorisation of residential care settings reveals little about homes themselves, or more broadly about the nature of residential care. Rather it masks the phenomenal diversity that exists across the sector, both within and across legal categories of homes.

Furthermore, the study findings raise concerns about current and pending registration requirements and practices. Not only does the law and its implementation work against the registration of many community-based residential settings that are providing important (if imperfect) support to children, but it is also more facilitative of the establishment of more conventional institutions. The nature of the legal requirements for registration propels creative, responsive community-based residential initiatives pursuing registration towards care of a more stereotypically institutional nature, resulting in the loss of some of their more positive qualities in the process. They can also introduce practices that jar with the essence of the care environments, and are somewhat incoherent in the context.

The interface between legislation, government practice and residential care provision

In practice, all too often government's interactions with residential care settings are fraught with confusion and frustration. Mixed messages are communicated to unregistered homes: Contradictory funding mechanisms operate within and between departments and tiers of government. Social workers place children in care at unregistered homes while concomitantly homes' official registration is rejected. The drive to place children in family-based settings is not matched by the capacity of the Social Services to process, monitor or support placements adequately. Services aimed at 'prevention' and 'early intervention' – critical components of the Department of Social Development's vision for the provision of a developmental continuum of care for children – remain insufficiently resourced, and limited in reach. Homes are refused registration and are shut down on the grounds that residential care is unsuitable for children, while current circumstances render overburdened and under-funded state Social Services unable to support children in families adequately.

Paradoxically, at the core of the Developmental Social Welfare model that underpins all post-1994 social development policy in South Africa is a recognition of the value inherent in 'indigenous' responses. The model sets out to resource and empower local level insights and responses to social circumstances and to place emphasis on the provision of a wide range of

interventions that together support a broad 'continuum of care' for children as part of wider social development goals. It is precisely the creativity and sensitivity of local responses that the model aims to build upon in strengthening social service delivery.

However, it is also the complexity and the ambiguity that is described in the course of this report that makes the broad arena of residential care for children a difficult one for the State to systematise, support, monitor and regulate. The danger is that at this time of much policy and legislative review in South Africa we – as both government and the children's sector – promote unhelpful, inappropriate, unfacilitative policy and legislation based on conventional and simplistic notions of what residential care is and should be. It would be preferable to seize the opportunity to ensure flexibility in our policy and law that recognises the need to resource as well as regulate the wide variety of informal social care responses that exist.

1. Introduction

"An organisation in South Africa's Kwazulu-Natal province plans to build an AIDS orphan village to take the burden off grandmothers, who are frequently the main caretakers of an ever-growing number of these children." *(PlusNews, 12 October 2004)*

"We know that institutional care, unless used only when there is absolutely no other alternative and carefully regulated, violates the very principles of the Convention on the Rights of the Child as well as many of its articles." (*International Save the Children Alliance, 2003*)

"The reason for interacting with the children was that I looked at them and said 'Who are these children and where are their parents?" *(Founder, unregistered children's home, Gauteng)*

"Unfortunately government is too idealistic ... There are things that we demand not knowing that we're going to negatively affect the people that we're trying to help." *(Department of Social Development official)*

"Does it now mean that because of our restrictions we should not help the children? Does it mean that we should just leave the vulnerable children in the bush?" (*Founder, unregistered children's home, KwaZulu-Natal*)

1.1 Background and aim of study

In the midst of a burgeoning AIDS epidemic in sub-Saharan Africa, there is widespread local and international concern that responses to increasing numbers of orphans are resulting in a proliferation of orphanages across the region. This unease about the 'mushrooming' of residential care facilities emanates from the view that care for children – orphaned or otherwise – in a 'home' and 'community' environment is the ideal. In contrast, residential care is widely perceived as the 'last resort' for addressing children's care needs – a position that is shared by the South African government and other key players in the child welfare sector. The rationale is based on concerns about the negative impact of long-term institutionalisation on children, that orphanages operate as 'magnets' for children growing up in poverty-stricken environments, and the high costs of raising a child in an institution relative to a family setting, among others[1].

A growing grey literature from the child welfare sector considers the role of residential care in providing care to children, including in the context of HIV and AIDS in sub-Saharan Africa and elsewhere. However it draws on a limited evidence base: there is a dearth of academic or empirical research into the issue, in particular in sub-Saharan Africa. Very few studies systematically describe or analyse the phenomenon of residential care in Africa or South Africa[2]. This leaves little more than an anecdotal picture of how it manifests in practice on the ground.

Where studies do exist, the tendency is to focus attention on 'conventional' forms of institutions[3]: large, formal, top-down interventions which characteristically remove children from their home 'communities'. However, at least in South Africa, the residential care sector is constituted by a far more diverse set of group-care arrangements. Many residential care settings in the country do not conform neatly to conventional institutions in their origins, form or

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[1] See section 3.1 for further discussion.
[2] Exceptions include Powell et al (2006; 2005) in Zimbabwe and Afroline Media Initiatives & UNICEF in Kenya (2002).
[3] Two South African exceptions are Meiring (2005) and Abdulla et al (2007) each of which takes into consideration the operation of less formal and unregistered facilities.

function. In addition, they are frequently not registered with the State, and, as a result, their services are unmonitored and unsupported (financially or otherwise) by government.

It is within this context of inadequate description of the phenomenon of residential care – particularly in the context of HIV/AIDS – that this study aims to advance understanding by exploring the practice of residential care in contemporary South Africa, as well as how it relates to national policy and law and to international child welfare policy on the issue.

The study objectives are as follows:

1. To describe how the international child welfare sector conceptualises the role of residential care in the context of the HIV/AIDS epidemic.

2. To describe how the South African government defines the role of residential care in the context of the HIV/AIDS epidemic.

3. To explore a range of different kinds of residential care 'facilities' for children in the context of HIV/AIDS in South Africa.

4. To understand why a variety of residential care arrangements exist, in particular those that have emerged from community-based initiatives.

5. To consider the relationship between different forms of residential care in contemporary South Africa and related national law and policy and international child welfare policy on the issue.

Empirical research to explore the complex patterning of residential care provision in South Africa is timely for a number of reasons. At a global level, a campaign for international standards for 'children without parental care' and needing 'alternative care' of various kinds is well underway, and issues related to institutional care are high on the agenda of numerous participating international child welfare agencies and non-governmental organisations (NGOs). In South Africa, the existing legislation governing children's care and protection – the Child Care Act of 1983 – is in the midst of review. Its replacement, the Children's Act and Children's Amendment Bill, include a range of new provisions for residential care (under the broader ambit of "Child and Youth Care Centres"). Once the Act is passed, the associated Regulations as well as a set of Minimum Norms and Standards for residential care will require reworking and finalisation. In addition, there will be associated developments in service delivery arrangements and in workforce planning and training. If the potential benefits to children from these important initiatives are to be effective, those responsible for drafting, finalising, planning and implementation need to engage with the full spectrum of residential care arrangements, the complex patterning of care provision and the processes that have created it.

1.2   A note on focus and terminology

As Skelton (2005:4) points out, the residential care system in South Africa "straddles two systems: the system dealing with children in need of care, and the system dealing with children accused and convicted of crimes". This report considers only those facilities concerned with children 'in need of care' – those which would usually, in terms of South African law, be called Children's Homes.

A single accurate descriptive label to refer to the homes that participated in the study is however difficult to identify, considering the extent of variation between them. Many were expressly not Children's Homes as understood by South African legislation (see 3.2), and even the use of the term 'facility' is misleading in some cases in terms of the home's character or identity. We therefore make extensive use of terms such as 'settings', 'set-ups', 'homes' and 'care

arrangements' to enable inclusive reference to the range identified. We also refer to 'children's homes' as the generic form of residential care, and to the capitalised 'Children's Homes' when referring to facilities with official registration as such. The term 'residential care' is used interchangeably throughout the report with the term 'children's homes'. In general the term 'institution' is used only to refer to more conventional facilities.

Case studies throughout the report aim to provide texture to the variety of residential care, and to begin to illustrate the complexity of any attempt to categorise, systematise or regulate the sector. Where children's homes are described in more than one case study, a cross-reference to related case studies is provided.

2. Study design

The study was designed in order to report within a year and so maximise its influence on current policy opportunities. Of necessity, the design took account of the absence of evidence-based literature on effective practice or comprehensive data on needs and services with regard to residential care for children. Furthermore, it recognised that much of residential care provision is hidden from any form of official accounting.

The methods the study employed were therefore primarily exploratory and qualitative, seeking to improve understanding of provision rather than undertaking empirical mapping or cost benefit evaluation.

The data collection for the project was conducted in a series of overlapping phases over the period January – September 2006, as outlined below. Fieldwork was conducted by the four authors, with the support of a translator/field assistant in some instances in the Western Cape site.

2.1 Literature review

A literature review of South African and international academic and grey literature assessed existing evidence regarding the provision and (actual or perceived) role of residential care for children in the context of the HIV epidemic.

The search for academic literature utilised a range of relevant bibliographic search engines/databases. Search terms focussed on identifying research regarding policy and practice of residential care for children in the context of the HIV epidemic, in Africa and South Africa. Grey literature was sourced through internet search engine Google, through networks such as the Global Network for Better Care, and from the collection developed and maintained in the HIV/AIDS programme library at the Children's Institute over the past five years.

For the purposes of describing the international child welfare sector's conceptualisation of the role of residential care in the context of HIV and its place in the 'first resort'/'last resort' debate, attention focussed in particular on policies, reports and other documents associated with the campaign by international child welfare agencies for international standards for "children without parental care".

2.2 Policy review

A policy review examined current and pending South African policy and legal frameworks which relate to residential care provision for children. Key official documents included the following:

- Child Care Act no. 74 of 1983 and its regulations
- Children's Act no. 38 of 2005
- Children's Amendment Bill no. 19 of 2006
- Minimum standards for South African Child and Youth Care Centres
- OVC Policy Framework and National Action Plan.

2.3 Scoping of existing data

An empirical scoping of existing data on residential care provision for children in South Africa identified and collated the limited data about the range and extent of existing residential care provision for children in South Africa from existing sources. Ultimately the only national data available (although incomplete) was from the national Department of Social Development's own records.

Existing data therefore does not provide a representative picture of existing provision, in particular because of the absence of rigorous data on unregistered/informal homes. It does however highlight some aspects of the residential care response in contemporary South Africa, suggesting types of arrangements, and enabling the identification of gaps in knowledge and information.

2.4 Empirical scoping of residential care provision in field sites

The study seeks to understand and document some of the different forms that residential care for children is taking in practice in contemporary South Africa, the reasons that these different forms exist, and their place in responding to the HIV epidemic. In order to do so, a range of different residential care arrangements for children needed to be identified, including both settings that were officially registered and others that were not.

Residential care settings in South Africa must conform to a set of legislative requirements in order to operate legally. These include a provision that all homes must be officially registered with the Department of Social Development. In practice many homes operate outside of the law. The legal provisions for residential care are outlined in detail in section 6.1 as well as throughout the report.

The emphasis on exploring a range of different residential care arrangements, in particular those which were not registered as Children's Homes with the Department of Social Development, raised challenging sampling issues. Lists of registered and state Children's Homes are available from the Department of Social Development. However unregistered initiatives are impossible to identify in a systematic way without detailed community mapping - a task that was outside the aim, objectives, budget and timeframes of this project. Child care organisations such as the National Association of Child Care Workers (NACCW), the South African National Council for Child Welfare, and the Johannesburg-based Big Shoes Foundation (previously the Children's Homes Medical Outreach Project or CHOMP) have access to unregistered children's homes, but are not able to provide a comprehensive list of homes countrywide (or even locally). In some instances, care arrangements that would be considered by the law to require formalisation and registration as children's homes are not seen as residential facilities by those involved.

The study therefore deals in large part with a hidden population, from which it is impossible to draw a statistically representative sample. As a qualitative study that is focussed on "understanding rather than measuring difference" (Ritchie & Lewis, 2003), purposive sampling was more appropriate. Therefore, in order to identify residential care arrangements that could provide the base for a purposive sample, an empirical scoping exercise was conducted in each study site.

Four sites provided the physical locations around which children's homes were identified for participation in the study. The study sites selected shared the characteristic of high HIV/AIDS prevalence (as defined by provincial antenatal survey results) but otherwise exhibited variation, including provincial spread and a rural/urban/peri-urban mix. Other factors governing site selection included the presence of good entry points (e.g. strong relationships with one or more service providers due to previous research) and the location of the two research partner organisations in Gauteng and Cape Town. Staffing and budget capacity required that these factors be considered.

The four sites identified were as follows[4]:

1. A rural site in KwaZulu-Natal
2. A peri-urban site in Limpopo

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[4] Exact sites are not named in order to protect the confidentiality of participants.

3. An inner city site in Gauteng
4. A township site in the Western Cape

Table 1 below provides basic illustrative data on each of the sites:

Table 1. Background to research sites

Indicator[a]	W.Cape	Gauteng	Limpopo	KZN
HIV-prevalence rate among antenatal clinic attendees, 2005 [prov.][b]	15.7%	32.4%	21.5%	39.1%
HIV-prevalence rate among children 0-17 years, 2006 [prov.][c]	0.8%	2.5%	1.4%	3.2%
Proportion of population 0-19 years, 2001[d]	40%	23%	46%	60%
Proportion of children 0-17 years who are orphans[e], 2005 [prov.][f]	9%	11%	16%	23%
Age dependency ratio[g], 2001[prov.][h]	48.2	38.1	81.8	64.8
Proportion of households with no income[i], 2001[d]	25%	18%	24%	51%
Proportion of adult population who are employed[j], 2001[d]	39%	57%	34%	8%

a	This table is derived from ward-level data unless otherwise indicated.
b	Department of Health. (2006). *National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005.* Pretoria: National Department of Health.
c	Actuarial Society of South Africa. (2005). *ASSA2003 AIDS and Demographic Model*. Available: http://www.assa.org.za.
d	Statistics South Africa. (2003). *Census 2001.* Available: http://www.demarcation.org.za.
e	The term 'orphan' refers to a child under the age of 18 years whose biological mother, biological father or both parents have died or whose whereabouts are unknown.
f	Statistics South Africa. (2006). *General Household Survey 2005.* Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, University of Cape Town.
g	The age dependency ratio is an index that reflects the ratio of the independent proportion of the population (i.e. working age population 16 to 65 years old) against the dependent proportion of the population (i.e. non-working 0 to 15 years old and over 65 years old). A higher index value indicates a more dependent population.
h	Census 2001 calculations. Source: Day, C. & Gray, A. (2006). Health and related indicators. In P. Ijumba & A. Padarath (eds.), *South African health review 2006.* Durban: Health Systems Trust.
i	'Income' refers to money received from salary, wages or own business, including monetary benefits from employer (e.g. medical aid). It includes money from other sources such as remittances and social grants.
j	'Employed' refers to a person who works for pay, profit or family gain. Such a person can be an employer, an employee, or self-employed.

The scoping exercise entailed identifying residential care arrangements which should be available to children in need of care living within the site.   These included those run by the State, those registered as Children's Homes, those operating through foster care and private place of safety legislation, and those that were not registered at all.   Residential care settings identified were not necessarily all located within the geographical area of the site, but were all providing residential care to children from the site.

Identification was achieved by mapping local knowledge of formal and informal placement options for children: from local state and NGO social workers, community volunteers, clinics treating HIV-infected children, the police, organisations and networks working in or knowledgeable about the area, and other relevant roleplayers.   These scoping interviews were telephonic or face-to-face, as was feasible and appropriate.

The clustering of homes on the basis of geographical catchment simplified collection of data regarding context (including that of social service provision), as well as enabling some exploration of links/relationships between homes.

2.5   Primary research in residential care facilities

Key to understanding the role of residential care in the context of HIV is a solid understanding of its provision, from the perspective of those providing the care.   Children's homes identified in the scoping exercise provided the basis of the sample for this component of the study. In each

case, in-depth interviews were conducted with managerial staff/the person in charge at the home. While the intention at the outset of the study had been to interview a care-worker in addition to management in each setting, this was not always possible.

Broad topic guides (rather than structured schedules) were developed and piloted for use in the interviews.

Interviews were audio-recorded and transcribed where possible, and detailed notes taken where not[5]. Researchers also documented observations of interactions in the facility, the facility environment, and events that occurred during the interview.

Interviews were conducted in a total of 34 residential care settings, across the four study sites. Table 2 below provides more detail. The variation in the number of homes accessed in each site is primarily a function of local service delivery levels.

In addition to interviews, homes were requested to complete a simple audit of children resident at the time of the interview. It was not possible to obtain an audit from every home: staff at some homes were not willing to complete the audit despite having been willing to be interviewed, and others failed to submit the completed forms despite repeated attempts on the part of the research team to collect them. A total of 28 audits (providing information about a total of 1007 children) were collected and collated for analysis of basic information about the population of children resident in the homes participating in the study.

Table 2. Number of residential care facilities which participated in the study, by research site

Site	Children's audit completed	Children's audit not completed	Total
Gauteng site	11	2	13
KwaZulu-Natal site	2	0	2
Limpopo site	4	2	6
Western Cape site	11	2	13
Total	**28**	**6**	**34**

2.6 Primary research with social service providers

A key strength of site-based research is that it enables the exploration of relationships between role-players in the sites. In this instance, it also provided an opportunity for mapping experiences of the care needs of children and of residential care provision in the sites from multiple perspectives. In each site, interviews were conducted with government social workers in district welfare offices responsible for the provision of services in the research site, as well as with a limited number of NGOs providing statutory social work services for children in the area. Interviews were semi-structured, and based on a topic guide developed and piloted for research purposes.

2.7 Analysis

All interviews with residential care facility staff and social service providers, as well as researchers' fieldnotes, were coded using Atlas-ti software and analysed thematically. Throughout the process, hypotheses, conclusions and recommendations about the data were formulated, examined and challenged.

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[5] In a few instances, interviewees preferred not to be recorded.

2.8 Limitations

The illegal nature of unregistered homes – and concerns about the welfare of children in them should the homes be closed down – understandably fuels mistrust and caution on the part of many of those running them as well as those who provide them with support. Owing to the time-consuming nature of developing trust, it was not possible to identify all unregistered homes in each site within the time-frames of the empirical scoping phase of the study, or to gain access to all of those identified. Fear and mistrust of the research on the part of staff at some of the unregistered homes that were identified resulted in access being denied in three cases. It is not possible to know whether poor conditions in the respective homes prompted this gatekeeping.

The existence of long-term research contacts in the KwaZulu-Natal and Limpopo sites, and the significantly lower levels of service provision in each, meant that the project team were confident that no unregistered homes in these sites were excluded from the study. However, in the Western Cape and Gauteng sites, additional unregistered homes continued to emerge even after the scoping phase had ended. This points to a much larger unregistered population than is reported on in this study.

The choice to go for study breadth in order to document a range of residential care settings meant compromising on depth (in light of the study time-frames). This led to limited direct observation in the homes and a reliance on respondent reporting. Where it was possible to obtain more than one perspective on a home, from a manager and a care-worker for example, this went some way towards identifying any reporting bias and offered opportunities to investigate inconsistencies. It was not always ethically desirable to return to homes repeatedly because some were operating with very few carers or staff. Some homes in the Western Cape site were inundated by researchers, which also affected the quality of engagement it was possible to achieve. Flexibility and sensitivity to these issues went some way towards addressing these concerns.

Although great care was taken to ensure confidentiality and to allay fears of the research as being an evaluation or as being punitive in any way, it was apparent in some cases that mistrust or anxiety on the part of respondents influenced how they reported and portrayed aspects of their activities. Similarly, despite having been given clarity that no direct benefits would accrue to homes taking part in the research, staff at some homes viewed the interview process as an opportunity that might assist with procuring funds, thus also influencing responses. Great care has been taken to interpret the relevant interviews with these points in mind.

2.9 Ethics

Ethics clearance for the project was granted by the Health Sciences Faculty's Research Ethics Committee at the University of Cape Town (Ref no. 003/005). An ethics statement was developed and agreed upon by the project team prior to engaging in fieldwork. Issues covered included privacy, anonymity and confidentiality; informed consent; circumstances in which confidentiality could not be guaranteed; professional integrity; and researchers' relationships with participants.

All participants in the research signed consent forms. Pseudonyms are used throughout the report to assist with confidentiality, although it is recognised that in some instances identity may not be concealed to all readers because of individuals' positions as office bearers, or because of knowledge of research sites.

3. The policy and legislative environment

3.1 The international child welfare sector's position on residential care in the context of AIDS

The international child welfare sector provides a clear and coherent position on residential care as one of a set of care options for children 'without parental care'[6]. Major international agencies concerned with the needs and rights of children such as UNICEF, Save the Children, and USAID's Displaced Children and Orphans Fund are aligned with other key international players[7] in a unanimous stance advocating for residential care as only a temporary 'last resort' for children[8].

The agencies' policy and other literature repeatedly reiterates a consistent set of negative impacts on children resulting from experiences of residential care (International HIV/AIDS Alliance & Family Health International, 2006; International Save the Children Alliance, 2003; International Social Service & UNICEF, 2004a, 2004b, 2004c; McCreery, 2003; Tolfree, 1995, 2003; UNAIDS, UNICEF, & USAID, 2004; UNICEF, 2006a; UNICEF & UNAIDS, 2004; Williamson, 2004). The concern is that residential care:

- Threatens children's normal developmental processes, primarily through a lack of individual attention and opportunities for attachment with adults;
- Fails to transfer critical life-skills to children, resulting in children being inadequately prepared to cope with life when they leave care and, in instances, predisposing care-leavers to antisocial behaviour;
- Results in children being dislocated from their families, their communities, and concomitantly, their cultural background and identity; resulting in problems of 'reintegrating' into society.
- Marginalises children from society, and is accompanied by experiences of stigma and discrimination;
- Frequently fails to respond to children's individual needs, characteristically prioritising the needs of institutional functioning;
- Exposes children to overcrowding and a lack of privacy;
- Frequently exposes children to increased illness, a lack of access to medical care, and/or education;
- Puts children at risk of sexual and physical abuse by residential care staff and older children, and in extreme circumstances has resulted in trafficking of children;
- Operates as a 'magnet' in poor neighbourhoods: ie. residential care settings are used by poverty-stricken caregivers as an "economic coping mechanism" (Williamson, 2004), resulting in children being placed there because of lack of access to resources, as opposed to a lack of suitable care.

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[6] The term 'children without parental care' is defined in a key document as "all children not living with their parents, for whatever reason and in whatever circumstances" (International Social Service & UNICEF, 2004a).

[7] These include the International HIV/AIDS Alliance, Family Health International, International Social Services, CARE, USAID, UNAIDS, the Bernard van Leer foundation, Christian AID, World Vision and Catholic Relief Services, among others.

[8] Although both the International AIDS Alliance and Family Health International endorse documents that take this stance, an OVC Toolkit they have produced takes a firmer line. They critique the idea that residential care should exist at all as a care option for children, because "it allows institutions to remain. They will continue to be magnets, attracting both children and resources" (International HIV/AIDS Alliance & Family Health International, 2006).

On the basis of these points, the sector argues that residential care violates the principles of the UN Convention on the Rights of the Child, as well as many of its articles. The placement of children in residential care facilities should therefore be avoided as far as possible.

Agency concerns about institutional care for children are heightened in the face of the AIDS pandemic. It is argued that as a result of ill-informed (if well-intentioned) donor and other responses to a growing number of orphans, "countries that were successfully on the path towards providing non-institutional care for more and more of their children are experiencing a renewed growth of recourse to residential solutions" (International Social Service & UNICEF, 2004b: 3). Evidence from a study of faith-based organisations' interventions in six African countries hard-hit by HIV is commonly cited to confirm this perception: 35% of orphanages recorded during the study had been established since 1999 (Foster, 2004)[9]. Agencies point out that the high costs of residential care in contrast to the costs of supporting family- and community-based interventions risk a concentration of expenditure on only small numbers of children affected by the epidemic, when large (and increasing) numbers are in need of support. Not only are residential interventions inappropriate for children, but the scale of the problem of care in the context of HIV in Africa is such that institutions could never address it, it is argued, and the high donor appeal of residential facilities increases the risk of disproportional expenditure that would be better directed at community-based responses. Furthermore, it is commonly suggested that people's struggles with poverty compounded by HIV will exacerbate the 'magnet' effect of residential facilities (International Social Service & UNICEF, 2004b; Loudon, 2002; Monk, 2001; Olson, Knight, & Foster, 2006; Tolfree, 2003; UNAIDS et al., 2004; UNICEF, 2003, 2006a; UNICEF & UNAIDS, 2004; UNICEF ESAR, USAID, & Family Health International, 2002).

In late 2004, a campaign by a number of agencies therefore began a call for international standards for children without parental care (International Social Service & UNICEF, 2004c:3), including standards of care for children in, or faced with the possibility of, residential care[10]. The care needs of children affected by HIV/AIDS were given particular consideration. The call was heeded by the UN Committee on the Rights of the Child who recommended that UN Guidelines for the protection and alternative care of children without parental care be drafted (UN Committee on the Rights of the Child, 2004). By mid-2006, a draft set of guidelines was in place, ready for discussion at an inter-state level[11]. The guidelines focussed on the dual aims of preventing children's separation from their biological parents, and in instances where this is not possible, ensuring that the best form of (preferably 'family-based') 'alternative care' is identified.

The guidelines defined residential care as "care provided in any non-family-based group setting" (International Social Service, UNICEF, & NGO Working Group on Children without Parental Care, 2006: para 30(f))[12]. They are clear in reiterating the use of residential care as a final and imperfect placement option for children, in particular for young children. As a fundamental principle, the guidelines urge for deinstitutionalisation strategies, especially in instances of large institutions, and that "no new facilities of this nature should be established under any circumstances" (International Social Service et al., 2006: para 20). Specific

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[9] See also Powell et al (2006; 2005) and conclusions drawn from their study of residential care in Zimbabwe.
[10] The campaign focuses in addition on children in both informal and formal foster care, children in emergency situations, and children who are 'without care', living in child-headed households or on the streets, for example.
[11] The guidelines were debated at an inter-state meeting held in Brazilia in August 2006. A number of changes were apparently made to the guidelines, but these were not yet publicly available at the time of writing (pers. comm. Nigel Cantwell).
[12] Earlier definitions of residential care in the campaign include "a group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society" (International Save the Children Alliance, 2003) and, subsequently, "any living situation [for children] that is not family-based" (International Social Service & UNICEF, 2004b).

provisions regarding residential care call for residential care facilities to be small, approximating family settings or small group homes, and providing only temporary care to children; for their admissions to be strictly monitored; and for sufficient carers to be in place to provide children with individualised attention (International Social Service et al., 2006: para 124-127).

3.2 The South African policy and legal framework on residential care in the context of AIDS[13]

South African policy does not address issues regarding the use of residential care for children in the face of the AIDS epidemic as overtly as the international policy literature. None of the relevant policies highlight the potential pitfalls of residential care for children, and the *White Paper for Social Welfare* (1997) and the draft *Minimum Norms and Standards for Child and Youth Care* (1998) are the only pieces that articulate residential care as a 'last resort'.

However, the approaches advocated by international consensus are nonetheless reflected in all existing welfare policy, including that which specifically addresses the impact of HIV/AIDS on children. There are justifiable concerns about the way post-democracy child welfare policies fail to articulate with each other, resulting in a lack of clarity and leaving gaps in service responses (see Streak, 2005). However all are explicitly developmental in their focus, and stress that support services and interventions must be family- and community-based[14].

Key HIV/AIDS-related policy documents addressing the impact of the epidemic on children – such as the *Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS* (2005b) and its associated *National Action Plan for Orphans and Other Children made vulnerable by HIV and AIDS, South Africa: 2006-2008* – make no reference to residential care. However, they reiterate wholesale the principles and strategies of the international *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF & UNAIDS, 2004), focussing on strengthening family- and community-based models of care for children. In these two over-arching policies, as well as others developed prior to them such as the *National Integrated Plan for Children Infected and Affected by AIDS* (2000), the *National Guidelines for Social Services for Children Infected and Affected by HIV/AIDS* (2002), and the *Guidelines for Establishment of Child Care Forums* (2003), interventions targeting vulnerable children focus on the provision of Home- and Community-based Care Services, and the establishment of community Child-Care Forums to identify and support children. The OVC Policy Framework in addition recommends the provision of formal foster care placements for orphans[15].

Unlike many other developing world governments (Tolfree, 1995), the South African government has a clear regulatory framework for residential care. This is primarily detailed in the Child Care Act of 1983 and its associated regulations, as well as in a Minimum Standards for Child and Youth Care policy (released in draft form in 1998, but never formally finalised despite instructions from the government that it be implemented[16]). This set of legislation is almost entirely concerned with the legal provisions associated with the protection of children who are not – or are not able to be – in the care of their biological parent(s).

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[13] For a detailed analysis of children's right to social services in South Africa, see Dutschke (2006).

[14] See for example, the Department of Social Development's interim policy on the Transformation of the Child and Youth Care System in South Africa (1998), the Minimum Standards for the South African Child & Youth Care System (1998), the Draft National Policy for Families (2004a), the National Policy Framework and Strategic plan for the Prevention and Management of Child Abuse, Neglect and Exploitation (2004b), the Integrated Service Delivery Model: toward improved social services (2005a) and the Department's Strategic Plan 2006/7-2009/10 (2006).

[15] See Meintjes, Budlender, Giese & Johnson (2005) for a critique of this specific aspect of the government's response.

[16] The finalisation of the Minimum Standards document will occur in tandem with the drafting of the regulations for the new Children's Act, anticipated during the course of 2007.

South African law currently sub-divides the broad category of residential or 'institutional' care into a set of different kinds of facilities, on the basis of the function they fulfil and the needs of the children they serve. These are as follows (Child Care Act of 1983, s.1.1):

- *Children's home:* "Any residence or home maintained for the reception, protection, care and bringing-up of more than six children apart from their parents, but does not include any school of industries or reform school".
- *Institution:* "A reform school, school of industries or a children's home established under section 29 or a children's home registered under section 30".
- *Place of care:* "means any building or premises maintained or used, whether for profit or otherwise, for the reception, protection and temporary or partial care of more than six children apart from their parents, but does not include any boarding school, school hostel or any establishment which is maintained or used mainly for the tuition or training of children and which is controlled by or which has been registered or approved by the State, including a provincial administration".
- *Place of safety:* "Any place established under section 28 and includes any place suitable for the reception of a child, into which the owner, occupier or person in charge thereof is willing to receive a child".
- *Reform school:* "A school maintained for the reception, care and training of children sent thereto in terms of the Criminal Procedure Act, 1977, or transferred thereto under this Act".
- *Shelter:* "Any building or premises maintained or used for the reception, protection and temporary care of more than six children in especially difficult circumstances". I.e.: place of care for children who are living "in circumstances which deny them their basic needs, such a children living on the streets or children exposed to armed conflict or violence".

The purpose and functioning of each of these types of facilities is slightly different. Reform schools are aimed at children who have been convicted, while places of safety perform a much broader range of functions but are intended specifically to provide short-term placements for children who are awaiting trial or sentence or until appropriate longer-term arrangements can be made for them (such as their return to families, or placement in foster care or a Children's Home) (Child Care Act, s.21(1)). In contrast, the general purpose of Children's Homes is for the "reception, care and bringing up of children" (Child Care Act, s.29(1)). There are slightly different provisions and regulations associated with each. The vast majority of Children's Homes are run by welfare organisations; only a small handful country-wide are managed entirely by the government.

By law, a court inquiry is required in order for children to be placed in any of these facilities. Based on a series of criteria which define a child in legal terms as being 'in need of care' (see Child Care Act, s.14(4)), the court may order that he/she be placed in a residential facility of some kind. (See section 7 for more detail.)

In addition, any care arrangement in which more than six children are resident with a caregiver who is not kin is required by law to be registered as an official facility with the Department of Social Development and to conform to a series of criteria articulated in the Child Care Act and its regulations. (Section 8 provides more detail and discussion of these criteria.) Registration as a children's home or other residential facility establishes the maximum number of children that may be cared for at the facility at any given time, and the legal age-range of children that may be resident, among other things. In addition, registration as a residential facility with the Department entitles the facility to apply for a government subsidy of its services. This is allocated on a per-capita basis, although a new financing policy – currently being piloted – aims to change this approach in the future.

In other words, in terms of current South African law, it is illegal to care for more than six unrelated children without court orders or legal emergency-placement orders. Concomitantly,

any group-care set-up that does not consist (solely) of kin (grandchildren, siblings, nephews or nieces etc.) is illegal unless approved by the Department of Social Development.

New children's legislation that will ultimately replace the Child Care Act of 1983 has been under preparation for many years. The Children's Act no. 38 was passed by parliament in 2005, but in order to operate in full requires the finalisation of the Children's Amendment Bill no. 19 of 2006. The Amendment Bill (Republic of South Africa, 2006b), which contains the bulk of provisions relating to 'alternative care' for children, including residential care, was under debate at parliamentary level at the time of writing (June 2007). Unlike the Child Care Act of 1983 which focuses primarily on children's protection, the new Act and its Amendment Bill attempt to legislate for a continuum of care for children: in other words, it includes provisions for so-called 'prevention' and 'early intervention' services for children (some of which are referred to as 'home- and community-based services' in other policy) as well as specifically articulating that a child may only be placed by the courts in a residential care facility "if another option is not appropriate" (Children's Amendment Bill 2006, s 158(1)). However, at the time of writing, the provisions for home- or community-based interventions in both the Children's Act and the Amendment Bill remained superficial and undefined. In contrast, provisions for residential care (and other forms of 'alternative care') in the Act and Bill are extensively developed. The imbalance waters down the clear expression of commitment to developmental welfare that was present in the original version of the Bill. It is nonetheless important to acknowledge the important additional inclusion of provisions for family- and community-based services in the new children's legislation, and the shift in focus in the legislation away from only providing for 'alternative care'.

The new legislation aggregates the range of types of residential care settings under the single title of "Child and Youth Care Centres". These it defines as follows (Children's Amendment Bill, s.191(1)): a *child and youth care centre* "is a facility for the provision of residential care to more than six children outside the child's family environment in accordance with a residential care programme or programmes suited for the children in the facility, but excludes

(a) a partial care facility;
(b) a drop-in centre;
(c) a boarding school;
(d) a school hostel or other residential facility attached to a school; or
(e) any other establishment which is maintained mainly for the tuition or training of children other than an establishment which is maintained for children ordered by a court to receive tuition or training".

The legislation requires residential facilities – Child and Youth Care Centres – to provide therapeutic programmes as appropriate to the targeted children's developmental and other needs (Children's Amendment Bill, s. 191(2-3)). This contrasts with the current context, in which the requirement for developmental and therapeutic programmes is located at policy rather than legislative level, in the Minimum Norms and Standards for Child and Youth Care Centres. The new legislation therefore explicitly frames residential care not only as a last resort for children's care, but also as an intervention that requires more than simply addressing children's basic physical needs (see section 6.7). Implied within the requirement for therapeutic programmes is a focus on short-term care for children in residential facilities. In addition, it positions Child and Youth Care Centres as ideally providing community-based services in addition to residential care.

In addition to reconceptualising residential care, the Children's Act of 2005 and its Amendment Bill provide substantially more detailed provisions for the sector. These include more detailed registration and operational requirements, specific provisions regarding Department of Social Development responses to unregistered homes, provisions for 'quality assurance' and a requirement that the Department ensures that there is a strategy in place to ensure "an

appropriate spread" (s. 192(1)) of Child and Youth Care Centres in every province to cater for the range of children's needs.

Other 'alternative care' options in the Children's Act no. 30 and the Children's Amendment Bill draw on but adjust those outlined in the Child Care Act of 1983. Formal court-ordered *foster care placement* of children 'in need of care and protection' with people other than their biological parents remains a key alternative care option, and is in particular being implemented as a response to the increasing numbers of orphans resulting from the AIDS epidemic (Meintjes et al., 2005). No more than six children can be legally placed in the care of a foster parent.

In addition however, the Children's Amendment Bill introduces a new form of foster care not previously provided for in legislation: *Cluster Foster Care*. This is described as "a scheme for providing for the reception of children in foster care in accordance with a foster care programme operated by –

(a) a social, religious or other non-governmental organisation; or
(b) a group of individuals, acting as caregivers of the children, and managed by a provincial department of social development or a designated child protection organisation" (Children's Amendment Bill, s. 3(d)).

Cluster foster care provisions as they currently stand in the Bill adapt foster care from being conceptualised as a family- or household-based intervention, to one which more closely approximates a residential care-type setting. Despite this fact, cluster foster-care schemes are not subject to the same requirements as residential care facilities. While not overtly mentioned in the Bill, it is understood that cluster foster-care schemes are envisaged as one of the approaches to addressing the anticipated increase in child-care burden resulting from the AIDS epidemic.

3.3 The intersection of national and international policy on residential care

In summary, both international policy and national (South African) policy and legislation not only have a shared vision of residential care as a 'last resort' placement option for children, but also view it as a minor component of the response to the AIDS epidemic. These positions are largely founded on attention to the negative impact of institutional living on children, repeatedly highlighted by the related literature.

The discourse surrounding residential care throughout both sets of policy (and legislation at the national level) is anchored in a perception of residential care as that provided by 'conventional' institutions. This institutional discourse projects and restricts residential care as a professionalised, highly structured, service-oriented, formalised intervention. Residential care is constructed through the language of 'facilities' or 'centres' with 'staff' and 'management' appointed in order to effectively implement 'programmes' and 'models of care'. This contributes to residential care being imaged and conceptualised as constituted by generally large-scale, top-down interventions: interventions that remove children from everyday society, dislocate them from family, neighbourhood, community and familiar cultural practice, involve them in unnatural environments, and prevent the development of attachment relationships with primary caregivers, among other things. In other words residential care is characterised by all the negative features attributed to it.

A clear distinction between residential care and family- or community-based care is inherent throughout. The definitions applied in policy as well as in South African legislation explicitly make reference to 'non-family-based' group care of children (although 'family' is not ever defined); and recommendations and provisions clearly envisage professional interventions designed to provide temporary therapeutic care to children in order to 'return' them to family or community settings.

Whether this image of residential care can be verified in the experience and understanding of those involved in providing and living within it, is the question at the core of this research. In the remainder of the report, we examine the phenomenon of residential care as it occurs 'on the ground' in the four identified study sites in South Africa. We consider basic data about the children resident in participating children's homes, and describe and explore the forms taken by homes, before returning in conclusion to reflect on these observations in light of the international and local policy and legislative discourses outlined above.

4. Official data on residential care in South Africa

Official data about the state of residential care in South Africa is extremely sketchy. There are no consolidated national statistics illustrating the number and types of residential care facilities for children in the country, despite efforts on the part of the national Department of Social Development over the past year to collate data. Similarly, it is not known how many children are resident in such facilities.

Publicly available offic ial national statistics date from 2003, providing a total of 204 registered Children's Homes countrywide (see Table 3).

Table 3. Registered Children's Homes in South Africa, 2003

Provinces	Number of children's homes
Gauteng	53
North West	4
Mpumalanga	4
Limpopo	8
Free State	14
KwaZulu-Natal	48
Western Cape	40
Eastern Cape	24
Northern Cape	9
TOTAL	**204**
Source: Pillay (2003). *Children's homes in South Africa.* Department of Social Development: Directorate: Rights Advocacy - Children.	

However in a study conducted one year later by Southern African Development Planning Evaluation and Research (2004), 21 of these homes were found either to have been incorrectly classified or to no longer exist. No data regarding the number of children in Children's Homes or other residential care facilities are provided by either of the above studies. In a subsequent report compiled for the Department of Social Development, Skelton (2005) provides an estimate of 10 361 children resident in 181 registered Children's Homes countrywide at the time of her study. This figure does not include children in secure care facilities, in places of safety or other residential care settings.

In early 2006, the Children's Directorate in the national Department of Social Development initiated an audit of residential care facilities countrywide. By May 2007, the audit was still not complete, with data on some districts in provinces outstanding. Draft findings from the audit revealed at minimum 193 registered Children's Homes across the country, at least half of which were located in KwaZulu-Natal and Gauteng provinces. In addition, five state-run Children's Homes were recorded. For this incomplete set of homes, the registered capacity was 12 920 children, substantially more than the numbers recorded in the Skelton (2005) study. Thirty-five percent of registered homes were documented to have a capacity of more than 60 children, with a quarter of these having a capacity of over 120. No data was collected regarding the actual number of children resident at the time of the audit.

As highlighted in section 2.4, collation of reliable data on the children's residential care sector is extremely difficult. Although provincial departments of Social Development retain basic records of registered facilities, data is not systematically maintained across provinces. In addition, the terrain is constantly shifting: registered homes close, others open (pers. comm. D. van Spuy, 2007). Perhaps most critical, however, is the fact that the number of unregistered set-

ups operating around the country is not known. Those working in both the state and non-profit children's sector frequently articulate that such arrangements are mushrooming, in particular in the face of the AIDS epidemic. The extent to which this is the case is difficult to ascertain, and attempts by the national Department of Social Development to enumerate unregistered homes have been unsuccessful.

This study's scoping exercise revealed how, anxious about possible closure for operating outside of the law, such care arrangements frequently conceal themselves from formal attempts to identify them, or are concealed by organisations which identify them as performing an important role and provide them with support. Alternatively, those taking children into their care are unaware of the legal requirements and/or do not consider themselves to be doing anything other than responding positively to the needs of children in their communities. Whatever the circumstances, the point is that it is generally accepted by child welfare professionals that there are numerous care arrangements operating in the country that would be considered unregistered children's homes in terms of the Child Care Act. As one of the only other studies which attempts to examine this issue in South Africa has documented, in the city of Johannesburg alone, one-third of the 77 children's homes surveyed in 2003 were not registered (Meiring, 2005).

It is therefore likely that the officially available data about the sector is a substantial underestimate of both numbers of homes and numbers of children resident.

5. Children in residential care in a time of AIDS

Twenty-eight of the 34 homes participating in the study provided basic quantitative information about each of the children resident at the time of the audit. At the time, there were 1 007 children resident in the 28 homes. The vast majority of these children were housed in registered facilities (see Table 4). This section of the report provides basic data regarding the characteristics of the child population in the residential care settings that participated in the study.

Table 4. Number of children resident in participating children's homes

Legal status of home	n	%
FC/PPOS*	69	7
Registered	705	70
Unregistered	233	23
Total	**1007**	**100**
*Residential care settings using foster care or private place of safety legislation as mechanism for bringing children into care. Note that this acronym is used in tables throughout this report		

Age and gender of children

The majority of children resident in the homes were aged between six and 18 years old (68%). Seventeen percent were under two years old (see Figure 1). Some children over 18 continued to live at the homes, including in registered homes in which 18 is the legal age limit except under exceptional circumstances[17].

Figure 1. Ages of children resident in participating children's homes
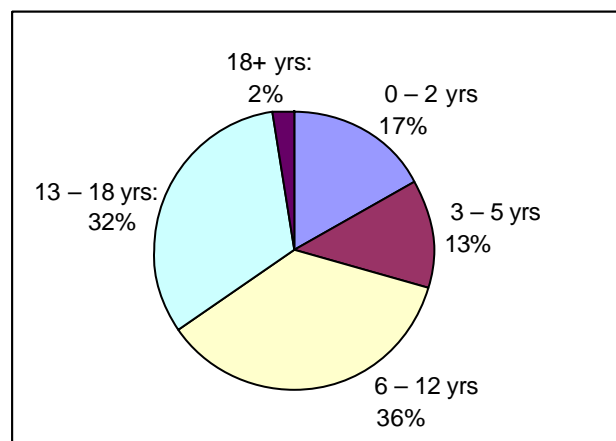
This age distribution pattern was roughly shared by both registered and unregistered homes. However those homes in the study that were providing residential care through foster care or private place of safety legislation were predominantly caring for babies and toddlers, with 89% of children resident in these homes aged under five years old[18].

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[17] Current legislation provides for children 18 years old and above to remain in residential care for the purposes of completing their education.
[18] These homes housed 20% of the total 0- to 5-year-old child population resident in the participating homes at the time.

There were almost equal numbers of boys and girls in the audit sample. This held across provinces and home categories. There was also an even split of boys and girls across the age ranges.

All homes admitted both boys and girls, with the exception of two: one focussed on girls who had been working as sex workers and the other on boys who had been living on the street or who had been considered at risk of doing so. Despite the even spread of boys and girls across the total sample, individual homes varied according to which sex they found themselves caring for. The manager of a Children's Home in Limpopo spoke of her surprise at the number of boys that came into the home relative to girls, who she had expected would be in the majority: "And when we started I thought I'm taking care of the 'girl child'", she laughed, "thinking of the problems that the girls are encountering when they're staying alone, and I ended up having boys!"

Orphanhood

Data on vital status of children's biological parents in the audit of children is incomplete, with information not known or not provided by the homes for a substantial 29% of the sample. Despite this limitation, the audit indicates that 53% of children had at least one parent living – 15% were known to have both parents living – with the possibility that both these figures are actually higher. Table 5 refers. Twenty-nine percent of the sampled children were recorded as either single or double orphans, with the possibility that this proportion could be as high as 57%.

Table 5. Orphan status of children resident in participating homes

Orphan status	n	%
Both parents living	149	15
Double orphan	90	9
Single - Maternal orphan	59	6
Single - Paternal orphan	42	4
Unknown - mother dead, father unknown*	100	10
Unknown - father dead, mother unknown*	2	0
Unknown - at least one parent alive	278	28
Indeterminate - unknown or not completed	287	29
Total	**1007**	**100**
* 'Unknown' refers to instances in which the home had been unable to ascertain any information about the vital status of the parent		

The qualitative data suggest however that it is unlikely that higher figures are the case in the homes that were included in the research from the Western Cape and Gauteng. This is illustrated by repeated statements from participants along the lines of the following:

"I would say 80% of our children still have parents, but not all of them are involved."

Social worker, Children's Home, Western Cape

"We do not have a lot of orphans. We have three at the moment [out of a total of 60 children] and these children were not admitted as orphans, but their parents died while they were here."

Manager, Children's Home, Gauteng

> "[Double orphans] are in the minority group hey. Percentage-wise I can't think off hand, I used to go through the list, now I've just forgotten about it. If it's 10% even then it's a lot…"

Manager, Children's Home, Western Cape

The greater number of homes included in the research from these sites masks the higher proportions of orphans resident in the homes in the other two research sites in KwaZulu-Natal and Limpopo. Half of the children in the homes in the KwaZulu-Natal site were single or double orphans. Whereas the proportion of orphaned children in all homes was consistently higher than that of the general child population, in the majority of homes orphans were not the dominant child population. This finding that a large proportion of children in residential care have living parents is concurrent with those repeatedly cited in the regional and international literature (see for example Powell, 2006; Tolfree, 1995).

HIV-positive children

More striking in the audit data is the proportion of children recorded as HIV positive. The data is again limited by non-completion of this information for 12% of the children, as well as the fact that 40% of children resident in the homes had not been tested for HIV (see 9.3 for further discussion of homes' HIV-testing practices). Nonetheless, of those children whose HIV status was known, 34% were HIV positive (Table 6). This equates to 16% of all children resident in the homes at the time, whether they had been tested for HIV or not. In stark contrast, HIV prevalence is estimated to have been 1.9% in the general child population under 14 years old in South Africa in 2006[19] (Dorrington, Johnson, Bradshaw, & Daniel, 2006).

These findings suggest that one of the primary and less frequently identified ways in which the HIV epidemic is impacting on the residential care sector is through a significant burden of care associated with the provision of care to HIV-positive children. As similarly observed by Meiring (2005) in her study of children's homes in Johannesburg, this feature of the child population in contemporary residential care in South Africa has critical implications for health care standards and interventions in homes (see section 9 for further discussion).

Table 6. HIV status of children resident in participating homes

HIV status	All children		Children with results	
	n	%	n	%
HIV positive	166	16	166	34
HIV negative	320	32	320	66
Not tested	402	40	-	-
Test results not in	2	0	-	-
Indeterminate	117	12	-	-
Total	**1007**	**100**	**486**	**100**

Reasons for children's residence in children's homes

The demographics of children in residential care do not however necessarily reflect their reason for being there. This is evident when the demographic data from the audit of children in homes is compared with audit data reflecting reasons for children's placement in care. As would be anticipated, there was a broad range of reasons which resulted in children being considered to be 'in need of care' either in legal or social terms, and provided with place in the participating

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[19] Ninety-three percent of children in the study who had tested HIV positive were aged 12 years or under.

homes. Some managers of homes who completed the audit were not willing to provide the reason for children's admission, or simply recorded the court-order statement: 'child in need of care'. This resulted in the reason for admission for 17% of the sample of children being recorded as indeterminate.

A few central reasons predominated nonetheless, with those explicitly related to HIV less prominent than might be expected considering the large proportion of HIV-positive children resident in homes. Of primary importance rather is that over 30% of children in the audit had experienced abuse and/or neglect. These findings which position abuse and neglect as the principal reason for children's residence in the homes were endorsed repeatedly by those working in both formal and informal homes. Even homes originally established to accommodate other categories of children (such as children living on the street) had found that there was a need to provide care to (other) abused and neglected children, resulting in an unanticipated shift in their target population.

Twenty-four percent of children in the homes were recorded as abandoned children. Again, this finding concurred with the observations of staff at homes, in particular with respect to babies and very young children. For example, the manager of a children's home in KwaZulu-Natal argued that the key reasons children were resident were:

> "… abuse and abandonment. Abuse ranging from - I mean alcoholic parents play a big part, who either just grossly neglect their children or actually physically abuse them. And increasingly we're getting girls who've been sexually abused, that's more and more these days, and the boys it tends to be, you know they've really been either grossly neglected or just beaten you know. And then babies who've been abandoned …"

And similarly, the founder of a home in the Western Cape site that admitted numerous babies and young children noted the extent to which abandonment is the reason for children coming to the home:

> "Abandoned babies, thrown in the bush, you know all these babies you have seen, even those who are toddlers now, they came here being a day old, the youngest baby here she's two weeks, two and a half weeks old, this child. Most of them we find them in the bushes and on the railway tracks, in toilets, in dangerous spots you know, they've been abandoned as a baby."

In contrast, and despite the HIV epidemic in South Africa, parental or child illness was not a predominant primary reason given for admission (6% and 2% respectively). The statistics for those admitted primarily due to orphaning, at 11% of audited children, were also considerably lower than those for abuse and neglect, and abandonment. In other words, more children were orphaned (through the loss of one or both parents) than was the basis for admission. Importantly, where orphaning was cited as a reason for a child's admission to a home it was generally coupled with children having experienced abuse or neglect, or with instances of an absence of any relatives to take care of children. In a few instances, a mother approached the home prior to her death, concerned that there were no safe or adequate alternative care arrangements for her children amongst her relatives.

While the extent to which HIV was a driver of other reasons for admission is not clear from the audit, participants in the research frequently noted associations. For example, a social worker at a home in the Western Cape site noted how they tended to receive children who are HIV-positive because people are less willing to care for them than healthy children:

> "We have got a child here where the mom - you know a sick child is like a baby, she has got a baby younger than this child who is HIV positive, but the HIV-positive child is two, three years old but is like a baby, still in nappies, still needs to be carried… The mom couldn't take care of two babies at the same time. The one baby is sicker than the other.

> She needs to work to have an income to feed both children, but who will take care? The
> family or the neighbours will take care of the healthy child, but not for the sick child."

Others observed that parents who are sick are sometimes reluctant to approach others for support with caring for their children because they don't want to disclose their own status, and described experiences in which this had lead to a child being neglected. A social worker at a home that cares specifically for HIV-positive children also noted that many children placed in their care are abandoned in hospital while sick.

Poverty – and a concomitant inability to provide adequate care – was cited as a reason for the admission of only 3% of children in the study. It could be that poverty in the research sites is so pervasive that it was taken for granted as a feature of life and thus was not acknowledged or recognised as driving children into care. Whatever the case, it is clear that – like HIV/AIDS – poverty exacerbates the difficulties for caregivers raising children, and heightens children's risks of neglect, abandonment and possibly abuse. For example, the founder of a currently unregistered home in rural KwaZulu-Natal described how the establishment of the home was inadvertent on her part, but that the poverty combined with a high rate of AIDS death in her community had driven its growth:

Case Study 1.   Ikusasa lethu (see also Case Study 11 and Case Study 16)

When school principal Sibongile Kuzwayo found one of her learners living in the bushes at the school, she and her colleagues responded by allowing him to live in a disused classroom and providing food and other support. He had a long history of abusive and neglectful relationships with a range of caregivers, which the local welfare office had been unsuccessful in addressing. This boy was subsequently joined by another couple of boys, one of whom who had been brought to her by other children because he was similarly living in the bushes and scavenging for food having run away from abusive home circumstances. Gradually the home grew, providing a safe place for children who were living alone or in abusive set-ups, or whose caregivers were not able to provide for them:

> "It was like adding two, three, like that. But we never invited that we could take, it was the
> needs. It was just [people] coming and telling us that there is a problem and now the
> children are on their own and there is no one around who can help because we are all so
> poor. Maybe the neighbour would come to me to report that now they can't afford [to
> support the children anymore]. Sometimes I feel pity for them if I don't have [resources to
> help]. It is hard for me to say I don't have today and that they have to go back".

Today, up to 25 children aged between five and 21 years old, both boys and girls, live at the home.

Tolfree's seminal study on residential care in the developing world highlights that while the categories of children commonly admitted to residential care are orphaned, abandoned, "unaccompanied"[20] and destitute children, "the underlying reason for admission is poverty" (1995:40)[21]. The case study above provides further evidence in support of his argument. As the founder of the home (along with others in the study) argued, "it is not that they don't love their children. They can't afford".

But contrary to assertions made in the literature that residential settings "serve to relieve members of the [orphaned] children's extended family of their sense of obligation", the case study also suggests that emergent children's homes can be an expression of community

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[20] Tolfree (1995:39) defines the term 'unaccompanied children' as "a generic term for children separated from their parents, usually in situations of war or natural disaster. Children so described will include those who have become separated accidentally from their families (for example in the process of flight) as well as orphaned and abandoned children, young people who have been abducted or conscripted into armies, and those who have chosen to leave their families".
[21] It is interesting to note the absence of any reference to abused children in his identified categories.

obligation towards children whose families cannot meet their needs. Homes need not be by definition a 'magnet' in a poor community, exploited by caregivers, but rather poverty and HIV/AIDS place immense strain on care networks and as such are fundamental drivers of children's admission into residential care arrangements.

In conclusion, the findings from the audit of the four research sites suggest that the child population in the children's homes was neither disproportionately skewed towards large proportions of very young children, nor predominantly constituted by children who have been orphaned. However homes were providing care to an exceptionally high ratio of HIV-positive children. This feature of the child population in the homes raises important considerations for the provision of adequate and appropriate care, including in relation to caregiver skills, training and continuity; and children's access to health services. We return to these questions later.

While it is tempting to become pre-occupied with 'categories' of children in homes, it is important not to conflate these with the reasons for children's admission into them. In this regard, the study suggests the widespread abuse, neglect and abandonment of children to be the major reasons for their entry into the residential care settings, and that HIV/AIDS and poverty are part of a complex causal pathway rather than the dominant reasons for admission in and of themselves. If this is indeed the case, the distinction has important implications for the design and delivery of so-called 'prevention' services.

6. The dimensions of residential care in the study sites

While there is a fair amount of uniformity in the kinds of circumstances that lead children to be in residential care for either short or longer periods, the residential care in which they are placed (or place themselves) is extremely varied across multiple dimensions. This section examines a range of different aspects of homes' functioning in the four study sites.

6.1 Legal status of homes

The 34 residential care settings that participated in this study included all Children's Homes officially registered as such in terms of the Child Care Act that were primarily responsible for receiving children from the sites, a Shelter that was operating as a children's home, a state-run Place of Safety and Children's Home, and unregistered homes that were either making use of existing foster care or place of safety placements to effectively run a residential facility as defined by current law, or were operating without any legal arrangements in place (see Table 7). Unregistered homes included in the study comprised all those identified by the scoping study which we were able to access within the research period.

In both the Western Cape and Gauteng sites, unregistered homes existed which did not emerge in time to be included in the study. Even so, almost one-third of all homes surveyed were not officially registered with the Department of Social Development, and a further 24% of homes were operating on the legal peripheries (at least under current legislation) by stretching the limits of foster care and emergency care/private place of safety legislation. While not able to illustrate uncontrolled mushrooming of facilities, these statistics do indicate that a large portion of what constitutes the residential care sector in each of the research sites is currently operating outside of the relevant law.

Table 7. Number and legal status of residential care facilities which participated in the study

Legal status of care arrangement*	Gauteng	KZN	Limpopo	W. Cape	Total n	Total %
Use of foster care/ place of safety legislation	2	0	2	4	8	24
Registered Children's Home	5	1	1	5	12	35
Registered Shelter	0	0	1	0	1	3
State-run Facility	0	0	2	0	2	6
Unregistered	6	1	0	4	11	32
TOTAL	**13**	**2**	**6**	**13**	**34**	**100**
* Note that registered Children's Homes, the registered Shelter and state-run facilities are grouped together as a single category of registered facilities in the tables throughout the remainder of the report.						

Unregistered homes remained so for three primary reasons. Some did not conceive of the care that they were providing to be anything other than a natural extension of their household; others were unable to fulfil the criteria for registration as an official Children's Home (see section 8 for more detail). And others were unaware that any official registration process with the Department of Social Development was necessary. This lack of understanding was exacerbated by the need for a separate registration process with the same department in order to qualify as a Non-Profit Organisation (NPO) legally entitled to raise funds.

Consider the following fairly typical exchange between a researcher and Ma Ramogae, a woman who had established an "orphanage" for children in her area, but was still oblivious to the registration requirements for Children's Homes. She had approached her area social worker for approval and support for her initiative, and claimed to have received this in writing:

M: The social worker … told me the procedure where to go, as long as I'm having the letter from the headman and the chief, the councillor, then I [should] proceed with the registration for the centre, then I registered the centre at Pretoria.

I: Oh, as an NPO?

M: Yes, as an NPO and then I got the certificate.

I: And did anyone explain to you the procedure of registering as an 'orphanage' or a Children's Home?

M: What?

I: There are two kinds of registration: there's NPO registration, and then there's also registration as a Children's Home or an 'orphanage'.

M: No, no-one didn't explain for me that you register as an ordinary [organisation] or you register at a children's place as an orphanage, no one explained to me. I just registered as an NPO, yes, yes.

The other mechanism applied by those establishing homes but not wanting or able to obtain official registration as a Children's Home involved creative – and somewhat unorthodox – use of existing foster care and private place of safety provisions. The law provides for individuals registered with the State as an emergency parent/private place of safety or foster parent to have up to a maximum of six children placed in their temporary care. Eight of the homes that participated in this study made use of these legislative provisions, placing children in the emergency or foster care of their (employed) care-workers. The approach diverges from the strict application of the law which envisages emergency and foster parents to be caring for children in their own households, and to take full responsibility for children 24 hours a day. In many of the applications documented in this study however, groups of children – though registered in the name of an individual – were cared for by shift-working care-workers, or by housemothers who were present in a more full-time capacity but who were employed by an organisation. The capacity of the home related to the number of individuals in whose care children were placed on paper, with up to six children placed per care-worker. Because the intention within the law is to support household-based care, such group-care settings are not subjected to the same requirements or monitoring from the State as Children's Homes, despite operating in practice along fairly similar lines. This approach enabled homes to access some financial support from the State in the form of foster care or emergency care grants – however the per capita amounts are significantly less than those available to registered Children's Homes.

In some instances, the application of this approach had been proposed by officials from the Department of Social Development as a way around registration as a Children's Home. In others, an explicit choice was made by founders to avoid the logistical and other challenges associated with Children's Home registration: "the red tape [of registration as a Children's Home] can set you back two years", noted the director of an organisation running a number of homes in this way. In addition, this organisation saw benefits to the approach because it enabled the establishment of small homes which could "render a service of excellence" because corporates and churches were willing to "embrace a smaller project" and assist with generous funding. Furthermore, the approach was attractive because it enabled the maintenance of some independence from government, and therefore control over which children were admitted or how they were subsequently placed, for example [22].

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[22] This relative independence from government control had both positive and negative implications. Negative aspects included situations in which racist criteria were applied to admission, or where financially lucrative inter-country adoptions were prioritised at the expense of local adoptions.

Despite being a conscious choice in order to have some legal protection and limited financial subsidisation for themselves and the children for whom they provided care, the approach was not always a comfortable compromise for those in charge of the homes however. One commented:

> "It would be easier if we could be registered [as a Children's Home], because at the moment the housemother is the foster mother. If she wanted to up and leave it would be a nightmare to transfer the children to someone else's care. For me, this is always the fear … But … the Welfare department wouldn't register us, I mean they are now registering places here there and everywhere, but they *said* they weren't, so this was the only way to go. We either said we won't do it, or we just wait, but I don't believe in waiting - if you want to do something, then just get on and do it, so we just went and did it the best way we could do it … But if you worry about everything that could happen, you won't do anything. So I actually have to just keep on telling myself 'stop worrying' - I'm a terrible worrier – 'stop worrying', you know."

Others were angry with the Department of Social Development for proposing this approach as a way around Children's Home registration. They not only suggested that these were attempts by the government to avoid the higher costs of the state subsidy for Children's Homes, but also argued that it placed those running homes in awkward legal positions in relation to their staff. The founder of a home who refused to implement this approach and persisted in her attempts to get officially registered as a Children's Home noted:

> "I was worried in terms of the money being deposited into [the care-workers'] accounts. How do you control it? Even if I have a signed legal contract with the caregiver, I do not have the legal grounds to hold her to that. Legally the kids would be hers, so legally the money would be hers."

This 'loophole' in the existing law has subsequently been formally incorporated into the Children's Amendment Bill no. 19 of 2006 in the form of the provisions for 'Cluster Foster Care' (see section 3.2), and is under debate in 2007. The move is fiercely contested by many in the non-governmental children's sector, including the National Association of Child and Youth Care Workers, who argue that the facilitation of "mini children's homes" that are not properly regulated or supported puts children at risk (National Association of Child Care Workers, 2006:3).

Much of the attention directed at residential care by both the State and non-governmental children's sector in South Africa is preoccupied with the legal status of existing and new residential care settings. Unregistered homes tend to be characterised in entirely negative terms, as for example (in the words of a representative from non-governmental social services), "out of the loop in terms of professional practices", or "operated in horrendous conditions … by [sub-text: under-informed and ill-equipped] 'township mamas'".

In light of these widespread perceptions, the inclusion of cluster foster care provisions in the draft Children's Amendment Bill seems somewhat paradoxical. Nonetheless based on these conceptions of unregistered residential care settings as inherently negative, multiple attempts are underway – through the provisions for Child and Youth Care Centres in the Children's Amendment Bill and through the activities of the relevant directorates within the Department of Social Development – to identify and register or close them, and to put in place more stringent requirements for residential care centres.

Importantly however, the legal categorisation of facilities reveals little about homes themselves, or more broadly about the nature of residential care. Residential settings differ markedly in form, model, history, ideology, access to resources, programmes, staffing, training, and focus, among other things. It is to the description and exploration of these that we now turn.

6.2 Size of homes

Homes varied in size (at the time of research) from seven children to 120 at a large children's village. While all registered facilities housed more than 20 children, almost three-quarters of unregistered homes (including those using foster-care placements) in the study were smaller, housing up to a maximum of 20 children (see Table 8).

Table 8. Size of residential facilities at time of study

Size of home	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
0 -10	5	63	0	0	0	0	5	15
11-20	2	25	0	0	7	64	9	26
21-40	1	13	4	27	3	27	8	24
41-60	0	0	7	47	1	9	8	24
61-120	0	0	4	27	0	0	4	12
Total	8	100	15	100	11	100	34	100

Space was not the only limitation in the size of unregistered homes, although it was an important factor in some. Managers of some of these set-ups also voiced their preference for maintaining small homes for a variety of reasons, including to facilitate a home- or family-like environment:

Case Study 2. Kagiso House

Kagiso House is located in an old period house in a fairly rough part of the inner-city. It is indistinguishable from the other houses in the street, with no identifying signage on the premises. Despite being encased in heavy-duty burglar bars and surrounded by razor wire, the interior of the house has a homely feel – with few signs that would indicate the space to be an institution. The house is organised much like a family home. Situated alongside an open-plan kitchen-dining room, there is a living room furnished with couches, a TV and sound-system. Bedrooms are located off a passage, with sleeping arrangements for four children per room. Bedding isn't matched. At one end of the house is a large bedroom including a couch and second TV as well as a desk: this space is occupied by the founder and her husband. Children wandered in and out of this room interrupting the interview with questions for the founder, who they called "Mommy".

The couple and their six adoptive and biological children share the home with 13 children under the age of ten years old. The children arrive at this unregistered home primarily via the police, but are also placed by social workers or brought by people in the neighbourhood. The founder notes that she has been struggling unsuccessfully for seven years to register the home with the Department of Social Development, and yet "these are the very same people who will ask you if you will take children". In the interim, the home is registered as a NPO and in the absence of financial support from the Department, raises funds in this capacity.

Four care-workers live on the premises and support the founders in caring for the children. Despite these trappings of professional care, of an organisation, and the home's attempts to become formally registered, the blur between family/household and institution is apparent. This is an explicit choice on the part of the founder. Not only are her own children mixed indistinguishably with the rest of the children living there, but she consciously wants the home to remain small. She explains that:

"My vision was to step as far away as possible from anything institutionalised or anything formalised in that sense. I rather want a more informal family structure within the home, so that you can work on a small group theory and what actually develops and happens within that. We try to keep it small. We had 14 children and we are now down to 13, but even this number is

more than what we initially wanted to have … The family unit and intimacy is what is needed in the children's lives in order to see more rapid rehabilitation."

In this respect she raises concerns that with official registration as a Children's Home may come demands from the Department of Social Development: "Then they will be able to tell us how they want us to work. It might mean that we will have to take in more kids…"

We return to the concept of creating 'home' for children later.

6.3 Length of time in operation

The length of time that a home has operated is not always clear-cut in instances where its formation and growth has (as in the example outlined in Case Study 1 earlier) been unintentional at first, rather than official from the start. In such instances data was collected on the date at which the first child was housed. Figure 2 below illustrates the periods during which homes which were included in the study began. While a handful of long-standing homes continued to exist since their launch in the late 19th and early 20th century, the vast majority (77%) of homes operating in the study sites were established over the last decade since 1995. In particular, numbers had increased since 2000. These increases may be an indication of homes being established to address real or perceived need resulting from burgeoning poverty and the HIV epidemic, although it is important to recognise the likelihood that many homes established previously may no longer exist. Only nine of the 34 participating homes identified the HIV epidemic as one of the primary reasons for their establishment.

The rate at which registered facilities had been established in the study sites had increased very little over time. In contrast, unregistered facilities have proliferated. (Note that the figures below for unregistered homes include those which operate using foster care and private place of safety legislation). The increase in unregistered and foster care-based facilities seems to reflect the government moratorium on the registration of new homes, in particular since the late 1990s. However, it may also indicate to some extent the life-cycles of informal set-ups in which particular individuals take children into their own home, but which cease to exist as children grow up and primary caregivers age.

Figure 2. Age of children's homes
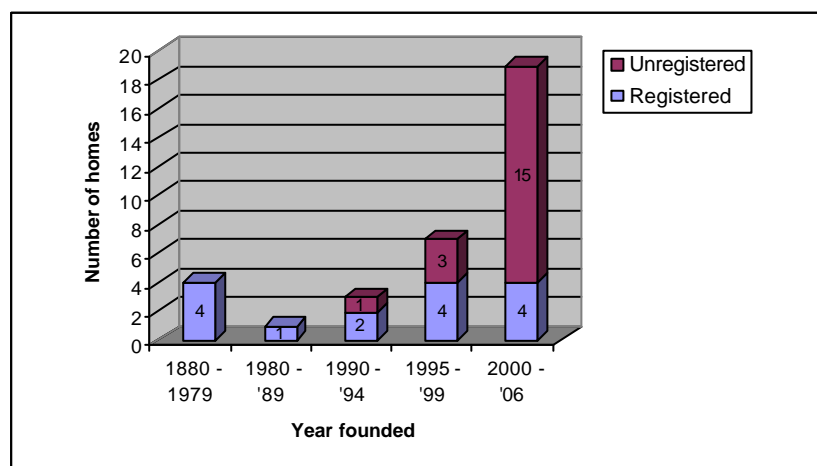
6.4 Living and care arrangements – 'models of care'[23]

The 34 homes which participated in the study ranged in structure from large dormitory-style institutions to expansive children's villages to small specialised units to homes which appear nothing other than a large household, among others. No two homes in the study were utilising identical models of care, and one or two differences in the way in which living and care arrangements were structured and provided tended to make a substantial difference to what more superficially appeared to be the application of very similar models of care.

Nonetheless it is possible to identify two basic configurations of living arrangement that underpin the range of home environments:

- a dormitory-style set-up in which groups of children – usually clustered into age-groups – share sleeping space, with communal eating, ablution and socialising space for a set of dormitories, and a central kitchen;
- a 'household'-style set-up in which small groups of (usually up to about ten) children of a range of ages and sometimes genders, commonly including sibling groups, operate as a unit sharing ablution facilities, relaxation space and in most instances eating together.

Household-style set-ups existed either as a stand-alone unit in a neighbourhood (frequently labelled by organisations running them as a 'community house'), or alternatively in clusters of varying sizes and commonly described in official discourses as a 'cottage system' or 'children's village'.

A number of homes in the study included a mix of both of these types of living arrangements. In such facilities housing children of all ages, it was common to find young children and babies housed in dormitory-style accommodation, while older children were divided into household-type set-ups. In some instances where a mix of living arrangements were operating, children who were in longer-term placements were those prioritised for household-type set-ups while those children in shorter-term or emergency placements were located in dormitories. The rationale usually provided for this approach was to create as little disruption in household-style set-ups as possible.

The care arrangements which accompany these living arrangements varied between and within homes. However they tended to be based either on groups of care-workers rotating through shifts, or on one or two carers supporting the same group of children fairly consistently (sometimes supported by subsidiary carers/assistants). The latter case tended to apply in household-style set-ups whether formal or informal, with such carers frequently being labelled 'housemothers' (in contrast to 'care-workers') in formal establishments.

As with Case Study 2 above, informal household-style homes tended, by definition, to operate with primary caregivers co-resident with children, and taking principal responsibility for their care 24 hours a day, seven days a week – essentially fulfilling a parental role. In these instances, it was often not a conscious choice about applying a particular 'model of care' so much as simply an integration of additional children into their own households. Consider the Nyathis for example:

Case Study 3.   The Nyathis

Vuyelwa and Mandla Nyathi live in a formally built area of an urban township in the Western Cape, adjoining a sprawling shack settlement. Theirs is the only double-storey home in their

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[23] Even a term like 'model' suggests a formality and consciously structured approach to care that is not present in many of the less formal and unregistered homes.

street, a brightly painted brick house located on a small stand. In all other ways, the home is indistinguishable from those surrounding it.

Ten years ago, Vuyelwa overheard a call from welfare services broadcast over the radio "announcing that there are so many children that are left in the streets to die. And I was so surprised, I didn't know. So I listened and listened … and then they appealed to the people to give, if someone can open his or her house to take children in". She describes how she approached her local Welfare office in response to the appeal, and almost immediately a six-month-old baby girl was placed with her and her husband. Two months later, a social worker visited her to check on the baby, and she was "so impressed, and we loved her – she was adorable! So they were so impressed they asked me if they can bring a second one, a boy, so we took in a second … and so it went on and on…".

Today they live with their four biological children and 19 others aged between one-and-a-half and 21 years. Six of the children have been placed in their foster care, though they receive foster care grants for only four of them, apparently because of administrative glitches in the Welfare office. The remainder of the children have no formal placement, though many of them have been brought into their care by social workers. Most of the children have lived with them for years, with over half arriving as infants.

In addition to the four foster care grants, the household survives on Mandla's salary from a local company. They have also participated for the past few years in a monthly support group for people like themselves caring for children that is run by a local NGO. As an affiliate of this NGO, they receive a monthly food parcel – "some food, packets of rice, soup and all that, so it helps a lot… It took a bit of a load, a *bit* of a load [off us when] it started giving us some food and then started giving us – bought us a washing machine and dryer and then life was a bit easier again because I had to do all the washing myself, all the nappies and all that you know".

Despite the financial and other assistance and Mandla's salary, he points out that "The financial matters, putting bread on the table on a daily basis is one of the big challenges". They worry too about paying for the children's education. "School fees!" whistles Vuyelwa, "It's a big challenge because if you're looking at the number of kids that we have now, 15 years down the line its going to be a crisis when it comes to education, to educate all of them". In the meanwhile, they beam with pride about how well the children are doing at school, and the improvements they have seen in them.

Vuyelwa, who is not employed, is the principle caregiver to all the children. When she attends her theology course sessions a few times a week, Mandla's sister-in-law comes over to the house to look after the children. And a neighbour helps out sometimes, taking children to the clinic if necessary and such like. Nobody receives payment.

Says Mandla, "Caring for the children is driven by care of the community… You cannot bear to see your neighbour going without food, or dying". Vuyelwa is quick to point out with respect to their extended household that "really there's no difference, it's only that they're not our biological children. Otherwise we try by all means to make them happy and they *are* happy. We are a very happy family, we love them so much and they love us so much, yeah".

Mandla asserts similarly: "I'm running a very basic, ordinary home but a very big family. Not an institution. No I don't think I have any intentions of institutionalising the place though institutionalisation would come with some [financial] benefits!"

Though running what would be considered an unregistered children's home in terms of the Child Care Act, the Nyathis and others like them intervene in children's lives by providing living arrangements within their means, and care arrangements that spontaneously make sense to them in the light of how they conceptualise their undertaking. These are not set-ups which attempt to mimic the constellations of care that occur in families and households. Rather they are homes which enlarge in the extension of existing 'family', with its existing approach to care.

In contrast, the research documented a widespread move amongst more official facilities to deliberately implement both a household-style living arrangement and a primary caregiver/ 'housemother' system of care. In these instances, a 'model of care' was very consciously

applied to the intervention, in the anticipation of improved outcomes for children. There was a perception amongst managers at facilities that household-style living supported by a system of housemothers enables increased bonding between children and their caregivers, allowing for more individual attention to be given to children and for children to develop a stronger sense of attachment to both caregivers and other children. For example, the social worker at a Children's Home in the Western Cape site commented about the improvements she has observed since adopting this type of arrangement:

> "The day workers would work during the day and in the evening somebody else comes in, then the next morning somebody else comes in. There was so much rotation happening and now we have one day care-worker working in each house with a house-mom. The kids see the same face everyday. They can hang onto her aprons everyday if they want to. They get all this loving and they will go to her room and sit by her. It's like having your own mother. So it is different now. Our nurse was saying to me that she does not have to come in everyday anymore because all the children are so healthy."

A social worker at a Children's Home that previously operated dormitory-style living arrangements with rotating care-workers, and was now implementing a cottage-based model similarly noted her assessment of the advantages of this approach:

> "We see the benefit of working with houses and working with housemothers because children are happy. They experience stability and consistency in their lives. They speak of 'in our house'. They see themselves as siblings and families. It is nice to see them relying and protecting each other and being loyal to their family and mother. The bonds they form I hope could help them in their future, but for now it really works. When house parents go on day-offs, children understand and the person who works in their place they also know."

In other words, it was identified that there are benefits for children in developing consistent bonds with a one or two primary caregivers, rather than experiencing a constant circulation of a number of different individual care-workers.

These kinds of shifts were in process in a number of the homes, with a mix of living and care arrangements operational, but with visions of eventually running entirely with household-type set-ups supported by primary caregivers. For some, a physical shift simply from a dormitory-style institution, to a cottage-system with housemothers was seen as sufficient; others felt that this was unsatisfactory and were establishing – in their terminology – "community houses" or "satellite homes". These were stand-alone houses located in ordinary neighbourhoods which operated as independent units with respect to day-to-day activities, while being grouped and managed under an organisational umbrella. A key motivation for shifting away from a village model towards living arrangements more embedded in naturally occurring communities was a concern with children's identity formation, and particularly the need for children to form an individual as opposed to group identity. In some instances it was further reasoned that "the village model teaches children to operate within a system but not in normal society", because of the way in which village approaches to household-style care tend to isolate children from the experience of ordinary neighbourhood living. Thus in some cases, a facility was implementing all three approaches to living and care arrangements – dormitory-style set-ups, a cottage-based system, and 'satellite' houses.

Discourse about household-style living arrangements staffed by at least one primary caregiver repeatedly incorporated reference to 'family' and often to 'home'. At the centre of the model of care was a notion that it provides a family-like environment and creates opportunities for children to have a sense of 'home'. The degree to which the model was seen to be providing family and home versus mimicking them varied between facilities. For example, management at a Children's Home in Gauteng noted that 'the cottage is not a normal family situation" but

argued that it is a beneficial approximation. In contrast, a children's village elsewhere explicitly positioned itself as taking a "family approach" in which each child has a "parent" (a "mother"), "brothers and sisters" who live as a "household" in a "family home".

Certainly, household-type living arrangements coupled with care arrangements involving a primary caregiver provide a more enabling context for creating home-like environments than do dormitories and routine staff rotation. However, the widespread sense that 'community houses' or cottage-based care systems necessarily achieve this seems erroneous. Not least, this notion simplifies the concept of what constitutes a 'home', and assumes that it is only a structurally determined entity. Consider the following approach by a children's village that for decades has focussed on providing 'family' and 'home' to children in South Africa:

Case Study 4.   New Horizons

A series of road signs lead through a middle-class residential suburb to New Horizons, a sprawling face-brick village facility complete with an administrative block, staff offices, a library, and series of "family homes" all linked by paved walk-ways and set amongst well kept green lawns and established gardens. One hundred and twenty children are accommodated in 15 family homes and two "youth houses", one for boys and one for girls over the age of 16 years.

A manager describes the home's model of care as a "long term family-based model", which aims to provide a permanent substitute for children's biological families. At the core of the model of care is an expectation of intense bonding between a consistent group of children and a single female primary caregiver. In order to create 'families' children are accommodated in household-type environments together with a "mother figure" and "brothers and sisters". Siblings are kept together. The eight children in each house are also mixed by age and gender, with opportunity for children who may not be biologically related "to operate as brothers and sisters inside the house". The primary caregiver is a fulltime housemother on duty 24 hours, seven days a week. A long-term commitment is expected from these women in order to ensure that they "form a very close relationship and act as a substitute or alternative mother figure for [the] children".

Although this is the ideal the home strives for, in reality housemothers do resign and thus cannot be permanent mothers. This causes a contradiction in the model, according to one housemother, who feels that children and housemothers should be prepared for eventual separation:

> "You have to build this relationship knowing that at a certain time you can leave this child. But the way they do it - like the [housemother] that was here, she normally used to sleep with the small ones, same bed like the real mother. Where is she now? … Because now she's no longer here … She resigned."

She also suggests that the mother figure in children's lives cannot be replaced because "most of the children have parents who are alive and who they wish to be living with. They know you are not their parent or family".

The arrangement requires enormous sacrifices from the housemothers, who are left with little time for their own lives and families outside of the home.

Management at the home describe how in order to facilitate a family environment, housemothers are allowed to run their units "semi-independently" to ensure that homes have their own "unique individuality". They are given an allowance to run the home, which enables them to make decisions about what food to buy, outings to go on or décor to buy for the home. This is a limited freedom however as housemothers must stick within line item allocations on the budget, which are determined by management.

For the most part, house rules are set by housemothers. This household autonomy is however balanced with rules set by home management, including for example the time by which children must be indoors in the evening. While these procedures do help to approximate a regular household environment more closely, Thandiwe, a housemother, worries about the impact for children when a housemother resigns:

> "For me as an individual I don't think it's the right thing [approach]. The way the organisation operates it's [as if these are] your children. But in the end, when I'm tired, I

just resign. So the children are used to my rules and then the other mother comes in and then it's another story for the children. Whereas if it can be one policy, it's like one thing for all the children in the institution."

Different houses' rules also mean that children from the various units are exposed to different levels of freedom and responsibility. This can be difficult to manage when, at 16, children move to one of the youth houses where a blanket policy applies.

Rules governing children's movements in and out of the complex are regulated both by official procedures that have been set in place by management and by individual housemothers. For example, housemothers are able to give permission for a child to walk to the nearby shops but children may not visit friends or have friends visit them without first going through a permission and consent procedure with the hosting child's parents involving the signing of multiple forms. According to staff, these kinds of visits rarely occur as a result.

Another important aspect of creating long-term 'family' for the children according to managers is that the households are supported by being part of a bigger village environment. Besides the other housemothers, the home is staffed by a range of professionals and a complex management structure.

Management insist that 'there's not a lot of difference between a household from outside and a household in the children's village set-up". They cite the absence of a male caregiver in the home as the main departure, but explain that the village director, child-care co-ordinator and male volunteers fill this role. With so many children and these men having a range of responsibilities at the home this is not always easy however, says one housemother: "It's only here and there you'll see the father figure around, here and there, it's not a fulltime part of a practical thing that they are doing."

The story of this children's village illustrates how, in many ways, contradictions are inherent in attempts to create 'home' within particular applications of a household-style model of care by welfare organisations – even where the organisation's choice of model is premised on achieving exactly this. These environments typically involved far more rules, routine and regulation than an average household. For example, on the whole children could not come and go as they pleased (even within appropriate age and other parameters), and their mobility as well as that of visitors and family tended to be carefully regulated – often by bureaucratic practices contrary to the functioning of regular households, like those outlined in Case Study 4. In many instances, a blanket application of regulations across all houses required housemothers and children to conform to practices that may make institutional sense, but did not cohere with creating a homely environment in which individuals and individual relationships could flourish. Some facilities adopting a cottage-model approach avoided this pitfall by allowing individual housemothers to set their own rules and make decisions around the functioning of the unit of which they were in charge. Although this clearly creates the potential for contexts that approximate the natural flow of family and home life, the approach was seen in instances to create tension for children and housemothers situated in different houses. In addition – as described by Thandiwe above – a more flexible approach risked causing problems relating to continuity of care when housemothers left the facility and were replaced. Models employing full-time housemothers are explicitly centred around providing continuity of care to children as a key component of establishing a sense of 'family' and 'home'. However the model can ironically result in significant disruptions to the nature of 'family' and 'home' when newcomers alter house rules, routines and practices. In addition, while housemothers have the benefit for children of enabling closer bonds with their adult caregiver, their departure can be shattering.

Homes that were able to more effectively establish 'home' for children tended to be those which operated – like the Nyathis in Case Study 3 above – without many rigid structures and procedures; which were able to adapt and shift in their practices as seemed appropriate at any time rather than adhering to predetermined processes; that involved children in the shaping and running of day-to-day life; which were embedded in neighbourhoods in ways that enabled fluid

interaction; and in which the founders were resident. Indeed the way in which the primary caregiver envisaged their role – and the enterprise that they were involved in – proved to be fundamental. Carers like Vuyelwa and Mandla Nyathi considered their role as that of parents, whose task was to raise a family, with life-long commitments to those children who come into their care. This was in distinct contrast to professionalised residential care in which most carers were employees fulfilling the requirements of a job (no matter the extent of commitment and personal sacrifice).

6.5 Facilities

The living and care arrangements described above populated a large variety of facilities across the research sites. While some operated in single-roomed houses indistinguishable from those in the surrounding neighbourhood, others were based in vast institutional complexes consisting of a diverse range of buildings and amenities. The contrasts were striking. Basic structures included expansive developments comprising residential cottages as well as buildings for office space and other functions; large single buildings with dormitory rooms and communal facilities; stand-alone houses; and converted shipping containers and other 'temporary' structures such as corrugated iron shacks and pre-packaged wooden 'wendy houses'. In some instances, combinations of structures were in place, often as a response to growth and change. For example, a Children's Home in the Western Cape site had grown to occupy the entire length of a street block, with a number of large buildings housing children in dormitories, some smaller cottages (staffed by housemothers), as well as buildings for office space, laundry rooms, a clinic and volunteer accommodation.

While some home structures provided little more than a roof over children's heads, others included amenities like chapels, pre-schools, clinics, swimming pools and other sports/ recreational facilities, libraries, training centres, and/or office spaces, in grounds of varying size and condition. More detailed descriptions of some of the facilities in which children were cared for are documented in the case studies throughout this report.

Importantly, official registration as a Children's Home with the Department of Social Development was not synonymous with access to adequate or extensive facilities, nor was a lack of registration necessarily accompanied by poor buildings and facilities. It was not uncommon for those homes which were operating using foster care or emergency place of safety placements, and those unregistered homes that had obtained Non-Profit Organisation registration to be well-resourced with adequate facilities to accommodate the children in their care.

Under-resourced, over-crowded homes were often creative – if not entirely or ideally safe – in their approaches to occupying available facilities. Consider for example, the sleeping arrangements at a home in the Western Cape site:

> **Case Study 5.** **Ikhaya lethemba** (see also Case Study 12)
>
> Nosiswe shares her three-roomed township home with 23 children, a few of whom are her own grandchildren, some of whom she officially fosters, and others who have been placed informally with her by – among others – their dying mothers, community members, and the local social workers.
>
> A make-shift kitchen area occupies the passage, and a simple living space occupies one room; a bathroom and bedroom the others. The living space is furnished with wooden benches around its peripheries and a recently donated television. The tiny bedroom is home to a double bed, two single beds and a bookshelf and cupboard both stacked with clothes and other goods. Immaculately piled on the double bed were three additional mattresses, carefully concealed under a worn floral duvet cover.

Bedtime requires coordination. The wooden shack in the yard – used during the day as a meeting/office space – is cleared of its tables and chairs, and mattresses are laid out on the floor. The boys sleep here. Inside the main house, mattresses are spread across the floor of the living area to accommodate those girls that cannot squeeze into the bedroom with Nosiswe. They block the back-door to the yard. In the morning, all is returned to the state required for daytime activities. The house is well-kept, but clearly over-crowded.

Despite the limited and basic facilities, the atmosphere at Nosiswe's set-up was considerably more homely than many of the well-resourced homes, highlighting the point that resources are not necessarily a defining factor in the creation of a homely or 'family-like' environment. In fact, it was suggested by a number of study participants that facilities which set resident children apart from either those in the neighbourhood around them, or alternatively contrast significantly with their own family environments, can have the contrary effect. Fancy accommodation in a poor neighbourhood, it was suggested, does not embed children there and instead serves to increase children's sense of difference (see section 6.8 for further discussion).

6.6 Adult roles in residential care: 'Staffing' homes

The diversity of living and care arrangements that constitute children's homes has clear implications for the nature and categories of people involved in providing care to resident children. The term 'staff' is a misnomer in some instances, as the term is implicitly associated with payment, appointment processes, and integration into an organisational structure – none of which were applicable to the people involved in some of the children's homes encountered during the research. In other cases, only some of these criteria applied. The distinction between 'staff' and 'volunteers' was also not always clear. It is therefore perhaps more helpful – and accurate – to think in terms of the functions people fulfilled in homes. It is this approach that is applied throughout the remainder of this section.

Adults contributing to the functioning of homes varied in number, in adult-to-child ratio, and in their degree of specialisation and levels of skill, among other things. Some homes were run by a parent or parents; others headed by a manager or founder, assisted by one or two employed or voluntary care-workers; and still others drew on large numbers of paid staff and volunteers to fill a range of positions and functions. Consider the contrast between the range of people involved in Case Study 3 for example (presented above), and those involved in a large Children's Home in Limpopo.

> **Case Study 6.   Littlewood Children's Home** (see also Case Study 9)
>
> Littlewood Children's Home is situated amidst vast open space at the end of an isolated *cul de sac*, between the city and its peripheral settlements. The complex is expansive, immediately 'institutional' in feel, and comprised of uniform single-storied red-brick buildings with turquoise trimmings, festooned with burglar bars and multitudes of security doors. Networks of cement paths, the main ones of which are covered, connect the buildings to each other. Twenty identical houses constitute the Children's Home residences. Other buildings include a reception, a clinic, baby and toddler accommodation, and dormitories for children needing place of safety care.
>
> A large team of approximately 40 staff is involved in running the complex. A manager oversees the running of the Children's Home, and is supported by what she describes as a "multi-disciplinary team" consisting of housemothers, employed as primary caregivers and tasked with the physical care of the children in their houses; child-care workers who are employed to run a range of life-skills, cultural, sporting and recreational programmes; social workers who liaise with the external social workers on relevant statutory work and provide therapeutic individual and group sessions for resident children; and nurses who see to the medical needs of the children. At the time of research, the home was also advertising to employ a psychologist. In addition, a range of support staff rally in the background: groundsmen keep the lawns neatly trimmed; security

guards check all entering and exiting the premises; a receptionist deals with visitors; a finance department manages all financial aspects of the home right down to whether a child can be allocated a fee for going on a school outing, and kitchen and laundry staff ensure all domestic functions are fulfilled.

The Children's Home manager reports to a manager who oversees the complex as a whole. In order to manage the range and numbers of staff involved in the institution, clear hierarchies have been established and numerous staff protocols are in place. Regular team meetings are held to discuss each accommodation unit and to ensure that the multi-disciplinary approach is being utilised fully, the manager of the Children's Home explains.

This home demonstrates the broadest range of categories of functions or roles that existed across the homes in the study, although – unlike in two children's villages – there was no on-site education facility. The range of functions fulfilled by adults across all the settings included management, care work, social work, administration, finance, medical, teaching, and various therapies including psychology and occupational and speech therapies. Few homes provided all these functions internally however, and in most instances those functions which were fulfilled involved a combination of paid and unpaid people in more or less formal capacities. Thus care needs in homes were fulfilled by any combination of paid care-workers, full-time care-workers with no remuneration, relief care-workers, volunteers who came in once a week to play with children, and of course parents who had extended their household to integrate additional children. The Children's Home in the above case study was exceptional in its almost total reliance on paid staff, only possible because of the large budget at its disposal.

Despite the huge variation, it is possible to identify two major functions that adults in most homes were filling, however formally or informally:

- Managing or leading the home; and
- The actual caring for children (referred to loosely as 'caregiving' or 'care provision' in the remainder of this section).

Notably, in many instances some individuals performed both functions.

In addition, over half the homes in the study – mostly registered homes and those operating through foster care legislation – had a professional social worker involved in some capacity. In some homes all functions were filled by the same individual(s) whereas in others the roles of manager, child-care worker and social worker were quite distinct.

The 'staffing' of residential care facilities is at the centre of concerns raised in the 'last resort' literature. Low levels of professional skill and knowledge amongst care-workers and managers, and inadequate staff-to-child ratios in developing world institutions are highlighted as impacting negatively on healthy child development. It is argued that in many such institutions, those responsible for children are more involved in domestic work than in stimulating and caring for children: in other words there tends to be disproportionate attention paid to addressing the physical needs of children and insufficient focus on children's developmental needs (see Tolfree, 1995). In keeping with these concerns, the South African Children's Amendment Bill articulates the specific need for regulations regarding the ratios of staff to children in residential facilities (s.209 (4)), as well as "matters relating to training, qualifications and experience of staff" (s. 212(q)). In addition, the most recent version of the Bill specifies that a person appointed[24] as a manager of a residential facility must have "the skills and training as prescribed" by (as yet undefined) regulations (s.209(2b)).

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[24] Here we see formal employment processes automatically envisaged as part of residential care facility functioning, another example of legal interpretation of children's homes as professional organisational interventions only.

These are indeed issues for concern and consideration. Importantly however, 'staff' training and skills and adult-to-child ratios are not the only factors which impact on quality care for children. The study findings suggest that adherence to these legislative requirements would not necessarily guarantee engaged, stimulating, appropriately developmental care for children. In the remainder of this section we further the discussion of this point with observations from the field.

Leading residential care settings

There is much debate in the children's sector in South Africa about the appropriate qualifications for those in charge of residential care facilities. Some well established organisations within the sector argue that a facility manager must have child and youth care training or be a social work professional (National Association of Child Care Workers, 2006). The argument for these minimum qualifications is located in a concept of residential care as professionalised 'alternative care' for children. It is made in part to prevent well-intentioned but perhaps misguided people from establishing children's homes that provide children with inadequate care, as well as to ensure that professional standards for child care interventions are implemented in homes.

Those in charge in the study homes had a wide range of skills and backgrounds. Some had no background in child care and were appointed because of their managerial skills. Others were qualified social workers, child-care workers, teachers, priests and pastors, and women and men with no specific training or experience in child care or community work. In all unregistered cases except one, the person in charge was the founder of the home, as was the case in just over half of the foster care or private places of safety. Only four of the registered homes still had their founders involved – in two cases as hands-on managers and in the other two as directors overseeing a range of interventions. The extent and nature of 'management' required for different manifestations of living and care arrangements varied substantially. A large formal institution like that described in Case Study 6 above by definition requires a different set of skills in its leadership to those required in small settings like those described in Case Study 2 and Case Study 3.

Besides qualifications, this study documented other key qualities that affect the insight and ability of those leading homes to create and maintain good standards of care for children. Certainly there are lessons to be learned from some of those homes which emerged as community-based responses to the needs of children. Consider for example, Sibongile in Case Study 1, 11 and 16. As founder of a home in which she was much loved and respected as a mentoring figure by children, she was not 'qualified' in either child-care work or social work. A teacher by training, she brought experience with children to the task, but more obviously her compassion, her vision, her commitment to creating opportunities for children, and her sensitive insights into local cultural practice including in relation to child-rearing, played a critical role in the nature of care provided to children at the home. The aspect of genuine care for children that is evidenced in Sibongile's approach was one that was apparent in a number of founders of (sometimes previously) unregistered homes, many of whom did not have formal qualifications but were nonetheless providing insightful and appropriate care. Commitment and willingness to make personal sacrifices as well as the resourcefulness of a number of 'unqualified' women running homes were significant factors in the nature of care provided to children.

Fulfilling the caring function

Child care in homes was provided by people with differing levels of skill and training in more and less formal capacities from paid child- and youth- care-workers to volunteer caregivers (and in many instances including founders in charge of homes). Those formally performing this function in a fulltime capacity were usually referred to as care-workers, caregivers, or

housemothers and housefathers. Here we use the term caregiver to refer loosely to all those fulfilling this role whether formally or not.

Some caregivers had formal training in the form of the Basic Qualification in Child Care (BQCC), and in a few cases this was a prerequisite for the job. In 41% of homes however, caregivers had no training at all. Forty-seven percent of the homes had caregivers who had received some training, but within this group there was great variation in terms of the nature of the training. In some cases training was sporadic and done on the job by the person fulfilling a management/leadership function. In other cases, some caregivers at a home had formal training while other of their colleagues did not. Registered homes were much more likely to have trained staff, with all caregivers in 40% of these homes having the BQCC qualification. This proportion increased to 80% when less formal child-care training was included (see Table 9). Lower levels of child-care training (whether formal or informal) were reported by homes using foster care or emergency care legislation (25%) and those that were unregistered (18%). None of the caregivers in unregistered homes had BQCC qualifications, though a number were undergoing training at the time of the study.

Table 9. Child-care training amongst care-workers in children's homes

Some child-care training	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes	2	25	12	80	2	18	16	47
No	5	63	2	13	7	64	14	41
Unknown	1	13	1	7	2	18	4	12
Total	8	100	15	100	11	100	34	100

While this may be cause for concern, as noted earlier it is important to recognise that the relationship between training and quality child care is not a simple one. While there was no formal attempt to assess quality of care in the homes, observations of child–caregiver interactions revealed instances in which trained caregivers did not provide engaged care to children, and others in which untrained caregivers provided developmentally conscious care (see section 6.7 for further discussion).

In other words, the nature of care provided to children differed substantially from one home to the next. Although staff training and child-to-adult ratios played a role, with a tendency for carers to err on the side of more supervision than active engagement in those homes where ratios were high, these were not the only factors that influenced care. Of particular importance in shaping caregiving were choices regarding living and care arrangements (as outlined in section 6.4) as well as the caregivers' conception of their role in the enterprise in which they were involved. Household-type set-ups with a primary caregiver seemed to enable carers to prioritise individual attention for children.

Also affecting the nature and quality of the care provided to children were the working conditions of caregivers. All caregivers, whether rotating shift workers or full-time housemothers, worked very long hours. Where caregivers were not full-time – as parents or housemothers – but were working shifts, a 12-hour shift was standard practice. A lack of financial resources often meant that caregivers worked even longer hours. The social worker at a large registered facility in the Western Cape empathised with the caregivers, acknowledging that 12-hour shifts impact on their health:

> "A lot of our [care-workers] do get sick here, and you know if you think of the long hours they work they do get tired … We get 21 days leave [per year], 21 days is not a lot to rest. It's emotionally draining to work in a place like this. I do understand what they're going

through and your body can take so much, and you push and push for perfection, for quality care."

Clearly absenteeism and illness can impact on the quality of care provided. Sacrifices demanded of those working as housemothers in care arrangements that required living 24 hours a day, seven days a week in a cottage or house with children often led to job dissatisfaction and subsequently higher staff turnover. As with illness, this undermined the consistency in caregiving that the care arrangement was designed to achieve.

Remuneration for caregivers also tended to be poor. As one manager replied when asked whether her caregivers were paid, "…it's a stipend, a stipend, you cannot say they are paid I'm afraid to say". Only in rare instances were caregivers receiving more substantial remuneration. For some carers, poor remuneration resulted in dissatisfaction with their jobs. Discussing their working hours and pay, two housemothers working for a foster care set-up in the Western Cape pointed out with incredulity that they only earn R2 000 a month despite working 24 hours, seven days a week. These housemothers also had to do more than care for the children, having in addition to clean, cook and iron. Again this was part of a conscious choice on the part of management to try and provide an environment approximating a natural 'household', but did not take into account the working conditions it created.

Not all homes using a 24-hour, seven-days-a-week housemother model were expecting caregivers to fulfil all domestic functions, and some recruited cleaners to bear some of the load. Given the stresses of the job many caregivers and their managers referred to people performing this function "for the love of children" rather than for the money. However, this sense of vocation or willing sacrifice was not universal and where caregivers approached their duties purely as a job, there was likely to be more dissatisfaction, and less adequate care provision to children.

Providing social work services

Fifty-six percent of the homes in the study had a social worker on their staff or available in a voluntary capacity. Registered homes were by far the most likely to have a social worker: only two of the 15 homes were without access (see Table 10). Conversely, unregistered homes were unlikely to have access to the services of a social worker. The two unregistered homes which did have a social worker were in the process of registering.

Table 10. Homes with access to a social worker

Social worker	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes	4	50	13	87	2	18	19	56
No	4	50	2	13	9	82	15	44
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

Those running homes identified internal social workers as playing a key role in moving children out of the home, a task that involved working both with families and with the child in the home. Social workers at the homes were however constrained in this role as they relied on the external social workers who placed children in residential care to complete the required statutory work and finalise the processes (see section 7.3 for more discussion).

As with caregivers, homes struggled to retain social work staff, largely because they paid less than other NGOs and the state department. The social worker at a Children's Home in the Western Cape explained that low salaries are a result of Children's Homes being expected to

pay for social work posts from the per capita subsidy they receive from the State. In contrast, social work posts in other NGOs performing statutory work are directly state-subsidised.

In summary, care provisioning for children in residential settings in the study sites was populated by a variety of categories of people, with diverse levels and types of skill and knowledge. While the value of professionalised knowledge bases amongst those providing care to children in residential care settings should not be under-estimated, neither should that of other less formal skills and attributes. Instances of both impressive and questionable practice were observed in settings led and staffed by both 'qualified' and 'unqualified' men and women. Important then, in considerations of what constitutes appropriate 'staffing' of residential care, is an approach which balances these qualities as appropriate to the particular manifestation of children's home in question.

6.7 Programme provision

As noted in section 3.2, the Children's Amendment Bill currently under debate in the South African parliament introduces a specific requirement for residential care facilities to provide therapeutic programmes that address resident children's needs. Under current legislation, the requirement to provide programmes is located in policy rather than law. Given this new legal provision, we turn to examining the implementation of programmes by homes in the study to address children's developmental and therapeutic needs.

The degree of awareness about the developmental and therapeutic needs of children in their care varied on the part of those running homes. Some were entirely cognisant of the fact that over and above the needs of any child for developmentally appropriate experiences, many of the children in their care were prone to additional psychological and developmental problems as a result of abuse, neglect and abandonment. The extent of these special needs amongst the children at one of the homes led the manager to describe the home's primary function as a "mending shop" for children. Others seemed less aware, and still others demonstrated little insight at all into problems faced by children in their care. Consider for example the following observations at a well-resourced private place of safety:

> **Case Study 7.   Loving Heart Sanctuary** (see also Case Study 17)
>
> Loving Heart Sanctuary occupies an ordinary house in a middle-class neighbourhood. It is clearly signposted by a corporate-sponsored billboard: Loving Heart Sanctuary: Home for abandoned babies. The home is the latest addition to a series of private places of safety established by a Christian welfare organisation, each of which is focussed on rapid placement of abandoned children into family-based care. A director of the organisation explains that the aim is for children to "pass through, and move back to the family and community". Only children up to the age of 18 months are admitted to the home, as children older than this are more difficult to place into adoption or foster care within short time-frames.
>
> Children are accommodated in a large, light nursery. The space is furnished with eight cots, some chairs, and a row of waist-high cupboards complete with changing mats and various other baby paraphernalia. A photo of each child, labelled with their name and formula milk allocation marks their allotted cot. One unused cot is entirely filled with donated baby toys.
>
> Martelize, the paid housemother in whose legal foster care the babies are placed, lives with her husband on the property. She is assisted in caring for the babies by a domestic worker during the day and a care-worker at night. In addition, the model requires a social worker to drive adoption processes, but at the time of the study this post was being advertised.
>
> At the time of fieldwork, five children were resident at the home although more could be accommodated. One, a five-month-old baby, had been abandoned in the local hospital and had lived in a ward there for her first three months prior to being placed at Loving Heart Sanctuary. Signs of unstimulated institutionalisation were immediately apparent in the baby. On three separate occasions she was observed lying silent and motionless in her cot. She was slow to

respond when attempts were made to interact with her and she struggled to support her own weight when held.

Each of three staff members at the home commented separately that, "this one is so good. She never cries". There was no acknowledgement of her physical and social developmental delays. Instead, she tended to be left lying quietly in her cot as caregivers tended to other, more engaging children.

With good reason, scenarios like this described in Case Study 7 – in which children's needs are neither recognised nor addressed – lie at the heart of anti-residential care discourses. However, these were in the minority in the study. Attempts to address children's developmental and therapeutic needs at the homes ranged across a broad spectrum of activities and interventions, with varying degrees of formality and conscious application.

Informal approaches to children's developmental and emotional needs

Informal and often unconsciously applied practices embedded in the everyday rituals and routines at these homes went some way toward supporting children appropriately. These approaches were generally not identified by caregivers as 'programmes' per se, although the processes occurring resulted in the achievement of the same objectives.

The backbone of these processes was the nature of the care being provided and quality of interactions between children and caregivers. In particular responsive, loving and engaged care, where children were held, played with, and interacted with caregivers and other children in an ongoing way throughout the day, contributed to children's development. Other examples of informal interventions included those which imparted basic life-skills to children in ways that would happen in regular households – such as by involving children in domestic activities, talking informally about issues such as sex and HIV/AIDS, and allowing them greater freedom and responsibility as they grew up. Consider the case of a Limpopo Children's Home housing 33 children from newborns to young teenagers. Despite the lack of formal 'programmes', no obvious signs of developmental delay were observed and children appeared well adjusted.

Case Study 8. Hope for Children

A long-time health worker and AIDS activist in her neighbourhood, Mantoa nonetheless never anticipated finding herself at the helm of a Children's Home. She didn't raise her own children, leaving the bulk of the task to her mother while she worked to support the family. Today, she smiles, children are her life.

Working as a home-based carer in peri-urban and rural settings, Mantoa increasingly found herself supporting children whose parents were ill or had died. As a result she established a programme to provide material, practical and emotional support to children affected by HIV/AIDS in their families and homes. It was through this work that Mantoa became an emergency mother to a couple of children for whom there was no tenable family support. And while her work supporting children in families continues to expand, so has the number of children needing temporary or more permanent alternatives.

Today she and four care-workers share a house donated by the local municipality with roughly 30 children, most of whom are young children under the age of seven, some of whom are early teens. The house has a kitchen, living room, dining room and four bedrooms. Wendy houses out in the back yard accommodate some of the older boys in bunk beds. The place has the appearance of an ordinary family home, bar the number of beds in the bedrooms and the tall stack of little-people-sized plastic chairs in the living room.

Mantoa believes that key to children's development is the opportunity to participate in and shape their environment, and to have an experience "just like a home kind of set-up". She and her team have instituted regular meetings with children who are old enough to attend school, at which decisions are made about the running of the home, and certain children take responsibility for

particular aspects of the home. Twelve-year-old Rebecca ensures that everyone has the soap and toothpaste they need; Abdullah checks the boys' routines; and he and other older boys will go to the supermarket a short walk away for emergency groceries, and so on.

The flexibility of the environment and the attitude of the caregivers enables children to request particular meals ("Can't we rather have rice today?"); articulate their preferences for school, for other activities, for outings; and choose what they participate in. The older children also assist with the care of younger children, and the girls observed at the home seemed confident in themselves and secure in their relationships with their adult carers. Beaming with pride, Mantoa laughs that the older girls "like to think they are in charge".

External service providers such as ECD workers, hospital-based psychologists and other volunteers are utilised as required to ensure that children's needs are met. Care-workers have all received training but even more important to Mantoa is that they are people "who've got the feeling of children at heart". As a result, she explains that the care-workers "are taking these children as their children, like if a child is crying, one will say 'no, that's my child's cry' and run in, 'what is it with my child?' and such things, so they become so bonded with the children."

Indeed care-workers were observed playing with babies or toddlers one-on-one or in small groups of twos or threes and to be consistently with the children in their care. Much of this interaction is spontaneous as the daily life of this home unfolds.

Mantoa's experiences do indeed seem to demonstrate developmental benefits for children in the provision of consistently conscious and responsive caregiving that draws on everyday care practices typical within functional family structures. Although training of care-workers no doubt played an important role in assisting engaged caregiving at the home, the case study highlights how a naturally stimulating environment for children can arise out of the nature of interactions between people in the home, both between carers and children and between children themselves. It was thus often a function of what caregivers understood their role to be vis-à-vis the children. This was evident in other homes as well, and some untrained caregivers who understood their role as that of a parental and nurturing figure were similarly observed to be providing consistently developmentally conscious care, even in the absence of having received any formal training.

The 'programme' approach

Many homes were implementing more formal interventions than those described above to address children's developmental and therapeutic needs. In some cases these were run in addition to the kinds of informal approaches discussed above, but in other cases 'programmes' were the only mechanism being implemented. Managers at homes described a wide range of specifically designed interventions or 'programmes' aimed at psychological support, child development, education and skills building, leisure and recreation, family reunification and host family placements, and spiritual development, among others. Importantly it was these interventions that staff at homes tended to understand as fulfilling the requirement of running "developmental and therapeutic programmes" as outlined in the new legislation.

A series of key differences in programme provision were identified across the participating homes. Firstly programmes differed in how structured they were, with some homes operating according to a strict time-table and others offering activities in a more haphazard fashion. Secondly, some programmes were run by the facility staff and volunteers, whereas others involved utilising the services of external organisations such as NGOs and churches. A third important difference was whether programmes happened on-site at the children's home, or whether children participated in an activity or service based in the surrounding neighbourhood; a fourth whether the intervention was applied in a blanket fashion to all children resident in the home or only to those individuals who needed to or were interested in participating. This had implications for the degree to which children's lives were isolated within the grounds of the residential care facility, and the extent to which they were able to pursue individual interests. In

general it was the smaller homes which made use of classes and services offered in the neighbourhood, although some of the large institutions used a combination of external and internal extra-murals.

These differences and the extent to which programmes were accompanied by sensitive care practices impacted on how successfully homes were achieving other stated goals, such as providing a home-like environment and ensuring children's appropriate development. Instances in which children were required to participate without freedom of choice in regulated formal programmes and interventions (such as, for example, regular psychological assessment) would not be part of everyday home-life experience for their peers. It might be argued that a formal programming focus risks encouraging a highly structured context of care that is easily focussed on groups rather than individuals, and does not necessarily fit neatly with the idea of creating a family environment.

The following case of a large Children's Home providing care to children from age seven to 19 reveals contradictions between its management's articulated commitment to providing children with a living and care environment as close as possible to that of a natural household and some of the choices made with regards to programme provisioning.

Case Study 9. **Littlewood Children's Home** (see also Case Study 6)

When the brand-new Littlewood Children's Home was in the process of being established, careful thought went into deciding about how best to staff the facility. Tebogo, the manager of the home, describes how she and the manager of the complex in which the Home is situated drew extensively on their respective experiences of working in a large Place of Safety. Both felt that children in the Place of Safety did not receive adequate care and were frequently not adequately occupied or stimulated as a result of child-care workers' insufficient training in programme provision. They therefore advocated for a staffing model that they anticipated would address two key elements in the provision of care at the Home: the creation of home-like environments (in line with current policy trends) and the provision of programmes.

In order to address the first aspect, housemothers were appointed as primary caregivers. Tebogo explains that a housemother must be "a person who's going to bond with the children, who's going to make a homely environment". Although on duty during the afternoon when children return from school, the housemothers' caring responsibilities are mainly in the mornings and evenings, and are particularly focussed on meeting children's physical needs:

> "[the housemother's] job is to see to it that the kids have eaten, have done their homework and they have slept. If there's an emergency at night she will wake up and attend to that problem."

Afternoons are the domain of the child-care workers who run life-skills, cultural, sporting and spiritual 'programmes' with children after school, explains Tebogo. Training in child care and programme provision is a requirement for the job of child-care worker. Additional therapeutic programmes are offered by social workers during this time, taking the form of either group or individual sessions. These programmes are seen to be essential for the children's appropriate development.

The home follows the regulations in the Child Care Act meticulously: all children have individual development plans (IDPs) drawn up by teams consisting of a social worker, child-care worker, housemother, nurse, the child and their family. These plans, explains Tebogo, cover the various physical, social and emotional goals of each child, and outline what needs to be done in order to meet these various needs. Tebogo outlines an example of how this works:

> "If maybe this child has personality problems, that's what we'll look into coming up with sessions, groups work sessions you know, trying to meet this child halfway in terms of relationships with other children. If this child needs to see a psychologist, then the social worker will look into that, the whole team will play and the whole team will know."

Programmes are the primary mechanism through which IDPs are implemented and thus through which the home is trying to address both the developmental and therapeutic needs of children. The home offers a large variety of (mostly group) programmes. Because of the value placed on programmes there is a strong emphasis on children's compulsory participation:

> "If like for instance the care-section has got life-skills programmes, spiritual programmes, sports programmes, cultural programmes, you know we need to see to it that children are involved in all these activities. In our disciplinary system, our group disciplinary system for children, there's somewhere we have indicated that you will take part in two activities that are being rendered. We won't allow it to say if today they're going to sports at the ground, you will be just sitting in your room sleeping, otherwise if you do that all the children will tend to do the same. Then we won't have control you see. Our job at the end of the day is to see to that all these children are engaged in programmes."

The way in which programmes are provided is highly structured, and a detailed daily schedule has been drawn up. This, Tebogo explains, "enables you to know that at this particular time what is happening, everyday of the week what is happening". She elaborates that staff must stick to this schedule and cannot spontaneously provide programmes:

> "A social worker or a nurse cannot just decide that I think I will have a group work today at four. It doesn't work that way. Social workers know when do they involve children in group work, or when do they involve children in interviews, care-workers know when do they do that, and nurses know when do they do that."

All programmes take place on the premises and children must be occupied at all times. If they are not occupied by one programme, they will be participating in another one:

> "With group work for the social workers, you don't involve all the children: a manageable group is up to ten. So if you have taken ten children, junior children, to go to talk about sexual abuse, then the rest of the children must be engaged in other programmes. If it was baking or garden time, they should continue with that while the social worker is busy at that particular time. So you'll see [the daily schedule] will tell you exactly what they do until lights off."

In other words, the manner in which programme provision in this home was structured and implemented worked at odds with the cultivation of a home-like context for resident children. Particularly in large institutions like that of the Children's Home described above, programmes often seemed ultimately to function as mechanisms for controlling, containing and supervising children rather than addressing their individual needs. In some instances, like that of a large registered home that lacked sufficient human resources, this was explicitly acknowledged:

> "They have to be under observation. So we put them in programmes. That means when they come from school, some time is for writing homework and we take them to different types of sports. But we must not give them the time to think, and when they come back they are tired, they come and go to the dining room and eat and sleep, you see, otherwise if you don't give them a programme, they will have a 'programme' themselves".

However highly routinised schedules which prevent children from having opportunities to entertain themselves in ways that they choose and which keep children within the confines of facilities present different dangers. In particular, as documented by Giese and Dawes (1999), such approaches risk delaying children's appropriate development. The application then of on-site scheduled activities to address children's developmental needs in the manner in which they are provided in the home described in Case Study 9 above is therefore in some respects contradictory to the goals both the home – and the policy it is implementing – set out to achieve.

Meeting children's developmental and emotional needs: part of everyday caring or a professional and specialist activity?

The division of labour between the two sets of staff directly involved in everyday care provision for children at Littlewood Children's Home also highlights an implicit perception that meeting children's developmental and emotional needs is a specialist activity distinct from the provision of everyday care. These same notions seemed to be evident in the practices of some of the other homes, too:

Case Study 10.   Ulonwabo

Ulonwabo was established by a social worker concerned with the extent to which she observed babies "getting stuck" in residential care "for years and years and years". The home is set up to provide care for up to 12 children under the age of three years, with a focus on identifying foster or adoptive families as rapidly as possible. The service provided by the home thus centres on getting all that is medically and legally necessary in place for children's fostering or adoption. An NGO, which provides medical services, routinely checks "the developmental status" of each child as some children, the manager explains, are admitted with developmental lag. As necessary this organisation then links them with specialised occupational and speech therapists who develop appropriate exercises for the children. In addition, a programme of developmental exercises has been developed for all children. The care-worker supervisor explains:

> "We have charts that show different exercises to be done with children of different age groups. For example, a child up to three months – they teach them to strengthen their neck muscles, sit, to lift their head. And from six to nine months, they teach them to stand, they strengthen the muscles that help them stand. And from 12 to 18 months they teach them … according to their developmental stage and age."

Although care-workers provide the day-to-day care for the children resident, they do not implement the developmental programmes identified for the children. Instead, a group of volunteers have been recruited specifically for this purpose.

Aside from these scheduled times for stimulation, children are exposed to a daily routine of being woken to be fed before returned back to bed. The care-worker supervisor explains that babies are trained "to do what we want them to do" through the use of strict time-tabling for feeding and sleeping. This is achieved by not attending to babies older than three months who cry for food or attention outside of the specific feeding times for that age group. Once babies and toddlers have been prepared for bed at 5pm they remain in their cots whether or not they are sleeping and wait for the night shift staff to arrive:

> "These children were trained, they do not cry. Around that time we sit and wait for night staff, but there will not be any child running or playing around. They will sit in their beds even when they are not sleeping. You will sometimes hear them talking from their beds. They will be in their beds and wait for the night staff the night staff will arrive and take them from their beds."

The babies' well-being is monitored systematically through taking their temperatures each morning and recording every nappy change and feeding in the child's file and "the condition of the child" at that time. Negligence is understood by the supervisor as failing to maintain these daily records.

In this way, a commitment to programming and professional services in some homes at times occurred at the expense of developmentally-sound everyday caregiving. The extent to which this is driven by discourses about the importance of formal programme provision for children in residential care is unclear. However, it suggests that at the point at which the Children's Act provisions are translated into more detailed regulations and minimum norms and standards for residential care, it would be worthwhile paying attention to a broader range of appropriate ways for addressing children's developmental and therapeutic needs.

6.8   'Community embeddedness'

One of the primary criticisms of residential care cited by the child welfare sector is that it isolates children from family and community, hampering their ability to adjust to life 'outside' the institutional setting (cf. section 3.1). We are reminded that in residential care, children's "lives are often lived in a parallel world that does not prepare them for life and healthy social interaction" (McCreery, 2003:1); that in the majority of instances they are "living in an artificial setting which effectively detaches them not only from their own immediate and extended family and from their community of origin, but also from meaningful interaction with the community in which the institution is located" (Tolfree, 2003:7); that they frequently experience "no preparation for life outside" (International Social Service & UNICEF, 2004a:8), and that as a result they tend to "lack cultural and practical knowledge and skills they need to fit into a community" (Williamson, 2004:4).

Indeed this is a risk that was observed in some of the homes that participated in the study. However many were embedded in 'community' to a greater or lesser degree. The study documented a range of practices on the part of those running homes that created or maintained links to families, to community, to cultural practice (or attempted to do so) – thereby situating children in neighbourhood, peer group, and kin. The extent to which this was consciously or unconsciously attempted or attained varied from one home to the next. Consider for example, the case of Ikusasa lethu, an unregistered children's home in KwaZulu-Natal.

> **Case Study 11.   Ikusasa lethu** (see also Case Study 1 and Case Study 16)
>
> Ikusasa lethu's small cement-block building is striking in its rust-red paint amidst the lush summertime green of its rural KwaZulu-Natal neighbourhood. A five-bedroom structure, built haphazardly as funds have allowed, it is located at the bottom corner of a large expanse of school ground, across the way from an ablution block adjoining a cooking and eating area. Cooking is done in a cooking hut (as is typical in the area) on an open fire, and a structure built with cement and stone tables with shade cloth covering provides an eating area for the home as well as for the school feeding scheme. The children living at the home maintain a flourishing vegetable garden and mealie patch in the rainy season, as well as a motley collection of animals – including pigs, chickens aplenty, ducks, and a few rabbits.
>
> This part of the school property buzzes with activity seven days a week. Children living in impoverished families come for meals each day including over the weekends; others simply come to hang out and play – including on the playground built by visiting volunteers a year or so back. There is a constant flow of children in and out, as learners participate in after-school activities or those resident at the home head off to their various schools, elsewhere with their peers, or to collect the water or wood needed for everyday living. The local NGO which runs a range of activities in the afternoons and during school holidays is within walking distance of Ikusasa lethu, and many of the 25 children living there are eager participants in their programmes.
>
> Right from the start when Sibongile Kuzwayo, school principal and inadvertent founder of Ikusasa lethu, assisted a child she found sleeping in the bushes at the school, she has made efforts to involve a range of local structures and residents in the home. She describes how after she discovered the first child needing care, she:
>
>> "… informed the school governing body of this boy's situation and they agreed that the boy be allowed to stay in the stick-and-stone classroom that was previously built by the community [and that was no longer in use]. The teachers were all willing to help this boy and would bring him left-over food from home and even remembered him when doing their monthly shopping. The teachers then started a fund for the purpose of helping this boy [and the additional boys who arrived]. Each teacher contributed R10 a month towards the fund."
>
> Neighbours to the school were also informed of the boys' circumstances, and Sibongile "welcomed any assistance from them where they felt that they were able to contribute". She approached the local traditional leaders – the *indunas* – to alert them similarly. "This was necessary," Sibongile explained,

> "… because in the event that something happened to the boys while living on the school premises, we would be held accountable. Their officials came to the school to investigate the matter and confirmed their approval. They also told the boy that when he grows up they will give him land, provided that he behaves himself".

Importantly consultation with the school governing body, the *indunas*, community members and relatives continues as the home develops, and many decisions – including which children should be staying in the home – are still made collectively.

Sibongile goes to great lengths to identify and engage with children's relatives, and to investigate possibilities for them to move out of the home, or to spend regular periods of time with them. She actively encourages the development of relationships where possible, though she is circumspect about the difficulties involved. In particular, she points out how the children's experiences of physical and sexual abuse at the hands of their relatives limits the family placement options open to her. In instances where it has not been possible to identify relatives for children to live with, Sibongile is nonetheless careful to negotiate the children's rights to land. She describes, for example, how when she was asked by a dying mother to take care of her daughters after her death until they were older, she saw it as a priority to ensure that their access to their mother's land was secure in the longer term:

> "Their mother's land is still there even though no one is using it. When they've grown up, they will go back there and restart it. With land there is no problem. If you have negotiated with the *induna* and also their aunties and uncles, they will make sure that their land is kept [for them] … In this area, they still respect somebody's land. They don't just jump in even if it looks like no-man's land."

Children living at Ikusasa lethu hail only from the local district. Sibongile is clear that this approach has benefited the children, in particular by enabling possibilities for continuity with their community of origin and limiting disruptions in their lives with the move into the home. She worries in this respect about the implications of official registration with the Department of Social Development, and the requirement that they would have to accept children from across the province: "if we were registered, then it would go totally out of our hands … If [the children are] from another district, it won't be easy."

The story of Ikusasa lethu begins to illustrate how, in the South African context, a notion of life 'inside' or 'outside' a children's home is not always as distinct as is implied by some of the literature. While the resident children experienced a particular set of living and care arrangements that differ structurally from other children in their neighbourhood, they also shared similar experiences, responsibilities, activities, cultural practice, context and lifestyle. Their world is contiguous with other children, rather than 'parallel'. Other homes demonstrated similarly: recall, for example, the day-to-day experiences of children living with the Nyathis in Case Study 3, which in generic terms matched those of children in any household in the neighbourhood.

The nature of rules and routines governing everyday life for children in residential care settings were key to the development and provision – or otherwise – of the homes' and concomitantly the children's 'community embeddedness'. Homes which were achieving an environment facilitative of children's participation in natural 'community' or society tended to have fewer strict and more relaxed rules about the comings and goings both of resident children and of adults and children living elsewhere in the neighbourhood, for example. In some cases – like those of Ikusasa lethu and the Nyathis – neighbours and others moved through the home as in any local household; children attended a range of local schools, churches and sports clubs, and interacted with other local children in public spaces. On the whole, women caring for children in extensions of their households were documented to provide these more embedded environments with greater ease and quite unconsciously.

At the other end of the continuum, there were children experiencing 'institutionalised isolation'. Emblematic of these experiences were the bureaucratic procedures that some institutions had

put in place seeking to control the flow of people in and out of the home. Recall for example, the requirements for visitors to the Children's Village in Case Study 4. This facility, and others like it, which barricaded outsiders' access through the presence of security guards, gates and multiple proforma forms for completion tended only to interact with surrounding neighbourhoods through formal mechanisms such as volunteer programmes, structured arrangements with other organisations, and highly regulated visiting procedures. Concerns about the need to control what happens on the premises (often underlined by a protective attitude towards the children in their care) thus prevented easy interaction between children and their friends, relatives, neighbourhood residents and community activities. A social worker at a registered Children's Home catering largely to HIV-positive children articulated staff's apprehension about facilitating a more flexible environment for children, and the processes she felt were necessary in order to establish one:

> "People want to come here, their friends want to come here and visit [the children] here. We're just working on a policy for – you know on how to handle this, because of the stigma… So we are careful who comes to visit them, how long can they stay here, where will they play, yeah we're working towards allowing children's friends but we will have kind of a pilot study with two children to see how it goes."

The study nonetheless documented a general trend amongst both registered and unregistered homes to incorporate practices that attempted to enable resident children to form and maintain relationships with people external to the home, including with their immediate and extended family. These were established with varying degrees of impact. A key distinction included whether approaches facilitated children's participation in the same neighbourhood processes and experiences as children living in families and households, as opposed to merely being brought into contact with community members: frequently interaction was purposeful and controlled, often occurring only within the grounds of the home concerned. For example, homes ran holiday programmes for resident and neighbourhood children; recruited organisations or individual volunteers to run recreational or life-skills programmes and organised for churches to run services on their premises. In fact, rather than promoting community embeddedness, activities which were organised to bring neighbourhood residents to the children's home in order to facilitate interaction run the risk of reinforcing children's sense of otherness and separation.

Some of the more effective techniques implemented by homes to embed children in neighbourhoods included their attendance at public schools and participation in churches and local sports clubs, and allowing flexibility in their movements. The use of 'host families' at a large Children's Home in Gauteng provided children with connections to 'community' as well as 'family life': Those children who were not able to spend time with relatives over weekends were linked to 'host families' who they would visit instead, thereby participating in family-based activities and developing a set of relationships with substitute 'kin'. Concerns about children's monitoring and protection meant that this range of approaches was not always logistically simple or manageable for larger homes, or for those catering for young children however.

Although many homes were committed to the importance of children maintaining relationships with their relatives while resident at the home, some homes had negative perceptions of children's families and resisted contact for fear of potential disruption to the children and the home. Some of the informal homes failed to make basic enquiries as to the existence of children's relatives apart from the child's parents, simply because, as one woman who had taken in 11 children said, asking about other relatives "didn't come to my mind".

In addition, staff at homes where the principle of family contact was valued noted frequent loss of interest or a lack of responsibility on the part of families, and worried about the implications

for children of further rejection. Some social workers interpreted this at least in part as a function of a child protection system that is disempowering of parents and relatives:

> "It's a known fact that once you've removed a child and made a recommendation regarding long-term placements, that parents often become inactive. They don't – they almost withdraw – because they have been disempowered in a sense: you have given them the message that they're not competent caring parents, so there's no feeling of, you know, I can take over that responsibility as a parent again."

They pointed out the responsibility of social workers in this regard:

> "When a social worker works with a family, she needs to make sure that this family understands that it's not the home's responsibility; we are just taking the child away to give you space to breath, to look at yourself before we return the child."

As a result, continuous "motivation [and] encouragment [is needed] to get the biological family involved", explained a Western Cape social worker. This was something that both facilities and state social services struggled to provide, and is rarely given prioritiy in the context of severe resource constraints.

The role of catchment area and location

The case of Ikusasa lethu above highlights two other key aspects of residential care settings which contribute to increasing or decreasing children's opportunities for participating in everyday neighbourhood and 'community'. These include the catchment area from which children in the home originate, and the physical location of the home.

As Sibongile explained, there are clear benefits for children, their families, and for the home, in working within a geographically limited catchment area. However small, local catchment areas were not common amongst the 34 homes in the study. Only five of the homes – all of which were not officially registered – had children resident exclusively from the local vicinity. Almost one-third of homes were located in one of the neighbourhoods which they served, but had children coming from the broader city or district. Eight homes catered for children from across their province and four were caring for children from other provinces as well. In other words, 36% of homes were catering to, at minimum, a provincial catchment area. Table 11 refers.

Table 11. Catchment area for homes participating in study, by registration status

Catchment area	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Immediate environs	0	0	0	0	5	45	5	15
City/District	4	50	4	27	3	27	11	32
Provincial	2	25	5	33	1	9	8	24
Provincial +	0	0	2	13	2	18	4	12
Indeterminate	2	25	4	27	0	0	6	18
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

Children's residence – temporary or otherwise – in homes located in or nearby their neighbourhoods of origin simplified the maintenance of ties between family and friends. Social workers in the research sites and management at some of the homes serving vast catchment areas argued that the placement of children far away from where they lived previously placed financial and other obstacles in the way of relatives wishing to maintain regular contact with children. A social worker in the Western Cape site explained, for example, how she has observed that while kin are sometimes not in a position to have a child live with them, they would be willing to visit the home if it was more easily within reach:

> "Yeah because you know families, they don't go and visit the children because they don't have fares [for public transport], and you find that the social worker there in the residential care centre, you know, in six months they never see the family member, and then you go to the family member and they say they don't have bus fare."

Therefore even where there is will on the part of relatives, various factors such as poverty and long working hours made sustained regular contact very difficult when combined with large distances to the children's home.

Apart from facilitating contact with willing relatives, having facilities located close to where children's families reside also makes it easier for staff at children's homes to render 'family reunification' services and to actively motivate parents or other relatives to get involved in children's lives – such as by attending sports matches or parents' evenings at school, explained the director of a welfare organisation operating a number of community-based houses around the country.

The value of housing children originating only from the immediate environs went beyond securing children's futures in their kinship networks and communities however. The manager at a Western Cape home emphasised benefits for children in the present, arguing that children need not be "disrupted from their own community" and are able to remain in their schools, to continue participating in other activities in which they are involved, and to maintain friendships and other local relationships. In other words, a local catchment area enabled possibilities for greater continuity – and less dislocation – in the lives of children finding themselves in residential care.

As is clear from Table 11 above, homes that were officially registered with the Department of Social Development, or those which admitted children through emergency or foster care placements, were not able to limit their catchment areas, as they relied on social workers to refer children to them. The director of an organisation operating a number of small group homes noted how, despite their preference to limit intake to children from the immediate environs, staff from the local social services office had not visited the centre even after repeated invitations, and thus children were referred to the homes by social workers in other areas who had come to see the home:

> "Referrals have come from outside the area, which that I don't like because I think the [facilities] should be for the children [from this area], but if you've got an empty house and there is a child needing care, I'm not going wait until [the local social workers] wake up … [It] is contrary to what I wanted, but then you have to just meet what the need is."

In this respect then, Sibongile's concerns in Case Study 11 about the impact of official registration on the nature of Ikusasa lethu seem well founded: it is likely that the home would be required to provide services to children from a much larger area, thus fundamentally changing the type of service and connection to 'community' that the home has been able to offer children to date.

In addition to catchment area, the physical location of a home was documented to play a role in facilitating or inhibiting children's opportunities for everyday community experience. Those homes which were located in high-walled suburbia, in industrial areas, or on the outskirts of towns in particular heightened the risk of children's isolation from conventional experiences of neighbourhood and community. The move amongst more consciously established facilities towards 'household'-style living arrangements located in 'community houses' or 'satellite homes' in explicitly residential neighbourhoods (described in section 6.4) is precisely to allow children to experience regular life and ultimately to facilitate their integration into life outside of residential care.

Interviews conducted in such homes however also suggested a complexity to being located in poor residential neighbourhoods. The fact that these care settings, even when they were eking out a fairly meagre existence, tended to be able to access resources more easily than many surrounding households, raised local expectations about support from the home. Caregivers at such homes noted conflictual experiences with others in the neighbourhood resulting from a failure on the part of the home to provide support. For example, the founder of an unregistered home located in a poor urban township described how, despite the fact that she runs a soup kitchen and support groups for community members, the home has repeatedly been the subject of "rude talk" when donations of food and blankets have been received.

6.9 Making ends meet: a maze of funding mechanisms

Registered and unregistered homes in the study relied on a variety of official and informal mechanisms to access funding and other resources necessary towards their functioning. Given vast differences both in 'models of care' being implemented and in access to funds, the study documented a considerable range in the per capita amounts available to support children in the homes. Homes operated on budgets of less than R300 per child per month to over R5 000 per child per month.

Government funding

The primary state mechanism for residential care facilities in South Africa to access financial support depends on registration with the Department of Social Development: as 'legitimate'/'sanctioned' social service providers, official Children's Homes, Places of Safety and Shelters are entitled to a per capita subsidy from the State[25]. The per capita amount with which facilities are provided varies not only by type of registration but also by province, and is allocated from Department of Social Development budgets. The vast majority of registered facilities in the study were accessing these state subsidies (see Table 12). However, one Children's Home was not receiving any funding (despite having been registered for a year) and two were receiving less than they were entitled to. One of the latter homes had been registered as a Children's Home for ten months but was still only receiving the emergency care grants that had been applicable previously.

Table 12. Homes' access to per capita state subsidy, by registration status

Per capita allocation	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes	0	0	12	80	0	0	12	35
Yes (but incorrect)	0	0	2	13	0	0	2	6
FCG / Emergency Care grants	6	75	0	0	0	0	6	18
No	2	25	1	7	11	100	14	41
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

Eleven homes were not registered and were therefore not receiving any per capita grants from the State even though social workers placed children in their care. Nor were the eight homes operating through loopholes in foster/emergency care legislation able to access the per capita subsidy. However, six of these eight homes received Foster Care/Emergency Care grants for at least some of the children in their care. The value of a Foster Care Grant (R610 in 2007) is just over half that of the per capita subsidy per child in a registered Children's Home.

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[25] A new funding policy proposes a shift away from per capita funding to programme-based funding, but this has not yet been implemented.

Some of the registered and unregistered homes had received financial support through other government funding mechanisms however. These included grants from the national Department of Social Development, from Departments of Health and Housing, and from municipalities, towards programming or capital costs. For example, one home had secured funding from the Department of Housing to build a children's village despite the fact that it was not yet registered with the Department of Social Development. A site had been secured and building of the village was proceeding, although there did not appear to be buy-in from the relevant provincial Social Development officials. As a staff member pointed out:

> "I know that they're not that keen on institutions, you know what I mean, they prefer kids to stay in the communities … But the community is not helping them … and the Social Services feel that we're taking them out of their community and out of their culture, so they're certainly not keen on the institution."

In another instance, substantial funding had been provided previously to an unregistered home by the national Department of Social Development from its budget for poverty alleviation. However, attempts to register the home officially and therefore to access the per capita subsidy were repeatedly unsuccessful. The founder was not only confused but infuriated as to why the national Department considered their services worth supporting and yet they had been unable to progress with the necessary provincial level procedures. She noted how:

> "[The national Department of Social Development] were aware [that I was running an unregistered children's home]; they were aware because it wasn't that they just gave me money and disappeared. They were monitoring. They were coming to us and spot-checking and doing everything."

Angry in light of the contradiction, she added how, in the interim, "the children are suffering. They are hungry. I'm running around trying to get something to feed these children while the officials are busy playing with books. Where must I stand? What must I do?" These disjunctures between the funding policies and practices of different tiers or directorates within the Department of Social Development, and of different government departments[26], created much confusion, frustration and anger on the part of those establishing or running homes.

NPO registration and access to non-government funding

Although the Department of Social Development's subsidy was recognised as key to the sustainability of those homes that received it, managers consistently stated that the amount was insufficient to make ends meet without additional fundraising. As one pointed out,

> "We rely on that [subsidy] but mostly we fundraise. That is how we get by, because we have staff to pay, food to buy, we have to maintain the place – as you can see, somebody is here painting [the walls] – and we have bills, bills, bills to pay. So we fundraise locally and internationally".

The limited extent of the per capita state subsidy was similarly acknowledged as insufficient for covering the costs of running a home by provincial Department of Social Development officials who participated in the study. "The money is never sufficient", pointed out one who advocated the importance of homes' registering as Non-Profit Organisations (NPOs) in order to address this challenge.

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[26] The KwaZulu-Natal provincial Department of Housing's Policy to Cope with the Effects of AIDS on Housing makes provision for subsidisation of capital costs to 'cluster homes' and 'children's villages' as a contribution to providing for 'orphans and vulnerable children'. For more discussion on the policy and its implementation in KwaZulu-Natal, see Abdulla et al (2007).

In order to be authorised to fundraise, homes must register with the Department of Social Development as Non-Profit Organisations. This is a much simpler registration process than that required for registration as a residential facility, and unlike the latter is managed at national government level. In stark contrast to Children's Home registrations (cf. Table 7), virtually all homes that participated in the study (88%) had successfully registered as NPOs (see Table 13). As noted in section 3.2, homes' registration as NPOs was related not only to being able to access funding but also to the fact that many were not aware of the Child Care Act requirements for registration as residential facilities, and were under the impression that NPO registration was all that was required.

Table 13. Non-Profit Organisation (NPO) registration status of homes

NPO registration	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes	8	100	13	87	9	82	30	88
No	0	0	0	0	2	18	2	6
N/A	0	0	2	13	0	0	2	6
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

The discrepancy in the number of homes with NPO registration and the number officially registered as Children's Homes highlights another contradictory practice on the part of the government. Those responsible for the monitoring of standards in children's residential care facilities in the provincial and national Departments of Social Development attempted to regulate the sector with rigorous gate-keeping procedures. Simultaneously, officials in the NPO directorate registered unregistered children's homes as NPOs – thereby providing them with some legitimacy and enabling them to fundraise. Again, the practice not only created intra-departmental difficulties, it also fuelled confusion on the part of those taking care of children.

For example, when Patience decided to establish a children's home in order to support children needing care in her neighbourhood in the Western Cape site, she easily registered her Thandanani Orphanage as a non-profit organisation. She also approached her local municipal council to request support with accessing a piece of land for the project: "The council gave us a piece of land on that side for the orphanage, and then we fundraised". She was delighted that her dream of establishing a residential facility for children in the neighbourhood had begun: she'd been concerned for some time about the closure of the only local Children's Home and the fact that children from the neighbourhood were being removed to homes in other areas:

> "We noticed it's a lot of children now, they take these children to other Children's Homes where they're not belonging according to culture and language, because they take them to XX, where they're speaking English and Afrikaans on that side. Only here in XX, there was no orphanage, and then we started. It was nine women at that time, we planned, hey there is a problem here, it's a lot of children ['in need of care'] here … you feel bad about that, then [we thought] that if there was an orphanage we can take care of these children properly, then we'll see day and night this child is having the right meal, is sleeping in a right place, something like that, that's why we planned to have this orphanage here."

However, Patience describes how, when she approached the Welfare Planning section of the Department of Social Development in order to register the initiative as a Children's Home, she was told that "they don't agree about the orphanage. There are a lot of orphanages and they wanted to reduce orphanages … then they said that it's not a right place to raise a child in the children's home, that it's better that the child communicate with the other children in the community, they said so". In Patience's case, her intervention was thwarted and instead she and her colleagues initiated a soup kitchen and a day-care centre. However, in many instances – like

those of the unregistered homes with NPO status in this study – the Department's lack of coordination resulted in homes operating outside of the law, being unable to garner financial support through official Department of Social Development mechanisms, but able to raise (in some cases substantial) financial resources from elsewhere, with the government unable to effectively monitor and regulate their set-ups.

With the credibility of NPO registration, many of the homes successfully raised funds from a range of sources: corporates, individuals, local and international charitable organisations, embassies and churches, among others. Donations secured were not always monetary and many homes relied heavily on the in-kind donations they received.

However, the success of the various homes in securing non-government funding and resources varied considerably. Key factors influencing the extent and nature of resources acquired by homes included the human resources in the home, and the home's location.

Homes located in the Western Cape site, for example, benefited a great deal from being situated in an urban area populated by a wide variety of corporates willing to contribute to 'social responsibility' projects. In addition, with the Western Cape a popular international travel destination, and a location eagerly frequented by large numbers of foreign volunteers, prominent homes in this site (and in particular those commonly identified – correctly or incorrectly – as addressing the needs of 'AIDS orphans') were able to secure much support in the form of donations, and volunteer labour. Although staff at these homes identified that managing volunteers can be challenging for a range of reasons, they recognised them as an invaluable source of financial and other resources both while in situ as well as after they had returned to their home countries. As noted by two participants in the study:

> "[The volunteer recruitment company] actually has on their website that describes [our home], it says 'you're welcome to raise funds and bring it because chances are you're going to want to bless this place once you are here', so oftentimes – probably one out of every six – will come to me and say 'I've raised this money, what are your needs? What can I buy?' … so they've rescued us time and time again."

> "What is generally good about the volunteers that have come to us is that 80% of them have helped us with uniforms or something, and most of them still continue to offer their support to us even after they have left."

With far more limited options for local corporate (or other) sponsorship, and as locations far less attractive (and less organised for) international volunteering, homes in the rural KwaZulu-Natal site as well as in Limpopo were less able to benefit through these mechanisms.

Arguably even more important than its location, the nature of the human resources available to a home significantly influenced both the acquisition as well as the types of financial and material resources obtained. Formal fundraising from established donor sources requires skills that many running homes did not have. In this respect, those caregivers whose community-based initiatives developed in response to the needs they observed around them tended to be at a disadvantage. Not only was their knowledge about avenues for funding frequently limited, but funding tended to be seen as a distant secondary to their primary enterprise of absorbing children into their care. Mantoa (see also Case Study 8), the founder of a home in Limpopo, described her surprise at discovering the resources with which others operated:

> "There was this lady who … said she's running the drop-in centres, and she told me she's getting – she's got a big donor from the US and she's getting a lot of money. And I thought how do these people get this funding? It's because – you know, when I started, I didn't think of getting money, I was thinking of taking care of the children. I would have maybe fought with the Department [to try and access financial support] because for a long time we were just surviving out of you know [our own pockets], assisting with our own funds you see … We're taking care of the children, we're not interested in so many things

[except] the health of these children. And … we didn't apply for funding from big donors; we don't have the contacts".

Mantoa and others like her relied extensively – and in some instances (like that of the Nyathis in Case Study 3) almost entirely – on their personal finances and on assistance from local networks of kin, friends, and other contacts. Commonly in such homes, there was little or no distinction between the finances of the 'children's home' and the personal finances of those running it. (In such instances this also tended to be synchronous with the perception on the part of those running the homes of their enterprise as a personal intervention rather than as service provision).

The role of networks

Links with other residential care set-ups, NGOs, community-based (CBOs) or faith-based organisations (FBOs) were hugely significant when it came to 'surviving' as a home, and particularly for those less able to secure other funding. These networks offered support in the form of sharing of resources, in-kind donations or sharing aspects of service provision to the children and thus some of the associated expenditure. For example, an unregistered home in Gauteng which operated with extremely limited funding sent their children to a local drop-in centre after school where they received a daily meal and assistance with homework. The home therefore didn't need to provide for this meal or to have care-workers available in the afternoons. Homes connected to specific churches and congregations (some of them international) used these religious networks to recruit staff and volunteers as well as to raise funds. These links tended to be particularly lucrative avenues for support. Churches were also often connected to other organisations and projects, and were thus a useful locus of networks for homes associated with them.

Homes led by people with good networking skills and extensive personal connections locally were therefore sustained – if often fairly meagrely – despite the absence of government subsidies. For example, founders of two homes (one registered and one unregistered), both with very limited formal fundraising skills, had in their capacity as community workers and activists been involved in local NGO and HIV arenas for many years. In supporting the children in their care, they relied heavily on these personal networks. Relationships tended to be reciprocal: the two women routinely supported in a range of ways others assisting children and HIV-infected/affected people in their neighbourhoods. For example, in response to a comment during an interview that much was being achieved by a home despite very limited staff, the founder of one home expounded on the key role of networking:

> "[We work] with the help of other people of course. Like as I say, the principal is assisting … and we're going to the social workers. It's just a network of people working together. It's only in the centre where we are alone, but we are not alone as such because we have got people who are coming for practicals and the high school children are coming on Fridays, every Friday, and there are people who are coming for ECD [Early Childhood Development] programmes that are run by them and there are psychologists who are always in and out from the University and the paediatricians, even the specialist paediatricians in town offered their services for free. And that makes work easier for us because now if a child gets sick and we have appointments with the paediatricians at the hospital … with the specialist paediatricians, we take the child now, you're not going to queue, they will ask if she's from the centre, 'we'll see her first' … So you know life becomes easy because of this network of people working with us."

Funding and its relationship to models of care

Finally, in a few instances homes had shifted – or been forced to shift – their approaches in order to secure continued funding. For example, management at a couple of long-established institutions argued that in the current funding context, financial support was easier to secure for

'community-based' or 'satellite' homes than for the large group-care homes they had historically been running. The advantage of operating 'community houses', explained one, is that it is possible to secure local corporate funding more easily, and to rely on volunteer networks to provide services for free because the scale of each of the community home's requirements are "a bite-sized chunk".

Other organisations had had less successful and contradictory experiences. In particular, a representative of a welfare organisation described how past attempts to run "a network of small neighbourhood homes" – a model of care that constitutes a good fit with the Department of Social Development's Developmental Model and the Inter-ministerial Committee's recommendations for residential care – had failed because of the form that the state funding mechanism takes. The Department of Social Development's per capita financing policy, when applied to small homes (which are more expensive to run), was completely inadequate. As a result, the organisation now runs two homes, each of which is large and far from the practice to which they aspire.

In summary, a few key points emerge. Firstly, the contradictory funding approaches of different parts of the State convey mixed messages to those in the residential care sector, and contribute to the confusion amongst those running both registered and unregistered facilities. In practice, funding channels are unclear, erratically or unsystematically applied, and often in conflict with policy. Rather than systematically supporting sustainable positive interventions, they fuel the development of disparate, sometimes unfavourable models of care.

In addition, because the primary mechanism for funding currently available to Children's Homes – in the form of the Department of Social Development's per capita subsidy – is insufficient to cover the range of expenses required by homes, they are heavily reliant on external financial and other support to survive. However the assumption that those running homes are capacitated to fundraise through formal channels is questionable. It could be argued therefore, that the way in which Children's Home financing is currently conceptualised risks favouring the success of those initiatives which are less community-based, less embedded in neighbourhood, and possibly larger than is desirable.

7. "A revolving door"? Children's journeys through residential care

The Child Care Act of 1983 stipulates a series of requirements for children to be placed legally in residential care settings in South Africa. Only social workers, police or individuals authorised by the courts are permitted to remove children from existing care settings that are putting them at risk. In addition, a court inquiry must find a child to be 'in need of care' in order for a legal placement into a residential facility to be made.

Section 14(4) of the Act outlines the set of criteria for children to be found "in need of care", as follows:

(a)   the child has no parent or guardian; or
(aA)   the child has a parent or guardian who cannot be traced; or
(AB)   the child –
    i.   has been abandoned or is without visible means of support;
    ii.   displays behaviour which cannot be controlled by his or her parents or the person in whose custody he or she is;
    iii.   lives in circumstances likely to cause or conduce to his or her seduction, abduction or sexual exploitation;
    iv.   lives in or is exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;
    v.   is in a state of physical or mental neglect;
    vi.   has been physically, emotionally or sexually abused or ill-treated by his or her parents or guardian or the person in whose custody he or she is; or
    vii.   is being maintained in contravention of section 10.

In emergency situations, police or social workers who find children abandoned, or in circumstances which require immediate removal, must complete a 'Form Four' – a temporary emergency detention order also legislated for in the Child Care Act. A court inquiry must then be subsequently scheduled.

As noted in section 3.2, residential care policy trends in addition clearly – and increasingly – advocate for children to remain only temporarily in any form of institution. The provisions both in the current Child Care Act (s.16) and in the new Children's Act (s.159) in South Africa support this principle by limiting the duration of court-ordered placements of children into residential care to a maximum of two years, at which point renewal is required. Extensions to these placements are similarly limited to a maximum of two years at a time.

Throughout the period of a child's placement in residential care, the expectation is that social work services will intervene with children and their families to enable 'family reunification' at a later point, and/or identify alternative family-based placements for children.

This section examines the ways in which these aspects of the Child Care Act were applied in the residential care settings in the study. It considers children's placement in the variety of existing homes, the ways in which homes identified and applied admission criteria for the reception of children, and movement – or otherwise – of children through homes.

7.1 Referrals: Children's placement in residential care settings

Children resident in homes in the study found their way there through a wide variety of routes. Table 14 below itemises by category the documented range of referral agents[27].

Table 14. Referrals to children's homes, by legal status

Referral agent	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Social worker	38	55	542	77	65	28	645	64
Caregiver/relative	12	17	0	0	94	40	106	11
Transfer from another home	1	1	70	10	4	2	75	7
CBO/ NGO/ FBO	0	0	5	1	35	15	40	4
Police	9	13	30	4	1	0	40	4
Health service	9	13	4	1	0	0	13	1
Informal networks	0	0	0	0	15	6	15	1
Centre director	0	0	0	0	12	5	12	1
Other	0	0	1	0	6	3	7	1
Indeterminate	0	0	53	8	1	0	54	5
Total	**69**	**100**	**705**	**100**	**233**	**100**	**1007**	**100**

The majority of children in the sample (64%) were referred into the homes by social workers. In addition, a further 7% of children had been moved from one home to another, again by a social worker. (Many of these were shifted from a so-called 'intake shelter' for children found living or working on the streets to a longer-term Children's Home). Four percent of children in the homes had been brought by the police.

Considering that social workers and the police[28] are the primary legal mechanisms via which children should be referred to homes, on the face of it, the data in Table 14 suggests that these systems are operating fairly smoothly and the majority of children are being legally placed in residential care. However, two points emerging from the research must be highlighted with regards to the unofficial application of their authority.

Firstly, the disaggregated data presented in Table 14 illustrates that social workers in the research sites were placing children not only in legally-operating registered facilities and those utilising foster care/emergency place of safety placements but also in unregistered homes. More than a quarter – a total of 28% – of all children resident in those unregistered homes for which an audit was completed had been placed by social workers. In the two urban research sites, social workers responsible for finding safe care for children resorted to placing children in unregistered homes because registered facilities tended to be full. Managers of unregistered homes complained about the way in which the Department of Social Development placed children in their care but were unwilling to register their homes. But the contradiction was similarly acknowledged by officials within the Department. For example, a supervisor of a team of social workers bemoaned the predicament in which she and her colleagues found themselves:

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[27] Note that information regarding the referral of 54 of the children for whom the audit was completed was not provided. This amounts to 5% of the total sample for whom the referral agent is indeterminate.

[28] The audit data underestimates the proportion of children brought to facilities by the police – three of the six homes (two of which were large) that did not complete the audit noted that a substantial proportion of children in their care were initially placed by the police.

> "We have limited places to place our children … Our first stop is [registered Children's Home], then we have [Children's Home], then we have [Children's Home]. Then there's another lady, she has an unregistered [home] … The health inspectors had no objection to the place being registered, but we as the Welfare Planners felt no, because of the space, because of the facilities that should be in, because of our minimum standards. Health didn't have a problem, but up until today we couldn't see why they are saying the place can be registered. Because it's the lady's own house: she is using her own kitchen, her bathroom, things like that. And we said 'no ways' until such time she gets a place we can register …
>
> But in the meanwhile we are being forced to use the place. I'm doing after-hours Child Protection Services: from four o' clock to the next day, we have a team of social workers who are on standby. And if at night, 11 o' clock, they phone you … to say 'we've got a child here that was abandoned, that was brought in by the police, please find a placement', where else can we look? We know the lady Mrs Nongwe has got a space, that she can take the child anytime. I phone her, 'Can I bring another child? We will sort out the thing next day'. And she says to me 'You refused that I can be registered, and yet you use me'. And I say we don't have anywhere else where we can go…
>
> The Welfare Planning supervisor for this section … will moan and groan and say all this stuff, and I say, 'Please, please, I don't want to listen'. She says, 'You are the supervisor for this section. You are supposed to stop these [social workers from placing children in unregistered homes]', and I say 'I know, but I'm doing this even myself when I'm on standby, because there is no other way'. I don't have any other option".

In other words, while social workers identified registered homes as their default first attempt for placement of children needing residential care, the reality of their working environment had them caught in a double-bind, and led to them placing children in unregistered homes.

Study participants running both registered and unregistered homes repeatedly cited their difficulties with police delivering children to them without the required documentation. Participants noted their frustration and concern about this common practice. As a manager of one home seethed: "[the local] police station don't even know what a Form Four is. They don't even have them. We keep them now! I actually went there to [meet with] the lady who deals with social issues and neither she – nor anyone at the police station – knew what [a Form Four] was".

Some refused to take children without its completion, others – not wanting to leave children in difficulty – demanded affidavits:

> "The problem is that every abandoned child – whether found by the police, social worker, or member of the community or anyone – needs a place. And as soon as the police identify a place like [ours], they bring children. I was not even aware that they knew of this place, because we have not always been here. I just saw them dropping in …
>
> As it is now, the police just bring a child without a clue of the procedures … The police in some instances are not aware of the Form Four, and as soon as they find an abandoned child or children, they bring them over. That's why they must bring affidavits if they do not have the Form Four. Because thereafter it means that I must now go to [Social Services], to get all the necessary documentation …
>
> I realise that [the police] are not fully aware of the procedures involved. They are just happy that they at least have places to take abandoned children to … Sometimes they find a child, and bring the child here, only for us to discover later that this is a sick child. If the child dies, what am I supposed to do? And nobody has given me the permission to have such a child with us, nobody knows the child is here. So we are trying to instil in them that they should have A, B, C, D when they bring children to us..."

Either way, people managing homes were fairly frequently faced with situations in which legal protocol was not followed by those in official positions.

As is evident from Table 14, a significant proportion of children were also placed in unregistered homes – and to a lesser extent those homes using foster care placements – via channels that would not be sanctioned by law. In particular, 40% of children resident in unregistered homes and 17% of children in homes using foster/emergency placements had been placed by their caregivers (including mothers, fathers, siblings, aunts, grandparents etc.). In addition, 6% of children in the unregistered homes had been brought through informal neighbourhood networks, and a further 15% were referred by local NGOs, CBOs, FBOs or other community structures such as churches. In a handful of instances, children arrived at the home on their own and asked for help.

Remember Sibongile in Case Study 1 and Case Study 11 who described how children attending her school had brought others who were homeless to her for help, and how poverty-stricken and/or elderly relatives caring for increasing numbers of children begged her to take children they could no longer manage to support. She in addition described how a CBO had asked her to take in five children who were living alone in desperate circumstances after abusive experiences at the hands of relatives. The CBO in collaboration with local social workers had been unable to secure place for the children in the only registered Children's Home in the district and had struggled to identify an alternative.

Others told similar stories of a patchwork of referral routes. Consider for example, the children living with Mama Nosiswe:

Case Study 12. Ikhaya lethemba (see also Case Study 5)

Struck by the struggles faced by people in her neighbourhood in the Western Cape, Nosiswe headed off to her local clinic many years ago to offer her services and see whether she could be trained as a community worker. She became a TB treatment supporter, and subsequently, as the HIV epidemic progressed, was trained in home-based care to support people living with AIDS in her neighbourhood. It was this community work that led Nosiswe into caring for children. "I tried by all means to help sick people with all my heart", she explains, "… I think I did a good job and had love because the sick person would end up saying, 'I trust you with my children. Please look after my children [after I die]'".

Nosiswe provides one story after the next of how her brood of children has grown. Some of the children are her own relatives: her own grandchildren who have lived with her since their birth, others who have been left in her care because their parents are too ill or have died, some of them in her Eastern Cape home village. Some of the unrelated children have been sent by their parents – people who are from the same village as Nosiswe was originally – prior to their death. Or requests have been made that the children be brought to her once their parents have been buried. She describes how on occasion caregivers "hide their illness … but when the last moments come, [they] write down that [the children must be brought to her]". Two children she cares for she found living alone after the death of their mother, a patient of hers in the Western Cape site, and took them in in the absence of any apparent alternatives. A couple were rejected by their relatives because they were sickly and assumed to be HIV positive. "Some of them come because they are [HIV] positive", she laments, "We go to families … challenge them that should be able to take care of their children. Even if they find that a child is positive, they should take care of him/her because it's his/her child. [I am] trying to stop this thing of having so many children". In a couple of cases, sickly parents have asked Nosiswe to help them out by caring for their children temporarily, until they are stronger and again able to care for them themselves. Some children have been placed in her (informal) care by social workers.

Nosiswe's and Sibongile's stories resonated with those of others running unregistered homes, in particular in the way in which existing relationships between caregivers at the home and

children's caregivers, neighbourhood residents or local organisations and structures were frequently central to the choice to place the child in their care.

Registered facilities also described how they were approached directly by a range of different people and organisations to take children into their care. However, in general – and in contrast to many of the unregistered homes – they sent them away, referring them to local social workers for assistance. This response was documented to result not only from an understanding that doing otherwise meant non-compliance with the Child Care Act, but also because in some instances, they were concerned about being flooded by the enormous need. As a manager of a recently registered home in the Western Cape site asserted, "I've told [community members that they cannot just turn up here with children], and I've made sure that it's clear. They are not allowed to just [bring children] – otherwise this [place] can be filled within a minute, within a minute this can be full…". In addition – although this was not noted by research participants – facilities do not receive any state subsidy for children who are not placed in their care through a court order. This may also have contributed to the reluctance of registered homes to accept children through informal channels. In the absence of any per capita state funding whatsoever, unregistered homes lacked the incentive to refuse admission to children arriving via unsanctioned routes.

Perhaps of most concern are those instances in which those running a home approached parents or caregivers to relinquish their children to live at the home. Whilst this was not a common practice, one of the 34 homes in the study actively recruited destitute children to their facility in this way, as one of a number of routes to children's residence there. The founder of a second home that had been closed down by the local Department of Social Development prior to the start of the study described a door-to-door campaign in the neighbourhood as the primary mechanism through which she and her colleagues identified children for the home. In response to a desire to intervene in the desperate situations of some of the children in the neighbourhood, she and others had decided to establish an "orphanage":

> "We've been doing this door to door, door to door: Every door, we knocked, we enter, we assess the family, wanting to know who is the breadwinner, if the breadwinner is not there how are they living? How are they coping? The cause of the death of the mother or the father? Are they getting social grants? Are they having ID documents? Are they having clinic cards? So many things… Then we started there … then we began [to stay] with those children … Sometimes we convinced [caregivers] to agree to us [taking the children]. We had to talk to them, even if they deny, we tried to talk to them. Every time we try to talk to them and show them the importance of their children to coming to the centre."

The rationale provided by residential care settings for taking in children without the prior involvement of social workers or the police varied widely. In some instances it was clear that caregivers were unaware of the legal requirements, not least in situations in which they did not perceive themselves to be running a children's home. In others, the degree of frustration with – and lack of faith in – local social work services led to homes prioritising the immediate care needs of children over and above the legal requirements. "We called them [to deal with the first few children in our care]", exclaimed one of the women about her local Welfare office, "… they promised that they would come back and we will talk about this, but then they never came back". Her organisation assisted numerous children and families in difficult circumstances through a variety of interventions other than the provision of residential care, and staff were routinely exasperated by the lack of action on the part of the Welfare office. A further contributing factor to homes taking in children without social worker involvement included their lack of knowledge about other local services available for families and children in need, and the absence of attempts to find out. This was particularly the case in instances where homes had

been established by those with good intentions but little research, and in response to people's notions – rather than experiences of – children's needs.

7.2 Admission criteria: Children's reception into residential care settings

Residential care arrangements in the study exhibited an extensive range of criteria by which their target population of children was identified. Not all homes had explicit target children in mind: in particular those which were responding spontaneously to instances of children needing some kind of alternative care were generally not setting conscious or strict criteria for children to receive their support. However those that had established criteria included broad approaches – such as 'children in need of care', a reference to the range of legal criteria identified in the existing Child Care Act – as well as very specific categories of children based for example on age, sex, race, and HIV status of children, and/or notions of vulnerability (such as orphanhood/ orphanhood as a result of AIDS/abandonment/living on the street/child sex workers etc.). Criteria initially identified by homes were frequently centred on (often questionable) ideological concepts of what constitutes a vulnerable child. Thus for example, we encountered homes which set out to target 'AIDS orphans' in anticipation of vast numbers of homeless, parentless, caregiverless children resulting from the epidemic. Or a series of 'community homes' which emerged primarily as a result of the founders' concerns that 'white' children who are found by courts to be 'in need of care' are inappropriately placed in other available homes in the area:

> "The thing is that we have a very culturally sensitive area that we work in … And now we found that there is no permanent place where we can have care for ['white'] children in difficult situations, but we can't culturally put them in a place like Gateway Place of Safety because there is one white child in about 95 Sotho speaking children, which is very difficult for them. I mean it is culturally sensitive. The thing is we take children firstly out of a traumatised situation and then we traumatise them even more."

More sensitive but ultimately no less directed approaches to identifying a target child population were present in homes that originated after careful observation of the reasons local children were made vulnerable and rendered in need of additional/alternative temporary or longer-term care arrangements. Consider for example the story told by the founder of a home for girls living and/or working on the street in the Gauteng research site about how she came to set her admission criteria. She had moved to the area from another province to work:

Case Study 13.   Our New Home

> "I was staying at [X apartment block] at the corner … Many children used to stand by the robots [there]. I would ask from people, 'What is happening there?', and they'd be telling me they are prostitutes, *abomagosha*.   So nobody cared about them, it was just a normal thing. I was not aware that those children were also selling drugs, and there were people who were like their bosses, like landlords - the drug-lords and the pimps… And their ages, that's what also struck me, some looked like they were so young like ten, 11 years old, but you would see them standing there, although there were those who were like 15, 16, 18 upwards, but you could see the youngest ones there, roaming the streets…
>
> So that's when I started interacting with the children. The reason for interacting with the children was that I looked at them and said, 'Who are these children and where are their parents?' Deep down in my heart, I'm a mother, I'm having five children – three girls and two boys – I thought that maybe if I was not there for my own children they would be like those children. It touched me that these children are so young, like my own children. So that's what touched me to go and start talking to the children. In fact I greeted them, I told them they were so beautiful, and so invited them for coffee to my flat. And so the next – they didn't come right away, it was only the next day when one of the girls greeted me and then I greeted them and I came closer to them and said, 'Guys, how about a cup of coffee?'

> Then she said, 'okay, we'll come'. I gave them the address again. And so I went to my flat and they came in, three of them … We didn't talk much, when they came in I just prepared the coffee for them, I gave them the coffee, they drank… It was the next day when they came again, but now it was the one and the other girls, the new ones from the street, they came for coffee. I was preparing coffee for them but when I came back, I found that one of the girls was fast asleep and the others, on the sofa, so I couldn't disturb them, I only covered them with my duvet. They slept…"

Through a process of growing trust, she was able to hear more about the girls' lives from them.

> "So now they started telling me about what is happening etc. and how are they working and that they've got the pimps and the drug-lords who want their money and they're also taking [and selling] the drugs…"

When she questioned the girls how they found themselves in these circumstances, they said this was the only way they could access accommodation:

> "They told me that if only they can have accommodation and have food, that would be step number one for them not to go to the street, because you have to work on the street so that you can manage to pay for the hotel – they were staying in these shabby hotels here – they were paying R30, R50, so at least you must have a client or two clients, so that you can get a loaf of bread. Because they're not even getting some decent meals… And so when I looked at that I just said my flat is here so I can stay with them because the problem which was at hand – the thing that we needed to fix immediately – was the accommodation issue …"

Within days, 16 girls had moved into her apartment. She has subsequently established a home with the express purpose of supporting girls who find themselves living and working on the streets, to assist them with attending school and establishing alternative ways of survival. On the basis of her careful observations of need in her neighbourhood, she limits residence in the home to this category of children, and refers any others who arrive on her doorstep to other homes in the area.

In his study of institutional care in the developing world, Tolfree (1995:49) notes a "tendency for institutions to admit children whose circumstances and needs fall outside their formal (or assumed) admission criteria". His assertion is borne out to some extent by the admission practices documented amongst the 34 residential homes which participated in this study. Roughly 40% of the homes in the study were opening their doors to children who they had not originally set out to reach. In some instances, the gap between their target population and the actual children admitted was marked; in others children fitting unanticipated criteria were taken in over and above those whose circumstances matched the target population. For example, the founder of an unregistered home in the Western Cape site pointed out how she found she needed to shift her expectations to the need around her:

> "Originally I wanted children who did not have parents at all, but sister what happened, it was just a heart for another child, because I was also a home-based care-worker. A woman would be chair-bound, she couldn't do anything; she is sick and doesn't know what's going on, so I'd be forced to take the child."

Likewise a housemother at another home commented:

> "When I saw the advert [for my job], it said orphaned and abandoned [children] … but when I came in here, I saw it's different, not all the children here are orphans. They've got their biological parents but because of the situation [at home]…"

While Tolfree argues that divergence from "stated goals" are commonly made in the interests of the institution rather than in the interests of children (1995:49), in most (though not all) instances documented in this study shifts occurred because well-intentioned but uninformed goals at the start needed revision, or – importantly – as a result of sensitive flexibility to context and the needs of children.

7.3 'Leaving care': Moving children out of residential settings

We turn now to examine how the movement of children out of homes in the study occurred in practice, including both the extent of its occurrence, and some of the factors which influenced it.

Data from the study's audit indicated that a large proportion of children had been resident in the homes in the study for more than a two-year period. Table 15 below illustrates an analysis of the length of time children over three years old had been resident in the audited children's home[29]. Fifty-seven percent of the children had been in homes for over two years, and 35% for over four years. Seven percent had been in homes for more than 10 years[30].

Table 15. Length of time children had been resident in children's home

Length of time in home (y)	3- to 5-year-olds		6- to 12- year-olds		13- to 18-year- olds		18+ year-olds		Total	
	n	%	n	%	n	%	n	%	n	%
0 - 0.5	17	19	29	10	13	5	0	0	59	9
0.6 - 2.0	37	41	70	24	89	33	1	5	197	29
2.1 - 4.0	20	22	82	28	45	17	4	20	151	22
4.1 - 6.0	6	7	58	20	37	14	3	15	104	15
6.1 - 8.0	0	0	20	7	21	8	4	20	45	7
8.1 - 10.0	0	0	7	2	26	10	5	25	38	6
10.1 - 12.0	0	0	7	2	31	11	2	10	40	6
12+	0	0	1	0	2	1	1	5	4	1
Indeterminate	10	11	23	8	6	2	0	0	39	6
Total	**90**	**100**	**297**	**100**	**270**	**100**	**20**	**100**	**677**	**100**

The audit data were supported by the study's qualitative findings, in which there was repeated reference from managers of homes, care-workers, and social workers to the tendency for children to remain in homes for long periods. As pointed out by the founder of a Children's Home in the Western Cape site, whose home had grown to accommodate in the region of 100 children over the course of five years:

> "We get children on a daily basis, but my main problem is that within these five years, I still have this first child who is in here. You know, the first child and the second child, and those babies – they are still here …"

As is standard in social work practice, attempts by social workers and staff at homes to move children out of homes focussed primarily on returning them into the care of their parents or to other relatives. In the main, very little attention was paid to identifying foster or adoption placements for children for whom placement with relatives was not possible. A handful of homes had been established specifically to identify adoption placements for young children (see for example Case Study 7 and Case Study 10), and were fairly successful in placing children into both local and international adoptions. A couple of homes referred incoming children who were identified as good candidates for adoption (see below) to other homes that were better geared for adoption procedures. And two Children's Homes in the Western Cape site routinely placed children into foster care with unrelated foster parents in the surrounding neighbourhoods. In these cases, foster care was used exclusively as a long-term, adoption-like placement for

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[29] Only those homes that had been operating for more than two years, and children over the age of three years, were included in the analysis in order to avoid excessively skewed data.

[30] Note that this information was not completed for 39 (6%) of the 677 children aged three years or more in the sample of homes operating for more than two years.

children after investigations had determined that the child would not be able to be returned to family.

However, in instances where there were not clear family placement options (owing to a child's abandonment, HIV status or age, or because relatives were unwilling or could not provide a safe home to the child, for example), it was frequently assumed that the child would remain in residential care permanently. Debbie's comment below represents a common perspective amongst those running homes:

> "We do have a reunification process. We look at the closest family member, if the mother and father are not available. We have reunited some other kids that were here with their families. When we take in the children and before we decide whether this will be a long-term place for the child to stay, we will first look at their background and try and find their families… We have just reunited a boy of one year and five months old with his grandmother as the mother's whereabouts is unknown. [The reason that other children have remained here for a long time is] because no one has come forward and we don't even have information about their backgrounds. We depend on information that we get from the police and we also try our best to find out information about the child. If we are unable to get any information, what do we do?"

Frequently then, the discourse was one of children "getting stuck" in residential care, although this was not the case in all instances of long-term care. The difficulties of identifying relatives or others to care for children, perceptions of particular categories of children's appeal as candidates for adoption or foster placement, and the limited service provision and lack of capacity in the state and other statutory Social Services, resulted in children remaining in residential care far longer than legislation or policy deemed appropriate. In the remainder of this section we consider some of these factors which influenced the extent to which movement of children through homes was achieved.

Homes' foci

The way in which homes viewed their role in relation to the children in their care was central to their approaches to 'turnover' or otherwise. In this regard, three modes of operating can be identified. The focus at some homes was specifically on moving children through as quickly as possible; others aimed to provide a long-term home to children. In addition, some homes saw their role as two-fold: to provide temporary care to those children whom it was possible to reunite with family; and to provide long-term care for those children where this was not an option. Table 16 indicates the foci of homes that participated in the study.

Table 16. Homes' vision as long- or short- term placements for children

Vision/Focus	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Long-term	4	50	2	13	4	36	10	29
Short-term	3	38	6	40	0	0	9	26
Both	1	13	7	47	6	55	14	41
Unknown	0	0	0	0	1	9	1	3
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

Despite the provisions in the Child Care Act, 70% of the homes in the study (24 homes in total) worked from the basis that some if not all of the children in their care would be resident permanently. Just over one-quarter of the homes were focussed exclusively on providing long-term care. In these instances, the intention tended to be to provide 'family' and 'home' to children, with little if any effort being made to retain or initiate contact with children's kin.

Remember the Nyathis in Case Study 3, who were clear that they were not running an institution but rather "a big family". Or Nosiswe (Case Study 5 and Case Study 12) who similarly absorbed into her household children who were ostensibly without relatives who were willing to care for them. She too was explicit in her life-long commitment to the children who arrived on her doorstep. Even when the children in her care grew up and were able to live independently (as a couple had), she said, they should always "know that this is home". As a result, only one child had ever moved out of Nosiswe's home, in this case because his uncle approached her indicating his eagerness to take his nephew into his care.

In other words, for the Nyathis and Nosiswe, and others like them, the lack of turnover of children from their homes was located primarily in the notion they had of their enterprise. Any personal attempts to move children elsewhere would have been contradictory to the central principle of what they were providing for children – a permanent, safe 'family' and home centred on the existence of meaningful long-term relationships, as opposed to a place of interim 'alternative care' while 'family' was being re-established or sought elsewhere (see also section 6.4 for additional discussion).

Most of the homes prioritising long-term care for children were not officially registered as Children's Homes. However this was not exclusively the case. Staff at registered homes that traditionally focused on long-term care indicated that in recent times they were being required to shift towards combining this approach with moving children out into family-based care because, explained one, "we are bound to act according to legislation". Responses were reluctant however: the long-term care model applied at this home was premised on an ideological position that this was the only way to make a "meaningful … and sustainable" impact on a child's life. Consequently, there had been limited change in the rates of movement of children out of the home.

At the other extreme were those homes that were specifically focussed on achieving a high turnover of children. These homes were well-resourced and largely limited to babies and young children. If not running well-developed foster or adoption programmes themselves, they were generally operating in tandem with adoption agencies or – in one instance – an NGO providing professional foster care services and support. In these cases, interventions were conceptualised clearly as services, and activities and interactions were directed at gearing children to a state of readiness for foster care or adoption. On the whole, interactions were explicitly not about developing relationships internally. Some of these homes had been very successful in moving children into family care settings. For example, 178 children had been placed 'out' of one of these homes that had been operating for under three years.

Again, the different approaches highlight how very diverse the phenomenon of residential care is in South Africa.

'Categories' of children

Social workers and those running homes consistently referred to particular categories of children as more difficult to move out of residential care. These included older children, HIV-positive children, and children with behaviour problems.

The role of children's abuse and neglect in slowing the process of reunification or alternative family placement should not be underestimated, a manager at a Gauteng Children's Home explained. Because children who get placed at this home "are by and large traumatised, difficult, problem children" it can be difficult to find a foster placement that will last. In the absence of adequate support services (discussed below), staff at homes had to be careful not to set children up for a cycle of rejection by backing family placements that were likely to fail.

In terms of adoption, the general consensus was that most prospective parents were only willing to take in young children. As the founder of a home in the Limpopo field site noted:

> "People like small babies. It's only one who took a 13-year-old girl in 2004, and came again and took a three-year-old little girl. But preferably people like small babies: they want babies that would take them as their real parents."

A widespread perception on the part of both social workers and staff at a number of the children's homes was that people were unwilling to adopt or foster HIV-positive children. The founder of a Western Cape Children's Home, for example, blamed the low rate of success in finding kin- or non-kin family-based placements on people not wanting to provide care to sick children:

> "You can imagine, infected children, it's always difficult for people to take them in their homes. That's the main problem. That's why we're still full, because most of these children are really not well, mmm... It's difficult to get foster parents or whoever, or the family to adopt an infected child, that is for sure. Nobody wants to take in the child."

A Gauteng-based home with services focussed on adoption went as far as to automatically categorise HIV-positive children as "not adoption-worthy" and transfer them to other homes. HIV/AIDS was in many instances viewed as a death sentence for children, despite the fact that there was fairly common acknowledgement that access to antiretroviral treatment was transforming children's health and longer-term prospects. Even at a home caring exclusively for HIV-positive children, the social worker maintained that fostering or adoption was not an option because people need to take in a healthy child, "not someone who is about to die".

As a result of these perceptions, HIV-positive children were therefore often referred to homes which specialised in caring for children living with HIV where it was expected they would remain, and where there was frequently little attention paid to identifying alternative placements.

The extent to which this perception was located in reality was questioned by staff at a home in the Western Cape site however, who ran a successful programme of foster care for the HIV-positive children coming into their care (see also section 9).

Notions of set categories of children as unattractive options for long-term family-based placements limited attempts on the part of both homes and the Social Services to move children out of residential care settings. Apart from the exception above, in the event that short-term care was identified as a priority, HIV-negative infants and toddlers were the only children for whom foster care or adoption was routinely pursued.

'Worthy' placements

In some homes, perceptions about what constituted appropriate or 'good enough' family care prevented or limited children's mobility out of homes.

For example, in a couple of instances, founders' own negative experiences of orphanhood or being raised by relatives were at the centre of the lack of attention they paid to seeking out other placements for children. In others, ideological positions about the 'type' of family in which a child should be raised resulted in the application of strict criteria in some homes for prospective adoptive or foster parents over and above those required by the Child Care Act. These severely limited the pool of potential carers from which placements for children could be drawn.

Consider the criteria for adoption employed by a home in the Gauteng site that provided a temporary place of safety for abandoned babies while alternative placements were sought:

> "We work with a private adoption agency and our stipulations are quite – it's difficult to adopt from us. It's not difficult but we require quite bit more than a lot of other organisations usually. A family has to apply and it takes about two years before they actually get a baby. Before they actually get to adopt, they go through all sorts of things

such as marital counselling, we see if they're financially stable enough to have a baby, and their entire homes are screened, relatives as well, to make sure that – because most of the babies go to white families – that other family members don't have a problem with having a baby of a different race in the family. You know all sorts of areas, every area you can think of is addressed before the families are approved for adoption… Also we are a private organisation and a Christian organisation and so we have a stipulation on the families that they are born-again Christians and that it is a married couple, so we don't let single parents adopt generally unless it's a very special condition, they have to be married and they have to be born-again Christians…"

As a result of these criteria, although children were ultimately moving through this home, the pace at which this occurred was slower than it would most likely have been if less stringent criteria had been applied.

The state of social services

The barrier to moving children out of residential care most frequently identified by staff at homes was their dependence on external social workers to drive the process and complete the necessary investigative, therapeutic and support work with families or alternatives. Current practice divides responsibility for interventions regarding children in residential care between staff and social workers located in children's homes and the external social workers responsible for the original placement. Those within the home are responsible for working therapeutically with the child, whilst the external 'area social worker' is responsible for intervening with the child's family and conducting the statutory work associated with transferring a child out of residential care.

Participants in the research referred to blockages occurring at each of four stages to family reunification or family-based placement: tracing biological families, working with families to solve problems where they existed, building and maintaining relationships, and returning or placing the child (with support) with (a) family. That many children resident in the homes were there as a result of abusive and neglectful family environments heightened the challenges involved in this process, as substantial, often complex and ongoing interventions were necessary in order to successfully and safely return or place a child.

At the centre of these processes were external social workers, the majority of whom struggled for a range of reasons to provide the necessary interventions adequately.

Case Study 14. Social services

Masego, one of two social workers responsible for a large area in one of the field sites, beams as she describes how much she likes her job. "I just can't imagine doing *anything* else", she stresses. "Just to know that I might make a difference in the life of even one person out of every 40 that come to me for help…" Despite her commitment and verve however, Masego is frank about some of the challenges of working in Social Services and how these affect the services provided to children in residential care in her area.

She is concerned in particular about two aspects of her work. Firstly, she argues that the biggest challenge she faces to being effective relates to the current structuring of social work service provision. As a social worker required to do generic rather than specialist work, she feels overwhelmed, spread too thin, and under-skilled for the broad range of functions she's expected to fulfil. The district supervisor agrees:

"We aren't specialising, so you'll find a social worker who is placed in [XX] clinic for instance, is supposed to do or offer any other service to a client who comes through the door … You know we do everything, everything in the sense that when someone comes in, he wants to be assisted with what – a neighbour dispute – you have to assist. The other one it's maintenance – you do your part and refer to the maintenance officer. And the other one

comes due to the HIV/AIDS pandemic, you have to assist in applying for the foster care, it's a process in itself. So you are really not focussed on one thing."

The result, they point out, is that they prioritise those cases that are immediate crises, or those instances in which there is most pressure exerted upon them.

"Usually you find that – if in cases of children who are maybe neglected or abandoned that would come as a crisis so to say, you'll attend to the crisis maybe in a form of removing the child if it warrants that and then you place the child at a place of safety … when you have just managed to address the crisis in terms of removing the child, opening a children's court enquiry, securing the detention order and you place the child, something else crops up. Maybe for a period of two weeks you haven't gone back to that very case to follow it up, and not because all that while you haven't been doing anything … The child has been rescued from those circumstances – you know it's kind of a relief for some time – though the actual work still has to be done …"

Masego chips in: "The case is not complete, you rush to the other one, it is not complete, your cases end up being incomplete, all of them, yeah."

Secondly, caseloads are high – in particular due to a vast number of applications for foster care placements for orphans. The social workers from this district who participated in the study are unanimous in identifying demands for foster care as both the major driver of the size of their case loads as well as their failure to better address children in residential care. Masego explains:

"The caseload is too much, more especially the issue of foster care. Most of the time we spend doing foster care cases: foster care cases wherein the children are staying with their grandparents or relatives. Most of them will be pressurising you because what they're interested in is money, they want to get the Foster Care Grant. You will find that for five days that you have been working, you have handled foster care cases, you have been going to court, doing supervision and when you evaluate your work at the end of week, you haven't done any case except foster care …"

The irony, she points out, is that on the whole in these instances these are not children in immediate crisis, but that applicants badger her and her colleagues to assist them so that they can access the financial support of the Foster Care Grant.

"The children are quite safe, they are with their grandparents, they're with their aunt and uncles and they're safe. But you forget about the child who needs proper placement, because these ones, the foster parent needs money, they're pushing you to have to their case now and to finalise it."

Her colleague from another office in the district adds to her point: Not only does her load of foster care cases impede other welfare activities, but in all instances, she feels unable to achieve adequately any of the interventions for which she is responsible.

"We are not doing justice to [foster care supervision, family support and reunification, community development, etc.] … I visit [children in foster care placements] individually but I'm not doing justice to it … I'm expected to visit children in school and check them, their progress with the teachers, but it's not happening as it is supposed to …".

The gap in provision of family reunification services, and other prevention and early intervention support services is acknowledged by the district supervisor. For example, she points out,

"When you have removed this child or these children, a social worker is expected to work with the parents. Whatever it is that was making this mother or this couple neglect their children should be addressed … so that the child can be reunited back into the family, but in most cases it's not so easy."

And as a result, the social workers concede, children on their case loads remain in residential care facilities far longer than they ideally should. It's easy, they reiterate, to prioritise other children over and above children in residential care: there at least they are safe in ways that many others are not. Masego is direct:

"You place a child there [in residential care] and you even forget that there is a child there. In fact you don't forget, but … you end up dumping the child there … You see it is a very serious problem … [You think] they are safe and then now let me attend to this one [rather], because that child is at [a children's home]."

>The senior social worker at the primary residential facility in the area empathises with the area social workers: "If a child is [here], at least they already have shelter, are getting three meals a day, going to school, unlike a child who is in a shack that is falling down, that is hungry…".

The case study neatly encapsulates a range of the factors that limited turnover in children's homes across the field sites in the study. These can be summarised as follows:

High case loads and high proportions of foster care placements

State social workers in all four field sites reported burgeoning case loads that consisted primarily of foster care placements needing either processing or supervision. In the context of the HIV epidemic, current South African policy encourages the use of the foster care system to provide support to those caring for orphans. A cash grant to the value of R610 per month (in 2007) can be accessed by official foster parents for each child placed legally in their care. In the face of extensive poverty and limited access to poverty relief, caregivers providing homes to orphans are increasingly making use of the foster care system as a way of obtaining financial support for their households. Between 2000 and May 2007, foster care placements across South Africa increased by over 700%, from 49 843 to 418 608 (SOCPEN daily records 31.05.2007).

Foster care placement and subsequent supervision processes place an onerous load on social workers, requiring detailed investigations, subsequent monitoring of placements and biennial review. The use of the foster care system – originally designed as a child protection mechanism – as a system for poverty relief, has vast and damaging repercussions throughout the social welfare system in general, and the child protection system specifically (see Meintjes et al., 2005 for a detailed exploration of this policy approach). As the social workers in the case study above conceded, for children in residential care in the research sites, social workers' large and ever increasing foster care caseloads increased the likelihood that they would remain in institutions for a long period. A social worker in one of the other field sites was frank: when an overstretched social worker places a child in residential care, "it's like, oh minus one on my caseload".

Generic social work services

The fact that social workers do 'generic work' compounded the impact of large caseloads. The range of service provision required of social workers was argued to be too broad a span to allow for consolidation of skills to best manage and address clients' needs. This was seen to contribute to children getting trapped in residential care – and to be a reason why they were placed there in the first instance: Without consolidated skills for assisting children and families, social workers felt they were at times without the necessary tools to deal with complex situations in families.

Lack of comprehensive delivery of the social service 'continuum of care'

In the face of vast case loads and insufficient capacity and resources, social workers – like Masego and her colleagues above – who participated in the study found themselves routinely addressing those cases that were crises or which were most immediately pressurising for them. In addition, they struggled to integrate into their service provision the range of interventions that would assist in keeping – or getting – children out of residential care.

The study findings repeatedly pointed to the absence of adequate 'prevention' and 'early intervention' services to limit and address the levels of abuse, neglect and abandonment feeding the residential care sector, as well as other support for children and families, including access to basic services and poverty alleviation. As the manager at a Gauteng-based Children's Home explained:

"Reunification is a bit of a problem sometimes. The biggest problem now is with the children who are taken from their families because of abuse, crime or proble m behaviour and you find that parents don't even want these children back in their homes. There is no way you can reunite them: you find that parents tell you that they cannot have the child back because they can't feed them, they can't afford them. They tell you that 'I have got nothing to give this child'."

The social workers in the case study highlight how limited prevention or early intervention social service provision channelled larger numbers of children into residential care than would otherwise be necessary. And their limited capacity available for – and attention paid to – reunification or alternative placements for children in residential care contributed to trapping them there. Gaps in after-placement support to family and foster placements were similarly identified by staff at homes as undermining the success rate of placing children out of residential care. A social worker based at a Western Cape home explained that the lack of support for placements by external social workers led to children being "stowed away in residential care" as social workers like her became wary of placing children out: "I need to know, after-care, I'm dependent on the outside social worker and she is just going to ignore the placement and that means the child gets lost within the system".

That social service provision occurs against a backdrop of poverty and weaknesses in service provision of other kinds heightens these tensions, and those running homes routinely found themselves in situations of ambiguity, in which it was unclear whether continued residence in the home was to the child's benefit or not.

Consider the case that follows:

Case Study 15. Sunshine House (see also Case Study 18)

Prior to Aphiwe's arrival at Sunshine House Children's Home, he had been living on the street with his mother. He had not been attending school, and began his education only once he was at the home. He is now a thriving and eager scholar in Grade Two.

The social worker at the home explains that "while his mom was still alive, she was still living on the street. The grandmother was not interested in making contact with the child because of her not being happy with her daughter's lifestyle. But when the mom died last year the grandmother came and ever since she's been taking the child for school holidays".

The grandmother's change of heart opened up the possibility for Aphiwe to be reunited with her permanently. Although the home operates on the principal that wherever possible, children should be returned to family and community settings, the social worker is concerned that there is no primary school in the area where Aphiwe's grandmother resides. She speaks with anger and frustration about the dilemma this places her in:

"Do I keep him here knowing that he attends the school? Do I place him with his family members where there's no school? And I know for sure that he's not going to walk those kilometres to get to a school. If we say that - we talk about protecting our children, how do we protect our children? Provide for them - if we look at his needs, it's that, we want him to be with his family but he's got educational needs, so it's a difficult decision for us to make".

In each of these instances – of insufficient social worker capacity, high case loads, the predominance of foster care, of generic social work service provision, and the broader context of service delivery – the likelihood of effective turnover of children through residential care services is slim. Unless the broader systemic issues that hinder basic service provision and the provision of a full continuum of social services to support families are addressed, it seems likely

that the demand for residential care will continue to grow and the difficulties of shifting children out of homes will increase.

Plugging the gaps: homes taking on reunification work

Residential facilities that were managing to achieve reunifications and family placements for children tended to have identified support for statutory placements elsewhere – such as private adoption agencies or NGOs running professional foster care programmes – or to have developed their own programmes. These were identified as the key to their success in moving children on, and keeping homes within their capacity limits. For example, at a home registered for a maximum of 40 children, the staff member responsible for running a foster care programme noted how, "we have never gone to that number because of our foster care programme. Our foster care programme helps us in that it gives us a revolving door".

In each instance, managers at these homes emphasised the importance of having trained and dedicated staff members to focus on processes to move children out. In particular, the role of social workers who were able to navigate the various legal processes involved was identified as crucial. The founder at a registered Children's Home described how substantial shifts in turnover rates had been achieved since a social worker had been employed:

> "I was doing it [moving children out] in very small numbers because I was busy with so many things. You know to reunite them, you have to visit their homes and do, you know, the foster thing and the adoption, and all those kinds of things. For me I didn't have time for that. But since the social worker came on board in November [8 months prior], I will say 40 or plus minus 40 or 45 children, some of them have been reunited, some adopted, fostered."

In addition, it was pointed out, there were benefits to having a social services professional on the team as this provided legitimacy to their efforts and enabled them to hold external social workers more accountable than previously: "Our social worker is in head office everyday going, 'these are the social workers who've dropped the ball, they haven't given me forms'."

Other mechanisms employed by homes to improve turnover rates included awareness- and education campaigns to recruit foster parents; the provision of financial support to families willing to take in children; and co-operative relationships with other facilities. For example, a children's home in the Gauteng site focussed on providing 'homes' to children referred babies with a good chance of adoption to a home established for this purpose.

In each instance, these approaches mitigated some of the effects of the overburdened social services system. However, most homes did not have the human or financial resources to prioritise and provide these services.

7.4 'Getting stuck' or staying put?

Children's journeys into and out of homes in the study were shaped by a range of determinants associated with the choices and perspectives of those running the home as well as, importantly, the design and functioning of the Social Services. For the most part, children did not move through the residential care settings in the study in the manner or at the pace envisaged by legislation. Rather many children entered into these settings in unsanctioned ways. Of primary importance is the fact that social workers and police were documented to have been responsible for placing a considerable proportion of those children resident in unregistered homes. In addition, a large proportion of children in the homes in the study had been resident for more than the timeframes considered to be ideal in policy. The operation and capacity of the State and other statutory Social Service providers were identified to drive much of the divergence from official policy.

Importantly, the study findings regarding the movement of children through homes highlight how existing legislation does not allow for a distinction between instances of residential care that are established with intentions of providing permanent care to children, and those in which children's long-term residence is unintentional. In each situation, the factors affecting whether children remain in long-term care in the home are intrinsically different. In the former, the perspectives and paradigms of those running the home are fundamental. In the latter, the capacity of the Social Services again appears to be at the core. Recognition of this distinction is important if children's long-term existence in residential care settings is to be adequately understood and addressed in new policy and law.

8. Working inside and outside the law: Registration of children's homes

In order to avoid breaking the law, any care arrangement that involves more than six children who are not the caregiver's kin must be approved by and registered with the Department of Social Development (cf. section 3.2). The current Child Care Act no. 74 and its regulations stipulate a range of criteria that care arrangements must fulfil in order to be considered for registration. These include:

- Having in place a management committee of a minimum of seven members (Act s.30(1))
- Having in place an official constitution governing the functioning of the home (Regulations s.30(2a); 30(3a-e))
- Environmental health clearance issued by the local authority, which includes approval of the building structure, layout and facilities (Regulations, s.30(2b))
- The completion and approval of a needs assessment confirming the need for the existence of the home (Regulations, s.30(2c)
- Proof of compliance with the Minimum Norms and Standards for Residential Care (Regulations, s.30(2d), which detail requirements for children's protection and safety; the physical and social environment of the home; children's access to resources including their own bed, clothing and cupboards; re-integration of children into family; among other things (Inter-Ministerial Committee on Young People at Risk, 1998)
- Proof that all appropriately-aged children attend school (Regulations, s31(b))
- Appropriately maintained records, including an 'Individual Development Plan' for every child (Regulations s.31A), a daily 'behaviour management register' (Regulations S.32(8b)), a register of children resident (s.33(1)) and a file for each child (s.33(2))
- The provision of developmental programmes for children (Regulations, s31A)

Assessments for registration are completed by officials from both the local authority and the Department of Social Development. Registration of approved homes is reviewed every two years.

Although the details will only be clarified in forthcoming Regulations, the draft Children's Amendment Bill B19-B (Republic of South Africa, 2006b) looks set to replicate as well as augment the existing requirements for registration of homes as Child and Youth Care Centres. In particular, the Bill refers to management and staff having "prescribed skills" (s. 201(2) c. & e.) for the approval of registration.

While registration can be an important mechanism for quality control and protecting children in care, the disjuncture between these registration requirements and care settings such as that of the Nyathis described in Case Study 3, and others like them, is immediately apparent. The need for many of these requirements – a management committee, a constitution, record-keeping, and particular material conditions, for example – are incongruous to those providing 'family' to unrelated children in an arrangement that is an extension of their household. However, consider too the requirements in relation to other unregistered homes which do view their enterprise as a 'children's home':

Case Study 16. Ikusasa lethu (see also Case Study 1 and Case Study 11)

Sibongile is eager for the small rurally-based Ikusasa lethu children's home to operate legally, and to be able to apply for the financial support from government that is available to official Children's Homes. So she and her colleagues at the local NGO from which the home receives various kinds of support approached the Department of Social Development to investigate registration processes.

This precipitated a visit from officials from the regional Social Development office to inspect the home and its facilities. Sibongile describes a litany of problems identified by the officials during their visit:

> "The first thing that they complained about was that some of the children were sharing beds. At the time we had the smaller children sharing beds, although our plan was to buy more beds [when we had the funds]. The second complaint was about the ages of our children. The ages range from five years to 21 years … they said that we are not allowed to have the small children in the same house as the bigger ones and also they complained about the boys and girls being in the same house. We understand that, but we have plans to separate the girls and boys. The other complaint was about the fact that we don't have electricity. The social worker asked us what would happen if we found these children burnt because of using candles. If this had to happen, we would all go to prison, she said, because we are not registered and we are breaking the law. The other thing they mentioned was that the rooms needed to look like children's rooms. They were referring to toys, pictures on the walls, television sets for entertainment, a play room for the children, etc. They expected us to have these facilities. They also expected us to have a social worker on duty on a 24-hour basis. At the time, the social worker who worked for [the organisation who helps us] had left. We do have a psychologist who visits the children once a week and gives counselling. Sometimes we also have doctors, psychologists, nurses and social workers who render their services on a voluntary basis to the children … Another issue was that we only had one housemother and about 25 children."

The officials' visit to Ikusasa lethu left Sibongile and her colleagues feeling that their genuine attempt to assist children in need was not valued, the circumstances of the children and the efforts made on their behalf misunderstood, and their motivation mistrusted:

> "They were very negative … They gave the impression that we doing this because we just wanted to have children living there … They kept reminding us of the law… What I noticed was that they did not believe that these children were living here because the need arose."

The expectation had been that there would be questions and legal issues and procedures to be considered, but that the visit would be more of an exchange. She had hoped for constructive engagement: "They should've asked us about our future plans or asked us if we have money and at least offered some form of help". She notes that:

> "We understood the reason why they were asking for some of the things and started with some of the improvements. We started building houses for the bigger boys and we also started buying more beds. But this was already on our plans. We also have another carer. We are trying to improve and it is not that we were not aware, it is just that we did not have the means and we have to do it step by step … What surprises me is, how can you have a social worker if you don't have money to pay the social worker? How can we employ more carers if we don't have money to pay them? Instead of saying that [we have to rectify these problems on our own before we can be registered], given the fact that we now have the structure in place, we should work hand in hand with them and that they will help us fund the payment of more carers, or more beds…"

The stress laid on legal compliance seemed to override a full appreciation of the children's needs and circumstances. Rather than lessen this concern, the suggestion from the visiting officials that the circumstances of all children resident at the home would need to be re-investigated by state social workers increased it. Sibongile was aware of cases in which children were put at risk because relatives who were not able or committed to taking care of them had done so because of the financial incentive of the Foster Care Grant offered to them by social workers.

Most critically however, there was concern over the appropriateness of some of the changes that need to be implemented in order for the home to be registered, in particular considering the context in which it operates:

> "As for electricity in such a deep rural place, no one around here has got electricity. Does it now mean that because of our restrictions we should not help the children? Does it mean that we are not even allowed to build the old traditional huts in order to give a child a shelter? Does it mean because the conditions are not of the same standard as in the urban

areas that we should just leave the vulnerable children in the bush? I do not have things at home like people who are living in the city…

They are quite right [about the fire hazard of candles]. But that can happen even to me in my [own] home, it can happen to anyone … I don't think that they have experience of the conditions in rural areas …

It doesn't mean because you grew up in a rural area that you must suffer and that you are not entitled to a proper life. No, I don't mean that, but they should look at the standard of the place [neighbourhood] ... Each [children's] home is different. They should understand that if they had visited a home that impressed them because it had a TV, a play-room and toys, I could also turn around and ask them if the children there had chickens or pigs or rabbits or do they grow mealies? If I was [a government official] I would consider that people are not the same and even these homes cannot be the same. There are some good things and some bad things, but it is the children's home and they are happy there."

The officials repeatedly articulated concerns about the home operating as a magnet for children in the area, with children for whom there were alternative options ending up there simply because "everyone would want to live here because the conditions are better". In light of these concerns, Sibongile is surprised at their requirements for changes that would increase the disparities between the standard of living at Ikusasa lethu and that of the surrounding neighbourhood – something which she actively tries to avoid.

The experiences of Ikusasa lethu were echoed in various forms by those of many of the other unregistered homes across research sites. Participants described similarly bureaucratic evaluations of their interventions by officials, with sets of requirements inflexibly applied; and unwarranted suspicion about motives. Understandable official concern over children not placed legally came across as accusations and threats despite the fact that social workers themselves had, in many instances, placed children, and that without the care being provided by the home "at the end of the day, the child is suffering" (as one respondent put it). Homes also shared concerns about the implications of registration for the ways in which they would be able to support children (cf. Case Study 11).

The focus of attention on homes' infrastructure and material resources in assessment processes for registration was striking. As Nosiswe, a woman deeply committed to providing a family and a home to the children who had congregated around her but living in her small house in a township neighbourhood (see Case Study 5 and Case Study 12), commented with disbelief:

"The social worker that was sent to me told me to go and look at Sunshine House [an exceptionally well-resourced and capacitated foreign-funded registered Children's Home in the neighbourhood]. I went there to look, and she said 'Do you see how big it is? And how there's nothing lacking?' And she said, 'You also have to be like that!'."

Participants observed how they were hindered in their registration time and time again as "trivial details [were] regarded as essential": such as the absence of battery-operated external lighting in case the electricity failed; a kitchen extractor fan in a large airy kitchen; electricity in a neighbourhood that was not electrified; and separate beds for young children in an environment where children routinely shared beds or slept on grass mats in family homes. Exclaimed one participant with a laugh: "It seems like they want a five-star hotel for a Children's Home!" In many of these instances, questions about the appropriateness of the registration requirements to the particular context were raised. Like Sibongile above, people running homes frequently identified a mismatch between the requirements and an acceptable environment in which to respond to children's needs considering the context in which they were operating and the kind of environment they were trying to create for children – a point summed up by Sibongile when she reflected how the raising of chickens, pigs and mealie fields was a far more locally appropriate developmental experience for children resident in rural KwaZulu-Natal

than would be access to television. (Few households in the district have access to a television, with the vast majority relying on radio as their primary media source.)

Participants' experiences and insights raise a series of important issues for consideration in relation to registration requirements for Children's Homes and other residential facilities, and how these are applied by the Social Services. The rigidly employed 'box-ticking' approach to the assessment of homes resulted in a number of homes remaining unregistered because they were not able to conform to the requirements. The problem was recognised by some officials. As noted by a welfare planner in one of the sites, "we have our minimum standards and it makes it difficult for people from [the] areas [we work in]. Because of … the environment they are coming from they do not qualify. There are a lot of expectations that we have from our side as the government". That the details of the requirements were experienced as out of keeping with the reality and feasibility of domestic arrangements and child rearing practice in the neighbourhoods in which applicants were living further compounds the problem. This was exacerbated by the opacity of the requirements to applicants. Consequently – and somewhat ironically – these homes were not able to receive financial support from government that would assist them in being able to better respond to and support children (cf. section 6.9), and the Department of Social Development continued to face difficulties in tracking and monitoring their provision of care.

Furthermore, the routine and bureaucratic application of the procedural and administrative detail of residential care law – and in particular those criteria that relate to the physical environment – appear not only to hinder the meaningful assessment of important factors relating to the quality of care being provided to children, but also to fail in the implementation of the Best Interests of the Child principle enshrined in both the international Convention on the Rights of the Child (United Nations, 1989) and the South African Constitution (Republic of South Africa, 1996). As Sibongile asked so poignantly, "Does it now mean that because of our restrictions we should not help the children? … Does it mean … that we should just leave the vulnerable children in the bush?" The removal of children from unregistered homes on the grounds that they have not been legally placed there – and without adequate investigation into the children's circumstances – can be questioned in the same light.

Not only does the law and its implementation work against the registration of many of these community-based residential settings that are providing important (if imperfect) support to children, but it is also much more facilitative of the establishment of more conventional institutions. Formal group-care facilities with clear management and staff structures, which operate as funded and resourced organisations, and provide care to children in highly structured and regulated environments quite distinct from household- and community-based care, are best placed to meet statutory requirements. This is made explicit in the regulations outlined above. The bureaucratic application of the legal provisions during assessment for registration further serves to entrench conventional institutions as the norm, and to prejudice creative, responsive, community-based initiatives. The paradox is two-fold:

Firstly, the requirements for registration as an official Children's Home privilege the establishment of conventional institutions by individuals or organisations with access to significant resources. These are commonly donor- or corporate-funded set-ups, usually initiated by well-intentioned but frequently ill-informed individuals or groups external to the neighbourhood in which they operate. Glossy and well-equipped with matching furniture and bed-linen, and popular children's characters painted on walls, such homes – and the children resident – are typically less integrated into the local environment and less likely to express the qualities and routines of family life than those homes established by neighbourhood residents. And while this is not ubiquitously the case, the individuals or teams who are involved frequently

lack local understanding and are often driven by questionable ideologies[31] and notions of children's family contexts.

Secondly, the nature of the legal requirements for registration drives community-based residential initiatives towards becoming more 'institutional' in their operation. They can also introduce practices that jar with the essence of the care environments, and are somewhat incoherent in the context. Remember Nosiswe's absorption of both related and unrelated children into her home (Case Study 12): eager to be able to apply for government funding, she was diligent in her efforts to fulfil the criteria she had been instructed were necessary for registration. Told to keep records of every child, she was found to have established a record even for those youngsters who were her grandchildren and nieces. The dissonance for her was not in the wasted effort this implied, but rather the strangeness of the notion that children for whom she is providing a family and a home would need records at all – whether related or not.

Nosiswe's experience is just one example of how the legislative requirements for registration can put some of the more positive qualities of unregistered community-based residential settings at risk. These include the ability to respond immediately to children in crisis; few disparities between the physical and care environment for resident children and those of the surrounding neighbourhood; living and care arrangements that are – or closely emulate – family and long-term households; and easy mobility of children as participants in everyday local society; among others.

The international drive for smaller, more local residential care settings that are embedded in communities and which minimise the physical and social separation of children from neighbourhood is clearly supported in principal by South African policy directives, including by the model of Developmental Social Welfare that lies at the centre of the Department of Social Development's post-1994 approach. Incongruously however, the application of the law in many respects propels residential care interventions further from home- and community-based care, and further from family- or home-like environments, rather than closer towards them. With its extended requirements for registration and an explicit stance on closing or transforming unregistered set-ups, the Children's Amendment Bill risks further entrenching this trend.

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[31] Examples documented during this study include homes established to provide care to children identified to be from particular racial groups, to 'rescue' children from 'uncaring' communities who these days lack *ubuntu* [humanity], or which limit fostering and adoption of resident children to practicing Christians, nuclear families, middle-income earners etc.

9. HIV/AIDS and residential care: prevention, management and treatment

The large proportion of HIV-positive children, as well as children who had been abused or abandoned, who were resident in the children's homes in this study (recall data presented in section 5) brings into sharp focus the need for careful attention to be paid to HIV-related interventions in homes.

This is recognised by the national Department of Social Development and a programme focussed on managing HIV and AIDS in homes has recently been developed (NICDAM, 2006). At the time of writing, the implementation guidelines for the programme were being piloted and were not yet widely available. According to officials in the Department, these will be adapted and improved on an ongoing basis as the process of training in homes is rolled out. The guidelines outline a range of best practices for homes providing care in the context of a burgeoning HIV epidemic. These include:

- Information regarding prevention of HIV infection and the spread of other communicable diseases through information, education and communication; implementing universal precautions; provision of condoms; and the use of post-exposure prophylaxis and the prevention of mother-to-child transmission (PMTCT);
- Protocols for testing children for HIV;
- Information relating to disclosure, including telling a child his/her status, disclosing a child's status to others and disclosure of his/her status by a child;
- Information about caring for children with HIV, including ways to facilitate early diagnosis; the importance of establishing partnerships with provincial Paediatric HIV Clinics; developing competence to deal with typical ailments in children with HIV; ensuring up-to-date immunisations; implementing effective infection control procedures; managing and administering antiretroviral treatment (ART); and ensuring that a plan of action for children requiring palliative care is in place;
- Psychosocial support for children infected with and affected by HIV. This includes networking with local NGOs and CBOs providing these services; and
- Support for caregivers in the home, including individual and group counselling, as well as opportunities for continuous learning and development.

Like other departmental policies for residential care, the guidelines assume formal models of residential care provision. That said, many of the practical tools could easily be implemented or adapted for implementation in less institutional settings, as most concern knowledge acquisition and networking.

The reality in practice differed substantially from that envisioned in the guidelines in most settings, whether registered or not. Two contrasting case studies of homes provide a sense of the range in HIV knowledge and practice in homes that participated in the study. These case studies are cross referred throughout the subsequent discussion on the different aspects of HIV-related practice such as prevention, testing, treatment and support.

> **Case Study 17. Loving Heart Sanctuary** (see also Case Study 7)
>
> Although the sign board outside this well-resourced private place of safety indicates that the home provides temporary care to abandoned babies, Dalene, the home's manager, explains that orphaned as well as "unwanted" babies are also accepted. Indeed this faith-based organisation has a programme which actively encourages women who are unhappily pregnant to utilise their services instead of having an abortion.

The home's target population heightens the likelihood that children coming into care are infected with HIV, and Dalene confirms a high HIV prevalence amongst the children they have received to date. All babies entering the home are immediately tested for HIV, as HIV status is viewed a critical factor in shaping children's options for placement in family-based care.

The staff at the home are explicit about which children are HIV positive. "This one has full-blown AIDS, she's not just HIV positive", the housefather noted without prompting to the researchers as he sat bottle-feeding an undersized eight-month old one evening. He confirmed that the child was not receiving antiretroviral treatment. He appeared to be content with the fact that she was receiving bactrim to prevent opportunistic infections and had been donated a course of immune-boosting injections.

Both caregivers and management at the home demonstrate a lack of knowledge about ART, including both how the treatment is provided and where it can be accessed. Manager Dalene "didn't know" but she thought that a couple of the babies that had passed through the home had "received anti-virals [sic] once or twice". She is not familiar with HIV services in the area, and did not know that the paediatric wing at the local hospital runs an HIV clinic. As far as possible, no public health services are being utilised for children at the home: management viewed private health care as preferable and are testing children for HIV through a private laboratory.

There is also limited understanding amongst staff at the home of HIV-prevention techniques. Despite the focus on abandoned babies and those given up at birth, attempts are not made to confirm that nevirapine is given within 72 hours of birth to prevent infection. There is no understanding of what is involved in universal precautions and such concern as there was with preventing the spread of communicable diseases focussed on protecting carers rather than children.

The lack of HIV knowledge and the absence of appropriate practice at Loving Heart Sanctuary stand in stark contrast with the carefully developed interventions at Sunshine House, a home that was established specifically to provide care to HIV-positive children.

Case Study 18. Sunshine House (see also Case Study 15)

Sunshine House is a large facility established almost decade ago to provide care to increasing numbers of HIV-positive children found abandoned in hospitals. Sharon, the social worker at the home, explains that "eight years ago there were a lot of children abandoned in hospitals due to the fact their moms couldn't take care of them, and also the stigma around having a sick child and having to answer questions to family members".

Initially a medical focus dominated at the home as it was conceptualised as a place where "children would come to die" continues Sharon, but when children started to "beat HIV" with the advent of accessible ART, it was recognised that a broader approach was required:

> "When Sunshine House started the AIDS centre it was run like a medical thing. You know, we had doctors, we had nurses; it was run perfectly. It's just later that we realised you know, it's not a hospice, it's not a sick bed anymore: it's a children's home, it's a residential care and children are getting better so we need to look after them holistically."

As part of the attempt to achieve this, when the home moved to new premises, a shift was made from running a dormitory-based operation to accommodating children in smaller cottages, in order to provide them with a more home-like environment.

The facility is home to 42 children aged two to 12 years, 39 of whom are known to be HIV positive.

A range of interventions designed to address the different aspects of caring for HIV-positive children are implemented at the home. Child-care workers receive extensive HIV training: "We were trained for three and a half months about HIV and how to handle a child like this and we were shown what to do and whatever, and only then we started working".

The training covers a broad spectrum of HIV-related information, including universal precautions, ART administration to children, and the physical and psychological manifestations of disease progression in children. Caregivers are provided with in-service training by volunteer therapists

and behaviour experts to whom children displaying psychological and behavioural problems are referred.

An on-site clinic staffed by volunteer nurses and doctors forms the hub of the home's programme managing and administering ART to 37 of the 39 HIV-positive children. However the children routinely attend the HIV clinic at the local community health centre, having in the past been treated exclusively at tertiary hospitals. A convenient agreement with the HIV clinic enables the home to set up appointments for the children, which helps considerably in limiting care-workers' and nurses' time away from the home where their capacity is needed most. In addition, clinic staff ensure that changes to a child's treatment programme are communicated to the senior nurse at the home.

Medication is drawn up for each child by the on-site nurses, but is managed by child-care workers responsible for the day-to-day care of the children in their allocated 'houses'. Adherence is monitored by the nurses, and is considered to be effective. Challenges arise however when children go to stay with relatives or host families over weekends and school holidays. The social worker explains that a strict training procedure has been implemented in an attempt to improve children's adherence outside of the home:

> "Every person who wants to take the child needs to phone us by Wednesday because if you never came to Sunshine House to learn about how to give the medication, you're not going to get the child. Until you come to Sunshine House for learning about HIV/AIDS, learning about how to draw up the medication, the third time you come you do it yourself so that we know you know how to draw up that medication … You need to understand how important the medication is for the child".

Despite this training, the home still struggles with adherence in these settings.

These challenges associated with ensuring children's treatment adherence when not at the home in part prompted the development of a "disclosure programme" at the home. A team consisting of the relevant care-worker, a nurse and a volunteer play and drama therapist tell all HIV-positive children over the age of six about their status. The hope is that with knowledge of their status, children will learn to take responsibility for managing their own HIV, explains Sharon:

> "We want to teach the children especially when they go to school, that they need to take responsibility for themselves. If they should get hurt at school that they know that 'I need to take care of my blood' … secondly these children are on medication … if they don't understand the importance of this medication and you let them go to the family and they're not reminding the family about their medication then it's useless, so then you're fighting a losing battle … And they need to know what is HIV, they need to know how to take care of themselves if they – look some of them are already in teenage stage they might, we don't know what's going on in the community, we don't know who's sleeping with who and they would want to do the same, so that's why it's important for our children to know that they're HIV positive."

Disclosure forms the central thrust of the home's HIV-prevention strategy with children, as it is the children's primary source of information about HIV and its transmission. The social worker hopes that informal conversations also happen in the cottages, "you know that mamas sit down around – discussing types of precautions around the table after their meals in the evenings when they sit down then they talk about certain issues", but she could not guarantee that this was happening. Staff are implementing universal precautions at the home, and a care-worker confirms that they have access to the necessary resources, such as gloves, to do this.

Programmes have also been established to address the developmental delays and psychological and behavioural challenges that can occur in children living with HIV. Many of the children struggle at school, and so special schools as well as additional educational support are made available as necessary. The home also has a volunteer speech therapist who "helps the children, those who are struggling with hearing." Emotional and sexual behaviour problems have also started to emerge, and so Sharon explains they have had to network with additional services, such as the behaviour unit at the tertiary children's hospital, as well as with volunteer psychologists.

Bearing in mind the vastly different levels and types of HIV knowledge, understanding and practice apparent at each of the homes described in the case studies above, we turn now to consider the particular aspects of health-related HIV care at homes in more detail.

9.1 Knowledge and understanding of HIV/AIDS

In both Case Study 17 and Case Study 18 above, those working in the homes acknowledged that HIV was something that affected their service provision, although their knowledge of HIV and interpretation of its impact on the home produced differing responses and management strategies.

However not all homes recognised the HIV epidemic as a relevant issue with implications for the adequate care of children. As a result, there were a few instances in which those responsible for running homes were oblivious of any necessary action to prevent, manage, or treat children's HIV. In the main however, staff and caregivers at homes acknowledged that the HIV epidemic was affecting care provision. Commonly – as in Case Study 17 – only isolated components of the spectrum of HIV interventions were being addressed.

Myths about HIV were also evident. For example, the founder and caregiver at a small household-based unregistered home in the Western Cape did not consider HIV to be affecting her because she observed all the children in her care to look healthy.

A lack of information on all aspects of managing HIV played a very important role. Only 50% of the homes had staff or caregivers that had any HIV training (see Table 17). The majority of these homes (12 of the 17) were registered facilities. Staff at five of the eight homes operating using foster care legislation had not received any training.

Table 17. Staff HIV training at homes in study sites

Staff HIV training	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes	1	13	12	80	2	18	15	44
Partial	1	13	0	0	1	9	2	6
No	6	75	1	7	5	45	12	35
Unknown	0	0	2	13	3	27	5	15
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

HIV training was not always adequate and across both those homes that had trained staff and those without, significant knowledge gaps were evident. Conversely, there were instances in which sound HIV practice was being implemented at homes where no formal training had taken place. Strengths and weaknesses in practices are discussed in subsequent sections in this chapter.

9.2 Preventing HIV infection and other communicable diseases

Children may contract the HI virus through vertical transmission from a positive mother at birth, through sexual abuse, consensual sex or coming into contact with infected blood through open wounds. Each of these transmission modes has implications for the ways in which homes respond to children in their care.

Prevention of mother-to-child Transmission (PMTCT)

Knowledge about PMTCT was low across the homes in all the field sites except in Gauteng, and there was much confusion about what it entailed. Staff at homes tended to assume that PMTCT involved only an intervention with mothers at birth, and were unaware that post-partum antiretrovirals are also given to babies. Even at a home with a large number of nurses on the staff, the manager was confused: "Is it not that nevirapine is given to the mother to prevent mother to child transmission?"

Many of the homes provided care to babies, and most had admitted newborns at one time or another. However in the absence of adequate knowledge, few considered checking on whether nevirapine had been administered to newborns coming into their care.

Confirmation or use of nevirapine was more common in the Gauteng site as a result of the influence of an NGO. Having been alerted to the importance of preventative intervention, the manager of one Gauteng private place of safety explained how their procedure when admitting babies had been altered:

> "We actually have nevirapine ourselves, and if a child comes in I will go to the house and assess them and if they're under 24 hours old I give them to the nurse [to administer the nevirapine]."

The manager believed that this simple intervention had dramatically reduced the infection rate amongst newborns admitted to their home.

Post-Exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is another important preventative measure for consideration given the population of children being cared for in the homes. As noted in section 5, many children were in the residential care settings in the study as a result of abusive experiences, some of which were sexual. As with PMTCT, there is only a small window of opportunity to implement this preventive measure.

The legal requirements for children's placement in homes delay admission – and in most instances if there is adherence to legal channels, referring children for PEP is no longer an option by the time they arrive at the home. Even in emergencies, other services have interacted with the child prior to the children's home accepting them and should be referring children for PEP. As the manager at a facility in Limpopo explained:

> "If the child comes here, already the CPU [Child Protection Unit] officer has been involved outside, be it an emergency or a planned admission … Obviously the CPU officer, it's a must that before placement they must via the hospital for all those medical check-ups and the like, so when the child is brought you already know that the child is from the doctor."

Given that PEP is taken for a month however, homes need to be involved in administering the treatment. The fact that staff at many homes were unaware of the existence of PEP as an intervention points to a gap in the handling of abuse cases.

Accessing PEP for exposed children is more complicated for homes housing teenagers, as according to the Child Care Act children over 14 must consent to medical treatment[32]. For example, the social worker at a Western Cape home who had referred children for PEP in the past described a situation where a 17-year-old boy had reported being raped but she had been unable to convince him to go for medical treatment within the 72-hour time period.

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[32] The age of consent will be lowered to 12 once the Children's Act is promulgated.

Prevention of transmission through consensual sex

There are a number of other prevention issues arising for homes providing care to adolescents. It was common for these, too, to be inadequately addressed by homes.

Consider for example a residential setting in Limpopo which housed a largely teenage population – and one in which many children had been raped or abused prior to admission. The housefather dismissed testing as an important component of preventing HIV infection saying that "it is up to the particular child to decide to go and test". Rather than educating and encouraging testing, he explained that the official stance at the home was to advocate abstinence: "We try to work hard that they must not have that chance of getting the sexual relationship. Seriously this is a Christian organisation and it's not allowed". This approach clearly did not take into account the fact that resident teenagers may have been exposed to HIV through previous abuse or sexual activity or that they may continue to be sexually active despite the abstinence message. Residents were not being equipped with comprehensive messages about preventing HIV infection.

A common working assumption amongst those homes caring for teenagers was a lack of sexual activity amongst young people in their care, as were other examples of abstinence-only messaging. Expecting children to ask staff for condoms was also encountered in the study.

In contrast, the founder and primary caregiver at an unregistered home in the Western Cape (cf. Case Study 5 and Case Study 12), who had a background in home-based care, was adamant about educating children about preventing HIV infection. "You are forced to really inform the child because you do not know what is going on out there", she explained. This caregiver took prevention further than most, recognising that talking about prevention when you do not provide children with the means to keep themselves safe is unlikely to be effective. Young people resident in her care are thus able to access condoms freely from a condom dispenser which is placed in the room where the boys sleep at night. She explains her thinking behind this:

> "Of course, the children grow up! I shouldn't just teach the old girls and boys that condoms are used, and yet they don't see anything here at home. They should see that I am not ashamed of bringing a box here and putting the condoms inside, because I can't always keep them close to me and they do not tell me about all the things that they do".

Universal precautions and infection control

Universal precautions are an important way of preventing both the spread of HIV as well as other communicable diseases. Across the homes, caregivers (although not always children) were aware of the golden rule of not touching others' blood, but taking precautions around the spread of other diseases seemed more haphazard, again seemingly the result of insufficient or incorrect information. Most homes reported not having sufficient gloves. Staff at only one home referred to washing their hands with anti-bacterial soap before and after dealing with a child, and tellingly this large Gauteng home was staffed with many nurses. Johannesburg-based research similarly found that the issue of communicable diseases was not being adequately dealt with in most homes (Meiring, 2005).

9.3 Testing for HIV

The finding on the part of this study as well as that of Meiring (2005) that residential care facilities around South Africa appear by default to have a large proportion of HIV-positive children in their care suggests that HIV testing should be a crucial – and standard – component of their response. In particular the testing of young children in instances where a mother is known to be/have been HIV positive or of unknown status is an important step towards the maintenance of children's health. Similarly, in instances of a history of sexual abuse, testing is

important. However, the legal requirements regarding consent for children's HIV testing – and subsequent treatment as necessary – are complex.

Under the Child Care Act of 1983 (s.39), the consent of a parent or legal guardian is required prior to the provision of medical treatment to any child under the age of 14 years old. In terms of the law, the definition of medical treatment includes HIV testing, the provision of antiretroviral therapy (ART) and post-exposure prophylaxis (PEP). In instances where a child is without a parent or legal guardian – as is the case for many children who have been orphaned or abandoned – the law requires for permission for HIV testing to be granted by the Minister of Social Development or by the High Court (as upper guardian of all children). In emergencies, the medical superintendent of the health facility may consent on behalf of the child.

A manager of a children's home is only considered to be the legal guardian of a child once the child has been committed to the children's home through a 'Form 8' court order following a full investigation. As noted by Meiring (2005), high case loads at children's courts mean that the time taken to place a child on a Form 8 into a children's home can be prohibitively long. In keeping with this, managers at registered facilities in the study sample indicated that the majority of children in their care were placed on interim or confirmed detention orders (Form 4 and Form 5) which do not entitle them to consent to testing on the children's behalf.

Despite the legal requirements for consent to testing, most homes were finding ways to test children: only eight homes (four unregistered, three registered and one private place of safety) were not testing children for HIV at all. Twenty-four homes (or 70% of the homes that participated in the study) were known to be testing children for HIV infection. Thirteen of these homes were routinely testing children on admission. Nine homes sent children for tests when they presented with symptoms indicative of HIV infection. In two cases it was not clear what the homes' procedure around testing was. Table 18 refers. In some cases in the Gauteng site, routine testing was possible because of a high court interdict allowing doctors to recommend children for testing in the absence of a legal guardian. In other cases, it was not clear how the legal requirements regarding consent were bypassed, though it is likely that health services were simply not strictly enforcing the consent procedures in the interests of children's health.

Table 18. HIV-testing practices at children's homes

HIV testing	FC/PPOS		Registered		Unregistered		Total	
	n	%	n	%	n	%	n	%
Yes - routine	5	63	4	27	6	55	15	44
Yes - if indicated	0	0	8	53	1	9	9	26
No	1	13	3	20	4	36	8	24
Unknown	2	25	0	0	0	0	2	6
Total	**8**	**100**	**15**	**100**	**11**	**100**	**34**	**100**

Routine testing of children was most common in homes dealing with babies and toddlers. Four of these homes, three unregistered, were testing in order to better manage children's health, "so that we could take care of them appropriately and be prepared when necessary", as the founder of a Gauteng home explained. Rather than out of concern for children's health, the rationale for testing by most private places of safety was reported by staff to be the importance of HIV status in securing placements for children in family care. In general, HIV-positive children were considered to be unplaceable, or at the very least presenting considerable challenges in the search for family-based care. The view articulated by a social worker at a home in Limpopo was commonplace amongst staff at these homes as well as amongst many social workers:

"You cannot place a child in adoption without knowing that the child is [HIV] negative… [because parents] must have a child that will stay some time with [them]… otherwise you would be subjecting them to a double trauma if they adopted a child who then died".

Assumptions about the foster care or adoption "worthiness" of HIV-positive children was therefore the driver behind the HIV testing of children in many homes, in particular those focussed on short-term as opposed to long-term residential care (for more discussion on this issue see section 7.3).

While many homes managed to find a way around the legal requirements for consent, the processes were often not simple. In some instances, lengthy time-consuming processes involved in obtaining official consent substantially delayed the testing of children. As the founder and director of a registered home housing almost 100 children (most of whom are younger children placed via a Form 4 or Form 5) in the Western Cape site, described:

"We don't do a test immediately when the child comes because we have to get the right papers … the child doesn't belong to us. The child belongs to the State when the child gets here, and the doctors know that immediately. [So] they [the doctors] will call me then they will say 'we want to run an HIV test to this child', and then, okay, they will give me forms to [give to] the social worker – the external social worker who's helping in the case of the child – and the social worker or the head of the department from the Department of Social Services or child Welfare or whoever will sign that [form] and that [form] will be taken to court [to be] filed. Then the commissioner of children has got to do the permission …"

This process she explains usually takes at least a week "because they don't sign right away unless the doctor is so pushy and the child's condition is bad, then they will fax the letter and the social worker will go quickly".

The situation for testing children resident in unregistered homes tends to be more complex. Caregivers who have not formalised their relationship with the children for whom they care are not recognised as legal guardians and therefore cannot legally give consent for an HIV test (Gerntholtz & Richter, 2004). Furthermore, unlike their counterparts in registered facilities, those running unregistered set-ups do not have the recourse to social workers and the courts to address this. Managers or caregivers in some unregistered homes described being turned away by health professionals. A woman caring informally for 14 children who had been abandoned at her crèche explained the problem she had been facing in trying to test the children in her care:

"You know the difficulty – the only problem [the doctors/nurses at the clinic] are telling us, I can't test the child without the parent's consent, the parents need to be there for the child to get tested and all that. Then the parent is not there – I don't know where the parent is – then I must go to the social workers and get a letter from them and all those things. Then I also went to the social workers, whereby they asked me about this registration and all these things. And at the end of the day the child is suffering."

Social workers could not process the permission letter without the facility being registered, with the result that at the time of the study these children (some of whom were symptomatic) remained untested.

The new Children's Act addresses this legal predicament in new provisions providing caregivers the right to consent – in the absence of a parent or guardian – to "any medical examination or treatment" of children in their care. This includes a person caring for a child in temporary safe care as well as "a primary caregiver". Furthermore the age of consent for HIV testing has been lowered from 14 to 12 years in the Act. Until such time as the Act is promulgated however, homes are – at least in theory – required to operate within the provisions of the Child Care Act.

9.4   Treatment, care and support

The multi-faceted nature of managing treatment, care and support for HIV-positive children raises particular challenges in a group setting owing to the care burden this places on homes. Staff at homes not only have to manage ART, but also to make decisions about disclosure and see to any developmental, behavioural and psychological problems children may be experiencing as a result of their HIV status.

The home in Case Study 18 above managed an HIV-treatment programme with few difficulties. Many of the 15 homes with children on ART struggled, however, with the logistics of utilising the public health services. In particular homes complained about long queues at clinics and antiretroviral (ARV) sites. As similarly documented in other research (Meiring, 2005), homes struggled with the loss of human capacity when child-care workers had to spend whole days waiting in queues with children and this has implications for their child-to-staff ratios and therefore for the quality of care they could provide. This was of particular concern for homes with large numbers of HIV-infected children where, apart from their regular trips to clinics and hospitals, the incidence of other illnesses was also higher. Some homes had been able to manage this difficulty by negotiating with their local clinic for priority treatment. Other homes used tertiary hospitals for HIV treatment and appreciated that there they could operate on an appointment basis. These homes were reluctant to shift to local clinics for their ARV services precisely because they were concerned about how they would cope with long queues.

In addition to the amount of time caregivers had to spend at medical facilities with children, medication shortages were noted as a challenge for some homes in the Gauteng site. A care-worker at one of these homes describes the uncertainty this generated:

> "The other children have to go to XX hospital and that is my biggest fear there … Sometimes they don't have this or that and when you go there, is not enough medication and they will say we can only give you medication for a week."

Research into the rollout of paediatric ART confirms that pharmacists at some hospitals are struggling to maintain stock levels of paediatric ARVs because of storage problems as well as difficulties in predicting the numbers of children that will come in for medication in any one week (Michaels, Eley, Ndhlovu, & Rutenberg, 2006).

Where children are on ART, homes bear the responsibility for administering the medication, something which the founder of one home caring for seven children on ARVs referred to as "a project on its own". Dosing of antiretroviral therapy in children is often complex with mixtures of tablets and syrups, uneven dosages at different times of the day, and frequent changes in dosages as children grow. Each child's treatment needs are different, so careful records of prescriptions have to be maintained. Ensuring adherence where homes are supervising large numbers of children on ART, or where care-workers do rotating shift work, can be particularly challenging. Many of the larger homes streamlined the process along the lines described in Case Study 18. Typically medical staff (usually nurses) prepared the medication, so that trained and consistent caregivers could administer it.

This said, once systems were in place, most homes found administering ART manageable. The manager at a home in KwaZulu-Natal described how, with adequate training, care-workers were successfully managing all the ins-and-outs of paediatric ARV provision:

> "They've been doing it for a year and a half now and they are brilliant. They haven't missed a dose. I mean to start with they didn't have a clue how to pull a syringe or anything, but everybody is very confident now you know, they really know what they're doing. It's great."

The advent of access to ART has also transformed homes in other ways. As noted by the social worker in Case Study 18, improved prognosis as a result of ART has meant that homes caring

for HIV-positive children have to plan their interventions differently as they contemplate children's futures rather than deaths. Because children on ARVs can live healthy and long lives, explained the founder and director of a Western Cape home caring for a number of HIV-positive children, it was identified that an attempt should be made to shift children from the home into family-based placements:

> "I think that's the major change: you know we thought we can provide emergency foster care to orphans and abandoned kids but the HIV-positive children, they would have to stay with us forever kind of story, until maybe they pass away. So there's a shift from sort of like providing a loving environment to the best of your ability, to suddenly realising, wow, you know we can actually normalise these children's lives almost a 100%, get them back into foster care ... I think the whole experience of pre-antiretrovirals and then experiencing antiretrovirals was just amazing for everybody."

This home runs a foster parent recruitment programme which raises awareness in the neighbourhood about caring for HIV-positive children. Contrary to popular perception (see section 7.3), the programme has resulted in HIV-positive children being placed in families as successfully as HIV-negative children.

With properly administered ART, and children living longer lives, the need to focus on issues such as disclosure and the psychological and developmental effects of HIV infection also emerges (Domek, 2005). Those running homes were divided on the issue of disclosure. At some homes, such as Sunshine House, clear advantages to disclosure were identified, both in terms of children's right to know their own health status and also in terms of them taking responsibility for their treatment and improving adherence.

On the other hand at some homes, explicit choices not to disclose to children were made. The founder of one such home in Limpopo explained this decision in terms of concerns around stigma should children tell others about their status:

> "They might tell others, their friends, their status because they don't understand the seriousness of their condition, and end up being stigmatised as a result. For example, at school a teacher might ask where a child is, and then another child might say that they are at the hospital because they have that disease."

9.5 Conclusion

The study highlights a pair of important findings for consideration. Firstly, that knowledge in homes about HIV and AIDS was uneven and far from comprehensive, and secondly, that homes' practices regarding HIV/AIDS tended to be unsystematic, and to address only limited components of the necessary spectrum of HIV interventions.

Caregiver HIV literacy is essential for achieving a comprehensive approach to managing HIV and AIDS in homes, such as that outlined in the Department of Social Development's guidelines. Gaps in knowledge and practice regarding important prevention strategies of PMTCT and PEP, as well as around hygiene practices to prevent the spread of communicable diseases were evident in the study. Messages about the importance of early diagnosis in exposed children of all ages could be strengthened together with a more considered approach toward disclosure.

Access to health services and in particular the ways in which homes interact with clinics and ARV sites affect the quality of care homes are able to offer to both HIV-positive and HIV-negative children in their care. Long queues which take caregivers away from homes for prolonged periods undermine care and supervision on offer at the home. Caregiver literacy in managing basic childhood illnesses as suggested in the management guidelines would go some way to alleviating this. Equally important is the development of good relationships between the

health services and children's homes where health services can be flexible in giving priority treatment to homes, or even providing outreach services where appropriate.

A number of homes demonstrated that administration and management of paediatric ART is possible in group-care settings, as long as systems for doing so are in place. An important aspect of ensuring that children receive the correct medication is consistency and continuity of carers as well as good communication between the home and the health providers prescribing the treatment. These lessons should be easily transferable to settings not currently administering ART.

There was some indication in the study that HIV-positive children were being shifted between homes to those that are seen as specialising in caring for HIV-infected children. Sometimes this was because a home was focussing on foster or adoptive placement, and staff believed that finding placements for HIV-positive children was not feasible. In other instances, a home was not willing to administer ART. Besides being discriminatory (and unnecessary), it seems unlikely that, given the HIV prevalence in homes participating in this study, specialist facilities will be able to sustain the burden of care being placed on the sector.

10. Conclusions: Conceptualising residential care and the challenges for policy and practice

In the context of limited empirical documentation of the phenomenon of residential care for children in the time of AIDS, this study set out to describe and analyse the sector as it happens 'on the ground' in South Africa. In addition, it aimed to consider how the practice of residential care relates to national policy and law and to international child welfare policy on the issue.

Recognising the complexity

The situation of residential care 'on the ground' in South Africa is much more complex than is generally acknowledged in policy discourse and debate both locally and internationally.

Residential care settings for children vary substantially across multiple axes, including:

- legal status;
- size;
- living arrangements into which children are incorporated;
- constellations of care around them;
- human resourcing;
- carers' notions of their role and the enterprise they are involved in;
- nature of care and 'services' provided to children;
- focus of the 'intervention' and the ideologies behind it;
- whether the intention is to provide short- or long-term care and relationships for children;
- extent of resources – including funding – available for care provision;
- degree of regulation inherent in the home's environment;
- location in which care happens; and the
- nature and form of its links to 'community', neighbourhood and society.

In each of these dimensions, the study identified significant diversity. Importantly, the particular configuration of these characteristics was unique for each home. No two homes in the study shared an identical configuration, and as noted in section 6.4, substantial differences were evident even in homes that initially appeared to be very similar.

Given this heterogeneity, the inherent focus in policy on conventional institutional forms (cf. section 3.3) seems misplaced in the South African context. At the core of policy discourse and debate is a series of overlapping dichotomies: A 'first resort' model of care for children juxtaposed with an explicit 'last resort' model; family- or community-based care juxtaposed with residential care; a context of care in which children's rights are protected juxtaposed with one in which rights are violated; and an existence embedded in everyday community juxtaposed with an existence 'inside' an institution, separate from community (Figure 3).

Figure 3. Dichotomies in the conceptualisation of care provision

Family- and Community-based Care	Institutional Care
'First resort'	'Last resort'
Continuity with family, community & cultural identity	Dislocation from family, community & cultural identity
Integrated into society	Marginalised from society
'Natural' care setting	Artificial care setting
Potential for secure, long-lasting attachments	Lower potential for secure, long-lasting attachments
Automatic transfer of necessary life-skills	Lack of preparation for life 'outside'
Children's rights protected	Children's rights violated
'Best interests' of the child	Best interests of others

A pair of assumptions underpins these dichotomies: first, that residential or institutional care is entirely distinct from family-based care or community-based care; and secondly that family- or community-based care is by definition more protective of children and their rights than is care in residential care settings. Both rest on a clear distinction between residential or institutional care, on the one hand, and community- or family-based care, on the other.

However the empirical evidence presented by this study clearly illustrates the blurring between family-based, community-based and residential care. Care arrangements that would be considered to be residential care settings in terms of the Child Care Act were in instances indistinguishable from family care in (extended) household settings. Adults in some homes assumed the role of parents or primary caregivers, not 'housemothers' or 'care-workers', as adults taking care of children in their neighbourhood rather than as employees. Several homes were embedded in neighbourhoods in ways that positioned resident children as community members no different to other children living in families and households. Segregation and dislocation from 'community', neighbourhood or society was not a given. Children's relationships with peers, friends and neighbours were often maintained. Daily routines and practices in many children's homes replicated those of everyday households.

Homes were in many instances community-based interventions in and of themselves: case studies presented throughout the report illustrate how the origins of many residential care settings lay in local individual or organisational responses to children with no obvious and safe alternative care options. In effect, they developed as expressions of community obligation to children whose families could not meet their needs. In the absence of adequate or accessible alternatives, many homes emerged as a natural extension of the provision of community-based support interventions. Children were abandoned at ECD or day-care centres and Social Services failed to assist; relationships developed during home-based care and HIV support group provision resulted in requests for children's long-term care or in responsibility being assumed by caring but unrelated adults; children living alone on the streets collected food at a soup-kitchen; orphan care programmes identified children living in unsafe settings; children developed relationships with an individual and converged on her for assistance; more and more children were brought by Social Services and others to women who had taken a couple of abandoned children into their legal emergency care; and so on. Only just over half of all homes in the study – both registered and unregistered – were prospectively initiated (by locals or 'outsiders') with the intention of establishing a residential facility per se.

The study findings also raise critical questions about typecasting 'family' environments as inherently safe and protective of children. That a substantial proportion of children were placed in the children's homes in this study as a result of abuse and neglect bears testimony to the flaw in this conceptualisation. Concomitantly, the notion that the principles and articles of the United Nations Convention on the Rights of the Child (UNCRC) are by definition violated by residential care settings seems to disregard the extent to which children's rights are not guaranteed in family- or community-based care.

In other words, the range of settings that constitute residential care 'on the ground' in South Africa blur the commonly understood boundaries between the so-called first and last resorts for children. Neat distinctions between these categories of care are not possible to achieve in practice, although there are good and bad, better and worse examples of each. Determining the actual quality of care, whatever the setting, is what matters in promoting the health and well-being of children.

Registration

In South Africa, the phenomenon of residential care itself tends to be understood in terms of an additional legally constituted dichotomy: as either officially registered with the Department of Social Development, or as unregistered and operating illegally. As highlighted in section 6.1,

there is a tendency for government and others in the social welfare sector to characterise homes that are not registered in entirely negative terms. In contrast, those that are registered and conform to the Minimum Norms and Standards for the sector are seen to perform a valuable role in providing the 'last resort' in a continuum of care for children.

However, evidence presented throughout the report illustrates that the legal categorisation of residential care settings reveals little about homes themselves, or more broadly about the nature of residential care. Rather it masks the phenomenal diversity that exists across the sector (and that is described above), both within 'categories' of homes and across them.

Of key importance here is that in some instances unregistered homes were in a position to provide enhanced care (or aspects of care) for children. The fact that unregistered homes were not regulated in the same way as registered facilities enabled a flexibility in approach not otherwise possible. Homes could embed themselves and resident children in the local environment by limiting their catchment areas; and by enabling (where appropriate) fluidity of resident and other children's movement in and out of the homes. Children could be provided with meaningful 'home' and attachment relationships through the presence of permanent and committed caregivers. Bureaucratic procedures of the kind that are arguably necessary in large (more commonly registered) facilities could be avoided. Unself-conscious models of care could be implemented. Routines and practices could be shifted as appropriate in the absence of restrictive legal regulations. Children in crisis could be responded to immediately, without delays resulting from the need for completion of legal forms and court orders.

The diversity of characteristics inherent within and across the different homes raises a series of critical questions concerning unregistered homes. Consider a situation in which children grow up over years in unrelated groups larger than an average sibling group, with carers who are consistent loving parental figures who treat them as their own and who provide them with long-term stability including beyond the age of 18 years old, and where children live just like others in their neighbourhood. What in practice makes this care arrangement different to a large household of kin? What in essence constitutes 'family care'? Is this by definition a less therapeutic and developmental caring environment than regulated institutional care as envisioned in South Africa's Children's Amendment Bill? Is the permanence of the arrangement a positive or negative quality in this case? Does the absence of formal programmes and individual development plans make it an inappropriate intervention that must be halted?

The intention here is not to idealise unregistered, informal, unregulated children's homes. Certainly there were to greater and lesser degrees negative – sometimes alarming – aspects in a number of such homes documented in the course of this study. However, regulated well-resourced Children's Homes were similarly documented to possess both positive and negative qualities. Evidence points to the way in which there is no neat overlap in practice between the legal categorisation of residential care settings and the nature and quality of care provided to children.

Richness and challenge in diversity

The narrow certainty and the lack of recognition of diversity in the dominant child welfare discourse about residential care, and in associated South African legal provisioning, is at odds with the situation on the ground, with the lived experience of children. As a result of this disjuncture, its application risks the State not being able to engage with a range of settings which require monitoring and support, and to driving family- and community-based residential initiatives towards care of a more stereotypically institutional nature, with the loss of some of their more positive qualities in the process.

In practice, all too often the government's current interactions with and responses to unregistered residential care facilities are fraught with confusion and frustration. Mixed

messages are communicated to unregistered homes: Contradictory funding mechanisms operate within and between departments and tiers of government. Social workers place children in care at unregistered homes while concomitantly homes' official registration is rejected. The drive to place children in family-based settings is not matched by the capacity of the Social Services to adequately process, monitor or support placements. Services aimed at 'prevention' and 'early intervention' – critical components of the Department of Social Development's vision for the provision of a developmental continuum of care for children – remain insufficiently resourced, and limited in reach. Homes are refused registration and are shut down on the grounds that residential care is unsuitable for children, but overburdened and under-funded state Social Services are not able to support children in families adequately under current circumstances.

Paradoxically, at the core of the Developmental Social Welfare model that underpins all post-1994 social development policy in South Africa is a recognition of the value inherent in 'indigenous' responses. The model sets out to resource and empower local level insights and responses to social circumstances and to place emphasis on the provision of a wide range of interventions that together support a broad 'continuum of care' for children as part of wider social development goals (Patel, 2005). It is precisely the creativity and sensitivity of local responses that the model aims to build upon in strengthening social services delivery.

However, it is also the complexity and the ambiguity described in the course of this report that makes the broad arena of residential care for children a difficult one for the State to systematise, support, monitor and regulate. The danger is that at this time of much policy and legislative review in South Africa, we – as both government and the children's sector – promote unhelpful, inappropriate, unfacilitative policy and legislation based on conventional and simplistic notions of what residential care is and should be. It would be preferable to seize the opportunity to ensure flexibility in our policy and law that recognises the need to resource as well as regulate the wide variety of informal social care responses that exist.

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