http://dx.doi.org/10.15270/41-4-317

THE RELATIONSHIP BETWEEN HIV/AIDS AND POVERTY: THE CASE OF THREE ADMINISTRATIVE AREAS IN THE TRANSKEI

T Mashologu-Kuse

INTRODUCTION

The paper is based on on-going research that is conducted under the auspicies of the Department of Social Development, University of Transkei. The findings of this research study, on completion, will highlight the relationship between HIV/AIDS and poverty in the Transkei region of the Eastern Cape.

Transkei, being a rural area, has had its fair share of problems that are the legacy of apartheid. Discrimination that existed at the time was entrenched through legislation, for instance, the Population Registration Act No. 30 of 1950, the Group Areas Act No. 41 of 1950 and the Reservation of Separate Amenities Act No. 49 of 1953, (Statutes of the Union of South Africa) which, among other things, viewed people and provided for them differently. The situation was exacerbated by the homeland policy that was a further endorsement of apartheid and its discriminatory laws. The result of this was that the homelands, of which Transkei was one, were underdeveloped. Rural areas were encouraged to be self-reliant on the notion that traditional structures in the rural areas were still in place to provide the necessary support to rural families. The result of this neglect of rural areas was poverty that reached alarming proportions since the majority of rural people were unemployed and the traditional structures were on the wane (Kuse, 2001).

EXTENT OF THE PROBLEM

The Transkei region of the Eastern Cape is an area of about 4, 287,000 ha, with a population of approximately 3.7 million (Mpambani, 1994:4). Of this figure, 95% of the population is rural and the remaining 5% lives in the few semi-urban centres of Umtata, Butterworth, etc. (Mpambani, 1994). Its people are culturally homogeneous and have a strong traditional orientation.

HIV/AIDS has reached alarming proportions and is becoming a growing concern of the global village. Internationally, HIV/AIDS sufferers i.e. adults and children, have been estimated at 42 million. AIDS orphans are reaching an alarming proportion especially in sub-Saharan Africa and the situation is becoming worse over the next decade. An estimation has been made that by the year 2010 sub-Saharan countries will be home to approximately 50 million orphaned children. More than a third of this will have lost one or both parents as a result of AIDS (Unicef, 2005). Presently, there is an estimate of 15 million children under the age of 18 who have lost a mother or both parents as a result of AIDS (Unicef, 2005). Nationally, it is not clear how many people die of AIDS, the numbers fluctuate between 5 and 5.3 million (Gabada, 2002). In the Eastern Cape statistics from an antenatal survey published by the National Department of Health indicate that 1500 people get infected with HIV/AIDS everyday (Ndudane, 2000). Statistics revealed by UNAIDS / UNICEF / WHO (2003) indicate that up to 1,000 adults and children are dying of AIDS on a daily basis in some of the worst affected countries in Africa and that the situation will continue to exist if the socio-economic conditions are not immediately addressed. This is endorsed by Whiteside and Hunter 2000, in Gabada, (2001), in their assertion that 95% of the infected people live in developing countries and that these high rates will continue to escalate where poverty and deprivation, poor health systems, lack of basic education, inequality and limited

http://dx.doi.org/10.15270/41-4-317

resources for prevention and care, prevail. This calls for developmental approaches to address the plight of the disadvantaged.

Poverty is a global phenomenon that continues to ravage the lives of many. Nationally, approximately 19 million people, 40% of the 43.9 million people living in South Africa, are considered poor with 71% living in rural areas (Poverty and Inequality in South Africa, 1998).

In Transkei poverty has reached fever pitch. In the 1990's the figure cited by Mpambani (1994) was 92% of families who were living in abject poverty. Mpambane (1994) comments in the following manner about poverty in the homelands and in Transkei. In South Africa "...absolute poverty is concentrated in regions created by administrative fiat - namely the homelands, which are largely the repository of women, children, and the aged who are not engaged in the formal sector of the economy. Transkei is one such area where the majority of the people live in abject poverty and destitution" (Mpambani, 1994:44). Latest documents highlight the Eastern Cape Province, of which the Transkei region is a part, as the second poorest province in South Africa (Promotion of Rural Livelihoods, 1999). It would seem that the situation is worsening instead of becoming better.

Poverty in Transkei is manifested in various fields, the most important of which is welfare that incorporates health, housing and education. In 1993, just before the new political dispensation, the figure for the poor, supplied by the central statistical office in Umtata was 131,394. Of this number, 1635 were destitute children. Family and individual allowances, in the form of disability, old age, foster care grants, that families receive, are below the level of subsistence. In order to be able to assess the extent of poverty of families, the researcher used the formula offered by the Institute for Planning Research at the University of Port Elizabeth (South African Institute of Race Relations, 1995) on the estimated household subsistence level (HSL) for Transkei rural and urban families, (R759.06 for a family of six). Presently, welfare recipients receive a variety of grants on a monthly basis ranging from R170 (child support grant) to R740 (disability, old-age and care dependency grants).

The infant mortality rate in Transkei is high. In 1990 the estimated figure was 85 for every 1,000 children. A study conducted in the 1990s indicated that nutritional diseases, notably kwashiokor and malnutrition were high, with 78.1% of males between the 0-9 age-group suffering from these diseases (Mpambani, 1994). The implication of these figures is that the bulk of children in Transkei are undernourished, an indication that families are poor and disadvantaged.

As mentioned earlier, except for the 5% peri-urban population around the main urban centres of Umtata and Butterworth, the bulk of the people of the Transkei region are rural. The allocation of rural land for housing purposes is still the monopoly of the chiefs. Lately, there is an increasing demand for housing in the urban areas as more people are flocking to towns in search of employment.

The quality of education in the Transkei leaves much to be desired. The dilapidated state of many schools, the alarming high pupil/teacher ratio, the shortage of classrooms, the absence of laboratories for experimentation and the fact that water is not available in some rural schools, are all an indication of the current financial problems that are manifested in the educational crisis of black children in the region. Of the 20,946 schools listed by the department of education, only 11, 317 schools were housed in modern conventional buildings and the rest of them (9,629) housed in temporary classrooms (Mpambani, 1994). The situation is slightly improving with the former President's (Mr Mandela) attempts to build new schools in the area. All of the above warrant a developmental approach in order to avoid the children being locked in a cycle of educational poverty.

http://dx.doi.org/10.15270/41-4-317

DEVELOPMENTAL APPROACH

The HIV/AIDS pandemic has been identified as a major problem area that is affecting the underdeveloped Sub-Saharan African countries and South Africa is top on the list (Gabada, 2001). Research on AIDS sufferers, conducted in the Transkei indicates that people living with AIDS experience isolation and rejection, leading to feelings of guilt and behavioural problems, as well as abuse and discrimination by family members (Ndudane, 2000). The pandemic also affects the family economically as the family income drops if the HIV/AIDS sufferer was a breadwinner before contracting the virus/disease. This situation leads to child-headed families as the stigma of AIDS excludes the children for possible adoption by the extended kin. Another research study conducted in the Transkei on HIV/AIDS infected and affected people, reveals that their social and family backgrounds are characterised by poverty and deprivation, unemployment, hunger, homelessness, squatting and are generally disadvantaged (Ndudane, 2000). These massive problems require developmental approaches in order to be mitigated.

Both Gray (1997) and Rankin (1997) believe that the developmental approach is the best method of addressing problems of the disadvantaged in South Africa. Both lament the fact that the welfare policies of the past were a result of the policies of apartheid and also part of South Africa's heritage. They believe that drastic economic decline, high levels of unemployment and poverty, lack of access to land and health and welfare services are all indicative of a deteriorating residual welfare state which warrants a developmental approach.

The developmental approach specifically targets the poorest and the most disadvantaged, the least powerful and the most vulnerable. It emphasises grass-roots participation, focuses on small activities and involves local people in the designing, implementation and management of social development projects. It is people-centred and seeks to eradicate poverty through empowerment of people especially the disadvantaged, notably women and children. South Africa embodies these ideals in its policies of Reconstruction and Development Programme - (RDP) (White Paper on Reconstruction and Development Programme, 1994). The thrust of the developmental approach is to promote the well-being of individuals and families so that they can experience change in their lives and become self-sufficient through empowerment and capacity building. This approach will equip disadvantaged families and communities with the necessary skills for development and survival.

Social development is based on the values of human dignity and respect, equality and social justice for all, which underpin human relationships. In African societies, a value that underpins all human relationships is 'ubuntu' (African Humanism) which epitomises mutual caring and affection, and the expression of the worth and the dignity of people through respectful, responsible relationships with one another (Tshabalala, 1991). In the simplest sense, 'ubuntu' can be referred to as 'African Humanism' encompassing values like 'universal brotherhood for Africans', "sharing, treating and respecting other people as human beings" (Khoza, 1995:2). "It is the belief in the centrality, sacredness, and foremost priority of the human being in all our conduct and throughout our lives" (Vilakazi, 1991:7). "It highlights qualities and characteristics of warmth, kindness, empathy, trust and honor" (Tshabalala, 1991:17). The gist of 'ubuntu' is that people should be concerned about the welfare of others and develop their communities through empowerment and capacity-building programmes that will lead to sustainability.

CONCEPTUAL FRAMEWORKS

The relationship of poverty and AIDS can be looked at from two angles:

http://dx.doi.org/10.15270/41-4-317

- Firstly, the consideration of poverty-related factors which impact negatively on the family's and community's coping capacities;
- Secondly, the processes through which the experience of HIV/AIDS by families and communities lead to an intensification of poverty (Cohen, 2005). The resources the people have, diminish their experience of the pandemic. Cohen (2005) maintains that this is mostly prevalent in urban areas.

For the purpose of this study, the researcher will consider the first one.

In 1997, sub-Saharan Africa was home to 21 million people, notably the socially and productive age-group of 15-45, who are living with HIV (Cohen, 2005), and the situation has been reported as getting worse over the next decade (Unicef, 2005). Commitments by African leaders were made at a UN General Assembly Special Session on HIV/AIDS held in 2001 that governments should develop national policies to address the pandemic. A follow-up was held in 2002 as Eastern and Southern countries convened for a meeting in Windhoek to address the plight caused by the pandemic especially on children. A report tabled indicated that children infected/affected by the pandemic were malnourished, could not afford medication, experienced low levels of education with associated low levels of literacy, and women and young girls were vulnerable to sexual abuse and choose prostitution in order to fend for their families (Unicef, 2005). These effects, if not addressed with the urgency they deserve, could lead to a culture of poverty, as lack of skills will be handed down to the next generation. This issue will be discussed later.

Nationally, an assertion made by the President of the Republic of South Africa, Mr Mbeki, and endorsed by the Minister of Health, Dr Tshabalala-Msimang, that there is a relationship between HIV/AIDS and poverty, lured the researcher to become inquisitive and to test that hypothesis. In an article on 'AIDS strategies are working' which appeared in the 'Daily Dispatch' on August 13, 2002, the health minister quoted poverty, and gender inequality, as the "...main factors that cause women to be more exposed to HIV infection and to succumb to AIDS quickly" (Daily Dispatch, 2002:2). This assertion has been endorsed by other national and international researchers, for instance, an UNAIDS spokesperson commented during a meeting with SADC countries on the pandemic, that "...people across the region keep saying to us that food is the first and best drug against HIV/AIDS" (Daily Dispatch, 2002, November 7:2). It is on the basis of this relationship that this study was borne.

The researcher found no conceptual framework enunciated by scholars on the relationship between poverty and HIV/AIDS. This study is therefore influenced by two theories of poverty propounded by structuralists (Della Fawa, 1980 in O'Neil, 1992; Lewis, 1966). A theory of poverty espoused by the structuralists put blame on society for the deprivation of the disadvantaged. The poor are handicapped by a lack of resources such as, for example, schools, clinics, housing, recreational and transport facilities, adequate amenities. Society fails to provide the infrastructure and resources that are necessary for human living (Della Fawa, 1980 in O'Neil, 1992).

Another set of theorists, Jordan (1974) and Coffield, Robinson and Sarsky (1980) both in O'Neil (1992), perceive poverty as maintained by the welfare system. The welfare system is structured in such a way that it does not assist people to break the cycle of poverty; it barely keeps them alive. Means tests are applied in such a way that only the very destitute receive grants that put them below the minimum level of subsistence. Thus, the cycle of poverty continues from generation to generation and this process may lead to an evolution of a culture of poverty (Coffield *et al.*, 1980 in O'Neil, 1992).

http://dx.doi.org/10.15270/41-4-317

The culture of poverty is a conceptual model, with its own structure, that describes a way of life handed down from one generation to the next along family lines (Lewis, 1966). In terms of this model, the "...dominant class asserts a set of values that prizes thrift and the accumulation of wealth and property and explains low economic status as a result of individual personal inadequacy and inferiority" (Lewis, 1966:394). It also attributes poverty to failure of society to provide political, economic and social organisation for the poor. Chronic unemployment and underemployment, low wages, gross underdevelopment, lack of property, lack of savings, absence of food reserves at home and chronic shortage of cash are all characteristics of the culture of poverty that can imprison both the family and the individual in a vicious circle. This perpetuates rather than eliminates poverty (Lewis, 1966:394). The culture of poverty is a "...reaction of the poor to their marginal position in a class-stratified, highly individuated, capitalistic society" (Lewis, 1966:394). Poverty in the context of this research study was borne out of a multiplicity of factors, including issues related to underdevelopment, unemployment, and inadequate family allowances that are below the poverty datum line of subsistence and lack of resources to address the plight of the Transkeian society. In South Africa, there is a paucity of literature on the HIV/AIDS pandemic. One of the main reasons for this is lack of openness on the part of those who are HIV/AIDS infected and affected. A few resources, in the form of internet sources, journal articles, newspaper cuttings and paper presentations, that were gleaned by the researcher provided general information on the pandemic and nothing on a conceptual framework to understand those living with HIV/AIDS and to offer care and support in a holistic manner.

AIMS OF THE STUDY

The overall aim of the study was to establish whether there is a relationship between HIV/AIDS and poverty in the Transkei region of the Eastern Cape. Specifically, it aimed at:

- establishing the extent of poverty of people who are HIV/AIDS infected and affected,
- how they are coping in their poverty-stricken environments and
- how those affected can be assisted and supported.

RESEARCH DESIGN AND METHODOLOGY

Mouton (2001) compares a research design to a house plan which explains how one intends 'building a house' (conducting the study). The design of this study will be exploratory in nature as De Vos (2000) explains that the researcher will be seeking to gain insight into a situation within a community. The study was conducted during the harvest season making it difficult for some women to present themselves to the clinic for interviewing. The researcher therefore did not reach the target number of 150. Only 90 respondents, 30 from each administrative area, whose family members were HIV/AIDS infected, were interviewed for the study. A questionnaire was used to collect biographical information and since this was a 'sensitive' area of research, a carefully-worded semi-structured interview guide was the main 'instrument' used to collect data from the respondents. This is a quantitative study that seeks to endorse or refute the hypothesis that there is a relationship between HIV/AIDS and poverty.

Ethical issues such as informed consent, confidentiality and voluntary participation in the study were adhered to (Neuman, 1994). Respondents were given forms to complete and return to the researcher, in order to ensure that informed consent was obtained.

http://dx.doi.org/10.15270/41-4-317

Profile of respondents

The study was conducted in three health clinics at EMbekweni (Viedgesville), EMhlakulo (Tsolo) and EBaziya (Engcobo) administrative areas of the Transkei. These health facilities have pregnant women who present themselves to the clinics for HIV/AIDS testing and counselling and, who were used as respondents for this study. The sample consisted of 90 women (30 from each clinic) who had an HIV/AIDS infected family member, usually a child. The age-range of the respondents was 18-45, all whom came from the rural areas situated within a radius of 100 kilometres from Umtata. Limitations of time and transport as well as a shortage of staff at the university prevented the researcher from going beyond this radius. The characteristics of these areas are: poverty, high levels of unemployment, lack of agricultural resources, landlessness, inadequate housing, poor quality of education and school facilities and a very low degree of social security benefits (Mpambani, 1994).

Research tools

According to Tutty, Rothery and Grinnell (1996), three major types of interviews can be used by researchers. These are:

- Structured or standardized interviews which use a common interview schedule that contain specific questions. The rationale of these interviews is that they offer all interviewees the same set of questions so that each person's response can be compared with other participants' responses. These interviews are generally used in comparative studies.
- Unstructured interviews, sometimes referred to as open-ended interviews. Here the researcher must generate questions that are appropriate to a given situation as well as the central purpose of the study.
- Semi-structured interviews which are in between the two extremes of interviews. In this case there are usually some predetermined questions or key words that are used as a guide.

For the purpose of this study, the researcher used semi-structured interviews.

This is an exploratory study in which a carefully-worded semi-structured interview schedule was administered by the researcher to the respondents. In addition, a questionnaire was administered to collect biographical information of the respondents.

Data was analysed using the SAS programme.

Results of the study

The results of the study revealed that HIV/AIDS infected people generally come from large families. Of the 90 respondents that were interviewed for the study, 36 (40%) of them have between 5 and 8 family members; another 36 (40%) families have between 8 and 10 members, and the remaining 18 (20%) have more than 10 members in a family. Only 27 (30%) respondents were employed, the rest of them 63 (70%) were unemployed. Those who were employed, either as domestic workers (16%), or as vendors (10%), were earning below the level of subsistence, as determined by the Institute for Research and Planning at the then University of Port Elizabeth (South African Institute of Race Relations, 1994/5). The remaining 4% makes a living through selling plastic papers. Of the 90 families interviewed, 42 (47%) were female-headed, with no families to support them in caring for the HIV/AIDS infected person. Only 31 (34%) respondents were living with their parents at the time of the investigation. The remaining 17% were living with their partners who were not assisting them in caring for the infected family member. The study

http://dx.doi.org/10.15270/41-4-317

highlighted that 81 (90%) families lived on child support grants. More than half of the respondents had children from 1 to 3 years of age and all of them reported that they could not afford a balanced diet for their children. Only 27 (30%) could afford to buy immune system boosters for the HIV/AIDS infected family members, who were mostly children.

DISCUSSION OF RESULTS

A glaring feature of this study is that HIV/AIDS infected and affected people come from large families, a substantial percentage of which consists of single mothers. The majority of these families are unemployed and live on child support grants as means of 'coping' with their desperate financial situation. The wages of the few employed as domestic workers and as vendors are far below the poverty datum line of subsistence as determined by the Institute for Research and Planning at the then University of Port Elizabeth. This places a huge responsibility on the few employed families and the self-employed family members who have to shoulder the basic necessities for the whole family.

Another glaring feature of this study is the high percentage (90) of families that are living on child support grants, an indication that there is no other source of income for these families and that the families are extremely poor with the majority of them not affording a balanced diet for their children. This, by implication, means that the government should raise their social grants to, at least, the level of subsistence. There is a great need on the part of the government to develop a new policy framework that vigorously seeks to address the plight of disadvantaged families in the Transkei (Kuse, 2001), especially to those infected and affected with HIV/AIDS, and to provide care and support to them. Lack of support from their kith and kin can also be attributed to, inter alia, the very poverty-stricken conditions of these families.

From the foregoing discussion, it would seem that the assertion made by the President, which forms the basis of this study, that there is a relationship between HIV/AIDS and poverty, is endorsed in this area. The high levels of unemployment coupled with female-headed families with no families to support them, and no support from their partners, leading to almost total dependency on child support grants are an indication of the plight of disadvantaged families in the Transkeian communities.

There is a great need to revisit our indigenous values, notably ubuntu, in order to vigorously address the plight of AIDS sufferers in terms of providing the necessary support. As stated earlier on, Ubuntu can be referred to as 'African Humanism.', "...treating and respecting other people as human beings" (Khoza, 1994:2).

Dhlomo (1991:50-51) asserts that adopting ubuntu as the philosophy of life will present the following advantages to our families and communities.

- Ubuntu is an indigenous, purely African product. Thus, if African families and communities develop it into a respectable philosophical framework that is pragmatic, they will be perfecting their own indigenous product that will have a lot to contribute to their development;
- Ubuntu takes cognisance of the fact that every person is a social being who can only realize his beingness (uBuntu) within the context of other human beings ('Umntu ngumntu ngabany'abantu');
- Ubuntu is a philosophy of tolerance and compassion. It does not give up on people ('Umntu akancanywa'). It also embraces an element of forgiveness;

- Ubuntu is a non-racial philosophy which regards all people as equal and treats them as human beings;
- Ubuntu has a democratic connotation that centers on the human being. It grants a person the right to pursue and realise the promise of being human. Thus, the democratic ideals of granting every citizen and his family the right to life, liberty and happiness will be achieved with the adoption and application of the philosophy of ubuntu.

In addressing the needs of AIDS sufferers, social workers should develop a 'holistic' multi-faceted approach at all levels of their professional intervention. Social workers have been criticised for not being fully equipped in terms of knowledge and skills in order to address the complexities of dealing with AIDS sufferers. One of the fundamental roles of social workers in addressing the AIDS pandemic should be disseminating skills, knowledge and attitudes to various professional bodies and they need to be fully trained and equipped in order to execute this responsibility. Further, it would be advisable to conduct an assessment of the extent and nature of AIDS related education in South Africa not only for social workers but also for other semi-professionals who are involved with the pandemic. Demmer (2004) believes that such a survey should "...examine their perception of what would be appropriate preparation for this work, their perceptions of their own competence in assisting clients affected by HIV/AIDS, and it could explore their training needs as well as suggestions for enhancing the role of the social work profession in dealing with the HIV/AIDS pandemic in South Africa"(Demmer, 2004:308).

CONCLUSION

The relationship between HIV/AIDS and poverty, which so far has been endorsed by the results of this research study, will bring a new perspective about the pandemic in South Africa, and also in the developing countries of the global village. HIV/AIDS in South Africa will be viewed from a socio-economic-environmental perspective in terms of understanding, caring and intervening in the lives of people living with HIV/AIDS. The contextual realities of those who are HIV/AIDS infected and affected will have to be taken cognisance of in order to come up with an effective intervention programme. Further, the results of this study will assist policy makers in formulating the kind of policies that would address the plight of disadvantaged families in South Africa.

BIBLIOGRAPHY

COFFIELD, F. ROBINSON, P. & SARSKY, J. 1980. **A cycle of deprivation: a case study of four families.** London, Heinemann.

COHEN, D. 2005. **Poverty and HIV/AIDS in sub-Saharan Africa.** Available: http://www.undp.org/hiv/publications/issues/english/issue27e.html

CRAGG, C.D. 1984. **Estimated household subsistence levels for Transkei urban and rural areas.** Carnegie Conference paper No. 44, Cape Town, Saldru.

DEMMER, C. 2004. AIDS and bereavement in South Africa. **Social Work/Maatskaplike Werk**, 40(3):296-318.

DE VOS, A.S. 2002. **Research at grassroots: for the social sciences and human professions.** Johannesburg, Van Schaik Publishers.

DHLOMO, O.D. 1991. **Strategic advantages that can be derived from uBuntu.** Paper presented at a one-day seminar on 'Incorporation of uBuntu', Pretoria.

http://dx.doi.org/10.15270/41-4-317

GABADA, N. 2002. **Awareness and knowledge of Unitra women workers about HIV/AIDS.** University of Transkei. (MA dissertation)

GRAY, M**.** 1997. A pragmatic approach to social development. **Social Work/Maatskaplike Werk**, 33(3):210-213.

KHOZA, R. 1994. **Ubuntu: Botho, Vumunhu, Vhuthu: African Humanism.** Johannesburg, Ekhaya Publications.

GRINNELL, J.M. 1981. **Social work research and evaluation.** Illinios, F.E. Peacock Publishers.

KUSE, T. T. 2001. **Family functioning and street children in the Transkei**. Johannesburg: University of the Witwatersrand. (PhD thesis)

LEWIS, O**.** 1966. Culture of poverty**. American Psychologist**, 215:4.

MOUTON, J. 2001. **How to succeed in your masters and doctoral studies?** Johannesburg: Van Schaik Publishers.

MPAMBANI, S.A. 1994. **Poverty profile of the Transkei region.** Johannesburg: Southern Africa Labour and Development Research Unit.

NDUDANE, N. 2000. **The Impact of HIV/AIDS on Family Life and Child Care in Transkei with special reference to Three Magisterial Districts: Umtata, Mount Frere and Lusikisiki.** (MA dissertation)

NEUMAN, W.L. 1994. **Social research methods: Qualitative and quantitative approaches** (2nd ed). Boston: Allyn and Bacon.

O'NEIL, M**.** 1992. Theoretical considerations regarding intervention in the area of poverty**. Social Work Practice,** (3):5-7.

POVERTY AND INEQUALITY IN SOUTH AFRICA. 1998; **Report prepared for the Office of the Executive Deputy President and the Inter-Ministerial Committee for Poverty and Inequality**, May 13.

PROMOTION OF RURAL LIVELIHOODS 1999. **A proposal for a Pilot Programme in the Eastern Cape**, October.

RANKIN, P. 1997. Developmental social welfare: Challenges facing South Africa. **Social Work/Maatskaplike Werk**, 33(3):184-192.

RSA 1994. White Paper on **Reconstruction and Development; Government Strategy for Fundamental Transformation**. 1994; Inaugural address to a Joint Sitting of Parliament, May 24.

RSA 1994. White Paper on **Reconstruction and Development**. 1994; Gazette No. 16085, Notice No. 1945 Cape Town, 15 November.

SIMONS, M. 1984. **Poverty and powerlessness: the politics of inequality.** Carnegie Conference Paper. Cape Town: Saldru.

SOUTH AFRICAN INSTITUTE OF RACE RELATIONS, 1994/95.

STATUTES OF THE UNION OF SOUTH AFRICA, 1950. **Population Registration Act no.30 of 1950.** Parow: CP Government Printers:279-299.

STATUTES OF THE UNION OF SOUTH AFRICA, 1950. **Group Areas Act no. 41 of 1950.** Parow: CP Government Printers:407-469.

http://dx.doi.org/10.15270/41-4-317

STATUTES OF THE UNION OF SOUTH AFRICA, 1953. **Reservation of Separate Amenities Act no. 49 of 1953.** Parow: CP Government Printers, 1953:328-330.

TSHABALALA, M. 1991. **Multi-cultural social work practice: alternative options for social work practice in South Africa.** Paper presented at Albion College, Michigan.

TSHABALALA-MSIMANG, M. 2002. Aids strategies are working, **Daily Despatch**, 13 August:2.

TUTTY, L.M; ROTHERY, M.A. & GRINNELL, R.M. 1996. **Qualitative research for social workers: phases, steps and tasks.** London, Allyn and Bacon.

UNAIDS, 2002. SADC meeting. **Daily Despatch**, 7 November:2.

UNAIDS/UNICEF / WHO. 2003. **AIDS has become Africa's biggest challenge.** July 10.

UNAIDS, 2003. **Joint Report Details Escalating Global Orphans Crisis Due to AIDS.** July 10.

UNICEF, 2005. **Children orphaned by HIV/AIDS.** July 3.
Available: http://www.unicef.org/newsline/02pr64windhoek.htm

Professor Thobeka Mashologu-Kuse, Department of Social Work, Nelson Mandela Metropolitan University, Port Elizabeth, South Africa.