Segal and Yahraes (1979:259) argue that "in some families -- notably the poor -- the demands and expectations of society at large may conflict with the realities of their lives. The result is often enormous stress, and children are likely to be among the vulnerable victims". They emphasise that parents who are poor are not less concerned about their children. They are simply over-burdened by life's conditions which severely limit the parents in their ability to provide the child with physical protection, food, emotional nurturance and intellectual stimulation (Bronfenbrenner, Goodson and Hess, 1974; Keniston, 1975).

6.2.1.1 Parental Capability

The mothers in both Case and Control groups lived under conditions of relative poverty, but as indicated in section 5.1, the extent of impoverishment was more severe in the Case group. As a result of their more extreme impoverishment, it appears that Case mothers may have been exposed to greater stress and frustration than Control mothers. Since the degree of stress and frustration is directly related to parental capability, it seems that Case mothers were more limited in their child-rearing roles. The findings on maternal characteristics substantiate this, especially in terms of the differences between Case and Control mothers (their alcohol consumption and social support systems). The contrasting profiles of Case and Control mothers will be discussed in section 6.3.

An example of the limits imposed on the Case mother's parental capability, is that economic necessity was more likely to force her to seek or resume employment before the child was 4 months old, compared with Control mothers who tended to go back to work or school when the child was more than 4 months old. Thus, significantly more Case children had been cared for by a care-giver other than the mother, from a younger age than Controls (see section 5.2). This finding may be explained in terms of the deprivation-based model:
A mother's absence from home due to employment is regarded as a form of maternal deprivation, which has negative effects on the child, e.g. the child's malnourished nutritional status (Bowlby, 1972). The deprivation-based model, however, has been critically questioned by Kamerman (1982), Barling and O'Leary (1983), Marks (1986) and others. These writers challenge the concept of maternal employment being considered as a mere dichotomy between mothers who work and those who stay at home with their children. Bronfenbrenner and Crouter (1982) suggest that the structure and content of work might

indeed be significant for the mother's role as parent. Hence, what needs to be examined is not the fact that mothers work, but rather whether or not mothers enjoy, feel stimulated by, and are benefiting from their work (Hoffman, 1961; Hoffman, 1974, 1979).
It should be noted that a similar percentage of Case and Control mothers worked or attended school and consequently did not care for the child themselves (see section 5.3.4). It is thus important to assess the quality of mother-child interaction and not the amount of time that the mother spent with the child.

6.2.1.2 Capability of the Child-minder

It is necessary to analyse the quality of care that the child received when the mother was at work, and not the fact that the child was cared for by someone other than the mother. Cross-cultural studies suggest no harmful effects of multiple mothering (i.e. mothers replaced by other adults), even in samples where infants were younger than 4 months old when they were separated from their mothers (Leiderman and Leiderman, 1974; Kagan, Kearsley and Zelazo, 1978). However, the care-givers in these studies were competent, nurturing women and there were sufficient material resources to provide for the child's physical needs. There is no indication that the standard of care-givers in the present study, especially of those in the Case group, were comparable to the care-givers in the above-mentioned studies. The predominant form of child care among the sample of working/school-going mothers in the present study was provided by the extended family (in particular older female adult relatives). Cases tended to use extra-familial care such as neighbours, servants and a creche, to a lesser extent than Controls. Nearly all the child-care arrangements were provided by the Soweto working class community. Cock, Emdon and Klugman (1984) note that members of this community had not received any training in child-care practices, and were often ill-equipped for the task.

The options of child-care arrangements in Soweto are severely limited (see section 3.5), and mothers were forced to rely on the people most accessible to them. These were the people within the mother's immediate socio-economic environment, e.g. the extended family. Case mothers were more impoverished than Controls and it would seem likely that Case child-care arrangements were less adequate than Controls. This fits in with the mothers' feelings towards their child-care arrangements: significantly more Case than Control mothers would have liked to change the way the child was being cared for i.e. to care for the child themselves or to find a good child-minder/creche.

An explanation for Case children spending significantly less time per day with the care-giver than did Control children, (see section 5.2.1.2) may be that Case care-givers were not able to take the children for longer hours. Most of the child care-givers (73% of Cases and 66% of Controls) were 50 years old or more. This is in agreement with Cock, Emdon and Klugman's (1984) findings that the average age of the care-givers they interviewed in Soweto, was 61 years old. They also discovered that many of the care-givers were sickly, "having spent a long, physically exhausting life in wage labour. Almost half (47%) [of their sample] had come into child minding through illness or having experienced stress in previous employment" (Cock, Emdon and Klugman, 1984:86). This probably parallels the situation of some of the care-givers in the present study.

It would appear that the quality of the care-givers in the Case group (and in the Control group, but to a lesser extent), was restricted by the limitation on their energy imposed by age, stress and possibly by illness, as well as by the inadequate facilities in the care-givers houses. As Cock, Emdon and Klugman (1984:86) write:

> These stark and almost Dickensian conditions must be qualified by the personal attributes of the childminder herself. The women who mind children are not a homogeneous group of people and childminding should not be characterized in crude, monochromatic terms as either good or bad. While one may find the physical amenities of a particular childminder's house very inadequate, it may be that the childminder herself is a warm, affectionate person who provides a great deal of emotional support, security and stimulation to her charges.

Yet, if these childminders do not have (and are not given) the material resources to feed the child sufficiently, the child will simply become malnourished. The younger the child is when it is put into such an environment, the more vulnerable and susceptible it is to nutritional deficiency. This is clearly evident in the Case group and it occurs not because the child is being cared for by someone other than the mother, but because both the care-giver and the mother are unable to satisfy all the child's basic physical needs.

6.3 Maternal Characteristics

The results of the maternal characteristics investigated reveal contrasting profiles of the Case and Control mothers. The major differences between the mothers in the two groups were related to: the mothers' first language or true home tongue; their drinking habits; and their social support systems. The major similarities between the mothers of the two groups were related to: the mothers' age; their level of formal education; their employment status and work histories; and their reproductive histories. As mentioned in section 5.6, these similarities demonstrate a degree of comparability between the two groups.

6.3.1 Age

The mean age of the mothers in the Case (25,9, SD 6,6) and Control (26,7, SD 5,8) groups was not significantly different. This does not support the findings of some studies in developing countries, which reveal that childhood malnutrition is more frequent among children of very young mothers (Antcobus, 1971; Baxi, 1957; James, 1976; Swenson, 1981, 1984). The 'older' age of mothers in the present study may be related to factors such as the intensive national family planning campaign (see section 6.3.2), and the mothers' relatively high level of education (see section 6.3.3).

6.3.2 Reproductive Factors

Researchers have indicated relationships between various maternal reproductive factors and child malnutrition. These maternal reproductive factors include: the interpregnancy interval to the subsequent pregnancy; the birth order of the child; and the mother's history of previous child and foetal deaths (Antcobus, 1971; James, 1976; Wolfers and Scrimshaw, 1975; Swenson, 1981; Chen, 1974).

Contrary to the findings of other studies, the results of the present study do not support these associations. The overall reproductive histories of Case and Control mothers showed similarities rather than differences between the two groups (see section 5.1.2, table 5 and section 5.3.6, table 16). Possible explanations for this discrepancy are: a raised standard of

health among the mothers; the mothers' relatively high level of schooling; and the effect of the intensive national family planning campaign.

A national family planning campaign resulted from the report of the Science Committee of the Presidents Council on "Demographic Trends in South Africa": the government established a "Population Development Programme". The specific objectives of this programme are:

- to stabilise the population at 80 million by the year 2100;
- to accelerate social and economic development in order to achieve parity in the development levels by the middle of next century;
- a total fertility rate of two children per women; and
- orderly spatial distribution.

(Dr. van der Merwe in the South African Institute of Race Relations, 1984:716).

It should be noted that many Blacks have reservations and suspicions about the motives of this programme (see South African Institute of Race Relations, 1984:716).

6.3.3 Education

The level of education of Case and Control mothers was not significantly different. Standard Six was the median education level in both groups. This level of schooling is higher than the average for the Black population[1] This discrepancy is expected because of the tendency for people with higher schooling to make more use of community medical facilities (the setting of this study).

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1 Marais and Fridjhon (1986:149) calculated that the median level of schooling for the economically active Black population was standard 2. This figure includes rural Blacks.

6.3.4 Language

In terms of the mothers' true home tongue or first language, significantly more Cases than Controls indicated Sotho, and significantly fewer indicated Zulu. However, the languages spoken most often by both groups at the time of the interviews were more comparably distributed (see section 5.3.2).

The present study yielded insufficient data regarding the relationship between language and socio-cultural practices. Therefore, any suspicions of such a relationship could not be confirmed.

6.3.5 Drinking Habits

Significantly more Case than Control mothers drank alcohol. However, there was no indication that these mothers had drinking problems (see section 5.3.8).

The use of alcohol can be explained by examining its physiological effects, together with psychological and social situational variables (Wilson, 1978; Washburne, 1956; Bolon, 1979).

Studies of alcohol and its properties have, until recently, been dominated by a quasi-disease model of psychopathology. This 'medical' model focuses, almost exclusively, on physiological and pharmacological effects of alcohol. (Jellinek, 1960; Kessel and Walton, 1965; Tarter and Sugerman, 1976; Bolon, 1979). From this model, we learn that alcohol is a potent drug that has a profound influence primarily on the nervous system. "A small amount of alcohol can result in changes in an individual's mood and behaviour, and as the concentration of alcohol in the blood increases, there are correspondingly more serious effects" (Lauer, 1978:122). A drinking problem implies the use of alcohol with adverse psychological, social, occupational or physical consequences which can be directly attributed to the alcohol (Camberwell Council on Alcoholism, 1980).

Regular and excessive alcohol consumption may be associated with 'diseases involving almost every organ of the body" (Freund, 1976:171), in particular the central and peripheral nervous systems and the hepatic system (Kissen and Begleiter, 1971-1974; Korsten and

Lieber, 1976). Foetal alcohol syndrome (a characteristic set of physical and mental defects) may occur in infants of women who drink excessive amounts of alcohol in early pregnancy (Clarren and Smith, 1978; Hanson, Jones and Smith, 1976; Jones and Smith, 1973; Camberwell Council on Alcoholism, 1980).

The mothers in the present study who did drink, were social drinkers and it is therefore unlikely that they drank excessive amounts of alcohol in early pregnancy.

The psychological effect of alcohol in the blood stream is a sense of release from tensions and inhibitions. (Lauer, 1978; Isbell, Fraser, Wikler, et al, 1955; Zwerling, 1959, Kessel and Walton, 1965; Ullman, 1962). This tension-reduction hypothesis posits that individuals "drink above all to escape or avoid conditioned anxiety generated by social stress" (Nathan and Lisman, [illegible]). Further, female drinkers differ from their male counterparts with regard to the patterns and consequences of their drinking (Beckman, 1[illegible] Corrigan, 1974; Tr[illegible]nd Nathan, 1976; McConville, 1983). For instance, women drinkers have reported that they drink primarily to relax and forget their problems (Beckman, 1975) and to enhance their feelings of womanliness (Wilsnack, 1974).

It has already been established that Case mothers were surrounded by greater stress than Control mothers. Although Case mothers possibly used alcohol as a means of relieving their stress, a review of the literature does not demonstrate any significant differences in personality characteristics between alcohol drinkers (including alcoholics) and non-alcohol drinkers (Freedman, Kaplan and Sadock, 1972; Masserman, 1963, NIAAA, 1972; Sutherland, Schroeder and Tordella, 1950; Syme, 1985).

Yet, various personality characteristics have been associated with individuals who use alcohol. Clinicians, journalists and other non-professionals in the field frequently describe the alcohol user and abuser as being "maladjusted, emotionally immature, socially isolated and poorly integrated; as lacking impulse control, having difficulties coping with frustration or tension, and suffering from feelings of unworthiness, guilt and depression" (Hoffman, 1976; 310-311).

It was beyond the scope of the present study to assess the personalities of Case and Control mothers, but some of the above-mentioned characteristics appear to 'fit' the Case mother: e.g. Case mothers did not seem to be well-adjusted to the urban area of Soweto,

and their social support systems were not as developed as the Control mothers': they seemed more socially isolated.

It is difficult to determine whether these personality characteristics developed because of the mothers' inherent traits or because of her social situation. Louw (1974:41) states that:

> urbanisation, industrialisation and deculturisation inevitably give rise to tensions, social pressures, frustrations and boredom which are fertile ground for the growth of alcohol use and alcoholism... the radical involvement of the Black population in these processes and the full availability of all forms of alcohol have given rise to an alcohol problem of disquieting proportions.

On 24 October 1982, the Star newspaper estimated that "half of South Africa's work-force of 8 665 700 were consumers of alcohol". Despite the well-recognised influence of social conditions on alcohol consumption, "it is with regard to social conditions that alcohol research has been especially deficient". (Bolon, 1979:5).

6.3.6 Social Support

The social support systems of Case mothers were largely restricted to female relatives, compared to Control mothers whose social support systems included males and groups within the community i.e. voluntary associations such as women's groups and churches, and involvement in group leisure activities such as group-related hobbies (see section 5.3.9).

Social support is a widely used concept that has acquired a variety of definitions (Thoits, 1982a; Specht, 1986; Gottlieb, 1981). Cobb (1976) defines social support as information leading the individual to believe that he or she is cared for and loved, esteemed and valued, and a member of a network of communication and mutual obligation. Cobb's socio-emotional conceptualization of support has been extended to include interpersonal transactions which involve emotional concern, instrumental aid, information, and/or appraisal between people - i.e. support that builds an individual's self-help or coping capabilities (House 1981; Hamburg and Killilea, 1979; Thoits, 1982a; Kahn and Antonucci, 1980; Camasso and Camasso, 1986). Marks (1986:37), in summarising House (1981), describes these different types of support as follows:

- emotional support refers to the provision of empathy, caring, love, and trust;

- instrumental aid refers to behaviour which directly helps the person in need;

- informational support refers to the provision of information that the person can use to solve problems; and

- appraisal support refers to the transmission of information relevant to self-evaluation.

The protective or moderating effect of social support has been highlighted in a number of studies (Gore, 1978; Cassel, 1976; Eaton, 1978; La Rocca, House and French, 1980; Henderson, Byrne and Duncan-Jones, 1981). For example, strong family ties and family cohesiveness (seemingly absent in the Case group) have been found to reduce levels of anxiety, depression and physical complaints (Camasso and Camasso, 1986, Gore, 1978; Mitchell and Moos, 1984; Kaplan, Robbins and Martin, 1983). Support from extrafamilial sources, specifically, neighbourhood ties, social club attendance and church attendance (also lacking in the Case group) has been found to be "negatively related to psychological distress" (Camasso and Camasso, 1986:380, supported by La Rocca, House and French, 1980; House, 1981; Williams, Ware and Donald, 1981). According to Cobb (1976) and Cassel (1976), social support protects the individual by activating his/her coping and problem-solving mechanisms, i.e. emotional nurturance may help individuals to mobilise their psychological resources, and tangible aid, information and guidance may heighten the individual's skill to contend directly with the stressful situation.

Supportive structures in the environment (i.e. a social network) must be present for an individual to have access to social support (Procidano and Heller, 1983). A considerable amount of evidence strongly suggests that both stressful events and the social resources needed to cope with these stressors are distributed unequally across social groups: the disadvantaged social classes experience greater life stress but have access to relatively fewer social supports (Camasso and Camasso, 1986; Thoits 1982b; La Rocca, House and French, 1980; Henderson, Byrne and Duncan-Jones, 1981; Cronkite and Moos 1984). Furthermore, in the 'lower' classes, high levels of stress cause a weakening in the already low levels of available support because the support network becomes completely overwhelmed (Turner, 1981; Van Tran and Wright,Jr., 1986). Being surrounded by a social network is only part

of having access to support. "If one possesses friends, family, and a circle of associates, one is not necessarily the automatic beneficiary in times of trouble" (Pearlin et al, 1981:340).

Social support is a complex phenomenon and its effects are contingent on the presence of a social network, the mobilization of support from this network and the individual's subjective perception of social support (Holahan and Moos, 1983; Procidano and Heller, 1983; Thoits, 1982a).

Case and Control mothers overwhelmingly came from the 'lower' classes, but within this, Case mothers were further disadvantaged. The greater impoverishment of the Case mothers appeared to limit their social network and the mobilization of support from this network. Case mothers are in a somewhat paradoxical situation: Social support systems seemingly facilitate the process of social and economic adaption into society by providing appropriate informational resources as well as tangible and emotional supports; and yet to become a recipient of such social support, one must have already achieved some level of social and economic adaption. It is likely, then, that Case mothers were often not well-adjusted to the urban setting.

6.4 Nutritional Practices

6.4.1 Dietary Patterns

The dietary patterns of the child followed those of the household. Both household and child Cases ate significantly less protein, less kilojoules and less fruit than did Controls. The Case-child's diet was grossly deficient (whereas the Control child's diet was generally adequate) in terms of the child's protein energy requirements (see section 5.4). Thus, it would appear that an undernourished household is likely to have an undernourished child.

Dietary patterns may be viewed historically in terms of the process of urbanisation. The diet of the Black population has undergone major changes with the immigration from rural to urban areas (see Finklehor, 1978; May and McLellan, 1971; Walker 1961, 1966; Webster, 1981). Urbanised Blacks have abandoned many of their traditional dietary practices, which were often deficient. The diet of the urban Black "consists primarily of maize, bread and

increased amounts of sugar. Meat may be eaten three or four times a week and children drink milk" (May and McLellan, 1971). The findings of the present study confirm this, where the quantities of these foods differed between the Case and Control groups. Fruit, however, was eaten by significantly fewer Cases (households and children) than Controls. Finklehor (1978:15) states that "the poor diet of the urban Black is influenced by the social and economic constraints imposed on this population". Finklehor (1978) argues that the food resources in South Africa are sufficient to adequately feed its entire population, but that the unequal distribution and consumption of available foods leaves many people without enough to eat.

6.4.2 Breastfeeding and Weaning Practices

Some of the dietary consequences of urbanization in the Black population have been identified by Walker (1961), Griffiths (1962) and May and McLellan (1971) as:

- a dramatic decrease in breastfeeding;
- infants being weaned at a much earlier age to commercial milk formulae; and
- the weaning foods often consisting of improperly diluted formulae or an inadequate commercial mixture.

The results of the present study indicate that the above-mentioned phenomena were more prevalent in the Case than the Control group. It appeared that the Case child was breastfed for a shorter period than the Control child, and that the Case mother had less breastmilk than the Control mother (see section 5.4.2). The majority of children in both groups (90% of Cases and 84% of Controls) were being fed some type of non-breast milk as a supplement or as an alternative to breastmilk. The Case child however was introduced to the non-breastmilk at an approaching significantly younger age than the Control child (see section 5.4.2.1).

6.4.3 Mothers' Attitude to Nutritional Practices

Case mothers were not aware that their children were underfed (see section 5.4.3). However, the Case child's diet was deficient and the fact that the mothers' did not recognize this may be explained as follows:

Firstly, it is possible that the mothers did actually know that their child was underfed, but that the mothers were ashamed or embarrassed to admit this to the interviewer. This is probably unlikely because there seems to have been a high level of trust and honesty between the interviewer and the respondents.

Secondly, and more feasibly, the mothers may have genuinely believed that their child's diet was adequate. The mothers' ignorance about their child's diet is alarming, since 72% of these mothers claimed to have learned predominantly from clinic or hospital workers about what a child should eat. Hence, the mothers' contact with clinic and hospital workers needs to be examined: Nutritional education should aim to change nutritional practices. This is done through imparting information and persuading the mother to apply her newly acquired knowledge. The mother, however, may not have the material resources to put what she has learned into practice, but such a mother would be aware of whether or not her child was underfed. Thus, the Case mothers in the present study demonstrate that they had not acquired nutritional information, even though they claimed to have been exposed to it.

Nutritional education is provided by the nursing staff at the Soweto Clinics and Baragwanath Hospital. They are highly trained and usually well-meaning, but they tend to be overworked and rushed (Critical Health, 1983). They therefore cannot provide nutritional education in the slow and repetitive manner necessary to achieve retention of the knowledge by the mothers (Critical Health, 1984a). The environment of the clinic and hospital is anxiety-provoking (Eutrym and Horder, 1983). It is also noisy, crowded and filled with activity and distractions. None of the abovementioned factors make for adequate learning conditions (Bryant, 1969).

It is beyond the scope of the present study to investigate the content and nature of the nutritional education provided at the clinic and hospital.

6.5 Medical Aspects

Significantly more Case than Control children had a history of one or more previous hospital admissions and had been hospitalised for a period of two days or longer, rather than just overnight. The Cases appeared to have been hospitalised predominantly for Gastro-Intestinal Pathology, which the mothers call diarrhoea, whereas Controls tended to have been hospitalised for Respiratory Tract Infections, which the mothers called chest problems (see section 5.5.1).

The medical condition of the child in the Case and Control groups at the time of the interview, was congruent with and followed the pattern of their medical histories. Significantly more Cases than Controls were diagnosed by the medical staff at the hospital or clinics as having Gastro-Intestinal Pathology and significantly fewer Cases that Controls were diagnosed with Respiratory Tract Infections (lower and upper) (see section 5.5.2).

6.5.1 The PEM-Infection Cycle

These results point to the generally recognized synergism between PEM and infection, especially diarrhoea (Scrimshaw, Taylor and Gordon, 1968; McLaren, 1981). "The relationship is synergistic because the consequences of malnutrition and infection together are usually greater than would be predicted from studying either alone" (Scrimshaw, 1975b:353).

The mechanisms by which infection worsens PEM and PEM worsens infection have been extensively investigated (Scrimshaw, Taylor and Gordon, 1968; Chandra, 1977; Poston, 1979; Geefhuysen, Rosen, and Katz, 1971), but it is beyond the scope of the present study to discuss these in any detail. Briefly, however, Scrimshaw (1975b:363-364) summarises the cyclical PEM infection relationship as follows:

> Infection contributes to PEM by depressing appetite, by provoking withdrawal of protein foods, by increasing metabolic loss of nitrogen, and often by reducing the digestion and absorbtion of protein. Conversely, even subclinical PEM reduces resistance to infection, although the mechanisms involved are still not entirely clear.

Case children were indeed victims of the PEM-infection cycle. Furthermore, their susceptibility to this cycle was increased by their relatively early use of commercial milk formulae (see section 5.4.2). Rowland (1983:153) asserts that the "exclusively breast-fed infant remains remarkably free of severe diarrhoea, even in situations of low environmental hygiene". The multiple antibacterial and antiviral factors in human milk are not present in commercial milk formulae and the onset of weaning is therefore inevitably associated with increased risks of infection, especially diarrhoea (Poston, 1979, Rowland, 1983). Certainly, an important strategy to break the PEM-infection cycle is to promote breast feeding (Critical Health, 1979; Rowland, 1983). Yet, it is difficult to promote breast-feeding because Black urban working-class women are forced, out of economic necessity, to wean their children early and return to work.

The Case children who were victims of the PEM-infection cycle, had a history of one or more previous hospital admissions for gasto-intestinal complaints (see section 5.5). This indicates that their contact with medical resources is not breaking the PEM-infection cycle. As mentioned in section 3.5.2, Baragwanath Hospital is greatly over-extended, and patients who have survived a critical period of illness, but are not yet fully recovered, may have to be discharged prematurely. This occurs to accommodate new admissions who present with a more severe condition. Since the hospital is struggling to provide a comprehensive curative service, it does not perform an effective preventative role.

The unequal allocation of resources in the present health care system serves to reinforce the emphasis on curative medical interventions (Doyal, 1979; Critical Health, 1984b). The curative based health care service is inappropriate because the majority of Black South Africans undoubtedly need preventative primary health care (de Beer, 1984). This is illustrated by the example of the PEM-infection cycle. Walker-Smith, Hamilton and Walker (1983:81) assert that the events which perpetuate the PEM-infection cycle can be prevented, largely, "by aggressive, early nutritional attention to diarrhoeal illnesses and their sequel". The curative medical interventions do attempt this, but not with the commitment of a preventative service.

Chapter 7. Conclusions and Recommendations

Malnutrition in South Africa exists in Soweto, other urban townships and more so in the so-called 'homelands' and rural areas, primarily as a result of the socio-economic and political system. Inadequate housing; overcrowding; female dominated households; inferior sanitary, health and welfare resources; low wages; and poverty, are the conditions provoked by enforced separate development; restrictions into urban areas; the migrant labour system; and no real participation of Blacks in political decisions (de Beer, 1984; Jinabhai, Coovadia and Abdool-Karim, 1986; Coovadia, 1986; 1987a). The thesis of this research project is contained in this framework. The fact that some families manage to protect against overt PEM within this situation does not detract in any way from the responsibility of the State to alleviate these circumstances.

This study has suggested that rather than poverty per se, major factors contributing to child malnutrition are:

- the degree of impoverishment;
- the breakdown of family structure;
- mothers with limited social support; and
- inadequate child care arrangements.

These characteristics imply a lack of adaptation to the urban setting.

Furthermore, an association was found between PEM and infection, especially diarrhoea.

This research concludes that the above-mentioned factors are of paramount importance and therefore focuses recommendations in these areas. The structure of the discussion in this chapter is presented diagramatically in figure 4 overleaf.

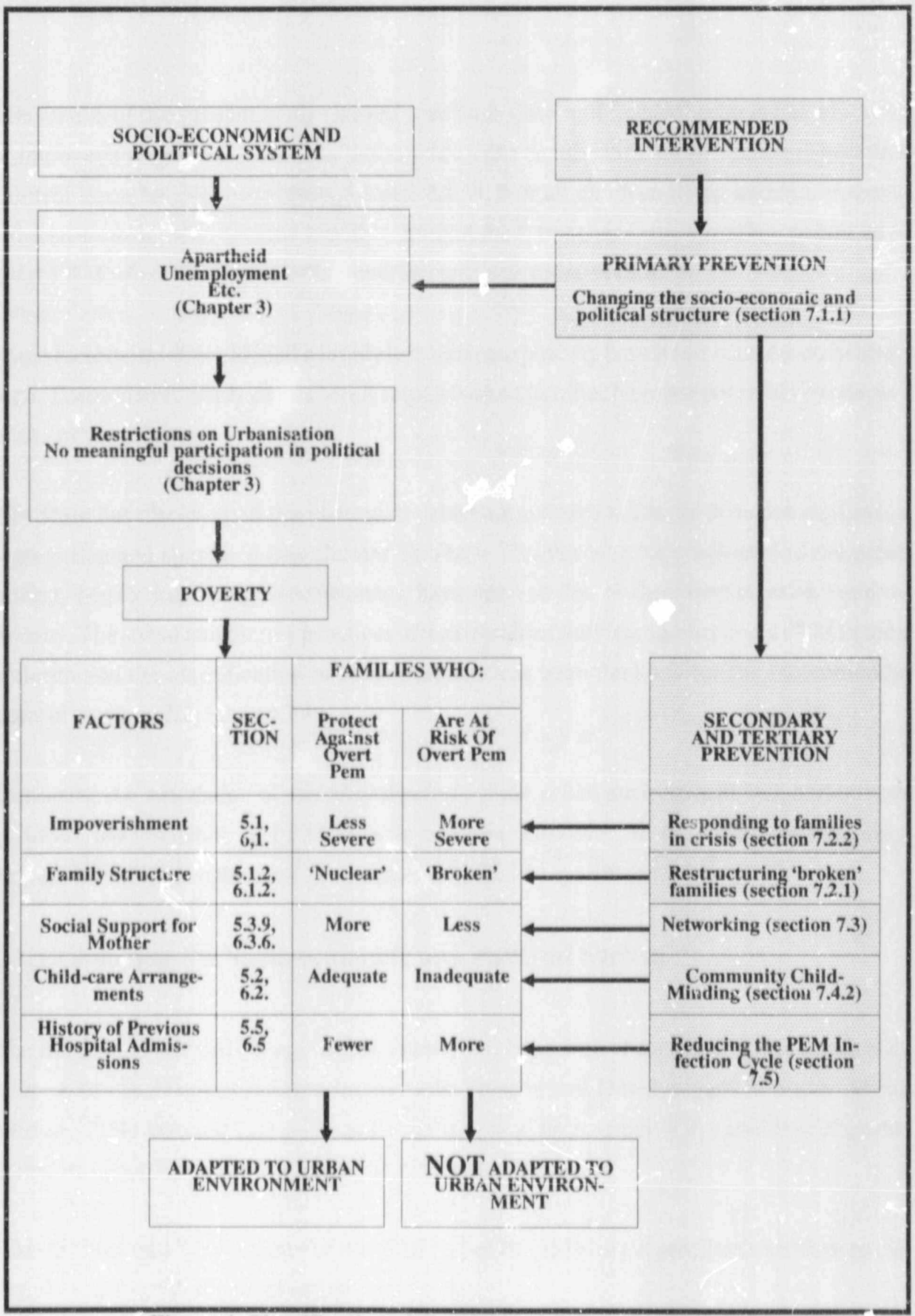

Figure 4. Classification of Conclusions & Recommendations

7.1 Responding to Poverty

The results of the present study showed that both Case and Control groups had elements of impoverishment, but that Case households were significantly more impoverished than Control households (see sections 5.1 and 6.1.1). Not all children living within a poverty-stricken environment became overtly malnourished, but there was a marked presence of overt PEM when the degree of impoverishment was more severe.

Some factors which could lead a family into extreme poverty have been considered in chapter 6. These factors imply that severely impoverished families have not successfully adapted to the urban setting.

The State has discouraged the process of urban adjustment in Blacks by enforcing laws of segregation and apartheid (see chapter 3). Those families who have adjusted to the urban setting, despite inhibiting circumstances, have done so due to their own creativity and ingenuity. The social and dietary practices of such families protects against overt PEM in their children and the identification of these practices has been the basis for the recommendations in sections 7.2, 7.3 and 7.4.

Increasing the adaptation of township dwellers to the urban environment will, undoubtedly, lower the incidence of PEM in their children. However, to eradicate the condition, change is required in the socio-economic and political system (see chapter 3).

7.1.1 Changing the Socio-economic and Political System

The need for structural change in this country has been well recognized. In his concluding address to the Second Carnegie Inquiry into Poverty and Development in South Africa, Wilson (1984) asserted that political flexibility has to be assumed if the problem of poverty and its consequences are going to be resolved.

Bishop Desmond Tutu (winner of the 1985 Nobel Peace Prize) urges South Africans to dismantle the apartheid system which consists of:

> A ruthless social stratification and caste system. Depending on your pigmentation, you are placed high or low on the social pyramid; and where you are or, rather, where your parents are, determines so many things for you. It will decide, with a rigidity unknown even in the strictest Calvinistic predestination, where you are born and where you can live. It will determine what sort of health care is available to you; indeed, it will determine your chances of survival or whether you will become part of the dismal infant mortality statistic. It will determine the probability that you will succumb to kwashiorkor, be potbellied or suffer from easily preventable deficiency diseases.... (Bishop Desmond Tutu, 1986: XV-XVI)

de Beer (1984:86) emphasizes the link between the attainment of health and the building of a non-racial, just and democratic society: "As disease is of social origin, it can only be conquered when no section of the society is able to seek wealth, power or status at the expense of any other section."

It is beyond the scope of the present study to debate alternative socio-economic and political structures or how they should be achieved. Nevertheless, some suggestions on the contribution of social workers, psychologists and health professionals are given below.

(i) Become involved in the activities of mass based political organizations that are working for a just, non-racial and democratic social order. It is likely however, that radical change will be brought about by members of the working class who constitute the bulk of these organizations;

(ii) Facilitate continued efforts by members of these organizations by, for example, participating in the detainee counselling service which attempts to rehabilitate "crushed" community members; and

(iii) Develop organizational and leadership skills in community members. This may be achieved through community social work around the issues of child-care (see section 7.4) and health (see section 7.5). Furthermore, expansion of the community's informal structure by networking (see section 7.3), may ultimately enable people to create a socio-economic and political system that meets their needs.

7.2 Family Intervention

The apparent association between PEM and family structure (as shown by the results of this study in section 5.1.2), implies that the family with the 'broken' structure is not meeting its childrens' nutritional needs. This finding suggests that generating new structures in 'broken' families may prevent PEM in their children.

The 'broken' structure of Case families does not appear "adequate to, and harmonious with, the functions of its individual members, its sub-groups, and the social environment of which it is a part" (Aponte, 1982:313). It would thus seem that these families have not successfully adapted to the urban area of Soweto (see section 6.1.2).

7.2.1 Family Therapy

Generating new structures in 'broken' families may be achieved through family therapy.

Family therapy is a broad treatment orientation which addresses:

> the disparateness between the rate at which changes in the family structure, function and role organization are 'demanded' and effected by our society, and the rate at which individual persons can adapt psychologically and emotionally to the changing expectations of them (Sherman, 1979:449).

There are many approaches to family therapy, all of which need to be adapted to work with Black, urban, South African families, where:

(i) female headed households are the norm (Simkins, 1986); and

(ii) a history of deprivation has influenced generations of dysfunctional interactive patterns (Burman and Reynolds, 1986).

Bearing this in mind, approaches based on communication theory seem particularly applicable, as detailed below.

7.2.1.1 The Communications Approach

Communications theory posits that an individual's symptoms or problems (eg. PEM in the child), "reflect a faulty interactional process and therefore affect each member of the family system" (Okun and Rappaport, 1980:106).

Communication theory focuses on "verbal and non-verbal levels of communication as a way of understanding family rules, power dynamics and negotiation processes" (Okun and Rappaport, 1980:106). Learning about family relationships depends on analyzing the observable, current interactions related to communication and metacommunication (i.e. the communication about the communication). The history of individual members is not considered (Jackson, 1967; Haley, 1976; Satir, 1971).

The communications approach is an active and directive form of intervention that operates in the here and now, and has behavioural change as its goal. It utilizes "the communication process to change the interactional system of the family" (Okun and Rappaport, 1980:107).

Change in the interactional system of the family is in effect change in its structure, function and role organization.

For elaboration on the communication approach see Haley (1963;1976), Jackson (1965a;1965b;1967), Rappaport (1976), Satir (1967; 1971) and Okun and Rappaport (1980).

7.2.1.2 Structural Family Therapy

Structural family therapy is viewed by Sherman (1979) as a method based predominantly on communication theory. Okun and Rappaport (1980) however, see it as a contrasting approach. Nevertheless, structural family therapy offers specific techniques for restructuring a family.

Structural family therapy focuses on the family system's structural dynamics, particularly the creation, maintenance and modification of boundaries, the context in which relationships and interactions occur (Okun and Rappaport, 1980).

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It is beyond the scope of the present study to discuss the various strategies used in restructuring the family. It is necessary to comment however, that these strategies require modification when applied to families that are neither nuclear nor extended in composition. For example, subsystems would not be identified in terms of parents and siblings, but rather in terms of role functions such as breadwinners and dependents.

For family restructuring strategies, see Minuchin (1967; 1974), Bowen (1976; 1978), and Kantor and Lehr (1975).

7.2.2 Families in Crisis

Case families are in a state of ongoing crisis and have been examined in section 6.1.2.2, in terms of McCubbin et als' (1982, 1983) Double ABCX model and Hoff's (1984) classifications of crises. Case families seem to be experiencing all three types of crises identified by Hoff (1984) viz. a situational crisis, a transitional state crisis, and a cultural social-structural crisis. Social work intervention thus needs to be related to these three types of crisis. The following sections contain brief introductions to the various approaches that may be used to respond to these crises.

7.2.2.1 Responding to Situational Crises

A situational crisis may be responded to by problem-solving and task centered approaches:

(a) The Problem-Solving Approach

Problem-solving is not a treatment modality, but rather an integrated component of case work, group work and family intervention processes. "It is done at the level of conscious awareness and with an orientation to the client's reality situation" (Hallowitz, 1979: 112).

The definition of problem solving is a broad one which includes "not only direct work with the client in this regard, but unilateral, internal problem-solving activity by the worker" (Hallowitz, 1979:117). A problem-solving approach thus has an assertive counselling component and requires the worker to use his/her own problem solving processes to understand and then partialize the client's situation (Turner, 1979). This must always be done with cau-

tion, however, as "there is a fine line between judiciously stimulating and guiding problem-solving work on the part of the client and the worker's doing this for him\her. Stepping over this fine line can at the very least be unhelpful and, at the worst, harmful" (Hallowitz, 1979:116).

A problem-solving approach is particularly useful in "situations where there is a risk of the areas of focus and the objectives of intervention becoming diffuse and unfocused" (Turner, 1979:544). It is hence an appropriate treatment approach for families in a situational crisis, since the pile-up in the family system originates from being overwhelmed by material or environmental, personal or physical, and interpersonal or social difficulties.

The problem-solving approach, as viewed by Haley (1976) focuses on the social situation rather than on the individual. This approach tackles "each problem with special techniques for the specific situation. The therapist's task is to formulate a presenting symptom clearly and to design an intervention in the client's social situation to change that presenting symptom" (Haley, 1976:45).

For a more comprehensive understanding of the problem-solving approach see Haley (1976), Hallowitz (1970; 1979), Perlman(1957; 1971), and Turner (1979).

(b) The Task-Centred Approach

> Task-centered treatment is a system of brief, time-limited practice that emphasizes helping clients with specific problems of their own choosing through discrete client and practitioner actions or tasks. Service interviews are devoted largely to the specification of problems, and to the identification and planning of appropriate tasks, which are then carried out between sessions... The core methods of the approach are activities designed to help clients to plan and implement problem-solving tasks (Reid, 1979: 494).

Like the problem-solving approach described above, task-centered work may be done with individuals, groups, and families, and is done at the level of conscious awareness, with an orientation to the client's reality situation.

Task-centered intervention is particularly useful "in situations where a parsimonious use of resources is essential" (Turner, 1979:543). Hence, this is an appropriate treatment ap-

proach for families in a situational crisis, where limited resources constitute a major causal component of the crisis.

For further information on the task-centered approach, see Reid, (1975; 1977; 1978; 1979), Reid and Epstein (1976), Bogatay and Farrow (1975), and Brown (1977).

(c) Environmental Intervention on Behalf of the Client

Reid (1979:482) observes that "change is effected primarily through problem-solving actions or tasks that the client and practitioner undertake outside the interview". The client's problem-solving efforts may need to be supplemented by tasks that the practitioner performs within the client's environment and social system. As Reid (1979:482) describes: "These tasks are usually designed to assist others in facilitating the client's task or to secure resources from the system that the client cannot readily obtain on his/her own."

Intervention on behalf of the client may include the practitioner taking action by telephone, letter, or consultations with persons in position of power and authority (Hallowitz, 1979).

In traditional social work, intervention in the client's environment has been under-emphasized. Yet, an essential component of the profession "includes work with significant others, systems and material aspects of a client's life" (Turner,1979:76). The challenge for social work, therefore, is to "identify the various components of environmental treatment, understand their interconnectedness" (Turner, 1979:77), and formulate effective environmental intervention strategies.

7.2.2.2 Responding to Transitional State Crises

Case families are experiencing a transitional state crisis which appears to be related to their broken family structure. As stated in section 6.1.2: the family with a 'broken' structure is in a transitional phase: the extended family in its traditional form is rapidly disappearing, and other adaptive and functional relationships have not yet emerged. As already mentioned, this indicates that these families have not successfully adjusted to the urban setting.

A transitional state crisis may be responded to by behaviour modification and cognitive restructuring.

(a) Behaviour Modification

> Behavioural techniques provide the practitioner with a range of resources for achieving specified behavioural changes in clients. Apart from the increased understanding of the processes involved in the acquiring and modification of general behaviour traits, learning theory has particular relevance for helping clients alter specific problem areas of functioning, when it is assessed that such changes will achieve the identifiable goals, without the necessity of understanding causes or interconnectedness between behaviours (Turner, 1979:542).

Thus, a family can learn to share responsibility for budgeting and delegate tasks for managing an efficient household, without having to understand the relationship dynamics required to do this. Behaviour modification is a "direct approach to the remediation of focal problems" (Stuart, 1979:433). It has thus been termed 'action therapy' (London. 1964).

Some basic principles of action therapy are as follows:

(i) To accept the explicit goals of the client, rather than to search for the client's unconscious needs;

(ii) To build upon the client's existing resources, rather than to reduce the client's pathology;

(iii) To change the "interaction between the client's behaviour and the environment which produces and sustains it" (Stuart, 1979:434), rather than to change the individual; and

(iv) To use the practitioner-client interaction "merely as an expedient to promote more meaningful changes in the client's social environment" (Stuart, 1979:435), rather than to invoke changes by relying on the direct influence of the practitioner upon the client (Stuart, 1979).

A transitional state crisis is related to difficulties in interaction between the client and the environment, and this is precisely what action therapy/behaviour modification attends to.