but concerns have been expressed that the imbalance in undergraduate enrolments might have long-term implications for planning and provision, given that women doctors, even if they choose to work full time, will still need maternity leave. We were told that UCT is now seeking suitable male applicants to balance its gender ratio.

> Women play an invaluable role in the medical profession, but they also tend to work fewer hours

3. The debate has highlighted some difficult underlying issues about the gender division of labour in the home and traditional expectations of medical work. The medical profession traditionally demands that doctors should work inordinately long hours. Men have managed to do this because they have been supported in the background by women. But many women doctors do not have that support because society still expects them to bear the brunt of child and home care. Because they cannot work these long hours, they choose part-time appointments. However, it is not only women who would prefer more time for family and leisure. Male doctors would like this too. The answer to the problem lies in the sharing of the 'invisible', unpaid labour in the home and society and in humane working conditions for all. We also need to train and employ more doctors.

More details of this research can be found in the monograph, *Doctors in a Divided Society: The profession and education of medical practitioners in South Africa*, which is available from www.hsrcpress.ac.za.

Dr Mignonne Breier is a chief research specialist and Ms Angelique Wildschut is a researcher in the Education, Sciences and Skills Development (ESSD) research programme.

FIELD NOTES

HSRC project with institutionalised children in BULGARIA

The ARK, a London-based foundation that supports projects working with children in distress, contracted the HSRC to develop monitoring and evaluation tools (M&E) for the de-institutionalisation of children in Bulgaria and to assess the outcome at the end of the process. ANDY DAWES flew to Bulgaria to pilot these tools.

I WORKED WITH the Bulgarian project staff, a welfare NGO called the Samarani (Samaritans) and the state Child Protection Department social workers of the Municipality of Stara Zagora to pilot the M&E tools and to develop a strategy for the de-institutionalisation programme.

Bulgaria has some 25 000 institutionalised children, many with health problems and disabilities (50% in the study area). They are normally institutionalised on a long-term basis, frequently from birth. The institutions have a strong 'medical care' orientation.

The negative psychological outcomes for children growing up in these conditions are well established. Foster care is not part of the social work tradition, and there are only some 50 foster parents in the entire country.

Institutional care is accepted practice for a wide range of children, not only those with disabilities, but no doubt because of a lack of alternatives. A significant challenge is that most children are of Roma origin (although they constitute less than 10% of the population). I believe there is considerable prejudice towards this group and it will be a challenge to place them once the de-institutionalisation process gets going.

In the study area, 45% of the children were infants when first placed – normally directly from the maternity wards. It appears that when young women from very poor backgrounds give birth, the child may be placed in care based on a judgement as to whether the child's well-being will be at risk if she remains with the mother. In addition, it is not uncommon for very poor families to request such a placement, believing the child will obtain better care than they can provide.

There is also a perverse incentive to take in and hold on to children because they are funded on a per capita basis. As placement planning and interventions for vulnerable families are rarely undertaken, long-term institutionalisation is often inevitable.

We developed tools for measuring child outcomes in the age bands 0–5, 6–11 and 12–17 and also measures for the assessment of the child's placement environment to assess the effects of different placement types (for example, foster care and small group homes) and conditions (for example, the child's relationship with the caregiver), on children's adjustment and well-being in the placement. The tools had been translated into Bulgarian prior to my arrival.

We piloted the tools in various contexts with all three age groups. The process was slow as few of my colleagues understood English (my PowerPoint was translated into Cyrillic script!). The tools were then adjusted in consultation with the social workers. A particular challenge was the translation of English idiom into Bulgarian. In several instances a measure had to be dropped or substantially altered so as to 'work' in the vernacular without changing the construct.

A concern was working with the Roma. There is no written Roma, and all children are schooled entirely in Bulgarian. I strongly encouraged the team to work with Roma NGOs and, if at all possible, with Roma social workers. This will prove a challenge as there is only one such individual in Stara Zagora.

> There is also a perverse incentive to take in and hold on to children because they are funded on a per capita basis

As part of my approach to finalising the tools, I spent several hours in the Roma community trying to obtain at least some understanding of their situation and how the tools might or might not work in that context. For example, I visited a family of five who lived in a one-roomed dwelling with a mud floor and plastic over the two window openings. The father slept on the floor and the rest of the family shared beds. There was no running water and only a pit latrine (the pit was full). The temperature that day was 5 °C and in midwinter it drops to minus 12 °C.

In contrast, I visited one of the local Roma clan leaders in a middle-class dwelling in the same neighbourhood. We discussed some of the Roma approaches to childcare and as a result I strongly recommended that the views and practices of these folk be a subject of ethnographic study before we finalise the de-institutionalisation process.

After my departure, the translation of the final post-pilot versions of the tools will be completed and I will make such final adjustments as may be necessary. I will then return them to Bulgaria and a final pilot study will be undertaken. Any subsequent adjustments will be made locally.

The ARK team was most hospitable and, at a party at the end of my visit, they expressed the view that their acceptance of both the M&E model and the tools had been facilitated by the fact that I came from a country with similar challenges to their own and with a sensitivity to the challenges of social work in a low-resource context.

It is unusual for the HSRC to be contracted for work in a non-African country, although ARK does have several projects in South Africa. Following this project, and based on my conversations with the London ARK head-office staff, there is a strong probability that we will be commissioned to undertake further work for ARK in South Africa.

Professor Andy Dawes is a research director in the Child, Youth, Family and Social Development (CYFSD) research programme. He works closely on the project with Dr Cathy Ward, a senior research specialist, also in CYFSD.

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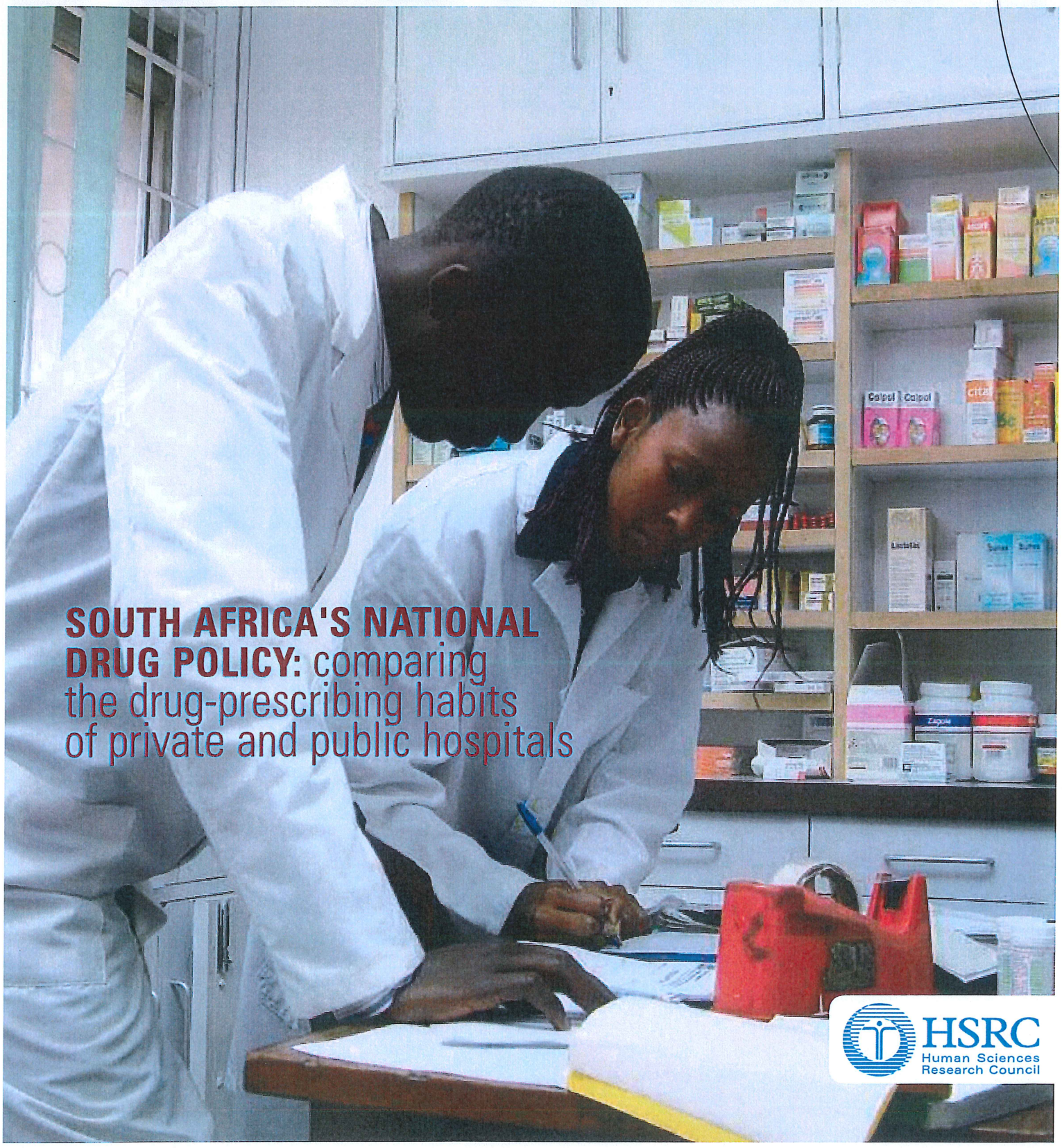

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