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WHAT IS CHILDCARE REALLY ABOUT?

**AN ETHNOGRAPHIC ANALYSIS
OF CARE RELATIONSHIPS IN A
RESOURCE-POOR COMMUNITY**

Rachel Bray and René Brandt

CSSR Working Paper No. 139



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Social Surveys Unit

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What is Childcare really about? An Ethnographic Analysis of Care Relationships in a Resource-Poor Community¹

Abstract

The main aim of this paper is to examine critically the nature of childcare, including ideals and practices, in a resource-poor community through close ethnographic analysis of three sets of data generated over the course of two years. We argue that childcare in Masiphumelele should be conceptualised as having an emotional component that operates in parallel with, and is as important as, material provision and practical action. Further, the analysis reveals the extent to which childcare is shaped by poverty and must be thought about in relation to broader physical and social mobility, and the continuities within such movement. We also show that HIV can further shape childcare by challenging existing cultural practices, such as those pertaining to communication between children and adults regarding death. Future work on childcare would benefit from the conceptual approach adopted across this work, one which views children and their carers in a series of interrelated and dynamic contexts that include both kin and non-kin, and extend from the household to the broader family and friendship networks which support these multiple individuals.

Why childcare?

The study of childcare is of interest to social scientists for two broad reasons. The first relates to the significance of the period in which we rely on the care of others. Infants and young children are learning at rates far higher than at any other time in their lives, making this a critical period in the life course in terms of physical, cognitive and social development (Gopnik, Meltzoff & Kuhl, 1999). Further, the significance of the quality of early caregiver relationships to children's social and emotional development is well established (Shonkoff &

¹ We would like to acknowledge and thank our colleagues who contributed to the research on which this paper draws, in particular Lindiwe Mthembu-Salter, Andy Dawes and Nomatamsanqa Fani.

Meisels, 2000). Childcare and parental monitoring constitute a significant pathway whereby environmental and personal factors impact on child development, making childcare a key factor protecting children from risk to adversity (Bauman *et al.*, 2002; Forehand *et al.*, 2002). The context in which growth and learning takes place is therefore fascinating in terms of how it shapes the future of individuals who may themselves begin caring for others from a young age.

The second reason to attend to this topic relates to caring for children as a role and status within society that stands to influence household organisation, the allocation of resources amongst families, the nature of relationships among both kin and neighbours, as well as the ongoing social and psychological well-being of children. Further, the care of young children involves at least two generations (usually more), and offers insight into the nature of inter-generational relations. And because childcare demands a combination of economic, social and emotional resources, the study of where these come from sheds light on aspects of social change.

Addressing the gaps

This paper focuses on the kinds of care that are often missed in research and policy debate, namely the everyday interactions between young children and their relatives or household members, and neighbours. A brief review of the psychological and anthropological literature in South Africa (the two disciplines most likely to investigate this area) revealed very little work of any substance, with the possible exception of Jones (1993) and Reynolds (1989)². Just as with child development more broadly, there is a dearth of historical work with local relevance (Richter & Dawes, in press). Further, with respect to policy-related work, the contemporary focus tends to be on the so-called “crisis of care” and the needs of orphans and children made vulnerable by HIV/AIDS (OVC). Discussion typically centres on the potential for such needs to be met within the household, usually by women, or by community resources such as home-based care networks (which tend to be staffed by women as well). Rarely is any analysis made of children and adults’ existing care roles, or the characteristics of care relationships.

² Although neither of these studies focuses directly on care relationships and actions, they offer fine-grained analyses of the impact of historical political and economic forces on family life in a particular time and place in South Africa. Each reflects on the ways in which children and the adults around them make sense of the frequent and severe disruptions to everyday life and interpersonal relations.

This absence may be explained by the contested nature of ‘care’ at an analytical level as well as its multidimensionality that gives scope for varied interpretations according to discipline and particular research or programme agendas. In lay terms, childcare is a broad concept describing a range of activities, responsibilities, decisions and emotions involving both caregivers and children. However, within research and policy circles, definitions of activities comprising ‘care’, and hence of ‘unpaid care’, are under debate. Caregiving activities are often ignored or listed as secondary activities in household surveys capturing data on work-related activities (Budlender, 2004; Budlender *et al.*, 2001 in Bray, 2003; see also Reynolds, 1991)³.

The aim of the paper is to describe and analyse the dynamics of care relationships with children through illustrative material from extended ethnographic work in a particular setting. We explore care ideals, experiences and the context influencing these from the point of view of both carers and children. We suggest that this analysis offers a lens through which we can think about the nature of caregiving relationships and how best to track their dimensions and implications for social life more broadly.

Importantly, the paper attempts to address childcare by directly examining care within HIV infected households, as well as investigating care in households that are affected by virtue of the high prevalence of HIV/AIDS in the broader community. Attention will be paid throughout to the potential implications of these differences and similarities across the research participants. However, it is also worth noting that the separating out of HIV specific issues, including in the context of care for children, is increasingly rejected in policy circles (Giese *et al.*, 2003). It may therefore be appropriate - both in terms of the nature of the data and broader policy guidelines, to examine care in infected and affected households simultaneously.

Efforts to understand the varied social impacts of the AIDS epidemic have sharpened the focus on roles and relationships within and across familial and domestic groupings, including those supporting the care of children. We would caution, however, that this important line of enquiry can only be pursued with some knowledge of how social institutions were (and perhaps still are) functioning, prior to, or alongside, the epidemic. Clearly, the everyday experience of carers is in a constant state of flux alongside changes in employment, poverty levels, health status and interpersonal relations. We raise this point because it demonstrates the importance of beginning an analysis of childcare with an acute eye to context, which includes sufficient sensitivity to

³ The Time Use Survey (TUS) is exceptional because it captures time spent by respondents (aged 10 years and upwards), caring for children and elderly, disabled or sick adults (Bray, 2003).

social and cultural nuance, as well as change over time. In short, it is important to gain as full an understanding as possible about the way in which social institutions around the care of children work, including their underlying norms and values, before we investigate the direction and nature of changes in everyday care practices, and the factors prompting these changes.

Research setting and data

The data informing this paper were generated in a series of studies conducted in Masiphumelele, a very poor community of approximately 12,000⁴ residents on the outskirts of urban Cape Town⁵. Described in more detail below, these qualitative studies focused on the early childhood period and gathered information through a series of structured and informal conversations with adults and children living in Masiphumelele.

The community of Masiphumelele

The majority of Masiphumelele's residents are Xhosa speaking and have moved to the area to look for work and improve their quality of life. Teenagers and young adults, in particular, often move to Masiphumelele in order to access what is perceived as better educational and employment opportunities⁶. The fact that the area is physically smaller and more bounded than most other poor communities in the Cape Town area lends support to the belief that there is less competition for work and therefore more opportunities. Residents also connect its small size with a sense of (relative) interconnectedness and safety.

Most residents maintain links with family members and homes in rural parts of the Eastern Cape. Levels of temporary migration between the Eastern Cape, Masiphumelele and other urban settlements in Cape Town are high. Official City of Cape Town estimates are that 1,700 families live in shacks and there are about 270 brick houses. Although most shacks are serviced with sanitation and electricity, a large and increasing number of families are building shacks on wetlands (unserviced, illegal and at considerable risk of fire). Unemployment

⁴ According to the 2001 Population Census, there were 8,249 people living in Masiphumelele. High levels of immigration have persisted and in 2004, the City of Cape Town gave a figure of 12,000. Some service providers now put the current population at nearer 20,000.

⁵ The socio-economic, demographic and HIV prevalence profile of Masiphumelele is representative of a large number of poor urban settlements in the Cape Town area.

⁶ While 2001 census data indicate that the employment rate in Masiphumelele is similar to that of African people in Cape Town as a whole (58 versus 54%), this is how many Masiphumelele residents explain their reason for moving there (Prof. Jeremy Seekings, Personal communication, October 2005).

and HIV prevalence are both high. A large proportion of individuals and their families rely heavily, or even solely, on state social assistance⁷.

In terms of services for children and adults, Masiphumelele has one primary school, one high school and 14 Early Childhood Development (ECD) facilities, ranging from crèches run in homes to one large pre-school. There are a large number of churches, a library, a community hall and a community centre used by various non-governmental organisations (NGOs) offering social support services. A primary health care facility, Nomzamo Clinic, was established in the community in 1997 and an HIV clinic has operated from the same site since 2000. A twice-weekly, doctor-driven HIV clinic is run as a joint initiative of the South Peninsula Municipality and the University of Cape Town (UCT). Patients of the clinic also have access to weekly support groups and income-generating projects through a local church-based NGO. Government, together with a US-funded project based at UCT's Desmond Tutu HIV Centre, began the roll-out of antiretroviral therapy (ARVs) at Nomzamo Clinic in June 2004.

The three data sets

Three studies inform this paper and are described below in chronological order. As will become evident, the data informing this paper were collected in different contexts and using different research questions. While the data used in the paper is adult-generated, the small portion of child-generated material suggests that further work in this direction would be fruitful (but requires sensitive planning).

The first study was part of a three-site South African study designed to investigate the standards applied to early childhood development by those involved in the everyday care of children⁸. It aimed to generate data on emic (insider or local) and etic (outsider or 'professional') perspectives on child development, and to use this material to inform the production of a set of child development standards appropriate to the South African context. A series of focus group discussions were held with children age eight to nine years, parents, crèche staff, primary school teachers, social workers and health personnel respectively. Topics explored in these discussions included factors influencing

⁷ The major sources of assistance are the Child Support Grant (CSG), the old age pension and the Disability Grant (for adults). A smaller but growing contribution is formed by the Care Dependency Grant (for children) and the Foster Care Grant (for carers of children formally fostered through the courts).

⁸ The study was titled 'Going Global with Indicators of Child Well-Being: Indicators of South African Children's Psychological Development in the Early Childhood Period'. Supported by UNICEF, it was conducted by members of the Child, Youth and Family Development Programme at the Human Sciences Research Council. The research team included Andy Dawes, Rachel Bray, Jane Kvalsvig, Zuhayr Kafaar, Sharmla Rama and Linda Richter.

child development, ways of assessing whether a child was developing normally, and the age at which participants expected children to be able to display a range of physical, cognitive, social and emotional skills.

The second study set out to explore young people's everyday experiences in the home, neighbourhood and at school⁹. It involved 15 months of ethnographic fieldwork with children and young people aged 9 to 23 years attending schools in Masiphumelele, Ocean View and Fish Hoek, three historically-divided communities on Cape Town's South Peninsula¹⁰. A range of qualitative methods were employed including written and visual narrative, social mapping, discussion and peer interviewing by young people. In this paper we draw only on the data collected from children living and attending school in Masiphumelele.

The third and final study focused most acutely on care relationships involving very young children, and provides the majority of our data for this paper. The primary objective of the study¹¹ was to investigate the psychological experiences of poor, HIV positive mothers caring for children under six years who were sick with AIDS and on antiretroviral therapy, and to attempt to understand the strategies which these women employ to cope psychologically. The study paid particular attention to the caregiving relationships involving women and their children, and to the social networks within families and neighbourhoods supporting each as individuals and in the care relationship. A series of structured and informal interviews were conducted. First, women answered a questionnaire on individual and household-level demographic information, their history of caregiving, their functional health and adherence to treatment, and their psychological well-being¹². Next they participated in a semi-structured interview in order to further explore these issues¹³. Each child's development was assessed using a test called the Griffiths Scales of Mental Development for Young

⁹ The study, 'Growing Up in the New South Africa: Perspectives from children and young people in the Cape Town area' was conducted from April 2004 to June 2005 by Rachel Bray, Imke Gooskens and Susan Moses of the Centre for Social Science Research, the University of Cape Town.

¹⁰ The location for this study was chosen because these three communities were zoned black, coloured and white respectively under apartheid. They are situated within a few kilometres of each other.

¹¹ Conducted during 2004 and the early part of 2005, this study was funded by OSSREA (Organization for Social Science Research in Eastern and Southern Africa) and implemented by the Child, Youth and Family Development Programme of the Human Sciences Research Programme. Both authors were centrally involved in planning and conducting the study.

¹² Four standardised scales were selected to assess maternal psychological well-being, in particular, risk for depression, symptoms of anxiety, social support, and coping strategies (for details, see appendices in Brandt, 2005a).

¹³ See Brandt (2005a) for a write-up of the interview and questionnaire data.

Children. Finally the researchers visited the homes of participating women and children twice and for a period of two hours each. During these visits, researchers observed the home setting and recorded as closely as possible interactions between mother, child and others playing a care role, as well as exploring mothers' opinions and experiences of caregiving through informal conversation. The home visits generated much of the data discussed in this paper.

Importantly, unlike the two former studies, this research focused exclusively on households in which the principal carer (in all cases, the mother) has AIDS and is on ARVs. Although we do not have exact parallel data from non-HIV infected households, Masiphumelele is a community with very high HIV prevalence (and low disclosure), and it is therefore very possible that the former studies included people living with HIV/AIDS as well, even though recruitment was not on the basis of HIV status. Moreover, the combination of a data set which explicitly focuses on HIV with those that do not, allows for the exploration of important issues regarding what is and is not specific to HIV. As contextual data from the studies will be shown to demonstrate, while there are specificities with respect to HIV/AIDS, the ideals and experiences within care relationships in which a carer is HIV positive typically reflect those existing in the broader community.

Teasing out the dynamics of childcare

Childcare is performed and experienced in multiple dimensions. The challenge to anyone trying to elucidate its specific dynamics in any given setting is where to begin. We do so by presenting our core argument around the nature and quality of care relationships involving children, and follow this with supporting ethnographic analysis. The remainder of the paper explores some more subtle aspects of care dynamics in greater detail.

Our main contention is that childcare in Masiphumelele should be conceptualised as having an emotional component that operates in parallel with, and is as important as, material provision and practical action. This point may seem simplistic or naïve. However, it goes against an assumption that sometimes underpins thinking on childcare in poor communities, namely, that care is driven by practical concerns and that the emotional lives and motivations of poor carers are less complex and relevant than in the case of more middle class communities (see Swartz (1998) on culture and mental health for a more general discussion of this point). The clarity with which the interwoven nature of emotional and practical aspects of care emerges from the data suggests the need for social scientists to reassess the way in which we approach the study of childcare.

A striking feature of statements made by carers of young children in Masiphumelele is the extent to which they contain a mixture of physical, economic, social and emotional responses to children's needs. Interestingly, emphasis is placed on all dimensions of the care relationship, and carers point out distinct care behaviours and their impact on the child's medium- and long-term mental, social and emotional development. Statements about the qualities of childcare often do not separate these care functions in the way that academic analyses tend to:

If the parents scold the children all the time, then this is bad for their development. Also poor nutrition can affect children's mental development. If parents neglect their children, leaving them on their own for a long time, then this will also hinder their development.... If their parents fight a lot, or drink too much, then children can be naughty.

(Study 1: Focus group comprising crèche staff)

Some adult carers were hesitant to define 'good' care, but spoke more readily of the opposite scenario and its impacts. One mother explained that 'poor care' means not meeting all of a child's needs with equal measure (R3¹⁴ in study 3). According to the father of a sixteen-month-old girl (C2 in study 3), the consequences of inadequate care are that children misbehave, are unreliable, and will lack the skills needed to resist peer pressure when they are in their teens. Still another carer from a focus group (study 1) stated that:

... if a parent does not pay attention to their child, this can have a negative effect. For example, if your child comes to you excited to show you something and you send him away, complaining about being too busy and needing to think about important things like where to get money to buy them food and clothes. This will have a harmful effect on the child's development.

While economic security has a role to play in childcare, as reflected in the above quotation, material provision alone, contrary to what is sometimes assumed, does not determine care ideals or the nature of care practices in this resource-poor community. Carers also emphasised the value of companionship, shared tasks and just 'being there' with children. When asked how they give love to their children, carers mentioned including them in activities, giving them attention and encouragement, and engaging with them in ways that teach social skills. The emphasis here is clearly upon the relational aspects of care (as

¹⁴ The notation 'R' for respondent and 'C' for child will be used to discuss the five women and their children who participated in study 3. See also Appendix 1 for further details of participating women and children.

opposed to the economic contributions of carers) as critical to enabling children to develop personal skills that will lead to healthy social relationships.

Interestingly, the only aspect of childcare given consistent priority across the three studies is one that conveys an inherent link between emotional and social inputs and outcomes. When asked ‘what do you think happens to children who are given lots of love?’, one mother responded, “They know the home rules and can respect others when growing up. They learn to share the love and its warmth” (R2 in study 3). Another defined ‘good care’ as “enabling a child to distinguish between right and wrong, and to ask for what he needs rather than wanting everyone else's share” (R1). She elaborated her views: “A loving, caring home are more important than the presence of material goods in the house. If a child has these, he [sic] will learn respect.”

A question arising from the data is the extent to which the emotional resources needed in childcare and in the home more generally are limited by practical and material scarcity. In some ways, this is a moot question. Concerns around current or future scarcity are always present amongst residents of Masiphumelele, although their intensity changes with particular situational shifts such as the gain or loss of employment. Carers themselves recognise a relationship that is well-documented in the literature, namely that economic and social pressures, manifested particularly in the inability to provide materially for one's children, have impacts on mental well-being and thus on the emotional resources available to childcare (Hundeide, 2002; Scheeper-Hughes, 1992; Whiting & Edwards, 1989). (We explore this relationship further in due course).

Nonetheless, carer's remarks suggest an interface between material and economic concerns and an awareness of children's emotional and developmental needs, as well as attention to their current and future roles in the family and community. The care environment is one in which there are limits on material goods as well as emotional resources. The norm expressed is that children must grow up aware of these limits and behave accordingly, which means to be mindful and respectful of such limits. Those who care for children have a responsibility to model and teach these values, the social benefits of which can only emerge through both emotional and social investment. Children must ask for what they need “rather than wanting everyone else's share”, they must “learn respect” and “respect others when growing up”. Even love is something that children must “learn to share”. This is consistent with the work of Scheeper-Hughes (1992), Case and Ardington (2004) and Mann (2002), all of which illustrate how contextual factors result in limits being placed on carer's emotional attachment and investment in children. Scheeper-Hughes (1992) found that mothers in highly impoverished areas of Brazil maintain distant relationships with their infants (not necessarily deliberately) until children are of

an age that the high risk of child mortality has passed. Case and Ardington (2004) showed that children who are fostered due to the AIDS-related death of carers in rural South Africa, receive less resources than the biological children of the foster family living in the same household, while Mann (2002), working in rural Malawi, found that some orphaned children reported unmet economic and emotional needs in their foster households compared with other children already resident. The available qualitative research on this issue points to a range of economic, interpersonal and social factors that make it difficult, and even inappropriate, to draw simplistic conclusions regarding carer's motivations, particularly with respect to emotional input.

A further point regarding emotional and material resources given to childcare is that the two are not mutually exclusive. This is particularly important when considering the role played by fathers and other male figures with respect to childcare, many of whom are physically absent for much of the time and provide, in the main, material support to the child and the household. The physical absence of fathers and partners is not an unexpected part of everyday life for many children, and women in Masiphumelele. These absences vary in duration and may be prompted by employment constraints, relationship choices or a combination thereof, as observed in other poor urban and rural settings (see, for example, Barbarin & Richter, 2001; Russell, 1995; Spiegel & Mehlwana, 1997; Shelmerdine, 2005). Some have pointed out the diminishing role of fathers in terms of everyday care for children, arguing that even for employed men, "the span of involvement within the household with their children and partners is shrinking" (Barbarin & Richter, 2001: 142). Others have suggested that connections between fathers and their children are primarily, or even solely, articulated around material provision (Russell, 1995). However, data reported in this paper are consistent with the findings of another study recently conducted in Masiphumelele, namely that material support (as often provided by physically absent fathers) reflects not only material provision, but symbolises emotionally imbued care relationships (Shelmerdine, 2005).

On first speaking to children aged nine and upwards (who participated in the second study), fathers' actions were usually described in material terms, for example, the present he gave last birthday or whether or not he sent money to their mother as a contribution to school fees. However, ongoing conversations around children's drawings and diary entries over one year soon revealed much richer and more complex relationships with fathers and other adult men who played a father role, including step-fathers, uncles and grandfathers. As such, the spending of money seemed to function as a form of currency or exchange in the relationship, and, in recounting these to others, as a trope for a deeper social and emotional connectedness.

The following extract from a teenage girl's diary illustrates some of the dynamics underlying the physical distance between children and parents, but points clearly to the emotional continuities within the diaspora:

I was chatting with my brother and told him I was missing our dad, and he said he is missing him too. My brother stayed with my father for a long time ... He is happy to be here but he misses his father. He would rather stay with his father, but he doesn't like the place where he lives. Last December he went to visit his father, I did not go, I wanted to stay with my mom for Christmas. He went alone. I miss my father as he is very caring; he loves us a lot. He cooks for us, really nice things.

In one sense, the apartness experienced within family groups can be understood as one of a number of felt constraints upon the social, economic and emotional resources immediately available. There is one less person around to contribute to everyday household maintenance, including the emotional demands of childcare. Yet such interpretations risk painting an impoverished picture of family relationships and the efforts made to maintain them. As Reynolds (1995: 17) states, "family groups have to be kept going at the cost of a permanent effort of maintenance". In other words, relationships between family members – including those involving care – have to be fed with economic, social and emotional inputs in order that they continue. Both men and women, including children, in Masiphumelele make full use of available technology, for example, electronic bank transfers and cellular 'phones, to reinforce the emotional bonds and material transactions that may be part of these.

How does poverty shape childcare?

An important point which the data reveals, and that the above-mentioned discussion has begun to touch on, is the extent to which poverty is a significant factor influencing and shaping childcare practices, although not necessarily ideals. This is not to suggest that carers and others living in poor communities lack agency and that poverty is an entirely deterministic force in their lives, but rather that it challenges practices that might be commonplace elsewhere and shapes the contexts in which decisions regarding childcare take place.

In posing a question orientated around poverty independently of childcare-related issues linked to HIV, we are of course mindful of the well-documented symbiotic relationship between poverty and HIV, both in terms of everyday experiences and outcomes (Giese *et al*, 2003; Marcus, 1999; Meintjies *et al*. 2003). Certain particularities of adult experiences of HIV and AIDS do, however, deserve separate consideration, for example the decisions surrounding,

and implications of, disclosure and the influence of perceived and actual stigma on family and neighbourhood relations. These will be discussed in further detail later.

We begin by considering those features of poverty more commonly identified in relation to the care and well-being of children, and then examine the ways in which broader structural aspects of poverty impinge on care relationships. We will illustrate how a richer conceptualisation of poverty is needed to unpack the relationships between poverty and childcare.

Accessing education

A large number of our conversations around household finances and providing 'good' care to children focused on education. All parents consulted in our research consider crèche important for preparing their children for school, and providing a safe and nurturing environment when a mother and other carers are out at work. Interestingly, however, despite the close proximity of several crèches and educational facilities, none of the five children taking part in the third study were attending crèche during the research period, although two had done so previously. While physical location is not a barrier to access, conversations with these carers shed light on a spectrum of constraints and decision-making that help us understand the interplay between poverty and childcare practices.

One mother (R1 in study 3) explained that she had to take her child out of crèche when she unexpectedly lost her job as a domestic worker. While this decision appeared at first to result solely from a lack of income, the particular circumstances and relationships in the household suggested other factors at play. Since being asked to leave her sister's home, this HIV positive mother and her five-year-old son have lived alone and spend most of the day together chatting, doing domestic chores and watching television. It is not difficult to imagine that she values the company of her child more highly in the light of her sister's decision, her fluctuating physical health and treatment routine. In terms of her values and plans for the future, she places a clear emphasis on her son's education and does not feel the schooling offered in Masiphumelele can be of much benefit to her son. She stated her preference to save what she is able to with a view to enrolling him in a school outside Masiphumelele that she herself attended and considers to offer a better education.

Similar strategic thinking around educational quality underlies the decision taken by another set of parents (R4 and her partner in study 3) to keep their four-year-old out of a local crèche and direct the available household income towards

the ‘best’ and more expensive schooling option for their nine-year-old daughter. This mother described the ways in which she is monitoring her son’s development; she observes that his abilities mirror those of a neighbour’s children who attend crèche and concludes that he is not ‘missing out’ on significant educational opportunities. Her partner, the father of both children, cites his observations of older children who have attended schools in Masiphumelele, and often before that in the Eastern Cape, struggling to achieve educationally or to find work. He considers that limited English-language skills and social confidence are a major factor hindering local teenagers, and for this reason it is important for his own children to be schooled in an English-medium environment with children from a mixture of backgrounds.

A third mother (R3 in study 3) explained that she stopped sending her four-year-old daughter to crèche when the child became unwell with an intestinal worm infection. At around the same time, she herself became too sick with symptoms of TB and HIV-related infections to run her spaza store and thus lost the related income. When we spoke about her plans for her daughter’s education, she said that she intended to re-enroll her at crèche now that the child’s health has improved. Upon hearing this, her daughter challenged her, asking whether she would really or is just saying so. This series of events and responses illustrates how childcare practices are influenced by deteriorating personal financial circumstances and health status. An additional contributory factor that emerged through a personal interviews and psychological testing rather than informal conversation around educational choice, was the poor state of this mother’s mental health. Interestingly, the four-year-old daughter picks up on the mother’s inability to act according to her stated ideals and plans, effectively raising a question around how important her mother considers her early education to be.

The cases described above illustrate a nuanced relationship between different dimensions of poverty, and the ideals and practices of childcare. Care-related decisions are made not only on the basis of financial constraints¹⁵, but in the context of an interplay of factors stemming from current structural poverty and the particular individual manifestations of longer-term deprivation. In the first two cases in particular, economic scarcity influenced carers to think and act strategically around how to educate their children by distributing their limited-resources in such a way that children experienced the benefits of a good education. This included schooling in an environment with the social benefits of learning and being exposed to a language and culture dominant in the workplace into which children will eventually need to enter as young, contributing adults.

¹⁵ An active family-focused non-governmental organisation (NGO) working in the area devotes much of its energies to identifying and supporting poor households in which there are young children not attending crèche. Their understanding is that a significant proportion of parents do not earn enough to afford the monthly fees of R50.

A number of quantitative studies on educational decision-making in the context of chronic/long-term poverty (in South Africa) have similarly shown carer perceptions of the social function of the school environment (as well as the child's intelligence) to be strong factors (for example, Cosser & du Toit, 2002). In the final case described, structural poverty manifested most clearly as a lack of alternative employment opportunities for a mother in poor health, while poor mental well-being stemming from a history of family rejection, forced separation from her older children, and the worries and physical weakness caused by TB and HIV infections were also contributing factors. These multiple and changing dimensions of poverty can place barriers between care ideals and care practices. Our analysis suggests that while it is important to distinguish between ideals and practice, these change in response to particular manifestations of poverty in ways that are subtle, but potentially important for child well-being. The intricacies of these processes must be carefully documented in order to fully understand the thinking and actions of those caring for children within resource-poor settings.

Residential security, mobility and unemployment

The quality and security of residential arrangements, and the related issues of mobility and unemployment, feature prominently in conversations with mothers about their experiences of raising children. Just as decisions with respect to accessing education were shown to be located within a particular context and set of values, a nuanced understanding of housing arrangements and childcare within this community requires an examination of cultural practices and contextual factors, including poverty.

A sense of home and the role of relatedness

With respect to residential security specifically, carers' accounts recognise both the direct and indirect effects of housing arrangements and accompanying relationships on childcare. Some pointed to the quality of housing, as evident in the following extract from a focus group with health workers living and working in Masiphumelele on factors affecting child development (study 1). Interestingly, the social impact of these, including the family's sense of worth, social standing and control over decisions to move, were voiced with equal concern as problems relating to infrastructure.

Participant 1: For me, the main problem we have here is housing. We need more proper houses to be built. People live in shacks. There is a sanitation issue which brings risk of infection. And there

- are also social problems. I say this because I live in a shack, I do not even have a plot. So I feel the same way.
- Interviewer: Can you give some examples of the social problems?
- Participant 1: It is about how the family feels. It is hard to explain.
- Interviewer: Do you mean in terms of respect, and status?
- Participant 1: Yes, that's it. If you have a house, the whole family feels better about themselves.
- Participant 2: And you are more secure. You can stay there and are not at risk of moving about.

The significance of residential security is also illustrated by the case of one mother (R4 in study 3) who experienced the uncertainties around her family's housing situation as the greatest source of stress when at the same time living with a positive HIV status, daily ARV treatment and the imminent birth of her fifth child. She lives with her partner and four children in a spacious and well-equipped shack owned by her partner's brother and, upon first visiting, her housing situation appeared relatively good. Yet conversations revealed high levels of anxiety caused by long-standing tensions with her sister-in-law (who lives in the adjacent shack) and the questions these raised about whether they would be able to continue to live there.

Rights to residence and a sense of some degree of permanence, preferably through home ownership by a resident household member, seem to have a strong influence on these women's sense of worth and stability and their confidence in being able to provide quality care for their children. A stable home is one in which both a child and "the whole family" can feel "better about themselves". As the term 'everyday expectable environment' is intended to convey, the key contextual elements of the childcare setting that are necessary from the child's point of view for 'adequate care' are at least one person with whom the child can form an attachment, and with whom s/he can develop a co-constructed understanding of how the day unfolds (LeVine, 1990). The latter requires a degree of predictability to the day's events and the spaces in which they occur that can be guaranteed where there is residential security. When carers are in a position of having to move these familiar spaces, and potentially the activities and relationships that occur within these, this predictability is threatened.

A further important point raised above is that residential security and the child's predictable environment that includes (but does not consist exclusively of) a stable physical home, is achieved through relationships with others - often male kin and partners. In four out of five households participating in study 3, residential security for the mother and her children relied on her relationship with her male partner or male kin. The value of residential security as part and

parcel of these relationships was apparent. One woman (R3) spoke of times when she had considered leaving her partner for his unfaithfulness but chose not to destroy the home environment they share with their daughter. Another spoke of her dependence on her brother and father for daily food and for a home for herself and her one-year-old (R5). Closer analysis of the dynamics underlying housing arrangements points to a further role that men play in childcare that has both emotional and material dimensions. Together with the above-mentioned case (R4 in study 3) in which the relationship with a sister-in-law was central to household security, this evidence points strongly to the shared nature of care-related responsibilities and roles, as well as the role of relatedness in understanding the relationship between residential security and childcare in contexts of poverty.

Mobility, unemployment and shared caregiving

In thinking about the links between women's concerns around their immediate residential security and their abilities to adequately care for their children, we are prompted to consider broader social and emotional dynamics connected to physical mobility and notions of 'home' and 'movement', including the issue of relatedness raised above. Amongst individuals and family groups in Masiphumelele there are very high levels of mobility over short and long periods between rural areas of the Eastern Cape and poor urban suburbs in the Western Cape. The economic aspects of structural poverty underlying these patterns include the effective unavailability of employment opportunities in rural areas of the Eastern Cape, and the scarcity and unpredictability of these in Masiphumelele and other poor communities on the periphery of Cape Town. Decisions to move are also made with a view to the best care setting and educational environment for children, and to a financial and residential arrangement that suits the needs and wishes of the parental and grandparental generation.

It is common for children under ten years of age to live with grandparents in the Eastern Cape while their parents endeavour to support them financially by finding work while living in Masiphumelele. Such arrangements mirror a pattern evident in black African communities for several generations: The care of children is shared/communal in the sense that members of the grandparental, parental and child's generation may take a leading or significant role in a young child's care for a certain period of time, with the handover of caregiving roles often occurring with a major shift in economic circumstances, employment or physical location. At least in South Africa, the severe restrictions on adult movement and employment imposed by the apartheid regime forced families to fragment and draw on cultural values relating to a sense of communal responsibility for children (Henderson, 1999; Jones, 1993; Ramphela, 2002). We did not directly explore the experience and meaning of 'home' for adults or

children in any of our studies. However, it became evident in conversation that 'home' in both a social and emotional sense may be one's current physical home in Masiphumelele, but may equally be in a home of ancestral origins, often in the Eastern Cape. Importantly, for many, these are not mutually exclusive, suggesting a sense of belonging in the social space that connects the two physical places.

The implications of these understandings for the study of childcare include a close look at the possibilities for change and continuity in social relationships both within and beyond the immediate family context. As we have illustrated above, the relationship dynamics in which adult carers participate have an effect on their abilities to provide an environment in which they can perform quality childcare. But shifts in residence can also affect childcare in more direct ways because they usually entail changes in the composition of the household, and thus those available for, or ascribed to, particular childcare tasks.

The account given of the shifts in residence and living arrangements by one mother (R1 in study 3) since the birth of her five-year-old son serves to contextualise both the changes and continuities that exist within high levels of mobility. When her son was born, R1 was living with her mother, brother and brother's wife in Khayelitsha, a very large and poor suburb on the outskirts of Cape Town. Later the same year, she, her son and her mother moved to her mother's ancestral home in the Eastern Cape. When her son was two years old, R1 moved to Masiphumelele to look for work, staying with a female friend and leaving her son in the care of her mother. A year later she returned to the Eastern Cape and after a few months brought her son back to Masiphumelele with her.

At this point she decided to leave her full-time domestic job because she believed that her employers were exploiting her. Following the loss of income, she and her (then) three-year-old son moved into her sister's home in Masiphumelele. Although she and her son relied on state assistance (in the form of her son's CSG) and finances were tight, she believed she was in a secure position until her sister unexpectedly asked them to leave. The reason given was that their presence and the daily visits at mealtimes by other relatives living nearby were becoming "too much for their household". R1 was clearly hurt, especially in the light of the fact that she had disclosed her HIV status to her sister (who was an AIDS educator at the time) and had expected her to be more sympathetic. In addition, both her sister and her sister's husband were employed at the time, unlike herself. At this point, she recalls being very stressed as she and her son were technically homeless. Her solution was finding a place for them both to sleep at the home of an acquaintance. This arrangement entailed them spending the entire day loitering near the clinic, arriving at night as a 'visitor' and keeping their daytime activities secret from the family whose home

they were sleeping in. Subsequently, R1 rented a small area of this family's plot and built a tiny one-room shack where she and her son now live.

Listening to such accounts, one is struck by the rapidity with which the everyday situations of parents and children change and by the varied aspects of these changes. Frequently, these entail physical relocation, a shift in personal status regarding employment and role in the home, as well as variation in household composition and income available to its members. Relationship dynamics may also shift, with (as already noted) important implications for carers' abilities to provide an available and nurturing environment for children. In poverty environments where both unemployment and cultural values centred on relatedness and shared caregiving are common, carers' relationships with household members, extended kin and neighbours form an important context for understanding caregiving.

In several households we observed a flexibility in roles played by adults and older children in response to individual employment and childcare needs. A mother (R5 in study 3) with a one-year-old son described how she, her son and others in their household (her brother, two sisters, younger sister's infant and their elderly father) rely heavily upon her brother's income from a cement production company, her Child Support Grant and a food parcel from a local NGO to meet daily needs. Her father sells wood at the roadside but makes very little money. It is often difficult to buy food at the end of the month, and at such times they ask another brother who lives nearby for 'emergency' contributions. She spoke of the barriers to their obtaining other sources of income; her sister does not have an identity document so cannot claim the CSG for her child, and she herself is dissuaded from seeking work by the fact that she would need to find someone to care for her one-year-old.

Two points emerge from this woman's account; firstly that her priority at this point is to ensure quality care for her young child, and that despite the precarious economic situation, the family supports around her enable her to do this. Secondly, she, her younger sister and father are all formally unemployed and play distinct important roles in childcare. Not only was she providing daily practical care to her one-year-old son, she was assisting her sister with care of her infant. Their father, it emerged, has a strong emotional bond with the one-year-old boy, spending long periods of time playing with him and comforting him when appropriate. In another household, a mother (R3) spoke of the way in which her employed partner joked and played rough and tumble games with their daughter, an element of care that she recognised to be important but was unable to provide because she was physically and mentally unwell. Childcare environments, influenced both by high levels of unemployment and cultural

practices, are therefore peopled environments, with both kin (in the case of R5) and non-kin (in the case of R1) and men and women playing important roles.

It has already been noted that the material provision provided by fathers who are predominantly physically absent from the household also symbolise emotional connectedness. However, the above cases further suggest that not all fathers, partners and male figures in Masiphumelele homes are absent. Rather, our data supports the conclusion that, in contrast to the typically pejorative representations of men in the context of poverty and, more recently, HIV/AIDS, men can and do play positive and supportive roles with respect to childcare and the household more broadly.¹⁶ For example, in study 3, in addition to absent men, fathers and partners, there were men who played an active role in childcare and other domestic duties. These included R3's live-in partner and father to her child who cooked and cleaned as well as played with his daughter, and R5's brother and father mentioned above who were clearly significant male figures in the life of R5's young child. Further, the material illustrates that men who are unemployed can still contribute in important ways to sustaining the household, for example, through assisting with childcare. This is not a representation of the unemployed male that is typically considered, perhaps because, for some of the reasons noted earlier, caregiving activities are often ignored or listed as secondary activities in surveys capturing data on work-related activities (Budlender, 2004).

The relationship between poverty/unemployment and role allocation within and across households, and the implications for childcare, is one worth re-emphasising. In a situation of high unemployment such as prevails in Masiphumelele, there are different role allocations that involve varying degrees of income-generation/material provision and household maintenance, including childcare. The data suggests that there is often a flexible shifting of roles that takes place to allow for change in employment dynamics, but also in response to other shifts or events affecting the household, for example, the ill health of one of its members. Amongst the five households in study 3 with AIDS-sick mothers, other household members (in these cases, men) took on a range of roles: C3's (age 4) father takes responsibility for aspects of caregiving for which her mother does not have energy or mental strength. Further, when his partner is in hospital, C3's father cares for his child full-time, including arranging care by neighbours when he is at work. The above-mentioned examples speak of the ways in which groups of individuals, that may form more or less temporary households, adapt in response to illnesses such as HIV/AIDS and/or economic shocks.

¹⁶ For recent examples of roles played by men in the context of HIV/AIDS, see Denis and Ntsimane (2006) and Montgomery *et al.* (in press).

To the outsider, these changes appear to be primarily disruptive; yet threads of continuity at social and emotional levels are maintained (for example, through telephone conversations, remittances, annual or more frequent visits) and decisions taken regarding childcare are not random. Instead they reflect what Reynolds (1995: 17) has termed the “cost of a permanent effort of maintenance” in which relationships are fed with social, emotional and economic inputs. Both kin and non-kin contribute to the care of children, and enter into care relationships with them, including aunts (particularly mother’s sisters), grandmothers, older children and young adults (often newly arrived from the Eastern Cape), neighbours and friends. A large proportion of practical ‘caregiving’, as observed in the studies reported on in this paper, happens in relationships and physical spaces that are outside the household: children spend time with other children (neighbours, cousins), and eat, socialise and explore with these children under the watch of an adult neighbour or extended family member. These often informal interactions support the child directly, and the mother/carer indirectly, and “may serve as a buffer against the stresses of poverty, which in turn, may lead to more effective parenting practices” (Bromer & Henly, 2004: 944). This is noteworthy given the point made earlier that these kinds of care are often not captured in research despite constituting a significant amount of time spent by those involved in situations of multiple care (Budlender, 2004). Teenagers may join households in Masiphumelele with the hope of accessing a better education than is possible in the Eastern Cape, however, their presence also enables them to contribute to household production in ways that compensate for the direct economic impact of having another body to feed and educate, most notably where such children assist with childcare. For example, one woman (R4 in study 3) trained her older daughter in hairdressing while she was pregnant so that her daughter could continue with customers if R4 is busy with the infant.

Some mothers and carers prefer to draw on neighbourly friendships than kin networks. For example, one mother (R1 in study 3) entrusted her son’s care to two friends (one her sister’s neighbour and another her own), rather than her sister. Similarly, after losing her job and her place in her sister’s home (as described earlier), she took the decision to find a new home for herself and her son, independently of family members (she chose not to move in with, or near, her brother in Khayelitsha who has offered her consistent support over the years). Such decisions shed light on the way family relationships are experienced, in this case by mothers with young children, and on the extent to which they are to be relied upon. The women carers we conversed with described their considerations thus: On the one hand, one can reasonably expect a degree of support from close relatives. Ultimately, however, their decisions are outside one’s own sphere of control and there are high potential social and

emotional costs to falling out of favour with one's kin. For these reasons, the best route is often to set up home on one's own with one's children and seek support from neighbours and friends. Reliance on neighbours and friends rather than kin may therefore have fewer complications and be more reliable. However, friends and neighbours can also be essential supports where family is not available, for example, in the case of R3 where neither she nor her partner had family members living close by. Instead, they relied on Mozambican friends of theirs in the community. The girlfriend cared for R3's mentally ill brother when she visited Mozambique, assisted with childcare from time to time, and is happy to housesit and look after the brother when needed.

The fact that so many different role-players contribute to the childcare environment, either directly or indirectly by supporting the carers, lends support to the critique levelled at analyses of childcare based on the notion of a single (most responsible) caregiver. Others have indicated the limitations of such an approach in situations of multiple care and suggested the use of systemic approaches able to capture the influences of carer relationships with kin and non-kin on childcare (see for example, Cole & Cole 2001, Donald & Dawes, 2000). For similar reasons, Hosegood and Ford (2003), in their analysis of child mobility, point to the shortcomings of using child-headed household as an indicator of vulnerability. In particular, they emphasise the need to document co-residency patterns of adult household members, the involvement of neighbours and their respective child-care roles.

Psychological well-being

In addition to the role of tangible factors such as unemployment, mobility and education, psychological well-being has a role to play in influencing the relationship between poverty and childcare by shaping the contexts within which childcare takes place. For reasons that have been well-documented elsewhere (see, for example, Desjarlais, Eisenberg, Good & Kleinman, 1995), poverty poses a mental health risk to individuals and communities. Poverty is associated with a range of risk factors, such as poor amenities, criminality and violence, and also with reduced access to critical resources, including psychosocial services which can ameliorate the association between risk and adverse outcomes. In more recent times, the high prevalence of HIV/AIDS in poor communities, particularly in sub-Saharan Africa, has further compounded the mental health risks for persons living in such communities, both those infected and affected by HIV (Baingana, Thomas & Comblain, 2005; Freeman, 2004).

Risk to the mental health of carers has important implications for their capacity to provide emotionally responsive care to their children. Research has shown

convincingly that poor psychological functioning in mothers, including depression, predicts poor monitoring of children and other adverse impacts on children's emotional and intellectual development (Cooper *et al.*, 1999; Forehand *et al.*, 2001; Jones *et al.*, 2002; Wild, 2001; see also Brandt, 2005b for a recent review). Mothers in Masiphumelele recounted instances when they had pushed their child away, refusing their request for love and attention, because they were mentally preoccupied by financial or health-related worry. R1 (in study 3), for example, an AIDS-sick mother, said that she had pushed her young son away at times, and would regret this within minutes and call him over for a cuddle. In a focus group looking at factors influencing the healthy development of young children (study 1), mothers' examples of poor care included "pushing children away when they are excited to show you something but your mind is consumed by worries about the next meal, or a job or something like that". Mothers said that the way parents interact with their children is critical (alongside other major influences such as poverty, alcoholism and inherited characteristics of the child). When one mother (R3) spoke about 'good enough care' for children under 5 years, she said:

When small children receive care from a relaxed person it is clear with how happy they look. My [HIV] status affects the energy I can give to my youngest child at the moment. She is left to do things for herself earlier than other children are. I cared for my older children in a more relaxed way when they were small [before I became infected]. I was not as pensive and worried.

Our observations confirmed her descriptions. Her interactions with her daughter are muted and discouraging of further engagement, and she was visibly weakened physically, mentally and emotionally.

The carers we spoke to were keenly aware of the link between their own mental well-being and the quality of care they could provide to their children. All carers acknowledged the impact of their reactions on their children and the importance of summoning the strength to give them the love and care that they wish to. However, even in the absence of critical community-level services, several other factors can account for the fact that mental health risk does not necessarily result in poor care. Psychological research has identified other factors that moderate this relationship, including the social supports available to the individual carer and whether s/he has an internal or external locus of control¹⁷ (Klein *et al.*,

¹⁷ This term, as used by psychologists in particular, refers to the extent to which someone perceives events in their external environment to be within their control. Someone with an external locus of control tends to perceive themselves as having little control over their environment, while an internal locus of control refers to someone who perceives themselves as having agency in relation to the events in their life.

2000). The presence of HIV (and decisions around disclosure) may heighten the influence of these factors owing to changes in carer mental and functional health, as well as available social support (for more on this relationship, see Brandt 2005a; Brandt, Dawes & Bray, in press). Such dynamics illustrate the importance of social relationships – or, as we describe above, ‘relatedness’ – for emotional/psychological well-being. They also serve to caution the researcher in trying to isolate linear causal relationships in generating an understanding of influences on childcare.

How does HIV shape childcare in the context of poverty?

An important question in light of the high HIV prevalence in Masiphumelele (as in other similar communities in South and southern Africa) is in what ways, if any, HIV shapes childcare in the context of poverty. As was mentioned in the previous section, poverty and HIV are highly interrelated. However, an important issue that is often glossed over is whether HIV and AIDS, in comparison with other illnesses and stressors, in fact contribute anything unique to our understanding of how individuals and communities function. While our data does not permit a systematic comparison, some interesting findings emerged that have a bearing on this broad question (and its relevance to ideals and practices of childcare).

The data quite clearly show that many issues, indeed most, are relevant to understanding both infected and affected carers and their relationships with their children. This is particularly so since many carers either live in a household with, or know, someone who is HIV-infected due to the high prevalence in Masiphumelele and other communities in Cape Town where many residents have friends or family. HIV/AIDS touched the lives of all carers and adults who participated in the research in more or less direct ways. Further, this is consistent with research indicating that HIV/AIDS is typically only one of a range of stressors experienced by children and their carers, and does not independently influence their social and emotional well-being (Forehand *et al.*, 2001; see Brandt, 2005b for a review). Nonetheless, in addition to the points mentioned earlier in the analysis, the data does indicate some particular ways in which HIV or AIDS might influence childcare and the contexts in which it takes place.

First, the stigma associated with HIV status may serve to heighten women carers’ concerns around residential security, which could in turn prompt them to limit their use of certain available sources of support. In the case of R4 (in study 3), for example, she had not disclosed her HIV status other than to her partner,

and was especially concerned to withhold this information from her sister-in-law (and landlady) who posed a threat to the family's residential security, and with whom relations were already strained. Consequently, she did not attend a support group for fear that she would be seen entering a location associated with HIV, word would get back to her sister-in-law and she would use this as another lever in her attempts to move them out.

Second, as the case of R4 also demonstrates, carers had several difficult issues to consider with respect to disclosure of their HIV status to family members. As was demonstrated earlier in discussing how carers access support for childcare and for themselves, there are high potential social and emotional costs to falling out of favour with one's kin. While disclosure can increase the level of support offered by family, it was evident in our conversations with AIDS-sick mothers (in study 3) that they considered carefully whether and how to disclose to certain family members in case it had negative effects on their relationship with that person (Brandt, 2005a; Brandt, Dawes & Bray, in press). At the time of our first interview with R2, she had just disclosed to her brother, mother, and boyfriend. When we returned for a second visit she had disclosed to her sister, who asked her if she is HIV positive because she had been seen frequenting the local clinic and support group. The sister asked because she is also HIV positive and had been scared to tell people. They discovered that they had both been concealing this from each other. R2 reported that they are closer with each other as a family and especially the sister since they are in the same situation. They share food and space, the children can have meals in each other's house, or both when there is insufficient in each. (The only sibling who does not know is her fourth brother who she feels she is not ready to tell). In the case of R1, she has told everyone in the family (and most community members) of her status except her mother who lives in the Eastern Cape. Her explanation as to why not suggests that she fears the consequences for her mother's health, and perhaps the relationship between the two of them: "When my mother heard a rumour from someone, it affected her and she became very ill. When she asked me about it I denied being HIV positive because I felt it would shock her too much". Therefore both in relation to care and support more generally, and in the context of disclosure of HIV status, reliance on kin may have more complications than reliance on neighbours and friends.

Third, HIV and AIDS presents a challenge to existing cultural practices in some African communities, especially with respect to the nature of communication between children and adults, and talking about death. A group of social workers participating in a focus group (study 1) articulated the normative belief and practice in the community, namely, that death is something that is not typically spoken about, either in relation to HIV/AIDS or in general:

- Social worker 1: Mothers don't bother teaching their children about death.
- Interviewer: Why do you think this is the case?
- Social worker 1: Once you start on the topic, then the child will have more questions that are too difficult to answer.
- Social worker 2: Also the language we use to discuss death and related things is quite complex, and is not familiar to a child, so they don't understand. We don't like to stress children with horrible things like death. We would rather protect them. Even sometimes there is a big gathering for the funeral, and the children don't know why everyone is there.

While this is an issue for all carers, it is particularly important for families affected by HIV/AIDS who must deal with the issue of disclosing to children that they have a potentially life-threatening illness. For those carers with full-blown AIDS who may be visibly weakened and impaired in their daily functioning, this may even become imperative. However, it is the high HIV prevalence in the community in which our carers lived that seemed to be challenging the existing norm, since children can see how many sick people there are in the community, and how ill their own carer is, too, without necessarily being told. This is illustrated in the case of R3 (in study 3), who was confronted by her four-year-old daughter after being hospitalised for a short period due to illness:

When R3 arrived home, her daughter asked why she had stayed in hospital. She replied that she had had a bad 'flu. Her daughter said that she did not think this was true, and that she thinks she was in hospital because she has AIDS. R3, surprised by this challenge, asked why she thinks so. Her daughter said that she had overheard one of the neighbours saying so. R3 asked which neighbour it was and her daughter replied, "I'm not going to tell you as I don't want you to fight with that person". R3 told us (the researchers) that "Traditionally, children are expected not to ask lots of questions, and especially tell their parents that they are not telling the truth." R3 said she did not want to punish C3 for disrespecting that custom. So, R3 decided not to reprimand C3 for the accusation because she knew that C3 had a point.

(Excerpt from fieldnotes)

Just as might be case with the children in the focus group excerpt above who were not told about the funeral, C3 understood much more than her carer was willing to explain to her. Further, her understanding was the result of seeing HIV in the community and overhearing the talk of a neighbour. Research indicates that a large number of mothers are reluctant to disclose their HIV

status, but especially to children as young as those included in study 3 (4-5 years) (Kirshenbaum & Nevid, 2002; Murphy, Marelich & Hoffman, 2002). In a focus group with mothers, teachers and crèche staff (study 1), women debated when it is 'right' to speak to children about terminal illness and death. When one mother, after some silence, suggested ten years, the others nodded their heads in agreement. In contrast, another mother (in study 3) was of the opinion that parents should start to talk to children about death from the time they are about four years, but in such a way that they can understand. However, the data clearly shows that this is not the norm as only one of the sixteen¹⁸ children of the AIDS-sick mothers in study 3, half of whom lived in the same household as their mother and half of whom lived with another family member outside of Cape Town, had been told about their mother's HIV status.

The mother who had disclosed (R1 in study 3), told her four-year-old son about her HIV status around the time that she began treatment with antiretrovirals. Before she spoke with him about her status, he had told her that he was planning to return to the Eastern Cape to live with his grandmother (who he refers to as "mama" having spent two years being cared for by her). When he heard about his mother's status, he announced that he had changed his mind and decided to stay and look after her. R1 told us that her son takes active interest in her state of health, asking about the ways the virus is affecting her and when she is tired or feeling unwell, bringing her water and medicines.

While R1's approach to disclosure and talking about death with her child was different to that taken by R3, it is nonetheless clear that neither decision was taken lightly. These carers were aware of their children's developmental stage and of the delicate balance between informing and protecting them. For example, R1 told us that, a year previously, when her sister had forced them to leave her house, her son could not understand why this was happening and she decided not to explain the reasons as he was "still small". Her view is that children should come first, whether this means protecting them from infection by not allowing them to share fruit with others, or by informing them fully about HIV and its consequences. She stands by these opinions even when they attract some hurtful and ostracising reactions from neighbours and friends. Indeed, a key difference between R1 and R3 is that R1 was an emotionally strong person who had taken a firm position in her life, speaking openly in the community about her HIV status and providing her son with the most intimate knowledge of the everyday implications of his mother's status in terms of her mental and physical health. However, the data also points to the fact that decisions about discussing death and disclosure took place within an existing relationship

¹⁸ This figure does not include two children who were under 18 months of age at the time of the study.

between carer and child in which a certain level and type of communication exists, and in which the carer has either more or less emotional resources to deal with these issues. While R3 appeared vulnerable and relatively isolated, and had a history of rejections, R1, despite her own past difficulties, displayed remarkable resilience and had taken charge of her situation. Though the relationship is not linear, the nature of communication between carers and children therefore seems to be highly influenced by carer mental well-being and access to effective support. This is consistent with research that has shown that mothers with higher levels of social support are more likely to disclose to their children (Murphy, Steers & Dello Stritto, 2001), while mothers with psychiatric histories are likely to make more (inappropriately) detailed disclosures (Kirshenbaum & Nevid, 2002).

Fourth, HIV, but AIDS in particular, can render some mothers and carers cautious about remaining emotionally attached and invested in their relationships with their children. When asked the question ‘what happens if a child is given lots of love?’ some carers in study 3 said that it would have only positive outcomes for the child and those around them. Others alluded to the possibility that the child will become too demanding, selfish and lacking in self-control. According to one mother (R3), the problem with giving lots of love is that the child becomes accustomed to it and may find any subsequent carer who gives them less love to be mean or harsh. In this light, moderating the depth or frequency of attention paid to children is seen as a means of encouraging respect towards others, particularly adults. While this strategy may have relevance regardless of the carer’s HIV status, in the context of HIV, such a strategy can be seen as a means of adjusting the child’s symbolic environment in the light of anticipated changes in their material and socio-emotional environments following carer illness or death. From a carer’s point of view, such actions, whether taken consciously or unconsciously, may represent an attempt to provide the child with the emotional resources to cope with a change in caregiver. Such decisions are tangible and accessible actions that carers are able to take while they are alive that might have an impact on their child’s well-being once they have died. Further, it must also be said that periods of illness or hospitalisation may lead to reduced emotional availability of carers as well as their reduced physical unavailability and monitoring. The impact of this reduced role will depend partly on the number of other carers who are both physically and emotionally available to the child(ren) during these times.

This point notwithstanding, there is empirical evidence to suggest that during the times when HIV-infected carer’s health permits, carers may instead overcompensate by investing more rather than less in their relationships with their children out of guilt that their children will be left without a parent or carer too early (Black *et al.*, 1994; Byrne, 1998; Ciambrone, 2003; Johnson & Lobo,

2001; Soskolne, 2003). This was most poignantly reflected in the comments on one AIDS-sick mother (R3 in study 3) who believed that one's approach to childcare depended on one's HIV status. She commented that, "If you know you are HIV positive, you are more restless because you do not know for how long you will be around to see them growing, so every moment is precious." She was able to compare her own experience with her youngest child who was born after her diagnosis, with that of her two older children who she raised while being HIV negative. Aware that her life expectancy is shorter but unknown, she is more motivated to spend time with her daughter. Corroborating ethnographic evidence finds that HIV positive mothers see their status as a reason to put extra effort into providing their children with the best educational opportunities possible (De Lannoy, work in progress).

Although the data reported on here does not specifically shed light on these issues, two final points regarding the relationship between HIV and childcare in the context of poverty should also be mentioned. Much has been made in the media and policy literature in particular, of the role of grandparents in responding to the epidemic and the large numbers of children orphaned as a result of AIDS (Ferreira, Keikelame & Mosaval, 2001). This is clearly a very important way in which HIV is influencing the nature of childcare in poor communities. However, we would once again caution that such statements must always be grounded in an enquiry regarding how communities and families were functioning prior to, or alongside, the epidemic. In the case of Masiphumelele, for example, prior to the epidemic, many younger children were cared for by their grandparents living in the Eastern Cape, while teenagers frequently moved to Cape Town to live with their parents or other family members and reap the benefits of closer proximity to better schools and work opportunities. Hence the role of alternate or shared caregiver in Masiphumelele is more likely to be filled by a teenager or young adult than by a member of the older generation¹⁹. Similarly, the issue of child-headed households that has received equal attention as a consequence of the AIDS epidemic, may also have a very particular meaning and impact in a community such as Masiphumelele with a higher proportion of young people than in the Eastern Cape, even before the epidemic. Particularly where child-headed is used to refer also to youth in their late teens and early twenties, the change in this community may not be a large one.

¹⁹ See Case and Ardington (2004) and Giese *et al.* (2003) for further discussion of AIDS orphans.

Children's contributions to the care relationship

The preceding analysis has focused on factors influencing the nature and quality of childcare, with a primary emphasis on adult carers. Here we turn to children's roles in caring, particularly for adults who would be identified as their carers. Much of what we observe in terms of roles and the playing out of relationships is not specific to situations where adult carers are HIV positive, however, our data suggest that the status of other residents in the home may influence aspects of these relationships.

We argue that social scientists should attend to children's contributions to care relationships for two broad reasons. The first is simply to acknowledge the everyday actions and associated emotional investments performed by children, and the implications of these for an understanding of 'care'. Analysis of data collected from children and their families in Masiphumelele over a two-year period shows that most five to nine-year-olds are involved in domestic tasks, many of which directly assist their carers (see Bray, 2003). These include helping with cooking, cleaning the home, washing their own and others clothing, and making tea for their carers. Many carry or watch over their younger siblings for periods of the day. In addition, young children often run errands and pass messages between households of extended family members or neighbours.

The manner in which one mother (R2 in study 3) describes her links with extended family living in Masiphumelele illustrates the active involvement of children in the maintaining of social relationships:

We all keep an eye on how each person is doing, and often visit each other. Most of us have cell phones and we send our children on errands to each other's homes and to send messages between our houses.

One consequence of this role is that children are always well-informed about family goings-on, and therefore have the relevant knowledge for participating in relationships beyond the household. Moreover, we see that care within households, when broadly defined, often involves giving and taking between children and adult carers. Interestingly, children age 12 to 15 years (participating in study 1) produced drawings and accompanying descriptions that showed the high value they place on respect for, and care of, others. These values were also expressed when children recounted the positive qualities of their peers, for example, 'She is a good person as she thinks about others. He cares for others, especially his family'.

The examples indicate that children can and do contribute in both practical and emotional ways. In this light, care should not be understood as a one-way process where social, emotional and material resources flow in one direction, namely from carers to their children. Instead, if we understand the flow of resources to be two-way within a context of multiple relationships contributing to care, we recognise the potential positive impact of children's input to these relationships on adult well-being, and hence on adult abilities to continue caring and fulfilling other roles in the home and family. The mother described above (R1) spoke of the way in which her four-year-old son attended to her needs when she was not feeling well, and how his practical and emotional care boosts her own morale and gives her all the more reason to 'live positively'. If carers recognise the mutuality of care, they are arguably more likely to be making decisions that will enhance both their own well-being and that of their children. We can envisage that children's contributions to caring relationships are experienced as all the more valuable when adults face a combination of social, economic and health pressures (for R1 these currently comprise unemployment, strained family relationships and AIDS). However, for HIV-infected carers, the likelihood of certain kinds of help might be moderated by the amount of information which the child has about the parent's illness (in addition to the child's developmental stage). For example, C3 who was told that her mother did not have AIDS, as opposed to C1 who was told about his mother's illness and became actively involved in her care. Much of the literature on childcare in South Africa emphasises the importance of parental, but specifically maternal, well-being to the provision of good quality childcare (Barbarin & Richter, 2001). Though these case studies do not dispute this relationship and indeed would seem to confirm it, they suggest further nuances to the experience of childcare from both children's and carers' perspectives, and the subsequent need to adapt our thinking around the nature of 'care' in ways that acknowledge children's inputs to the relationship.

The second reason for social scientists to attend to children's engagement in caring relationships relates to the immediate and longer-term impacts of such a role on child well-being. In the case described above (R1), it was evident that the close and mutually supportive relationship between mother and four-year-old son had immediate emotional and social benefits for both, and for the son these included a sense of security in their small household unit. The mother's decision to disclose her status to her son seems to have contributed to a high level of trust between them. She now trusts him not to disclose her status to her own mother, The seriousness with which he approaches this and other responsibilities that come with his active engagement in caring for his mother indicates that he is proud of his role, and derives from it considerable self-esteem. Yet there remains an underlying question of whether the experience of

assuming such roles, to the point of parenting his own mother, will have costs in the longer term.

The limited research available on this topic, what has been termed the “parental child”, suggests that outcomes differ according to the age at which children assume aspects of the care role (Keigher *et al.*, 2005). Intuitively, we might assume that very young children take on fewer care-related tasks and emotional responsibilities, partly because they are unlikely to be familiar with their carers’ entire set of circumstances. However, research shows that even infants can respond behaviourally and emotionally to their (unconscious) awareness of their mother’s needs, including that for support (Berg, 2000). In the context of HIV, for example, Byrne (1998) has shown that some infants compensated for their HIV positive mother’s lack of engagement during a feeding interaction. Further, in the studies reported on here, very young children, of preschool age, such as C1, were actively involved in care, including the provision of emotional support.

The few studies conducted on the impacts of care-giving on children alert us to some potential outcomes, yet at the same time caution us to their highly context-specific nature. For example, research in urban mid-West America with children caring for mothers with AIDS found behavioural difficulties amongst eight to 14-year-olds (for example, fighting at school) stemming from children’s feelings of stigma, isolation and worries about their mothers’ health (Keigher *et al.*, 2005). The same study reports problems experienced by teenagers in making the transition to adulthood from both a career and emotional point of view.

In mid-West America, however, children are taking on what would be considered unusual roles when their mothers become sick from AIDS. In contrast, children in Masiphumelele are doing what is normally expected of, and (according to the children) often enjoyed by, children (Bray, 2003). Thus, up to a certain point, children may be doing what they consider appropriate for their carers in the context of their relationship with each individual, their membership of the household, and, in some cases, their understanding of how AIDS makes a person feel. This is consistent with research that highlights the fact that ‘the parental child’ may not be atypical in urban poor families where children may regularly participate in household activities, even at an early age (Chase, 1999 in Keigher *et al.*, 2005; Winton, 2003 in Keigher *et al.*, 2005). The questions that remain, and lie beyond the scope of this paper, concern the point at which the contributions of children in Masiphumelele traverse local norms and pose certain social and psychological risks, and what exactly those risks entail.

These points regarding the nature of children’s engagement in care relationships and its potential impacts are pertinent to a broader understanding of current changes in household structure and relationships. Although much research and

policy concern is directed towards so-called ‘child-headed households’, there is evidence to suggest that children’s caring roles are more ubiquitous and potentially costly to well-being in households where adults are sick or dying (Giese *et al.*, 2003). Nonetheless, research with children in child-headed households can shed light on the possible social, psychological and economic impacts of an active care role.

A recent study of the developmental vulnerabilities and strengths amongst children living in child-headed households found that, when compared to counterparts in adult-headed households, these children were better at social networking, managing time and money and engaging in family interaction (Donald & Clacherty, forthcoming). Children in child-headed households were found to be proficient in recognising the need for, and giving, emotional support to others in their families, and to conflict resolution within the family. They were also better at seeking out and nurturing both peer and adult support. The enhanced social skills observed amongst these children lends support to our arguments around the positive way in which children’s engagement in social relationships involving care is experienced (and interpreted) by both children and adults. However, longitudinal studies will be needed to begin to examine the longer-term costs that may be hidden behind the short-term social benefits.

Conclusions and recommendations

The close analysis of childcare relationships in Masiphumelele raises some important methodological and conceptual issues for the study of childcare, family relationships and child well-being more generally. We draw attention to those concerning research design and methodology, before offering suggestions around the conceptualisation of childcare with implications for further research. Finally, we reflect on how some of these issues can be approached in more quantitative studies.

The data upon which this paper is based come from three distinct studies, only one of which was designed specifically to analyse the nature of childcare relationships (study 3). Yet, this paper would not have been able to offer an analysis with any substance or nuance without significant contributions from all three studies. On the one hand, this points to the value of triangulation in trying to understand the complex connections between action, ideology and context. We were able to see patterns in these spheres emerging across the data sets. On the other hand, the fact that each study generated data of different types cautions us to the importance of distinguishing between these types during analysis. For example, some of our ethnographic material reflects cultural practices around childcare or individual interpretations of – and challenges to – these practices,

while other material sheds light on individual and collective ideals that may or may not be different from practices.

A final methodological point raised by this paper concerns sampling. The reader will recall that all carers participating in study 3 were directly affected by HIV, whereas this was not the case in the two other studies. Access to both HIV-specific and non-specific data enabled us to see that certain processes around the conceptualisation and practice of childcare are not unique to HIV-infected households, as they might first have seemed.

In terms of conceptual contributions, this paper suggests that further thought is needed within the research community around what an understanding of care as a two-way relationship means for conceptualising and measuring resource distribution within and across households. Our analysis challenges prevalent models of family support in which the direction of such support is assumed to be from 'independent' adults to 'dependent' children. Children are found to contribute practically and emotionally to the care of those adults who would be classified as their carers. This occurs in the everyday rhythm of home life, and is not something that emerges only under special circumstances such as adult illness. Thus definitions of 'dependent' and 'independent' need to be questioned, particularly in contexts where the physical and mental health of adults is at enhanced risk and the composition of their support networks of primary interest. Put briefly, the nature and degree of children's contributions to adult well-being deserve serious consideration.

In addition, acknowledging the relational nature of childcare has implications for our judgement of the 'quality' of childcare. Models of childcare tend to posit certain essential components of good quality care, the majority of which centre on practical provision. For example, UNICEF's 'extended model of care' identifies six major types of care behaviour: feeding and breastfeeding, food preparation and handling, hygiene behaviour, psychosocial care, care for women and home-health practices (Engle *et al.*, 1997). The category 'psychosocial care' is usually meant to encompass emotional aspects of care relationships, but the specific form and function of these, and their impact on 'quality', remain unexplored. The findings presented above challenge the utility of these models in a number of ways. Firstly, there may be a critical difference between emic and etic perspectives on what 'care' consists of. The statements of carers in Masiphumelele show clearly that emotional dimensions of care exist alongside more instrumental aspects of care, and are given equal priority.

Moreover, the fact that the emotional aspects of care are considered to have both emotional and practical outcomes, and instrumental care (such as material provision) is experienced as symbolic of emotional input, demonstrates that any

measurement of the quality of care relationships needs to account for these dual functions. Such interconnectedness between elements that together comprise ‘good quality care’ is, of course, a direct manifestation of the way in which care is embedded in social relationships. One important implication here, is that quality care may not necessarily depend on physical proximity (for example, co-residence) nor on relational proximity (for example, close kinship ties). In this regard, our study suggests that enquiry into forms of family support should look beyond the extended family as key contributors to childcare and other personal and household productive roles.

We have demonstrated that the care of children in Masiphumelele takes place in the context of relationships that are at once fluid and structured. Attempts to model the sources of influence upon children’s lives and their relative importance, tend to describe these in terms of a series of spheres or contexts, beginning with key individuals in the household (or co-resident group), and moving outwards to include the neighbourhood, extended family, broader community and wider society (for example, see Bronfenbrenner (1986, 1995)). While helpful in acknowledging the range of relationships involving children, most existing models risk creating an impression of distinction between these spheres (and excluding the possibility of primary care roles being played by those outside the current household). The experiences of children and their carers in Masiphumelele illustrate that the social institutions represented in each of these spheres sometimes undergo frequent change in their composition and the ways in which they resource care relationships. Similarly, the sources from which children draw support (and the context to which they contribute) shift over time. Yet there are patterns and predictabilities within this fluidity, the historical, socio-economic and cultural underpinnings of which we argue are critical to any exploration of ideals and practices in childcare. Our suggestions towards a rather different conceptualisation of childcare, one that recognises continuities within change, questions the assumption that physical and social mobility has solely negative implications for children’s lives.

It is within this dynamic of change and continuity across physical and social space that the relationship between poverty and childcare should be approached. Poverty is often seen as that which places certain constraints on the realisation of ideals (for example, sending children to crèche), but this paper has shown how it also shapes the contexts in which care takes place and the availability of non-material resources. For example, employment patterns directly affect the number of individuals contributing to the care and monitoring of children during the working day. Employed adults who work long hours or commute large distances are unavailable, and unemployed women and men fulfil a vital role in this area. Poverty strongly influences the quality and security of residential arrangements, as well as mobility and unemployment, thereby influencing the

nature of childcare and shaping it in ways that might not otherwise be evident (for example, due to the number of carers available in areas of high unemployment).

This analysis has also attempted to illustrate some of the ways in which HIV/AIDS can shape childcare, over and above the influence of poverty. One of these is a heightened concern regarding residential security, given the potential threats involved in disclosure of HIV status in a community where levels of stigma remain high. A second is the fact that infected carers may invest even more in relations with non-kin, given the high potential social and emotional costs to falling out with one's kin. The high visibility of HIV/AIDS also poses a challenge to existing cultural practices, especially with respect to the nature of communication between adults and children, and talking about death. This situation might create a gap between ideals articulated by carers and usual practice. The interesting point here is that carers recognise and grapple with this inconsistency, indicating that it may over time precipitate change in practice.

In light of our findings, we offer some brief suggestions concerning survey design, particularly in the context of panel surveys aiming for a longitudinal perspective. Our analysis has demonstrated the limitations of approaching childcare purely as an aspect of household reproduction that can be measured through an analysis of intra-household resource distribution. Several recent longitudinal South African social surveys, for example, the Cape Area Panel Study, are designed to capture the physical movement of adults and young people between households and carers. The directions and value of remittances are also recorded. Parallel information on the different roles played by these individuals, including their economic, practical, social and emotional elements, would greatly enhance our understanding of the impact of physical mobility on social relationships within and beyond the household, particularly with respect to the sourcing of support following demographic or economic shifts. Research is needed into how such information could be sensibly incorporated into existing survey design, as well as the possibility of drawing on different sections of the data to generate a more detailed picture of the care of children and other household members. Smaller qualitative studies can be a useful starting point in such an undertaking, with the goal of identifying key local factors and practices on which large-scale surveys can be built.

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Appendix 1. Data set 3: Summary descriptive data on caregivers and their children

		1	2	3	4	5	
Caregivers:							
Identifying data	Age (years)		23	37	32	33	26
	Highest grade passed		11	Less than 7	6	5	11
	Relationship status		Single	Single; Lives with partner	Divorced; Lives with partner	Single; Lives with partner	Single
	Employment		Unemployed (lost job as domestic worker during study)	Informally employed (sells cigarettes, sewing jobs, beadwork)	Informally employed (occasional spaza shop)	Informally employed (runs hair salon from home)	Unemployed (has never had a job)
Household data	Monthly income to household (Rands)	Regular (incl. grants)	910	170	1 650	1 270	1 970
		Irregular (approx.)	None	200	750	500	100
		Total	910	370	2 400	1 770	2 070
	Other resources available to household		Some food assistance from brother (not local)	Monthly food parcel. Communal eating for children. Weekly meal with brother.	Monthly food parcel. Sometimes food from neighbours for C3.	None	Monthly food parcel. Occasional financial assistance from relative.
	Major household expenses		Rent	No rent. No utility bills.	Crèche. No rent.	No rent	No rent
	Household size		2	5	4	7	7
	Number of adults		1	3	3	3	5
	Number of children		1	2	1	4	2
Medical data	Years since diagnosis		2	1½	3	4½	1½
	Weeks on treatment		16	2	16	4	7
	Attend support group		Yes	Yes	Yes	No	Yes
Children:							
Identifying data	Date of birth		11/06/99	07/07/03	05/03/00	08/11/00	06/02/04
	Age (years . months)		5.5	1.4	4.9	4.1	0.11
	Sex		Male	Female	Female	Male	Male
Caregiving data	Consistency of caregivers		C1's carers at diff ages: 0-18months mother and grandmother; 18months-3yrs grandmother; 3 years onwards mother	Only biological mother	Only biological mother	Only biological mother	Only biological mother

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The CSSR is an umbrella organisation comprising five units:

The **AIDS and Society Research Unit** (ASRU) supports innovative research into the social dimensions of AIDS in South Africa. Special emphasis is placed on exploring the interface between qualitative and quantitative research. By forging creative links between academic research and outreach activities, we hope to improve our understanding of the relationship between AIDS and society and to make a difference to those living with AIDS. Focus areas include: AIDS-stigma, sexual relationships in the age of AIDS, the social and economic factors influencing disclosure (of HIV-status to others), the interface between traditional medicine and biomedicine, and the impact of providing antiretroviral treatment on individuals and households.

The **Data First Resource Unit** ('Data First') provides training and resources for research. Its main functions are: 1) to provide access to digital data resources and specialised published material; 2) to facilitate the collection, exchange and use of data sets on a collaborative basis; 3) to provide basic and advanced training in data analysis; 4) the ongoing development of a web site to disseminate data and research output.

The **Democracy in Africa Research Unit** (DARU) supports students and scholars who conduct systematic research in the following three areas: 1) public opinion and political culture in Africa and its role in democratisation and consolidation; 2) elections and voting in Africa; and 3) the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has developed close working relationships with projects such as the Afrobarometer (a cross national survey of public opinion in fifteen African countries), the Comparative National Elections Project, and the Health Economics and AIDS Research Unit at the University of Natal.

The **Social Surveys Unit** (SSU) promotes critical analysis of the methodology, ethics and results of South African social science research. Our core activities include the overlapping Cape Area Study and Cape Area Panel Study. The Cape Area Study comprises a series of surveys of social, economic and political aspects of life in Cape Town. The Cape Area Panel Study is an ongoing study of 4800 young adults in Cape Town as they move from school into the worlds of work, unemployment, adulthood and parenthood.

The **Southern Africa Labour and Development Research Unit** (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. In line with its historical contribution, SALDRU's researchers continue to conduct research detailing changing patterns of well-being in South Africa and assessing the impact of government policy on the poor. Current research work falls into the following research themes: post-apartheid poverty; employment and migration dynamics; family support structures in an era of rapid social change; the financial strategies of the poor; public works and public infrastructure programmes; common property resources and the poor.
