

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

*Responding to Multi-Dimensional Forms of Poverty in the Context of
HIV/AIDS: The Experience of Mothers in Khayelitsha*

Dianna Kane / KNXDIA001

A minor dissertation submitted in partial fulfillment of the requirements for the
award of the degree of
MPhil in HIV/AIDS & Society

Faculty of the Humanities

University of Cape Town

2008

COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:

Signed by candidate

Signature removed

Date:

18.02.2008

Acknowledgments

It takes a village to write a thesis. I hold infinite gratitude to the following people, whose contributions to my life this year cannot be done justice with words.

To Judith Head, my supervisor, for her wisdom on the *process* that is a dissertation and for constantly reminding me to keep my sights on the 'big picture.' There really are 100 ways to kill a cat.

To Beth Mills, who stuck with me through countless proposals, and whose patience, careful editing, and encouragement has had an immeasurable impact on this final product.

To Penny Morrell and Hannah Lane, my dynamic and dependable "social capital," proving that three minds really are better than one. You challenge me, motivate me, and make me laugh.

To my family and friends in America and elsewhere, for your support of the direction my life has taken, no matter how far away.

To the women of Philani Nutrition Center, who have opened their hearts and shared their families with me. Ndiyabulela. I am humbled to know you.

And, finally, to my mother - still the most "capable" woman I know.

Abstract

South Africa is a highly unequal society, comprised of a small wealthy, elite class and a large population living in deep, chronic poverty plagued with unemployment. Those suffering from the greatest poverty are unemployed women caring for children. In the context of a distinct underclass that has been historically marginalized from the labour market and a welfare system does not provide assistance for the unemployed, these women are left to cope with their own poverty. Additionally, the HIV/AIDS epidemic exacerbates existing vulnerabilities and compromises the capabilities of these women and children. Guided by a livelihood framework and based on a multi-dimensional definition of poverty, the study explored how women navigate within their difficult environment to respond to the poverty of their children.

A qualitative study was conducted on a group of HIV-positive, unemployed mothers participating in Philani Nutrition Center's outreach program in Khayelitsha township outside Cape Town. The mothers highlighted several forms of poverty in their lives, including material deprivation, poor housing, and social isolation. Some of these deprivations were attributed to a lack of income, which they directly correlated to unemployment. The women are further constrained by a high burden of childcare and domestic responsibilities, worsened by having sick children. The mothers' own HIV infection reduces her physical capabilities as well as caused depression, anxiety, and loneliness as a result of HIV-related stigma.

In an attempt to ensure some aspects of wellbeing, the mothers accessed resources at government and community level and applied their personal strengths to their problems. They demonstrated that government grants were often used to address material deprivation while community organizations offered personal support to alleviate psychosocial elements of wellbeing. The women's skills at budgeting and managing a household, as well as their individual faith and positive outlooks further contributed to the wellbeing of the children.

Within this constrained and difficult context, this thesis concludes that the current responses of both government, community, and individuals are only able to mitigate the women's poverty. For sustainable solutions and poverty eradication, a structural transformation must occur. A comprehensive social protection system and the extension of work and educational opportunities is necessary for the underclass to meaningfully engage in society and begin transforming their lives. Numerous other recommendations are made for interventions that support and enable the efforts of mothers.

Table of Contents

ACKNOWLEDGMENTS	I
ABSTRACT	II
CHAPTER ONE - INTRODUCTION.....	1
CHAPTER TWO – APPLYING THEORY TO THE SOUTH AFRICAN CONTEXT.....	6
CONCEPTUALIZING POVERTY.....	6
A CLASS-BASED ANALYSIS OF POVERTY.....	8
THE UNDERCLASS.....	10
THE GENDERED EXPERIENCE OF CLASS.....	11
HIV AND AIDS - ITS INTERSECTION WITH CLASS AND GENDER AND ITS IMPLICATIONS FOR THE EXPERIENCE OF POVERTY	13
SOCIAL WELFARE, POLICIES, & INTERVENTIONS TO PROMOTE POVERTY REDUCTION	14
LOCAL INSIGHTS INTO COPING STRATEGIES	17
CHAPTER THREE – METHODOLOGY	21
OBJECTIVES OF RESEARCH.....	21
RESEARCH DESIGN.....	21
STUDY POPULATION.....	22
DATA COLLECTION METHODS	25
ETHICAL CONSIDERATIONS	27
CHAPTER FOUR – THE MOTHERS IN CONTEXT	30
PROFILE OF KHAYELITSHA.....	30
MEETING THE PHILANI WOMEN	31
<i>The Philani outreach workers.....</i>	32
<i>Mother #1: Nonkululeko / Outreach Worker: Pelisa.....</i>	33
<i>Mother #2: Naledi / Outreach Worker: Patience</i>	34
<i>Mother #3: Nothemba / Outreach Worker: Phumla.....</i>	34
<i>Mother #4: Nohuvuyo / Outreach Worker: Pinky.....</i>	35
<i>Mother #5: Nokuthula / Outreach Worker: Pelokazi.....</i>	36
HOUSEHOLD VULNERABILITY & CHALLENGES	38
<i>Unemployment & Household Income.....</i>	38
<i>Housing & Neighborhood.....</i>	41
<i>Illness.....</i>	42
GOALS & ASPIRATIONS.....	45
CONCLUSION.....	46
CHAPTER FIVE – RESPONDING TO POVERTY	49
GOVERNMENT SERVICES	49
<i>Social assistance grants.....</i>	49
<i>Public Health Care Services.....</i>	53
COMMUNITY RESOURCES.....	55
<i>Community-based Organizations</i>	55
<i>Social Networks.....</i>	61
INNER STRENGTH & RESILIENCY	66
CONCLUSION.....	70
CHAPTER SIX – RECOMMENDATIONS AND CONCLUSION.....	75
APPENDICES	81

APPENDIX 1: LIVELIHOOD FRAMEWORKS	81
<i>Learning About Livelihoods Framework</i>	81
<i>PGIEP Livelihoods Framework</i>	82
APPENDIX 2: MAPS.....	83
<i>Map of Greater Cape Town</i>	83
<i>Map of Khayelitsha, Site B</i>	83
APPENDIX 3: PHOTOS OF HOUSING IN KHAYELITSHA.....	84
<i>Typical zinc shack</i>	84
<i>A Philani shelter</i>	84
APPENDIX 4: INTERVIEW CONSENT FORM.....	85
REFERENCES	86
INTERVIEWS	91
<i>Philani mothers and outreach workers</i>	91
<i>Philani social worker</i>	91

University of Cape Town

Chapter One - Introduction

South Africa is a highly unequal society, comprised of a small wealthy, elite class and a large population living in deep, chronic poverty plagued with unemployment. Mid-year estimates for 2006 report that 47.4 million people currently live in South Africa (Statistics South Africa 2008). International economic measures of poverty deem that at least 45% of South Africans are living in absolute poverty¹ (Meintjes et al. 2003:14). South Africa's gini coefficient, a measurement of the distribution of wealth, is among the highest in the world. Where 0 represents equal income distribution and 1 represents the inverse, South Africa's gini was 0.77 in 2001, an 8% increase from 1996 (Schwabe 2004:1). These results not only speak to the great disparities in wages in South Africa, but also to the high levels of unemployment. In 1999, according to the strict definition of unemployment, 23.3% of the population was not formally employed. An expanded definition that includes discouraged job seekers brings the proportion up to 36.2% (Seekings & Nattrass 2006:319). The role of unemployment is a major factor in the high rates of inequality in South Africa and there is a proven positive correlation between unemployment and poverty (Seekings & Nattrass 2006:12). In the period from 1999-2002, the poor in South Africa increased by approximately 4 million people as the number of unemployed rose by about 2 million (Seekings & Nattrass 2006:319).

Both statistical and empirical evidence prove that those suffering from the greatest poverty in South Africa are unemployed, black² women and their children³. In March 2007, 25.0% of black men were unemployed (according to a strict definition of

¹ Set at US\$2 per day.

² The apartheid government implemented a set of racial classifications through which to direct their discriminatory policies. These crude classifications are still used in modern-day South Africa. Due to their use in popularly accepted terminology, the terms "black" and "African" will be used in this thesis to refer to the Xhosa-speaking women participating in this study.

³ The UN Convention on Rights of the Child defines child as any person under the age of 18 unless the age of adulthood in a given country is set lower. Most other reports follow this definition, including research units like The Children's Institute of the University of Cape Town (a leading research and advocacy group focused on children and children's rights in South Africa). However, the definition of a child can vary depending on policies and organizations. For instance, the current age cut-off for the receipt of South Africa's Child Support Grant is 14 years. However at I write the government has announced that this will soon be extended to 18 years.

unemployment), compared to 4.1% of white⁴ men (Statistics South Africa 2007a:xvi). Black women are at an even greater disadvantage when it comes to employment: in the same year, 36.4% of black women were unemployed as opposed to 4.6% of white women (Statistics South Africa 2007a:xvi). Female-headed households are especially vulnerable to income poverty, with 80% reporting no wage earners at all and 3 in 5 defined as "poor" (Budlender 2002; Gender Advocacy Programme 2001). Women are often the primary caregivers of children, with black women often carrying a "double burden" of poverty and childcare (Brandt, et al. 2006:523). Highlighting the incidence of poverty among children in South Africa are statistics that state, 43% of children have inadequate access to water (Jacobs et al. 2005:61), 49% have inadequate sanitation (Jacobs et al. 2005:62), and 12% live in informal settlements (Jacobs et al. 2005:64). Children of lower-class families also complete fewer years of school than children of middle- or upper-class families (Seekings & Nattrass 2006:294). Poor educational achievement has obvious implications for the replication of class and poverty within households and over generations.

In the midst of widespread unemployment, structural inequality, and poverty in South Africa, the HIV/AIDS epidemic arrived. Barnett & Whiteside state that HIV and AIDS illuminates existing global inequalities (Barnett & Whiteside 2002:24), clearly demonstrated in the situation of Sub-Saharan Africa which carries 63% of global HIV infections (UNAIDS Epidemic Update 2006) as well as the world's highest gini coefficient (Barnett & Whiteside 2002:130). The same is true of the epidemic in South Africa, with HIV prevalence concentrated in the poorest areas and among the most vulnerable populations. In a survey of HIV-affected households, 44% had an income of less than R1000 per month and only 43% of these had piped water in their dwelling. Of these households, 68% of caregivers were women and girls (Steinberg et al. 2002:ii). Not only has it been established that women experience higher rates of poverty, they are also the population carrying the greatest incidence of HIV infection. HIV prevalence in South Africa in 2007 is estimated at 11% of the general population (5.3 million people)

⁴ The term "white" is the classification given by the Apartheid government to refer to light-skinned people of European descent, including both the English and Afrikaans-speaking populations.

(Statistics South Africa 2007b:1). For women between the ages of 20-64 years, it is estimated that there is a 18.1% prevalence rate (Statistics South Africa 2007b:2). Prevalence among pregnant women attending antenatal clinics in 2004 was even higher, averaging out at 29.5%, though as high as 40.7% in some provinces (Department of Health 2005:8). Young South African women aged 15-24 are especially affected, and are four times more likely to be HIV-infected than their male counterparts (UNAIDS 2006:10-13). Furthermore, in the year 2000, HIV/AIDS was the leading cause of death among children under 5 years, accounting for 40% of deaths (Jacobs et al. 2005:59).

The poverty experienced by women and children in South Africa is exacerbated by HIV/AIDS, arguably creating a "triple burden" among women and increasing their level of vulnerability. Some approaches to analyzing poverty view these women as passive victims in the cycles of poverty and HIV infection or they are simply ignored. "The agency of parents and especially mothers... is often ignored, despite its importance in mitigating both current and *future* child vulnerability" (Gillespie, et al. 2005:21). This thesis will argue that for poverty and HIV/AIDS to be effectively addressed, "the valuable skills, insights, and accumulated experiences of women and girls living with HIV and AIDS must be taken seriously by policy-makers"(Esplen 2007:5). Working with Philani Nutrition Center, a community-based organization in Khayelitsha⁵ that focuses on empowering mothers of vulnerable children⁶, I investigated mothers' capabilities in the midst of poverty. Their stories proved to be extremely complex and involved a number of structural and individual factors that served to constrain or enable their responses to poverty.

⁵ A black township 30 kilometers outside of Cape Town's city center, created in the 1980s under the height of apartheid violence. A map of Cape Town and Khayelitsha can be found in Appendix 2.

⁶ This is a broad term to include all children whose rights may be at stake, as a result of HIV/AIDS, poverty, or a number of other factors. Vulnerable children are those who are under the age of 18 and who deal with the following aspects of poverty: material problems (food, money, clothing, shelter, health care, education); emotional problems (insufficient care, love, support, space to grieve); social problems (lack of supportive peer group, role models, guidance, risks in the immediate environment) (Davids, et al. 2006:2). Children living with HIV or with an HIV-positive caregiver, or those exposed to poverty, discrimination, or exclusion as a result of HIV, are also considered "vulnerable" (UNICEF 2003:11). Richter & Rama (2006) suggest the term "children living in communities affected by HIV/AIDS" to stress the vulnerability of all children in AIDS-affected communities. Due to the presence of HIV in each of the households studied, all of the children in these households can be considered "vulnerable."

In order to explore the dynamics within the mothers' lives, the structural causes of poverty and inequality in South Africa and theoretical arguments for the heightened vulnerability of unemployed, HIV-positive mothers⁷ will first be discussed. Chapter two also introduces livelihood frameworks, which illustrate how households⁸ operate within their macro environment. Chapter three outlines the methodology of this empirically-based research. Chapter four introduces the research participants and grounds them within the theoretical framework previously presented. Importantly, it establishes the specific kinds of poverty they experience. Chapter five then identifies what resources the participants access at government and community level in order to mitigate their poverty, as well as the effect that their individual circumstances and capabilities has on determining wellbeing. Ultimately, this thesis will demonstrate the effect that the structural environment has on the wellbeing of women and their children, as well as how mothers personally engage with their resources to mitigate poverty. It argues, "although a significant shaper of childcare practices, poverty is not an entirely deterministic force and... adults engage creatively with their environments in order to achieve individually and culturally constructed ideals for the care of their children" (Bray & Brandt 2007:14). Finally, this thesis makes recommendations for multi-dimensional interventions that increase the capabilities of poor families, strengthening their resilience to vulnerabilities

⁷ Philani Nutrition Center universally refers to the women in their outreach program as "mothers," regardless of the fact that some may not be biological mothers of the children they are caring for. Due to their extensive use of the term and an understanding among the interview participants as to its meaning, "mother" will most commonly be used when referring to these women, and will be interchangeable with "caregiver" ("the person(s) in the household responsible for providing care to a co-resident child or sick adult or negotiating care on their behalf" (Giese, et al.2003:iv-v) In South Africa, this person is usually a woman. In this thesis, they are all women).

⁸ For this thesis, the term "household" will refer to those people living in the same physical space, regardless of their biological connection to the other members. Defining a household by individuals that share meals together or sleep in the same space has been often used in relevant literature (de Satge' et al. 2002:29). Therefore, family members living in the Eastern Cape who may comprise the "greater household" will not be included when referring to the household in this thesis, though a discussion of the women's interaction with their greater household may be raised. Indeed, a study which extends the capabilities framework to the greater household and looks at the urban-rural dynamic is urgently needed. Placing limits on the definition of the household is an attempt to analyze the resources and strategies of a micro family unit. However, when these strategies involve extended households and family networks, this will be noted. The "household" as defined in relation to its physical space, is also the definition used by Seekings & Nattrass (2006) when discussing household poverty statistics. Though the term "family" is often more strongly associated with biological and generational relationships despite geographical location, in this thesis the term will be used interchangeably with the term "household." "Family" therefore does not necessarily assume biological relationship, but refers to co-resident, and hence interdependent, individuals. When extended or non-resident family members are referred to, this will be noted.

and minimizing the impact of poverty in their lives, while also advocating for a transformation of the structural context to address the root causes of poverty.

University of Cape Town

Chapter Two – Applying theory to the South African context

Before launching into a discussion of the lived experiences of unemployed, HIV-positive mothers, several theoretical discussions must be necessarily had. First and foremost, the concept of "poverty" is often used in development literature without being clearly defined. The first part of this chapter deals with this issue and attempts to ground both the definition of poverty, as well as its causal factors, in a theoretical context that will be helpful in understanding of the lived realities of the women. The chapter will also introduce the concept of "the underclass," arguing that the chronically unemployed in South Africa deserve their own class category in order to specifically address the unique challenges and poverty that this class faces. It will be argued that gender and HIV/AIDS affects the experience of poverty and inequality on the women and households presented here. Current South African policies and welfare programs will be critically analyzed in their effectiveness at poverty alleviation and "pro-poor" growth in order to establish the institutional context in which the women find themselves. The chapter will then utilize livelihood frameworks to understand how individuals and households cope with poverty given the present structural difficulties. This theoretical framework is continuously contextualized within the South African historical, social, economic, and cultural environment in which the participants exist.

Conceptualizing Poverty

Classic measures of poverty rely on economic definitions, commonly set at an internationally defined monetary amount, such as "US\$2 per day," needed to ensure a minimum standard of living (UNDP 2008). Commonly found in development literature, statistics based on these measures are intended to convey how many people are not able to meet their basic needs and are living in extreme poverty. However, these measures are inherently flawed due to their assumptions about basic needs and their attempt to universalize a monetary amount needed to ensure quality of life. Economic-centered approaches provide much less information on a local and lived experience of poverty than other measures can. As argued by Amartya Sen, an exclusively income-centered

view of poverty does not reveal the ways that poverty limits people's freedoms to live their lives the way they choose. The freedoms that must be upheld to keep people free from poverty have to do with political, social, emotional, and human rights and an individual's ability to exercise free choice. Lack of financial resources may be one inhibitor to these freedoms, but government oppression and political structures can also serve to deprive someone of their freedoms, hence forcing them into a certain form of poverty (Sen, 1985; Sen 1999). Hence, poverty is not something only experienced as *external* to the individual in a lack of material assets, but can also be experienced *internally* as a direct result of reduced capabilities due to illness, lack of education, insecurity, depression, or inability to sell their labour power.

This holistic approach also aims to see people's capabilities in an economically poor environment and views poverty in relation to overall wellbeing. The Research Group on Wellbeing in Developing Countries conducted a study titled "Consultations with the Poor" in which five major aspects of wellbeing were identified: "material (having a secure livelihood and fulfillment of your basic needs), physical (health, strength, and appearance), security (including peace of mind), freedom of choice and action (including self development and mobility), and social wellbeing (good family and community relationships)" (Camfield 2006:7).⁹ Like Sen, wellbeing theory argues that fear, insecurity, hopelessness, and powerlessness are indicators of mental and emotional poverty, in the way that they impact upon an individual's independence, confidence, agency, and mobility (Camfield 2006:8). This approach provides a wider lens by which to define people's needs, as well as allowing the various non-material strengths and capabilities of the poor to be recognized.

A focus on wellbeing and capabilities also includes a focus on process as well as outcome. Traditional economic measures of poverty rely on outcomes only, or what the family or individual is able to bring home at the end of the day. The inclusion of process contributes to the understanding of the lived experience of poverty by providing insight into the trade-offs employed by families in coping strategies, which will be relevant to

⁹ For a thorough critical review of various multi-dimensional frameworks of poverty, see Hulme & McKay (2005).

the discussion of the women's responses to poverty. Hulme & McKay (2005) also make a strong argument for including a time dimension in any analysis of poverty, claiming that *chronic* poverty, as opposed to transient poverty, is a distinctly different experience that involves unique responses. This paper explores the lives of HIV-positive mothers through this multi-dimensional lens, encompassing the social and psychological aspects and processes of poverty, with an ultimate goal of achieving holistic wellbeing. This approach provides the opportunity to examine the multiple capabilities of the women in their efforts to mitigate the experiences and effects of various deprivations.

A class-based analysis of poverty

The cause of poverty in society is possibly one of the most debated topics in modern development literature. It is critical to understand the context that the women operate within to ensure effective poverty-alleviation interventions. Wright (1995) identifies four basic theories of poverty distinguished by whether the theory is rooted in individual or societal attributes, and whether poverty is viewed as an unfortunate by-product or as an inherent feature of the individual or society in question (Wright 1995:86). Some argue for a genetic or ethnic-based cause of poverty (an inherent feature of individual attributes) while others argue that society is responsible for the reproduction of poverty over generations (an unfortunate by-product of individual attributes).

Marxist theory argues that poverty is an inherent feature of a capitalist socio-economic system. According to this view, poverty is essential to the successful functioning of the capitalist system. It "is not an accident; it is not a by-product. It is an inherent, and crucial, feature of a society whose economic structure is grounded in class and exploitation" (Wright 1995:90). The reproduction of the system relies on the continued need of workers to sell their labour power to the capitalist in order to ensure their own survival. This, in turn, produces profits for capitalists and continues to entrench workers in their dependency on the capitalist. The capitalist system therefore *requires* the capitalist class to reap profits at the expense of the working class. Capitalist relations of production dictate that the relationship between capitalist and worker is one of exploiter and exploited. Relative poverty is hence a necessary attribute that keeps the worker dependent on the capitalist. Once the capitalist mode of production is established, these

relationships are manifested and further entrenched in the society's social and political structure (Wright 1995:91-95).

Since South Africa operates under a capitalist system with high rates of wage labour and dependence on the capitalist, this theory is useful in illustrating the structural causes of the poverty experienced by the participants of this study. South Africa's history of racial discrimination, embedded in a system of capitalist exploitation, is a prime example of the way that an economic system has become integrated into the social, cultural, and political aspects of the society. The great disparities in income and poverty between races were the result of apartheid labour-market policies that gave preference to white candidates while limiting job opportunities for those of other racial groups. Simultaneously, educational spending and skills training was focused on lifting up the poor white population at the expense of non-white populations. These unequal, highly racist policies effectively allowed whites to build assets and achieve high-ranking positions with little competition. This placed them in a favourable position to control the means of production. At the same time, black labour was being channeled to cities and away from rural agriculture in order to provide low-wage labour for white-owned business and factories. The proletarianisation of the peasantry in South Africa, alongside the limited educational opportunities for blacks, left most of the African population to depend on wage labour for income, and ultimately, survival. Seekings & Nattrass (2006:16) state, "they [the apartheid government] were so successful at constraining the options of Africans to earn a living by any means other than formal employment that, when employment slowed and stagnated from the mid-1970s onward, open unemployment was inevitable."

This history of racial exploitation and oppression served the clear economic purpose of privileging whites during the development of a capitalist economic system, the legacy of which can still be seen today. Wolpe (1972) argues, "apartheid... can best be understood as the mechanism specific to South Africa in the period of secondary industrialization, of maintaining a high rate of capitalist exploitation through a system which guarantees a cheap and controlled labour force" (Wolpe 1972:7). The result of this system can be seen in the high rates of unemployment and dependence on wage labour among black South Africans.

The underclass

An important distinction within class-based poverty is the difference between economic *oppression* and economic *exploitation*. Situations of non-exploitative economic oppression exist when the capitalist does not require the labour power of some workers, but only seeks to restrict their access to certain resources. "The underclass," by definition unemployed, are "a group that is economically oppressed but not consistently exploited" (Wright 1995:96). Furthermore, "the underclass" refers to people who are actually marginalized from engaging with the means of production. Their labour power, which is the only asset that the working class in capitalism actually "owns," carries no value in the current economic system. In a system that requires one to sell their labour, this group is left without the means to survive.

Wright's highly theoretical account of the underclass implies that all unemployed people are part of it. In their empirical study of inequality in South Africa, Seekings & Natrass argue that people move in and out of employment. Nevertheless, a 'hard core' of people exists "who are excluded from access to opportunities to find it or are at least very disadvantaged in terms of such access" (Seekings & Natrass 2006:273). Therefore, aside from simply being unemployed, the underclass are marginalized from the economy and are particularly vulnerable.

Additionally, the same economic and societal structures that created this unemployed underclass are also serving to reproduce it over time. As a marginalized group, members of the underclass often cluster together. Disadvantage is reproduced within neighborhoods and social groups and transferred through generations. Underclass individuals are said to be "locked in a class trajectory that leads away from rather than back to other classes" (Seekings & Natrass 2006:276) due to the urban and social decay and exclusion from job markets that characterizes this group.

Several sources of disadvantage predispose society to the production of an underclass. The first is that of a lack of human capital, or the skills necessitated by the labour market, the second is the type of social capital they have access to (the social networks that link people to job opportunities), and the third is a lack of financial capital to become self-employed (Seekings & Natrass 2006:280-286). Other forms of disadvantage result from

geographical location in respect to access to job opportunities. These cumulative disadvantages result in the continual reproduction and reinforcement of the underclass, further justifying their recognition as a distinct class that cannot be categorized with other disadvantaged workers (Seekings & Natrass 2006:275-276).

The cumulative disadvantage transferred over generations has resulted in an underclass in South Africa, marginalized from the labour force and experiencing long-term unemployment. Eighty-three percent of the unemployed in South Africa have been so for more than 6 months, with nearly two-thirds stating that they have *never* worked (Seekings & Natrass 2006:278-279). In a context "where unemployment means poverty," underclass households experience a distinctly low quality of life, with their income almost entirely dependent on public welfare and remittances. Only 10% of these households have access to piped water inside their dwelling and only 18% had an indoor toilet (Seekings & Natrass 2006:289-291). Relating to multi-dimensional definition of poverty are the common sentiments of anxiety, depression, and overall dissatisfaction with life expressed by members of these households (Seekings & Natrass 2006:295). As a group distinctly separate from temporarily unemployed members of the working class or the "working poor," the underclass is a group that "lack[s] the capital to give them a significant chance of securing employment in the future" (Seekings & Natrass 2006:298), and therefore has little hope of their situation improving.

These class distinctions will be raised again at a later point when introducing the research participants. The women's lives illustrate enormous difficulties that belonging to the underclass present.

The gendered experience of class

Since this thesis is examining the experience of women, a discussion of the gendered element of class experience is necessary. Some feminist theorists argue that "the differentiation [of classes] based on gender is a fundamental one because it is so closely bound up with the organization of reproduction of the class which is in creation... the organization of domestic life has its own effect in reinforcing gender divisions within the labour force " (Mackintosh 1989:178). Mackintosh documents the transition of a Senegalese rural economy to capitalism, charting the development of a class structure as

a result of the community's new dependence on the wage labour. This shift affected changes in migration patterns, land ownership, and household production, as well as dynamics between men and women. Since women still carried the burden of domestic activities, their engagement in wage labour was limited, creating a dependence on their husbands for monetary income. Increased pressure was also placed on women to sell their labour power outside the home while maintaining the reproductive and domestic duties necessitated by the family. The result of this transition was a "new, transformed, yet still subordinate position for women" (Mackintosh 1989:163).

Mackintosh's account is illuminated by Delphy (1977), who argues that the oppressed position of women is a construct of patriarchy, which operates like relationships of capitalism. Delphy argues that family and domestic life is the site of the economic exploitation of women. Their labour power is exploited indirectly (through their role in reproducing the working class), yet carries no economic value. Women therefore constitute a distinct, super-exploited class, and through their exploitation, contribute to the reproduction of the systems of both patriarchy *and* capitalism (Delphy 1977:16,33). In South Africa, the exploitation of women has been linked to the development of capitalism due to the role their domestic labour played in supplementing low wage migrant labour. Women maintained households which provided childcare, retirement, and health care for migrant workers, allowing employers to pay very low wages. In fact, by relying on the support function of the workers' wives in the labour reserve areas, capital was able to buy labour below value (Wolpe 1972). Patriarchal gender norms therefore enabled more surplus value to be extracted from the working class.

A gendered analysis of class adds depth to the statistics of poverty experienced by women and children presented in the introduction and will also frame the upcoming discussion of the mothers. Women's traditional role in the home has marginalized them from both education and engagement in the labour force, positioning them to be likely members of the underclass. The theory of patriarchy provides a basis by which to analyze the women's experience. The "super-exploited" position of women within a capitalist and patriarchal context also supports the specific focus on women in this thesis on poverty mitigation strategies.

HIV and AIDS - its intersection with class and gender and its implications for the experience of poverty

In addition to being most affected by poverty, women are also carrying the greatest burden of HIV infection in South Africa. Though they are more physiologically at risk of infection, women are also structurally at risk as a result of the oppressive capitalist and patriarchal context that dictates power relations and creates scenarios in which HIV/AIDS can flourish. Abdool Karim (2005) makes the structural linkage to HIV infection based on

gender gaps in literacy levels, employment patterns, access to credit, land ownership, and school enrollment rates. This imbalance in access to, and control of, productive forces and resources translate into an unequal balance in sexual relations in favour of men (Abdool Karim 2005:246).

Hence, women's dependence on men and their lack of economic and sexual independence increase their vulnerability to HIV and AIDS.

The structural position of women not only places them at higher risk of infection but also makes them more vulnerable to the social and economic effects of AIDS illness. As women assume the burden of care of sick family members, they are more vulnerable to impoverishment and loss of employment as a result; furthermore, girls are more likely to be removed from school to help with the care of sick adults. Some authors even argue that women will face more discrimination as a result of their HIV-positive status than men, due to the stigma attached to HIV as an infection linked to promiscuity (Whiteside & Lee 2006:387). Empirical evidence has shown that men are responding to the AIDS epidemic among women by calling "for the greater control of women and a retreat from any relaxation of gendered male control over women, and, particularly, young women" (Preston-Whyte 2006:372). Associating HIV infection with sexual promiscuity among women reproduces gendered ideologies that maintain women's subservient position and reinforce AIDS-related stigma.

Furthermore, it is a well-documented trend that "poverty deepens the effects of HIV/AIDS on households and HIV/AIDS in turn aggravates already existing poverty" (Jacobs, et al 2005:22). Underdevelopment, lack of education, limited access to health

care, and migration are associated with the global spread of the disease (Preston-Whyte 2006:367). In addition, the poor have increased susceptibility to disease and infection as a result of malnutrition and poor living conditions (Nkurunziza & Rakodi 2005; Stillwagon 2002). HIV further exacerbates the poverty in poor households by infecting its economically active members, diverting scarce income to medical costs, and increasing the burden of care. In a household impact survey conducted in South Africa, the income of HIV-affected households is nearly half that of non-affected households (Booyesen 2002:10). HIV/AIDS has been identified as the "tipping point from poverty to destitution" among already poor households (Steinberg et al. 2002:i), empirically demonstrated to weaken household and community support due to the increasing number of households affected by the disease and the growing burdens of care (Meintjes, et al. 2003:14). HIV infection in a caregiver, especially in a female-headed household, puts the children at increased risk of poverty as well as potential orphanhood (Richter & Rama 2006:17).

The impacts of HIV infection on the wellbeing and poverty of women and children is the reason why HIV-positive women, and mothers in particular, have been selected as the primary focus of this research. The connections between the structures that make women vulnerable to HIV infection with those that lead to unemployment and economic oppression will be discussed in relation to the participants of this study.

Social Welfare, Policies, & Interventions to Promote Poverty Reduction

The explanation for poverty thus far has focused on the structures and systems of exploitation in place in society. The levels of poverty are also greatly influenced by the policies adopted and implemented by the government. Some theorists argue that poverty and inequality can be substantially curbed within the capitalist framework as the result of a well-targeted pro-poor agenda of governing bodies (Sachs 2001; Wright 1995). "Pro-poor" policies are those in which economic growth provides substantial and effective results in poverty reduction, increased income in poor households, longer and healthier lives, access to information and technology, increased capacity to meaningful engagement in society as citizens and parents, and safety from crime and violence (May

2006:146). The ideology of pro-poor growth therefore contains theoretical components of multi-dimensional poverty as previously outlined, arguing that unless all of these deprivations are addressed, growth cannot be characterized as "pro-poor" (May 2006:146).

Policies that have proven to achieve the characteristics of pro-poor growth are those that reduce inequalities, have high redistributive effects, and create opportunities for the poor to build assets and engage in the labour market. Policies that encourage local job creation, especially in economies where subsistence agriculture and rural livelihoods have deteriorated, also effectively address poverty reduction. An environment that encourages entrepreneurship and industry in informal sectors can specifically target the poverty of a marginalized underclass who may not have the skills or experience to benefit from formal job creations programs. Alternately, policies that degrade the environment, increase costs of basic goods and services, and increase imports thereby undermining locally manufactured goods, do not have the effect of reducing levels of poverty in a society. In actuality, some of these policies can actually *produce* poverty through setting up industries that depend upon cheap, often migrant, labour that also serve to undermine local community and household structures (May 2006).

Post-apartheid poverty-reduction policies have had ambitious goals but have not demonstrated effective pro-poor strategy in practice. The first year of democracy in 1994 saw the creation of the Reconstruction and Development Programme (RDP), which had respectable goals for holistic human wellbeing and development, including increased work opportunities, improved housing and access to health care, "and all those aspects that promote the physical, social, and emotional wellbeing of all people in our country" (ANC 1994:52). The RDP was effectively replaced by the Growth, Employment, and Redistribution strategy (GEAR) in 1996 and focused on reducing budget deficits, liberalizing trade, and promoting investment in South Africa yet ultimately failing to stimulate large-scale job creation (Lewis 2001:3-5; Seekings & Natrass 2006:349). While these policies may have improved the conditions of skilled workers in South Africa, "it did little to improve the economy's capacity to create jobs. In the post-apartheid distributional regime, the unemployed were the biggest losers" (Seekings & Natrass 2006: 251).

Sound redistributive and social protection policies are also crucial in tackling inequality and reducing poverty. "Given the inadequacies of the market and the limited capacity of poor households to sustain themselves through livelihood shocks and stressors by drawing on their own resources, there is a strong case for public intervention" (Nkurunziza & Rakodi 2005:24). However, a government's approach must be two-fold, offering both social security as a safety net and social protection as a springboard out of poverty, and a combination of both short-term and long-term support. Social "safety nets" alone are inadequate in that they "seek to ameliorate the difficulties of those who cannot get paid work because of ill health, disability, or other factors not related to structural conditions... [yet,] growing unemployment and casualisation of work, deepening and widening poverty, macroeconomic shocks and financial volatility, the HIV/AIDS crisis and other disasters require more than a social safety net" (Taylor 2007:12-13). Alternately, "social protection" focuses on building the assets and capitals of the poor, with an understanding of the multi-dimensional experience of poverty.

The Department of Social Development is the primary actor in South Africa's state anti-poverty campaign, with social assistance grants absorbing 99% of their three-year projected budget (Department of Social Development 2006:140). These grants are intended to catch those who are particularly vulnerable as a result of age or ability. As of 31 January 2006, there were reportedly 11 million beneficiaries of social assistance grants (ibid:57). The five most accessed grants are: Child Support grant (R200), available to children under the age of 14; Old Age Pensions (R870), available to men over the age of 65 and women over the age of 60; Disability grant (R870), available to those temporarily or permanently unable to work as a result of sickness, disability, or injury¹⁰; Foster Care grant (R590), available to caregivers of non-biological children in need of care and protection; and Care Dependency grant (R870), for caregivers of children with serious disabilities requiring full-time care.¹¹ The Child Support grant and Old Age pension are considered "safety net" grants and they are means-tested. Take-up

¹⁰ With specific reference to HIV infection, an individual's CD4 count, measuring the number of immune cells left in the body, must be below 200 in order to qualify for the disability grant. This is a quantitative, medically determined standard and does not measure the *experience* of illness of a patient.

¹¹ Monthly cash transfer amounts as of 1 April 2006. Source: Department of Social Development.

rates for all grants have been steadily increasing, as has the Department of Social Development's allocated budget for such programs (Poggenpoel 2004:7).

The historical legacies of apartheid welfare policies are illuminated when analyzed in conjunction with the welfare spending discussed here. Even in light of current statistics of pervasive and chronic unemployment, current welfare policies in South Africa assume full employment in society and only provide for those who are "unable" to work; these systems "serve to reinforce such relative privilege rather than provide for the very poor, and such a system... displays clear continuities from the apartheid distributional regime" (Seekings & Nattress 2005:47). The current labour market policies and growth agenda in South Africa therefore represent only an adjustment from apartheid policies rather than a profound pro-poor transformation. As previously discussed, apartheid entrenched the capitalist system and set the stage for the massive unemployment currently experienced. Similar policies are still operating today, though in a de-racialized manner. The current situation of mass chronic unemployment requires a structural intervention that effectively enhances the capabilities of the poor to engage in the economy and provide for the family's various deprivations.

The constraints of the current system will be examined through its effect on the life of South African women who are the subject of this thesis, which highlights the less obvious gaps in social assistance coverage and barriers to access.

Local Insights into Coping Strategies

Despite the considerable and growing expansion of welfare services in South Africa, households without access to wages do not receive unemployment pay. They cope with poverty through their own capabilities. In order to contextualize the household-level impact of the structural constraints previously discussed, a number of "livelihood frameworks" have been developed. These frameworks illustrate the linkages between macro policies and micro coping strategies and livelihood outcomes, placing people and households at the center of development. A livelihoods framework enables us to "identify (and value) what people are already doing to cope with risk and uncertainty; make the connections between factors that constrain or enhance their livelihoods on the one hand, and policies and institutions in the wider environment; and identify measures

that can strengthen assets, enhance capabilities and reduce vulnerabilities" (de Satge' et al. 2002:4).¹² This thesis draws on elements of two different livelihood frameworks, based on this same set of principles but unique in their illustrative properties.¹³ The frameworks identify how the capabilities (also commonly referred to in other frameworks as *human capital*, or skills, health, knowledge) of the poor are used to transform both social and material assets (also known as *social, natural, physical, and financial capital*) into activities that produce desirable livelihood outcomes, be it increased income, wellbeing, or sustainability (de Satge' et al. 2002:98). Most livelihood frameworks agree, "analyzing vulnerability ought to go beyond identifying the risks and threats to examine households' resilience in resisting and recovering from the negative effects of a changing environment or their ability to exploit opportunities." (Nkurunziza & Rakodi 2005:12).

The external economic, institutional/political, social, and natural/built environment, from household to global level, serves to enable or constrain the livelihood strategies of the poor. The external environment is referred to as the *vulnerability context* and includes HIV/AIDS, large-scale inequalities and unemployment, and capital-intensive growth that exclude the poor (de Satge' et al. 2002:127). The ability to apply household capabilities and utilize assets to foster resilience within the vulnerability context is influenced by laws, policies, culture, and institutions. Therefore, capabilities are both *affected by* the vulnerability context as well as actively *affect* and mitigate the household experience of vulnerability. Utilizing this framework in this thesis helps to describe each woman's experience of poverty and her ability to navigate within her vulnerability context.

A high vulnerability context in South Africa reduces the assets available to households. Empirical evidence from South Africa on the ways in which impoverished communities cope with AIDS illness suggests that households first reduce spending on clothing, electricity, and other services. Some households are forced to reduce spending on food, while nearly a third of their income is now directed towards meeting health care-associated costs. Women often take time away from income-generating activities or

¹² For a clear overview of various livelihood frameworks, see de Satge' et al (2002). Another helpful framework is: Moser (1998).

¹³ The Policy Guidelines for Integrating Environmental Planning into Land Reform (PGIEP) framework and the Learning about Livelihoods (LAL) framework are presented in de Satge' (2002), and also available in Appendix 1 of this thesis.

school to address the need for increased care in the home. Sometimes, in order to cope with reduced care to dependent ratios, children are sent to live with extended family members (Steinberg et al. 2002). The care of children in resource-poor or AIDS-affected settings often involves the support of neighbors and extended family. However, some research has shown that the presence of HIV infection greatly reduces the availability of this support. Swartz reports that HIV-positive women receive less social support than people in other difficult situations. "HIV positive women have also been found to experience significantly less socio-economic, spiritual, and family support than HIV negative women. Many infected mothers are either reluctant to, or desist altogether, from seeking assistance" (Swartz 2005:21). This is a prime example of how the vulnerability context, in this case related to the social effects of HIV and AIDS, impacts upon an individual's capabilities, access to social and material assets, and overall wellbeing.

Other household coping strategies involve changes in household composition and family dynamics to deal with increased dependency ratios and burden of illness. Children may also take on significant responsibilities in the event of a sick caregiver or a lack of resources to deal with a growing burden of care. A common assumption about poor families caring for sick adults and orphaned children is that the care afforded to children will undoubtedly be inadequate. However, rather than assessing a family's ability to care based on the measures reported by demographic and economic surveys, researchers must explore the emotional dynamics of care relationships and "the ways in which the economic, social, and health environment can play out at the level of interpersonal relationships... it is at this very micro-level that care is performed, experienced, and arguably "matters" in terms of long-term child well-being and adult outcomes" (Bray & Brandt 2007:2).

Women have demonstrated a unique ability to use their personal capabilities and utilize the assets and resources available to them to care for their families. These strategies, in the context of a lack of a comprehensive system of social protection and pro-poor policies for the unemployed and differential access to resources, are often what make the difference in a household's experience of poverty. Raised throughout this thesis is the way that capabilities are needed in order access certain resources (in terms of being physically healthy enough to travel), as well as how diminished capabilities make one

eligible for other resources (such as a Disability grant), and the inverse relationship of how some resources enhance capabilities (social networks contributing to improved emotional wellbeing). Chapter five will identify other unique capabilities of the women as they apply their inner strengths to improve their situation. Some of the more nuanced capabilities are those relating to knowledge received from both formal and informal education, personal creativity, female intuition, ability to multi-task, and the inner strength gained from faith. The livelihood framework established in this section will serve as a tool to draw linkages between the structural context and household experiences of poverty, based on the differential impact of various stresses and shocks.

University of Cape Town

Chapter Three – Methodology

Objectives of Research

The overall aim of the research was to explore how HIV-positive mothers who are living within a state of vulnerability and poverty use their capabilities to engage with their meager resources in order to ensure their children's wellbeing.

The specific objectives of study were to:

1. Investigate the forms of poverty experienced by such households, as identified and prioritized by the women interviewed.
2. Investigate the responses of mothers in mitigating their poverty, with an emphasis on ensuring the wellbeing of children. Investigate the resources they access (both public and private, material and non-material) and the types of poverty these resources address.
3. Identify the main factors that enable a caregiver to meet the needs of her children. These factors include individual capabilities, household composition, health, eligibility, and access to grants.
4. Define aspects of wellbeing that are not being met and the main factors contributing to this.
5. Explore the extent to which the structural context has impacted on the existence and experience of poverty in the women's households.

The following research plan was carried out over the period of July to October 2007.

Research Design

A case study design was chosen for this project in order to achieve the stated research objectives. A case study is defined as “a very detailed research enquiry into a single example (of a social process, organization, or collectivity) seen as a social unit in its own right and as a holistic entity” (Payne & Payne 2004:31). Case studies are not appropriate for a researcher attempting to sample from a population and then generalize the results. Rather, they explore specific examples of a social unit that can shed insight into some aspects of social reality (Payne & Payne 2004:32). Though some case studies are

conducted purely to satisfy a researcher's interest or for evaluative purposes, a case study can also generate meaningful and useful data to inform the activities of organizations, policy documents, and targeted interventions in its ability to "develop fresh insights" (Payne & Payne 2004:33).

For this project, a small case study was undertaken of a group of women assisted by the Philani Nutrition Center and the outreach workers who support them. This small study does not claim to be representative; that is not the purpose of case studies. Rather, its aim is to research a situation that has significance with others in South Africa and to highlight issues that need to be researched or interviews that need to be made. Philani is one of many organizations trying to uplift women living in difficult circumstances. Khayelitsha is a poor township similar to hundreds of others in South Africa as the statistics on poverty, unemployment, and HIV presented in chapter one. The situation of the women discussed here is not atypical. Their experiences suggest yield important insights for others.

Study Population

The area of study is Khayelitsha, a black township that illustrates many of the inequalities and poverty discussed in the previous chapters. Participants were recruited from Philani Nutrition Center, an organization that works with mothers and children dealing with poverty and HIV infection.¹⁴ My long-standing involvement as an intern and project-manager at Philani inspired the topic of this research and provided me with access to a population of mothers who are dealing with the issues previously outlined. The research project was approved by Philani Nutrition's Executive Committee and individual consent was received by each of the participants (a discussion of the consent process is discussed in the next section and a copy of the consent form is included in Appendix 4).

As stated, in order to draw linkages across the case studies, several variables needed to be held constant. First, all of the interviews were conducted within the South African context described in the first two chapters. Several other specific criteria were required

¹⁴ Malnutrition in children is the main focus of the Philani program, though their intervention address a number of contributory factors, such as HIV infection and poverty. Philani operates six drop-in nutrition centers as well as an extensive outreach program reaching families in their homes.

of the participants to ensure that the mothers experience a common set of basic circumstances within their greater context. This is referred to as purposive sampling (Babbie, et al. 2006:283) and involves requesting participants on the basis of certain personal characteristics that the researcher attributes significance to in relation to the study.

Hence, the five South African women studied met the follow criteria:

- Female residents of Khayelitsha township, site B¹⁵
- Participants in Philani Nutrition Center's Outreach program
- Not engaged in any formal employment
- Over the age of 18 and under the age of 60 (therefore eligible for state grants targeting the very young and very old)
- The primary caregiver for at least one child (though not necessarily a biological child) under the age of 18
- HIV-positive and comfortable speaking about this

The specifications of the participants were chosen based on literature detailing the challenges women face as a result of the intersection of motherhood, unemployment, and HIV-infection (see chapter one and two). I set an age range on the participants to those of adult, pre-pension age, to ensure that they would fall within the "gap" of South Africa's current welfare scheme, a significant variable when exploring their responses to poverty. Limiting the geographic scope of the study both focused the area of research and ensured a similar context for the five women. The purpose of studying women only is due to their common role as primary caregivers of children as well as the unique issues they face as a result of gender inequality. I also have the greatest access to women due to my connection to Philani. HIV-positive people who are employed, as well as all HIV-negative people, are left out of the study because this research project is not attempting to draw comparisons between groups of people, but rather to explore in detail the lived

¹⁵ A map of Khayelitsha can be found in Appendix 2 with marks designating the approximate location of the homes of the mothers in this study. For privacy, names have not been attached to the marking of these locations.

experiences of those mothers living with HIV infection as well as unemployment and therefore surviving on public or private assistance. HIV is chosen as a component of this study not for the purpose of establishing its uniqueness among various illnesses, but rather to explore the impact of a commonly experienced infection and documented source of vulnerability on the women's lives and coping strategies.

It is significant to note that the variables set as constants are indicative of the lives of many women in South Africa, as demonstrated in chapter one. The following chapter will place these women within their local context of Khayelitsha to further show that they may be studied as *examples* of mothers in this area, with great numbers experiencing unemployment, HIV-infection, and the responsibility of caring for children. As will be demonstrated in following chapters, these traits among people who live in Khayelitsha often correlate to a certain degree of poverty in their lives, though no specific standard of poverty was held constant. Conversely, it is the *differences* in their experience of poverty that is the point of exploration here.

Many factors were left out of this selection criteria, such as health status, number of children, and presence of a partner. The decision to allow a number of unrestricted variables is an attempt to identify sources of difference in the women's responses to poverty, as noted above. The chosen criteria are aspects related to the *context* that unifies all of the women and grounds them as example cases, and the remaining undefined variables are those that I hypothesize may influence their ability to respond to the poverty in their households.

I sent out a request for participants at Philani Nutrition Center and the first five women who met the criteria and agreed to participate were chosen (see "ethical considerations for a discussion on the process of recruiting participants). I did not pre-interview or personally self-select the participants from a group of "eligible" women so that I would not unconsciously introduce personal bias (such as wishing to include a potential participant simply because I was drawn to her personality). The sample therefore involves some degree of random selection. Also, the wide range in the women's non-controlled circumstances was a natural occurrence.

Data Collection Methods

Qualitative research methods were used to obtain data for the study. A qualitative approach is inherently concerned with obtaining an "insider's perspective" and understanding a participant's experience in context. This type of research focuses on process rather than outcome. A narrow and specific context is of crucial significance to qualitative research, which contributes to a deep understanding of the particular sample group (Babbie et al 2006:270-273). An aim of qualitative research is to "encounter social phenomenon as they *naturally occur*" and "seek out and *interpret the meanings* that people bring to their own actions" (Payne & Payne 2004:176, original emphasis). Due to the nature of the research topic, involving unique capabilities and the process of mitigating poverty, a qualitative approach provides the most detailed insight and desirable data.

The specific qualitative methods used in this project were in-depth, semi-structured interviews and participant observation. The same semi-structured interview schedule was used throughout the interviews so as to provide consistency of theme and topics, but to also allow for the women's unique experiences to emerge. With the goal of gaining an "insider's perspective", the women were given the opportunity to introduce a topic of importance to them. Depth interviewing was also applied in order to understand why the women feel and act the way they do, establishing linkages to other issues in their lives. This was the preferred method for the study (as opposed to focus group or survey) due to the very private and personal nature of the topic and its dependence on understanding the individual circumstance and capabilities of each woman.

Though quantitative surveys and interviews may have produced more consistent or stream-lined data, qualitative interviewing was conducted due to its ability to provide "*flexibility and elaboration of answers*" (Payne & Payne 2004:133, original emphasis) and a belief that "the social world is too complex to be represented by fixed questions" (Payne & Payne 2004:131). However, this type of interviewing is also vulnerable to "interviewer bias;" the influence that an interviewer may have on the interviewee's responses. The steps taken to minimize this potential hazard are discussed in the ethical considerations.

Face-to-face interviews were conducted between the researcher and the five mothers in their homes (and in one case, at the respite care center). Each mother's Philani outreach worker accompanied me to the interview and participated in the discussion. The outreach workers are knowledgeable about the current situation and history of the mothers' lives and served as a source of triangulation, confirming certain information and filling in gaps when necessary. The outreach workers have an average caseload of 34 mothers, all in similar situations to the five women studied here. The outreach workers commonly shared stories from their experiences with the other women they care for, thus providing the study with a much wider scope.

Having an additional person present in an interview may inhibit the interviewee from fully disclosing certain information. In this situation, I think that the presence of the outreach worker actually contributed to the mother's level of comfort and openness because each knows and trusts her outreach worker.

The interview with each mother and their outreach worker lasted 2-3 hours, was conducted in English, and tape recorded and transcribed immediately after the interview. The tape recorder was used with permission from the mothers and did not appear to inhibit their responses. In cases where the mother did not speak English, the outreach worker (or in one case, a respite care staff member) provided informal translation. It is significant to note that the outreach workers often *explained* the mother's answers rather than giving verbatim translations. Though this adds another dimension to the interviews and contributes to a greater understanding of the mothers' situation in one respect, it is also regrettable that the mother's true voice was not always heard.

I made detailed notes of my observations after each interview, describing visual and experiential aspects that cannot be captured by tape recorder. Some of the observations included the mother's personality and comfort level during the interview, the interaction between her and her children and outreach worker, and the type of house she lived in. I also noted the main points of the interviews so as to begin identifying themes in the mothers' experiences.

Numerous interviews, both planned and impromptu, were held with Philani's head social worker, who monitors all of the 3,000 people in the outreach program. She was able to

provide a broader perspective to the interviews. Additionally, countless informal conversations have been had with numerous Philani outreach workers about their work with women like those in these case studies.

In addition to the field notes I kept, my participant observation began two years ago when I became involved at Philani Nutrition Center. Since then, I have accompanied outreach workers on many home visits to mothers in the outreach program. This experience has significantly contributed to my understanding of the issues affecting mothers in Khayelitsha and has been a great source of information and inspiration.

Due to the multiple methods of data collection, involving the five individuals framing the case study, their five outreach workers, interviews with Philani's social worker, participant observation, and numerous informal conversations with many other outreach workers, the replication of empirical data from these various sources confirms its validity and credibility (Babbie, et al. 2006:274-278; 280-283).

Ethical Considerations

Conducting research in the contexts of poverty and vulnerability I have hitherto described poses ethical dilemmas. Living within such circumstances place individuals at risk of exploitation due to their own compromised position. That I recruited participants for this study from Philani Nutrition Center, a strong source of support in the lives of the women discussed, could also imply pressure to participate. This subtle pressure may exist either out of felt obligation to the Center or underlying hope to receive added benefits from their cooperation. Conversely, the fear of losing their current benefits may also have prompted their involvement. Additionally, my position as an outsider, as a white person (and the implications of class and income associated with this), and as an academic, may have conveyed to the women that some benefit or compensation for their participation could result.

In order to minimize these complications and clearly state my intentions, I presented a letter to the site B outreach workers, describing the research focus and requesting voluntary participants. For those who thought they had mothers in their caseload to fit my criteria, I asked that they approach the mother with a consent form, explaining the

research to the family and asking for their willingness to participate.¹⁶ I stressed that the outreach workers clearly convey that no material benefits would be awarded for their cooperation and that participation in this project would have no effect on their relationship with Philani Nutrition Center, either positively or negatively. This approach to recruiting participants allowed for consent to occur in private between the outreach worker and the mother, preventing the potential pressure to participate that may have resulted if I had consulted the mothers personally.

During the interview process itself, I was conscious of my role as a middle-income, white person. Utilizing my basic proficiency in isiXhosa played a critical role in conveying respect in the woman's home, as well as interest in her life and culture. A great deal can be conveyed through body language and demeanor to facilitate an open and honest conversation. It is crucial to find common threads in the human experience between the researcher and the participant when we come from different backgrounds and it is through such universal emotions that we can bridge social gaps.

The HIV infection of the woman also posed another unique ethical challenge due to the high levels of stigma attached to it. The outreach workers were already aware of the status of all of the families in their caseload, though it is possible that they were the only one the mother had told. I therefore stipulated on the consent form that the participant should be comfortable speaking about their HIV status before agreeing to take part in the interview. The participant also chose the location and time of day for the interview to take place in order to minimize the chance of other family members overhearing our conversation. The participants were informed that they could withdraw from the interview at any time. Pseudonyms were assigned to the participants to guarantee privacy of identity.

Even during the write-up of the research, there remained ethical considerations. I found myself deeply troubled when attempting to compile the "research data" and form conclusions about the women's lives. I became acutely aware of the broader implications of my thesis and struggled with how to represent the women. I neither wanted to over-

¹⁶ The consent form can be found in Appendix 4, though signed copies of the forms will be kept with the author to maintain the women's anonymity.

emphasize their extreme poverty (in an attempt to motivate structural change) or to focus unduly on their strengths and resiliencies thus potentially overshadowing their hardships. Due to my long-standing involvement at Philani, I also wanted to express my deep respect for the organization and the women and children they serve, while also representing the enormous structural constraints. This thesis attempted to find such a balance and do justice to the lives of the women and children presented here.

University of Cape Town

Chapter Four – The Mothers in Context

Profile of Khayelitsha

As stated, the specific focus area of this study is the black township of Khayelitsha¹⁷.

The township is largely comprised of informal shack settlements and is geographically distant from Cape Town's city centers of economic development. The area speaks to the statistics of poverty, HIV infection, and inequality discussed above. The result is a large population of people limited to a highly under-resourced area with few job opportunities and sparse access to basic services. The living conditions in Khayelitsha speak to "the impoverishing effects of the legacy of apartheid and to the failure of the post-apartheid economy to alleviate that poverty" (De Swardt 2005:101). In a study conducted in 2002, 52% of men in Khayelitsha were unemployed (De Swardt 2005:102). Figures for women are even higher, with 72% of women having no paid work (De Swardt 2005:103). In a survey conducted in 2004, 55% percent of households were receiving one or more social grants (De Swardt 2005:104).

This is in an area where 51% of residents receive water from a tap outside their house, only 60% have access to a flush toilet, and high levels of food insecurity exist. De Swardt states, "this nexus of poor living conditions related to shelter, sanitation and water, geographic location, insufficient access to electricity, low incomes and low educational levels seriously aggravated the problems related to ill-health and morbidity" (De Swardt 2005:110).

The legacy of apartheid's discriminatory spending on education is evident in statistics from Khayelitsha: only one-third of Khayelitsha residents completed secondary school, but few school-leavers find jobs (De Swardt 2005:104). It is in this situation that HIV/AIDS flourishes. About 22% of Khayelitsha residents are estimated to be HIV-positive (De Swardt 2005:110).

¹⁷ A map of Cape Town and Khayelitsha can be found in Appendix 2.

Meeting the Philani Women

It is in the context of these great challenges that the community-based organization, Philani Nutrition Center, was founded. Philani was established in Khayelitsha in the early 1980s, to address the needs of malnourished children. The intervention is structured on a community-health model, operated by local outreach workers. Philani currently operates 6 centers where mothers may bring their children for nutritional counseling and referrals. The centers also provide mothers with the opportunity to earn income through a weaving project and enroll their children in subsidized crèche facilities. Philani has also developed an extensive outreach program, run by nearly 80 outreach workers who serve more than 3,000 malnourished children. The outreach program also has a special program for mothers-to-be, assisting young HIV-positive women in having a healthy pregnancy.

Though Philani enters the household through the child, its work is family-focused. Outreach workers often address other household needs in order to support the child. The Philani model focuses on enabling women to overcome the malnourishment and other devastating side effects of poverty through making several key changes within the household. Even though Philani focuses on developing the woman's ability to care for the child, the organization recognizes that sometimes, in the midst of dire circumstances of income poverty, this is not enough. Philani therefore has a relief grant that is intended for intervening in a desperately poor household on a temporary basis while they await their government grants. Nokwanele Mbewu, the head social worker at Philani, explains:

Nokwanele: The belief of the outreach program is not to give any handouts, but where the circumstances are beyond just building the relationship and empowering the person to just live with what they have at home... where there is really poverty, for example, if you have an HIV-positive woman at home with kids and no food, there's nothing...[and] the child does not have a Child Support grant, there is totally no income in the house, we do what we call a relief.

Desmond Tutu has also established a special fund at Philani, offering R300/month to families that have shown extraordinary strength and determination.

Nokwanele: ...and then the second part is the Desmond Tutu fund... the aim is to give it to people who have made something special, like mothers who have managed despite anything to survive and to do something extraordinary. So it's kind of like acknowledging their strength and also encouraging them to continue. But we're not strictly giving it to those mothers, we also giving it to families in severe poverty situations.

In addition to these services, Philani has a fund that allows them to intervene where the family's living situation is unsuitable. Nearly every month, Philani builds a shelter for one of their outreach families.

The Philani outreach workers

The Philani outreach workers are women from within the community who are trained in child nutrition and community health. Their work involves conducting home visits to educate and monitor the mothers and children in their "caseload" and report back to Philani. This is considered a part-time volunteer position and they receive 1000/month stipend for their time. The outreach workers are all mothers as well and come from similar backgrounds to the women enrolled in the program, allowing them the unique ability to offer personal advice and experience. A Philani outreach worker has an average of 34 children in their caseload, though since their intervention addresses the entire household, they often reach many more children and women than this.

The following descriptions of the Philani mothers participating in this study are intended to illustrate their individual lives in the context described thus far. Each of the mothers were joined by their designated local outreach worker, who contributed to the interviews yet were not the primary subject of investigation. Following their biographies is a table summarizing the mothers' basic information for quick reference.

Mother #1: Nonkululeko¹⁸ / Outreach Worker: Pelisa

Twenty-nine year old Nonkululeko lives in a shack similar to the countless others in informal settlements across South Africa.¹⁹ It is made of corrugated zinc sheets and other materials to fill in holes and gaps. A public toilet stands in front of the home though it appears to be only used by this family. The lounge was clean and comprised of a red two-seater sofa, two red single-seat chairs, a cupboard with a TV and radio on top, and a few children's toys in the corner. The walls were damaged and sagging in areas, but completely covered with the plastic wrapping from some kind of strawberry product. Aside from the lounge, the shack has two other rooms: a kitchen that contains a single bed and a bedroom with a double bed.

Nonkululeko lives with her husband, Mpumelelo, and her daughters, Siphokazi (9) and Sisipho (14 months). Mpumelelo's nieces, aged 19 and 12, recently moved from the Eastern Cape to live with them after their mother passed away. Their grandmother sends money for their schooling but Nonkululeko and Mpumelelo provide their food and cover other daily expenses. Mpumelelo is a panel beater at an auto shop earning R490 per week, though after transport costs, is left with R355. Nonkululeko was working as a day cleaner at a nightclub in Cape Town until last year when she was forced to resign due to illness. The family's income is supplemented by Siphokazi's Child Support grant of R200.

Nonkululeko and Sisipho were both diagnosed HIV-positive on a visit to a doctor when Sisipho was one-month old. Sisipho also has Downs Syndrome and problems with her eyes and legs. The child is currently on anti-retroviral treatment and improving.

Nonkululeko has applied for a Care Dependency grant for Sisipho, which would bring in an additional R870 a month. Nonkululeko remains within a healthy CD4 range, though she says she's begun experiencing some tiredness and sickness that she associates with HIV. Her older daughter, Siphokazi, is HIV-negative.

¹⁸ As stated in chapter three above, all names have been changed to maintain the privacy of the women, their children, and their outreach workers. For the reader's ease in distinguishing between mother and outreach worker, all mothers have been designated a name beginning with "N" while outreach workers' names all begin with "P." Children were given names beginning with "S." All other people directly referred to by the mothers have also been assigned pseudonyms. Philani's outreach worker has kept her own name, as she is a representative of the organization.

¹⁹ A photo of a typical shack is included in Appendix 3.

Nonkuleleko does not know Mpumelelo's HIV status and he refuses to discuss this with her. Nonkululeko says that their relationship has deteriorated since she disclosed her status to him and claims that Mpumelelo's drinking has recently increased.

Mother #2: Naledi / Outreach Worker: Patience

Naledi lives with her daughter Sivenathi (4). She stays in a shack with her niece, Mampho, and Mampho's daughter, Sinovuyo (5). Their sole source of income is Child Support grants for the two children. Neither the children attend crèche due to a lack of income. Both women have been unemployed for several years.

The shack they live in is one single room, with little furniture or belongings. Naledi explains that it used to be two rooms, but burned down in a fire last year. The women rebuilt the shack using what burnt zinc materials they could recover after the fire. There is no bed and they sleep on mattresses set up on crates.

Naledi and her baby tested HIV-negative during pregnancy and after birth, only testing positive at a routine check-up for the child a year later. Naledi guesses that she contracted HIV through unprotected sex shortly after the child's birth, transmitting HIV to the child through breastfeeding. Naledi asserts that she is healthy and fit and without any symptoms of physical illness. Sivenathi is on ARV treatment, but she is often sick.

Naledi has three other children who are living in the Eastern Cape with a friend of her mother. There is a girl, 21, and two boys, 17 and 6. They have been staying with this other lady for quite some time since Naledi left for Cape Town to look for work. The father of the oldest child assists her in paying her school fees, but the fathers of the other children are not involved.

Mother #3: Nothemba / Outreach Worker: Phumla

Nothemba was living in a shack with her partner, Sethu, and their 18-month old daughter, Sinazo. Sethu has only occasional work and the family was not receiving any grants at the time of the interview. They were only surviving off some money that Nothemba's brother would send to her.

Nothemba learned of her status when she was pregnant with Sinazo. At the time of the interview, Nothemba had just recently been admitted to Baphumelele Respite Care Center in Site B, with an advanced stage of AIDS. At Baphumelele, she started ARV treatment and agreed to participate in the interview. Sinazo, also HIV-positive, was sent to Baphumelele Children's Home to be cared for, but was immediately transferred to Red Cross Children's Hospital to start anti-retroviral treatment. Nothemba did not know Sethu's HIV status.

Shortly after the interview was conducted, we heard news that Nothemba had finally received her Disability grant and had discharged herself from the Respite Care Center to live with her brother. Staff at the Respite Care Center advised her against this, as her health was still far from stable, but they were unable to convince her. Nothemba has since passed away. The child has been discharged from hospital and now resides at Baphumelele Children's Home.

Mother #4: Noluvuyo / Outreach Worker: Pinky

Noluvuyo lives with her daughters Sinethu (4) and Siyamthanda (6) in a very low-lying area near the railway lines and the river. Extensive flooding plagues the area, comprised of informal shack dwellings. On the days I visited, the paths between the shacks were high with water and there was the distinct smell of sewage. Even though this section is not geographically very far from more developed areas, it is difficult to reach it by car and the families must walk a great distance to reach shops, transportation, clinics, schools, and other facilities.

Noluvuyo is 24 years old and has been unemployed since she moved to the Western Cape three years ago. She has some primary school education but is functionally illiterate. She and her children live in a shelter built by Philani.²⁰ The shelter is 5x3m, made of pre-fabricated fireproof materials, and has a solid cement floor. There are two single beds, a couch, cupboards, and a two-plate stove atop a table. Noluvuyo says the house still gets wet when it rains, but it seems to be a sturdier structure than those of many other people in the area.

²⁰ A photo of a Philani-built shelter is included in Appendix 3.

Noluvuyo was diagnosed with HIV when Sinethu was referred to the hospital and tested positive. At this time, she was late in her pregnancy with her third child. This child passed away shortly after birth due to HIV-related illness. Nolvuyo's HIV infection progressed to AIDS in January 2007 and she started anti-retroviral treatment immediately thereafter; in August 2007 she reported feeling well and increasingly stronger. Sinethu is also on ARV treatment. Nolvuyo receives a Disability grant, two Child Support grants, and the Desmond Tutu grant from Philani.

Mother #5: Nokuthula / Outreach Worker: Pelokazi

Nokuthula also lives in an informal shack settlement by the river, only accessible by navigating the narrow lanes between the shacks on foot. She stays in a shack with her husband and two children. The shack was immaculately clean and organized and painted bright blue on the inside and with colorful dishes lining the shelves. Seating was very limited and comprised of a bench, a wooden child-size chair and an upside-down bucket. The cooking area was a table in the corner that held a gas burner and a few pots. The wooden coffee table in the middle of the room was made by her husband. There was a bedroom off the kitchen where her baby slept and her daughter played.

Nokuthula's 6-year old daughter Sinalo and 6-week old son Sipho were both healthy and vibrant. Nokuthula was diagnosed HIV-positive when she was pregnant with her first child. Nokuthula was part of the mother-to-be program at Philani while she was pregnant with her son, but now that her children are healthy she will receive only occasional check-ups from Philani. Both of her children are HIV-negative. The status of her husband is unknown to her. Nokuthula has her CD4 count checked regularly and has not experienced any symptoms of illness.

Nokuthula explains that her husband is a craftsman, selling his products informally and earning an average of R500 per month, though Nokuthula said this was not consistent. Nokuthula was employed as a domestic worker but resigned in early 2007 when she became pregnant. Nokuthula receives the Child Support grant for Sinalo and soon for Sipho too.

Table 1: Summary of Mothers' Biographical Information

Mother	Philani Outreach Worker	Total # people in household	# total children in household	# children HIV-positive	Married?	Household Income ²¹	Health Status	Type of Housing	Last Work Experience	Translator for Interview
Nonkululeko	Pelisa	6	2 biological – 2 non-biological	1	Yes	R200 CSG + husband's income (R355/wk)	HIV+; Some illness, not on ARVs	Three-room shack; average condition	Cleaner in cape town	None
Naledi	Patience	4	1 biological + 1 non-biological	1	No	R200 CSG (x2)	HIV+; Healthy; not on ARVs	One-room shack; poor conditions	Unknown	None
Nothemba	Phumla	3	1 biological	1	No	R870 DIS	HIV+; AIDS illness/on ARVs; passed away	Shack; poor conditions	Unknown	Yes; Themba
Noluvuyo	Pinky	3	2 biological	1	No	R870 DIS + R200 CSG (x2) + R300 DT	HIV+; Healthy; On ARVs	One-room Bungalow; good condition	Never worked	Yes; Pinky
Nokuthula	Pelokazi	4	2 biological	0	Yes	R200CSG + husband's income(+/- R500/pm)	HIV+; Healthy; not on ARVs	Two-room shack; good condition	Domestic worker in cape town	Yes; Pelokazi

²¹ CSG=Child Support Grant; DIS=Disability grant; DT=Desmond Tutu grant (Philani)

Household Vulnerability & Challenges

As seen from the short biographies of the women's lives and circumstances, there are differences among the women that may affect their experiences of poverty. However, as described above, they all live within a context of vulnerability comprised of structural class-based oppression and gender inequality. This chapter outlines what the women themselves felt about their situation. The issues they raise speak to the multi-dimensional nature of poverty and its impact on limiting capabilities. Here, unemployment (and lack of income), housing, and illness emerged as factors that enhance household vulnerability and speak to areas where structural change is necessary in preventing some forms of poverty. Within these broad categories, the mothers describe the experience of poverty in their life through material deprivation, lack of security, emotional anxiety, poor physical health, and unreliable social support.

Unemployment & Household Income

While unemployment and poverty are not inherently linked, the statistics for South Africa show a strong correlation between the two and this is evident in the mother's stories. Owning few productive assets, with no income coming from wages and lacking comprehensive social protection, unemployment usually means there is very little money in the household; the women express their anxiety about their financial insecurity and the effects this has on the poverty experienced by their households.

Pinky: The biggest problem in this area is unemployment, it affects the children's lives and you see so many malnourished children. Even if you come into the house, hey, there's no life in this house.

Not being able to find work or have money to support their children is a serious source of stress for the mothers interviewed. Some of the mothers discuss their reliance on government grants and the limitations of this support. Naledi's belief is that if she could find work, some of the symptoms of her poverty, especially related to caring for the material needs of her children, would be addressed.

Dianna: What are other things that make you stressed?

Naledi: Because I am not working. I can't afford to support my child because I have this R200 [Child Support grant] and I have to buy everything for this child...

and I have these other three children and I didn't buy anything for them since 2001. Everything is from that friend of my mom, so I am stressed with that.

What can I do for them? I want them to come to me, but I don't have money. So if I can work, I can at least...

Pelokazi translates for Nokuthula, expressing similar concerns:

D: What are any things that you worry about? What causes stress?

Pelokazi: The children. [Nokuthula] would like to give everything, but it's not easy to do that, because she is not working and the father is depending on [his informal and unpredictable] business [for money].

Another complication relating to the mother's unemployment is an increased dependence on her husband for financial support. Nonkululeko expresses her frustration with her husband's fickle use of his wages. Thus, even though his income is dependable, it does not always translate to consistent support for the family. Nonkululeko relates the impact that her lack of income and her husband's selective support has on the poverty experienced by her and her children:

Nonkululeko:.. On Monday I was going to Groote Schuur [hospital] for my appointment but I didn't go because I don't have money for the taxi. I try to, you know, I'm not working so it's difficult for someone to give you some money because you are staying here and my husband is drinking so sometimes he cares, sometimes he don't care.

I know you [my husband] don't give me some money for me because I'm not working, but you just supposed to support your child. Even Pelisa, I told her, I've got a problem. I don't have a problem for his money, but try to support the children. My brother sometimes he give me the money so I don't mind. If [my husband] just give me the money for the child I don't mind.

As a result of a lack of income discussed above, the mothers express anxiety over providing even the most basic provisions for their children. This material deprivation is possibly the most tangible aspect of poverty, yet the discussion on wellbeing reinforces the significance of emotional health.

Naledi: Sometimes it's hard because sometimes I'm stressed. [My daughter] don't understand when I'm stressed and she wants something, "mommy give me a piece of chicken." Sometimes it's very hard but sometimes it's easy when I have got food. If there's nothing, I'm stressed but the only thing I'm stressed is the food, the clothes. If she doesn't have shoes, I'm going to be stressed.

Nonkululeko describes the relative needs of her two children, according to their age. She struggles with the additional needs of her 9-year old daughter, more difficult to satisfy than those of her youngest child.

D: Do the children have everything they need?

Nonkululeko: No, even my child hasn't got clothes. I just went last week for the shoes. I don't mind about the little one. She has got everything.

Caring for children is a significant commitment for the mothers and requires a good portion of their day. Some of them equated this care to that of a full-time job.

Nonkululeko tells of her daily routines caring for children and the energy that it requires of her.

Nonkululeko: Like my older one, neh? For now, I've got a problem because most of the time I'm looking after the little one, but the older one... I cook food, if there is a problem how to wash, I wake up and then I wash her, because she is still young... Every time I do this, I am working every morning. Then I am going to sleep. I am the same as somebody's working. Because I do everything everyday. This morning she didn't see the shoe. I can try to look, where is the shoe, you know? And then I, oh it's difficult, she don't want to eat in the morning. Only the amasi²², but you can't force her.

Though the mothers continue to speak of the material needs of their families, it becomes evident that they are emotionally affected by their inability to provide basic care for their children. Emotional anxiety will resurface many times throughout this account of the women's lives as a significant form of poverty experienced by these women.

²² Yogurt-like soured milk.

Housing & Neighborhood

In an informal urban settlement like Khayelitsha, the shacks that many of the mothers live in present a significant form of poverty and a safety risk for children. Lack of proper sanitation and clean water pose additional threats, and fire is a constant danger in these overcrowded areas. Also, crime is a major issue. Concerns for the safety of their children were raised by several of the mothers and were expressed with a sense of helplessness over their ability to protect them. These conditions cause fear and insecurity in the women's lives, the effects of which are stressful and debilitating.

Naledi: I'm worried about... the food, clothes, and the place to stay. We've got no toilets, no water, the place is dirty. And this is a child, so if she wants to play, she just goes outside to play and it is dirty. So you know, you can't see her all the time what she is playing with, but when you see, you say don't play with that, so if I can stay in the right place with her.

D: In your community, do you feel safe there?

N: No. Maybe she can be raped, or maybe stealed by someone. She is not safe, and I am not safe. And the house I am staying is not safe. It's just a shack. So if someone wants to get in, they can just get in. Not safe at all, but I am staying there... [The shack] was two rooms, then it was burnt, all of the two rooms. Then I started fresh, I took those zinc [walls] that were burnt and I put them back up.

D: Do you all stay in the same bed?

N: We don't have [a] bed. We just put the crates and put the mat on the crates. Mampho is putting the crate on that side and I am putting my crate on this side [and we are sleeping with our children].

The mothers link housing to serious concerns for their child's safety. Nonkululeko also identifies housing as a primary form of poverty and anxiety over her child's future:

D: What are other problems? Is there a lot of crime? Do you feel safe?

Nonkululeko: It's not the safest. Even I pray everyday, I want my own house, the right house for me. And I pray god, don't take me because I want my child to have a house, to leave my child with a nice place. And I take my sister to stay with her.

I don't have mother, I don't have father, so where must my child stay? You know the family is difficult now.

Another reality in Khayelitsha is that of alcohol abuse. Nonkululeko's outreach worker, Pelisa, commented:

Pelisa: You see, when [Nonkululeko's] husband comes in drunk, [the older child] is scared. She wants to be close to her mother's chest and then what about the baby? But she gets so scared.

Illness

Illness is another factor of that makes households vulnerable to poverty, as well as intensifying the effects of poverty due to its impact on the mother's capabilities. Illness caused Nonkululeko to resign from her job as a cleaner and has also limited her ability to care for her children. Her child's illness also limits Nonkululeko's capacity to work outside the home. Additionally, both Nonkululeko and Nothemba describe how the presence of illness restricted them from applying for social assistance grants in their time of need.

Nonkululeko: So I was sleeping there at Somerset [Hospital] and I didn't have a chance to come to do the grant because I'm sleeping with my child. After that a new doctor said, I'm right now. She says I'm well for working. I said I can't work because I've got a problem with the child. So if I get another person to look after my child, that money I supposed to make something for my child, I'm supposed to pay somebody else to look after my child. But I want to work if I find something, but it's difficult for now.

D: Do you feel like you're well enough to work?

N: No, when I use the water, I feel cold and I feel sick. Just now I'm using the [washing] machine because I can't use my hands, even the nappies I buy the disposable. Even now, I don't know what's happening. I lose weight, I've got the arthritis. I am sick most of the time.

Nonkululeko's illness has also had a direct effect on her 9-year old daughter's education. While she was working in the center of Cape Town, her child was able to attend a multi-lingual and well-resourced school there; however, when she needed to quit her job as a

result of her illness, her daughter had to transfer to a low-quality Khayelitsha school, a clear point of frustration for Nonkululeko, expressed by her outreach worker.

Pelisa: She was working at that time so she wanted the children to grow up in multi-racial schools. That's what she's trying to say. So when she got sick, the child has to go to these schools in the location [Khayelitsha]. So at this time now she's disappointed.

Nothemba's advanced AIDS illness placed a significant strain on her physical ability to care for her child and even constrained her access to health care. Nothemba describes the double burden of mother and child HIV infection, translated and retold by Themba.

Themba: [Nothemba] is sick and the child is sick... that's why she doesn't have grant. The child was supposed to start ARV's last August but she couldn't get her to clinic because [the mother] was sick. Until the child was here at Baphumelele, she just started the ARV's at Red Cross [Children's Hospital].

D: What is the most difficult thing about being a mother and how does being HIV-positive add to the difficulties?

T: She's saying it's really, really difficult especially being a mother and the child is also positive. It would have been better if she was a mother who is not positive because she would also be strong enough to carry the child.

D: What are some of the things that she is able to do even though she's sick and what are the things that she's proud of?

T: (Nothemba cries) She's saying that there wasn't much she could do, all she could do was love the child. It was tough.

D: Themba, would you ask [the outreach worker] how she thinks [Nothemba's] situation compares to the other women she works with?

T: [Phumla] says [Nothemba] was struggling the most, with the conditions of the house, and the extent of the illness.

Naledi stays home to care for her 4-year old daughter, who is consistently suffering from opportunistic infections as a result of her HIV infection. Naledi's child requires fulltime care, limiting her ability to look for paid work.

Naledi: yah I want to take care of her, but just if I could get something for staying with her without working.

...Philani gives me milk [for the baby] and they say I [should] come to do the work, make some things in the shop to make money. But the only thing is my baby is not well. She just two days well so I am trying to stay with her to take care of her.

Nonkululeko also expresses the additional burden of caring for a sick child:

Nonkululeko: I said I can't work because I've got a problem with the child. So if I get another person to look after my child, that money I supposed to make something for my child, I'm supposed to pay somebody else to look after my child.

Many of the outreach workers affirmed the hardships faced by mothers of sick children, implying that this is a predicament faced by many mothers in their caseloads. In a context of poverty where adult household members must work for wages in order to survive, mothers now have to choose between providing physical and emotional care for their children or working to meet their material needs.

Due to the high levels of stigma associated with HIV/AIDS, the effects of being HIV-positive can be felt long before physical symptoms of illness. The women describe feeling alone and ostracized from their families and community as a result of their HIV infections.

Nonkululeko: I've got a problem. My family knows... but my husband's family, they don't know nothing because he doesn't want to tell them. So it's difficult for me to talk to him because I don't know what he thinks about it.

Patience also comments on the additional stress that HIV has on Naledi's life:

D: Do you think that other people [have these problems]?

Naledi: They might. I'm not sure.

Patience: Sometimes I am not feeling right because her problems are difficult... to me... more than the other people.

D: What is it about being HIV-positive that makes it more difficult?

N: It's the stress... because sometimes [Naledi] is crying a lot... so I try to... (she hugs her)... it's difficult.

Goals & Aspirations

Even in the context of the many different aspects of poverty and extreme anxieties in their lives, the women expressed hope in a better future for their children. This section presents what the women value and desire for their children. An understanding of this will contribute to the later discussion on their responses to the poverty they face.

Noluvuyo speaks of her wish to provide her children with more than the absolute basics:

Pinky: To be a good mother, [Noluvuyo] likes her children to be happy, eat food (meat, veg, and rice). She is trying to satisfy her children, buy them toys, money for chips.

Nokuthula addresses the issue of education, which could possibly provide her children with greater opportunities and an escape from poverty. She remains positive about her ability to achieve this goal.

D: What are the things that it takes to be a good mother? What does she [Nokuthula] want for her children and their future?

Pelokazi: Education.

D: Does she think she will be able to give them that?

P: She thinks so.

Naledi recalls the daily moments that bring her joy and her desire to raise her child to be happy and healthy:

Naledi: I must love her, take care of her, feed her all the time, make sure she is clean, she is playing nice.

D: When you think about your daughter and the future, what do you hope for her?

N: I want her to be at school, to be right, to be healthy. For instance, if I can die, I would not like her to be taken by the family because they are not good. So maybe she be taken by the foster care or whatever, you know, because my family is not right.

While the mothers were able to articulate their many various forms of poverty, they also powerfully envisioned a different life for themselves and their children. These aspirations speak to the "freedoms" outlined by Sen that constitute an alternative way of viewing poverty alleviation. The mothers want their children to be "free" from poverty by having a healthy physical body, an educated mind, and a sense of joy and happiness in their lives.

Conclusion

The women's self-identified vulnerability context encompasses factors related to unemployment and a lack of income, poor housing and high crime levels, and illness in themselves and their children. Within these broad categories emerged experiences of many forms of poverty, including material deprivation and lack of basic necessities, emotional stress and anxiety, poor health, and minimal opportunities for work or quality education. Strongly expressed in the interviews were the mothers' concerns over the safety of their children. They expressed a profound inability to protect them. Not only do their stories speak to dismal living conditions but of a neighborhood wrought with crime. This context seriously impacts upon a family's wellbeing and sense of security.

The women's stories also present the special burdens that illness places on a mother and its impact on the poverty experienced by her household. The direct effects that HIV and AIDS has on the income poverty of a household is seen in Nonkululeko's, Nothemba's, and Noluvuyo's inability to work due to their illness. This is also apparent in Naledi's need to care for her HIV-positive child rather than engaging in income-generating activities. Due to the many ways that HIV and AIDS is affecting society, it is both a factor in the women's greater vulnerability context as well as an aspect of their personal struggles.

An important commonality among the women is that all five of them were diagnosed with HIV through visits to the doctor regarding their baby's health, either during pregnancy or shortly after the birth of the child. Had they not been bearing children, it is reasonable to assume that many of these women would still be unaware of their HIV status. Therefore, at least in these cases, becoming a mother has a significant impact on a woman's likelihood of being tested, learning her status, and receiving treatment and counseling. This is one of the many ways that HIV and motherhood are strongly

intertwined in South African society, as children provide women with the opportunity for testing, education, and treatment.

Also consistent across the stories is the women's lack of knowledge of their partner's HIV status. Their partners refused to discuss this with them so the women do not know if their partners have tested or if the men know their own results.²³ Feelings of loneliness and anxiety concerning their HIV status also emerged in this chapter. Nonkululeko told of her deteriorating relationship with her husband after she disclosed her status to him. Naledi spoke of the stress that knowing her HIV status adds to her life. Certainly the isolating effect of AIDS-related stigma has is a very real symptom of HIV infection.

Throughout this chapter emerged the significant responsibility among the women to care for their children. A problem emerging from their stories was the lack of support they receive from their children's fathers, evident even among the married women.

Nonkululeko expressed frustration with her husband's inconsistent financial support while she cares for the children. She expects herself, in addition to providing childcare and completing domestic tasks, to earn an income. Nonkululeko concurrently expresses exhaustion caring for her disabled child. This demonstrates how the systems of patriarchy and capitalism place double expectations on women and stretch their capacities to the breaking point.

Demonstrated in this chapter are the implications that unemployment has on household poverty in the context of structural dependence on wage-based income. Their lives are illuminated by the theory of the underclass and the legacy of the discriminatory and oppressive South African policies of the past. Their stories speak to a lack of skills and education, fragmented family life, illness, and chronic unemployment. Despite extensive improvements in access to health care, education, and social welfare, those on the fringes of capitalist society continue to be marginalized. The dependence on government grants is evident among the women, yet in a system without comprehensive support, there are huge discrepancies between the grants they receive.

Assigning this group to the ranking of underclass emphasizes that access to (or, rather, lack of access to) employment as a key factor in their experience of poverty. The impact

²³ The dynamics between partners relating to HIV testing and disclosure is a topic in need of further exploration.

of unemployment on living conditions, indicators of health, and education for children was highlighted in several of their stories. Nonkululeko expressed frustration with the quality of education available to her children. Naledi is unhappy with the lack of safe neighborhood play space for her child. Both of these women attribute their unsatisfactory situations to a lack of income as a result of unemployment.

The concerns raised by the women speak to a need for certain services to address their specific poverty. Free public transportation would allow the women to access necessary health care facilities and search for work opportunities in more developed areas. Their stories also highlight a need for supportive childcare services, such as free crèches and laundry services. This would benefit the mothers coping with illness as well as those who would like to work outside the home. The mothers' concern over having enough food for their children could be avoided by community soup kitchens or food vouchers.

There are several areas of poverty that were not explicitly raised by the mothers in the interviews. Malnutrition is a serious threat to the women and children in this study, evident in their enrollment in Philani's program as well as their concerns over having adequate food in the house. Skills development and adult education is another issue that was not raised here, yet expressed indirectly through their frustrations over not being able to find work with their minimal levels of formal education. Similarly, depression and mental health were not specifically highlighted, but were alluded to by the women's intense anxieties over not being able to meet their children's basic needs.

Chapter Five – Responding to Poverty

In the previous chapter, the mothers clearly identified their poverty, ranging from inadequate housing to insufficient food to illness. They have also indicated the life they want to have for themselves and their children. This chapter focuses on the ways the women alleviate their poverty and strive for greater wellbeing. The interviews highlight a combination of government and community support that is instrumental in the women's ability to mitigate poverty. Though already presented as contributing to the vulnerability context of the mothers, by not introducing a comprehensive social welfare system, the government also mitigates some forms of their poverty through the grants and services it offers. Community support through non-governmental organizations, family, friends, and neighbors is also instrumental in alleviating poverty. This chapter explores the elements of poverty that are addressed as a result of these resources, as well as the barriers and gaps to accessing them.

Government services

As briefly presented in chapter two, South Africa's social welfare program is primarily comprised of social assistance safety nets, though other government services (namely, free clinics) are also available. The types of poverty that these resources address will be considered, as well as barriers to access and present gaps in coverage. This section by no means intends to be a comprehensive analysis of available government services; rather, the services that are directly relevant to, and accessed by, the women interviewed will be discussed. The institutional context contributes to the vulnerability context of the women by failing to create jobs and provide comprehensive support, though it also provides much-needed grants for some people.

Social assistance grants

As discussed in chapter two, the state offers a number of cash grants to address the income poverty experienced by the young, the old, and the disabled. The gap in coverage for unemployed, able-bodied people of working age is a recurring theme in this thesis.

Nationally, the most widely accessed grant is the Child Support grant, currently set at R200 per month. All of the Philani mothers were receiving this grant for their children,

with the exception of Nothemba, who said she was too sick to apply for the grant. The mother's connection to Philani may have had a positive effect on their access to the grants, due to the information and support they receive from the organization. However, take-up rates for the grant are consistently high across the country and are continuing to rise, proving that many caregivers who are not connected to supportive organizations are also managing to access the grant (Booyesen 2003:7).

Pinky: But God is there. They are growing up now, even though she is not working anymore, doesn't know how they survived. The [Child Support] grant was a big help.

However, in the absence of an unemployment grant, some of the mothers depended almost entirely on the Child Support grants they receive on behalf of their children. Therefore, that which is supposed to be a safety net for children, intended to improve their wellbeing within low-income families, actually becomes the sole source of income for the family.

Naledi: So I'm staying here and [Mampho] has a grant for [for her child], and I have a grant for [my child]. So it's 200 and 200. So we are living with that. She's not working, she's looking for a job.

This grant is inadequate for Naledi to look after all the needs of her child while she is unemployed. Nokuthula also depends on the Child Support grant as her only source of consistent income. She reports spending the grant solely on food, though she later said that she prioritized crèche for her child and also paid those fees out of the grant money.

In the midst of an AIDS epidemic, where illness is present in many South African households, the South African Department of Social Services is encouraging uptake of the Disability grant to reduce the impacts of income poverty while sick. The grant is designed to temporarily or permanently support those whose disabilities or illnesses prevent them from working. In the context of high levels of unemployment, this may, according to Natrass (2006) perversely act as an incentive to becoming or staying ill as a strategy for accessing social assistance.

Noluvuyo and Nothemba are the only two women in the study whose stage of AIDS illness makes them eligible for the Disability grant. Since they have now been deemed

unable to work, the government is providing them with monthly income support. Noluvuyo reports that her receipt of the Disability grant in early 2007 has enabled her to provide for her children without the usual stress of having to live off the two Child Support grants alone. This is a sign that the Disability grant is meeting its stated purpose of providing families relief during illness and strengthening Noluvuyo's capabilities. However, there is a bureaucracy involved in accessing grants:

Pinky: [Noluvuyo] says it was difficult for her to get the grant, she didn't have an ID. So I'm the one who assisted her in getting the ID. So after she got the ID, I also assisted her to go to apply for the grant, so she got those papers from social services. We also had to help her fill out the forms because it was difficult for her to fill out the forms.

D: How has receiving the grant changed things in the house? What are some things that she is now able to buy with the grant that she was not able to buy before?

P: She managed to buy clothing for her and her children, blankets, the bed, and also the cupboards.

D: So before the grant they didn't have...

P: No, they had nothing. I used to borrow her money, I also... (asks Noluvuyo).. Oh! I have forgotten about that! I also offered her a place to stay because they didn't have the shelter... and food, and even...

D: Now with the grant, does she have most of the things she needs or are there still things that she struggles with?

P: For the time being, she says its ok.

D: What worries her?

P: Nothing worries her so far.

For those depending on social assistance, the experience of the "in-between" is a difficult situation and represents the gap in government support. The "in-between" refers to those who fall through the gaps in welfare provision. This includes people who are healthy but "in-between" jobs, as well as those experiencing increasing sickness but who are not yet

eligible for a Disability grant. Nonkululeko discusses being forced to resign from her job due to her increasingly poor health. However, her health is still well above the mark that qualifies for a Disability grant.²⁴ She is therefore in a difficult 'in-between' stage where she is unable to work and unable to collect any assistance from the State.

D: Do you get a Disability grant?

Nonkululeko: No, my doctor last month said I'm right.

D: Do you feel like you're well enough to work?

N: No... Even now, I don't know what's happening. I lose weight, I've got the arthritis. I am sick most of the time.

The Care Dependency grant presents another dichotomy in grant eligibility. This grant only targets children with serious and permanent physical disabilities, often to the exclusion of HIV-positive children with frequent opportunistic infections. However, all sick children require great care, yet most mothers are unable to access this grant. Because Nonkululeko's HIV-positive child also has physical and mental disabilities, she will soon receive the R870 Care Dependency grant, providing her with a monthly income so that she can look after her child's special needs on a full-time basis. Of the many sick children in this study, Nonkululeko's child is the only child that qualifies for the care dependency grant. All of the other women caring for their sick children full-time will only receive the R200 Child Support grant.

Naledi's story is a case in point for the "in-between," as she is receiving the most minimal amount of assistance of all the women in the study. She is unable to work due to the care required by her child, yet her daughter is not eligible for a care dependency grant.

Naledi's current CD4 count also does not qualify her for a disability grant, making her "eligible" for work, yet she has been unable to find employment. Though she receives a Child Support grant, Naledi has stated that this not enough to support her and her child. Naledi illustrates the difficult circumstance resulting from both mother and child falling into the category of "in-between."

²⁴ As explained earlier, stage of HIV illness is measured by CD4 count, which must be below 200 to be eligible for the disability grant.

Naledi: Yah, I want to take care of [my child], but just if I could get something for staying with her without working.

Applying for grants require a collection of documents and doctor's notes, items that many poor families spend a great deal of time struggling to obtain. Worse is the confusion around how to successfully navigate the application process. Obtaining and organizing the documents for this application is an exhausting process for Nonkululeko, caring for her disabled child. Not only are some mothers too weak to submit an application for the grant, the bureaucratic process is very difficult. There are also significant costs associated with the application process, related to obtaining documents and traveling to Home Affairs. The health, mobility, and income of the mother were significant when applying for any kind of grant.

Nothemba was unable to process applications for the Disability grant and Child Support grant due to her illness and inability to leave the house. She is arguably a candidate who needs social assistance the most, and yet she was also most unable to access it.

Themba: [Nothemba] is saying that she's not getting a grant now. She is about to get a Disability grant for herself, but for her child, she's not getting anything. She's trying, but she's weak.

D: Because she isn't able to get to social services?

T: Yes, because she hasn't had a chance because she was sick at home.

Public Health Care Services

Another aspect of the government's social services is to provide free clinics to all of its citizens. Though anti-retroviral treatment for AIDS has been slow to rollout on large scale in South Africa, considerable progress has been made, especially in the Western Cape province where Khayelitsha is situated. When discussing HIV status with the women, all five had visited clinics and were aware of their CD4 count. The two who needed treatment were receiving it as well as all of the HIV-positive children. The quality of the government's free health care may be debated, but the fact that the women were able to access this service is a significant success for in this disadvantaged area.

Even so, poor infrastructure and under-resourced clinics may mean that basic services are provided but the system may be unable to cope with after-hours or emergency situations.

Nonkululeko speaks of an evening when she was unable to access health care for her child:

Nonkululeko: Last of last month [the nurse] didn't want to take my child. Because the time I was going to Site B I was going at 6:00 later because she had a problem of the chest. When I was going back, she said there's no folder [for my child here] and I must go to [my clinic at] Site C. At that time I was going there, my child was very sick and here it was closed already.

The enormous burden of multiple HIV-positive members of the household and the expense of traveling to clinics and hospitals means, as we saw above, that appointments are missed. Nonkululeko received a scornful reaction from clinic staff over missed appointments, calling her lazy and irresponsible and discouraging her from returning. Nonkululeko describes her clinic as unsympathetic to the double health needs of both her and her child so that she often misses her own appointments at the clinic to go to her child's appointment at the hospital on the same day:

Nonkululeko: So the problem is, sometimes the date of mine is the same of my child at Red Cross [Children's Hospital]. So I can't go to the clinic then come back to Red Cross again. I must go to Red Cross because my child is having a problem....so every time if I've got an appointment for Red Cross, I'm supposed to go there. So I've got a problem because I've got arthritis, I don't know why... because I don't eat proper meals.

Pelisa: So sometimes they are both on the same day...

N: They are both important!

P: You know what the problem is now? They don't understand. She's supposed to be taking herself to Site C because it's the nearest but she wants to see if she can be transferred to Site B, but it's gonna be far for her and she won't have money to travel.

D: Why do you want to go to Site B?

P: Because maybe they will understand the problem. She can't have the same date for her child... like she's making excuses.

N: If I go to Site C, I tell them the problem, what's happening. They said it's a long time now, why is it? And I didn't find the results. Even now, I don't know what's happening. I lose weight, I've got the arthritis, I am sick most of the time. Sometimes I don't have time to go to Red Cross. I'm supposed to organize someone to take my child to Red Cross because I feel sick. I supposed I eat the medicines, I think so, because it's a long time. No, now for next month, it's not the same. If it's still bad, I'm going to Site B. I will tell them, I'm not making excuses, but this is the date already. It's not that it [my appointment] is not important, but the baby is also important.

Community Resources

Government actions are supported by the work of community-based organizations, faith groups, and personal social networks. Community-level support for HIV-positive people can be categorized as follows: emotional support, instrumental support (shopping, transport, etc), informational assistance, and financial support (including lending money) (Swartz 2005:29). Since all of the women in the study are members of Philani Nutrition Center, they have already been proactive in utilizing community support. However, this section goes beyond exploring the impact of community organizations to also include family, friends, and neighbors.

Community-based Organizations

Though there are thousands of community-based organizations operating in South Africa, this section will look at the work of two organizations in particular. Philani Nutrition Center and Baphumelele Respite Care Center were highlighted in the interviews as sources of support for the mothers. This section is not a comprehensive overview of the many organizations working in Khayelitsha, as the scope of this study only explores the resources directly relevant to the women interviewed.

Philani Nutrition Center

As already seen, Philani Nutrition Center is a prime example of an organization that has taken on a significant responsibility for providing care and services for the women in this study. This section explores the impact that Philani's multi-faceted service has on the

lives of the mothers and their children, with additional insight added by Nokwanele Mbewu, their head social worker.

Pelokazi, working as an outreach worker for several years, elaborates on the intervention she does with the mothers in the outreach program:

D: What are some of the things that you educate about?

Pelokazi: We educate about how to feed, feeding practice and hygiene, and also the way of taking care of a baby.

D: Do you give advice about how to, when you only have a little bit of money, what are the things to buy that are the best?

P: Yes, the cheaper things.

D: Also like the healthier things?

P: Yes, like vegetables are cheaper. It's nutritious food, yes. We also stress about it.

D: ok... most of the mothers that you're working with, do they take your advice and do their children get better?

P: yes.

D: Do you think it's a useful program?

P: Yes.

D: Of all of the mothers that you see, what do you think is the biggest problem that they have?

P: Less knowledge.

D: About what?

P: About the way of feeding their children. Especially when they are babies 0-6 years. They don't know how to feed or how to take care of the baby during the younger age. We promote exclusive breastfeeding from 0-6 or exclusive formula feeding. So most of them like to mix-feed the children and it's dangerous for babies, so we stress to educate.

As previously mentioned, the nutrition-based educational interventional is the main focus of the Philani program yet the organization offers a number of other services to address the poverty that contributes to malnutrition in the households. As seen in the biographies, none of the mothers in the study are receiving the Philani relief grant since they are all receiving the Child Support grant. Nothemba is the only mother receiving neither grant. The social worker at Philani explained that Nothemba was given money for transportation and to acquire the necessary ID documents in order to access the Child Support grant. However, she did not take the steps to do so and the outreach workers would not do it for her.

Noluvuyo is the only woman in the study receiving the Desmond Tutu grant, originally set for one year but which Nokwanele says will continue as long as the funding is there. Nokwanele describes several other families that are receiving DT from Philani for their extraordinary commitment and efforts in caring for their families, including mothers who work long hours to bring in an income, teenagers who care for younger siblings who are ill, and women raising foster children.

Last year, Noluvuyo had nowhere to go with her two children and they were in danger of sleeping on the street. Pinky, her outreach worker, brought the situation to Philani's attention and a shelter was built for her shortly after. Here, Pinky translates for Noluvuyo, who speaks of the peace of mind this has given her:

Pinky: The house from Philani has changed her life and her children's life because they had no place to stay. Even her family didn't want them. Things changed since the house but the family is not happy that she has the house. To her, the house brought happiness. It was a surprise to the family because they didn't expect her to own a house. They came to see on that day and they were happy on that day. Others were not so happy.

D: What makes her happy?

P: It's because her children are free and have shelter and food and she knows what her children need because before they didn't have a place to stay until I [lent] the shack of mine until Philani came.

Though Philani clearly offers valuable informative and physical support, the women identified the most significant support is their relationship with their outreach workers. These women, drawn from the community, assist mothers in applying for Child Support grants, give them education and advice on childcare practices and feeding, and at times even help the mothers care for the children. One mother reported that her outreach worker offered to take the child to an appointment at Red Cross when the mother was feeling ill. Another outreach worker offered a family a place to stay when they were without shelter. Most importantly of all, the mothers described in great detail the emotional support they received from the outreach workers. Especially in the context of a stigmatized HIV/AIDS epidemic that may cut people off from other support networks, a Philani outreach worker often takes on a significant role in the mother's life.

Nokwanele: Also, we say we are offering counseling, because through the outreach program it encompasses the building of the relationship, the main entry is the child, but when you get into the house, you do the intervention that is, sort of helping the whole family. So it's a holistic approach that is only entered through the child.

Naledi views her outreach worker, Patience, as a reliable and educated source of advice and information as well as a trusted friend. Naledi recounted her extreme anxieties relating to her HIV infection, but she states that Patience is the person she trusts to discuss these feelings. In this next quote, she says God brought Patience's into her life:

Naledi: Sometimes I feel stressed but I try to accept it. Once I feel I am stressed, I try to go to someone to talk to them, and they tell me, you must not feel stressed, you must accept it, it's not only you... So I talk to Patience.

D: Can you tell me about something that makes you happy?

N: God, neh? Sometimes stress can come, but after a time you say, ok let me ask God. By that time God tells me you must go to Patience and after I talk to Patience I feel better. And it's God that made that plan. So Busiswe says, hi how are you? And I say I am stressed too much. Maybe sometimes I don't go to her, she just comes to me in that time of stress. She says why today you so cross, what's wrong? I say, I'm stressed, I'm worried, my baby is very sick now. "You must take her to Philani, you must do this, you must do that, I will bring you some

Disprin, just to give you Panado." Sometimes the stress can just control. But not all the time. You don't have to let it happen all the time.

This powerful quotation displays the significance of emotional support in the wellbeing of the HIV-positive mothers, especially in a community that does not openly speak of the virus to one another. This form of poverty has nothing to do with the income in a household and rather to psychosocial wellbeing resulting from social inclusion and supportive friendships. Other mothers also mentioned the emotional support of the outreach workers:

D: Where do they [the women] get that strength from?

Pelokazi: Maybe the counseling from the clinics and the counseling from us.

Nonkululeko also speaks of her close relationship with her outreach worker, Pelisa:

Nonkululeko: Sometimes I have got a problem and I want to speak to Pelisa and Pelisa, ooh, nowhere to be found. I lost her phone number and I can't find her! God bless me for this time. I've got a friend... I give Pelisa my child even now, she is going to take my forms to do the grant. Pelisa just take two jerseys for my child. She is doing my problems.

Aside from emotional support, the outreach workers have also been active in the lives of the mothers when they have been physically ill.

Nokwanele: Our main target is children 0-6 years. And then we, also now, have diverted and targeted HIV-positive women, bedridden. Actually, it's not women only. Women and men HIV-positive bedridden people, for bridging the gaps in other areas. By that we mean that whatever the government is not able to provide we will provide. For example, to a few we provide food, groceries, or transport to the health institutions

Nothemba describes the physical help she's received from Phumla, her Philani outreach worker, when she was too sick to care for herself and her child.

Themba: [Nothemba's] saying that there was nothing coming from Philani besides her [Phumla], who was going to help her out with the child when she is sick, she will wash the child and do things for the child, help clean up the house.

Philani seems to be filling many of the gaps left by government services, offering both grants and physical support to some families. In addition to addressing poverty related to material deprivation, housing, lack of information, health care, and illness, Philani is also playing a vital role in the emotional wellbeing of the mothers.

Baphumelele Respite Care Center

As stated, at the time of the interview Nothemba had just been admitted to Baphumelele Respite Care Center to begin anti-retroviral treatment. The center was designed for patients coming from a condition of poverty who require extra medical attention and support to treat their illness. This short-term, live-in center allows patients to rest and be cared for while they regain the strength to return home. Nothemba's daughter was also in need of care and was sent to Baphumelele Children's Home, located on the same street. Through the support of Philani and a referral by her local clinic, Nothemba was able to utilize the respite care center as an opportunity to receive special care for herself and her daughter. Nothemba conveyed her appreciation that her child is finally getting the treatment she's needed for so long:

D: Is being here somewhat of a relief?

Themba: She [Nothemba] said it's a big relief knowing someone else is caring for the child. She's happy that she's here.

Baphumelele also considers what additional support patients will need when they return home. Nothemba reported that her boyfriend is unsupportive and the conditions of the house are unsuitable for a sick person and a child.

Themba: When she is discharged we will visit her house and see what kind of conditions she's living in and how we can provide aftercare to her. Our main focus would be to make sure there is someone who, at least once a week, is checking in on them and the child to make sure she is taking her medicine and healthy. Also to send someone if something needs to be fixed in the house, or cleaned. She is planning on going to her brother in Delft when she gets out, to stay with him.

Social Networks

Though community organizations are clearly playing a major role in the women's lives, support also comes from family, friends, and neighbors, some local and others more geographically removed.

As a result of a culture of migrant labour, shared caregiving, and the close ties with extended family members, some of the women are depending on friends and relatives living far away to mitigate certain forms of poverty. In addition to Naledi's four year old daughter, she has three other children currently living with her mother's friend in the Eastern Cape. This is not uncommon in South Africa, as the cost of raising children in the rural areas is cheaper, and also allows parents in Cape Town to work. Naledi shares her experience of having her children raised by another woman and the gratitude and indebtedness that she feels towards this woman, prompting her decision to leave the youngest child with her even after he began receiving a Child Support grant:

Naledi: I went home and I've talked to that lady, that mommy, she said if you want you can take him, but I thought, if I am taking this one, then maybe this grant I am going to take. It's been a long time they've been living with her, so now I want to take this grant and eat it and she has grown my baby up there so I don't want to take him because she don't have children, so she's not staying with much, because she don't have any children. She was not married; she didn't have any children. So I thought, I want him to be with me, but just because I'm thinking of her, maybe she will say oh she wants to take this money now I'm going to suffer.

The Child Support grant has therefore become Naledi's way of thanking this woman for caring for her children. However, this story highlights the subtle complexity of such arrangements. Should Naledi ever wish to raise her son herself, she may feel like she would be doing a disservice to this friend who is now depending on the child's grant.

Members of the local community have also been a source of support to the women in times of need, with other mothers being the most supportive. This may signal a felt connection between mothers due to their common experiences and understanding of certain burdens, often in reference to a lack of support from family. In some cases,

church members were also referred to as supportive and willing to offer help and support.²⁵

D: Who in the community helps you? are the people friendly? if you had to borrow something, could you ask the neighbors?

Pelokazi: There are some, but not all of them.

D: There are some? So if you had to borrow an egg, or some sugar, you could go to the neighbors?

P: Yes.

D: And the neighbors also come here to ask as well?

P: Yah yah.

D: Is it a good relationship with the family?

P: No.

D: Are there enough people in the community that can be your friend and support you? Do you have people around that are close to you?

P: Yes, church members.

Nothemba and Naledi have previously been discussed as two of the most destitute women in the study. Support from the community is especially important to these women.

D: Is there anyone else in the neighborhood that she can go to borrow something?

Themba: There are three ladies that [Nothemba] can go to borrow something. There is one who just comes with a plate of food or medicine when the child is sick or when she needs help with the child.

Naledi also mentions a few women who she can go to for help:

²⁵ The role of churches will not be explored here, but their role in offering support to HIV-positive, unemployed mothers, emotionally, spiritually, and possibly even with material assistance, is an area that deserves further exploration.

D: So in Cape Town, who are the people that you can count on? Who supports you?

Naledi: Yes, there is a lady who helps me, next door. There are two. They help me with the children, like when my baby is sick I go to this one and tell her I don't have money, I don't have food in the house. She gives me money and tells me you must buy this for the child, and do all these things for the child. Those two ladies, yes.

Even though each of the women said there were people in their community who were willing to help them, they could only name a few, and they named them quite specifically. This is a particularly important point when discussing "community" because support is often received from a small group of people and is not necessarily indicative of an overall supportive community.

A recurring topic in this thesis is the extra care required by a child with health needs and the impact of this on the mother's capabilities to create outcomes of wellbeing. Here, Naledi discusses the role of her community in helping her ensure that her daughter's health as well as the way she reciprocates and helps others:

D: Does the child need to take food with the ARVs?

Naledi: You must give food, she must eat.

D: Is there always food?

N: There is always food for her, because if I have no food in the house, I will try to go to these other houses so they help me, they give me something to eat. for me, I can sleep without food, I don't mind, but this one she must eat.

D: Do people come and ask you for help?

N: Yes, they are. Some are asking me while I am suffering, but if I can, I help her. With food, with whatever, with matches, soap. If I've got, I just share it.

D: Are there some people who are struggling more than you?

N: Yes... there are. This lady, she's got a grant, but she is suffering.

Even though some of the women report being able to count on neighbors and friends for support, these helpful people were often discussed as the exception to the rule.

Nonkululeko does not feel like she can count on her community for assistance, with the exception of one or two people. She also mentions that is difficult having her family far from her.

D: And the neighbors? Is the community helpful? If you ever needed to borrow money for a taxi?

Nonkululeko & Pelisa: (laughing) No!

D: What about for food?

N: I've got one neighbor, sometimes she helps me. so now the dad is not working, the blindness, so nobody's working. she's not my family.. but the mother is close to me so if I've got a problem, I'm going to sleep there

D: So the community is not friendly?

P: No.

N: And my family is far from me in Site C. so I don't have a close family.

Nonkululeko and Pelisa spoke of the community's behavior towards people living with HIV and Nonkululeko expressed that she often feels alone and unable to form close friendships as a result.

Pelisa: So, Dianna, not everyone is supportive. They gossip around about your problems. So it's not so easy to talk to anyone.

Nonkululeko: If you say, I've got a problem, then they tell everyone. But I'm not scared now because Jesus knows what's happening with me.

N: We are having a lot of people who are having the problem, but nobody can talk.

P: You see, many people are not supportive. These people gossip around and they call it "this thing."

N: ...And then, you can't eat with this plate and so my child is eating with separate plate. These people is wrong. I tell myself everyday it's better; I know I'm sick, but it's difficult because they may say you have this thing and you are going to be dead now, but me, maybe I'm still I have time, I have a long time.

Nothemba relates a similar experience of not being able to ask neighbors for help due to the stigma attached to her HIV infection, with the exception of one woman.

D: are there other people in the community that are struggling with the same problems and do they talk about that?

Themba: [Nothemba] says that she does not know of any other family who is living under the circumstances that she is. The people they do not talk about their problems.

D: How did her family react when she told them her status?

T: They were supportive and told her to be strong.

D: Does she think the community would have responded differently?

T: One lady has been supportive to her, especially the one that brings food, but she was scared of the others that they would think they could catch it or would gossip about her.

The outreach workers reflected on their community's view of AIDS and the silence that surrounds it:

D: It seems like Philani outreach workers are pretty important, because they seem to be the person that mothers trust. Why don't they trust the other people? Why do they keep it a secret?

Ntombenhisa: It's because people think that HIV belongs to someone although HIV is for US. Do you understand that? HIV is for US. Not for someone. They always said, look at her, or look at him, she is ill. She is positive, Yebo. So they laugh at each other. That is why most people keep it a secret.

Pinky also explains her opinion of the root cause of AIDS-related stigma.

Pinky: It's difficult to share because of the way it was introduced first, when it was discovered that it was this virus that is incurable. That is why people don't accept and don't share. [They think that] once you get infected you will die or maybe they think you have slept with many guys or sell yourself...

It's changing a bit now that there's treatment. The way the people were told is not right. They should be told that it's like any other chronic illness. She [Noluvuyo]

can't hide that she is ill although she never talk about it except that friend, who also is HIV-positive and asked her to go with her to the clinic.

During the interviews with all of the women, none seemed to perceive HIV as a death sentence, nor as a source of shame. However, regardless of their reported level of personal confidence regarding their status, none of the women have publicly disclosed their status, and some have not even told their families. The perception that they are avoiding the inevitable gossip of the neighbors by keeping their status a secret is a common experience among the women. This perceived need for secrecy also inhibits the women from building networks of support for themselves. Many depend solely on their outreach worker for emotional support and counseling.

Inner Strength & Resiliency

The previous two sections have discussed capabilities in the context of access to government and community resources and, in turn, the impacts these services have on the mother's capabilities. This section explores how mothers are utilizing their personal strengths to produce positive outcomes for their households' wellbeing. Their relative capability determines the extent to which they can navigate within the vulnerability context previously established and depends both on the resources accessed as well as on factors linked to personal characteristics, family history, education, health, skills, and faith.

Of great significance to the women's capabilities is the chronic state of economic poverty and unemployment that they have experienced for much of their lives. Many of the women interviewed grew up in households of financial instability, lack of resources, and poor quality education. Despite this experience, some of these women creatively engage with their environment to achieve some level of wellbeing for their families. The outreach workers are a prime example of women who have demonstrated an ability to cope with poverty and raise healthy children nonetheless. Now, the outreach workers transfer this knowledge to the mothers in the outreach program, with the intention of developing capabilities and coping strategies among them.

Nokuthula is a clear example of a mother who is able to skillfully utilize what is available to her to the greatest potential. While her family's household income is unsteady and is

relatively low compared to other women in the study, Nokuthula's two children are at a healthy weight for age. Pelokazi speaks about Nokuthula:

D: It seems like she has very healthy children, very clean house, and all those things. Why do some people have healthy children and some people have unhealthy children?

Pelokazi: Sometimes mothers are careless. They don't care about... Some mothers have been abused for a long time. So I think ...

D: Is her husband supportive?

P: Yes.

D: So that makes a big difference?

P: Yes.

D: Does Philani give milk or any other of those things to her?

P: No, Philani deals with the underweight for age children. So this is mother-to-be. And this, her baby is great, you see. The weight is right for his age, so there is nothing we can do, only education... the difficulty is with the food, but she knows how to take care of them.

D: How?

P: She knows, if the grant comes next Friday, she knows maybe buy enough vegetables and if the father is doing business, he will buy some. She knows how to (searching for the right word)...

D: Budget?

P: Yes.

Nokuthula embodies the stated goal of the Philani intervention. She faces a host of structural constraints as well as financial instability and HIV infection, yet she works within these constraints to find a healthy balance that works for her family. Nokuthula's life could still be drastically improved through significant structural changes, but in the meantime, she manages in her very difficult circumstances.

Several of the women strategize around their household composition in order to cope with poverty. Naledi stays with her brother's daughter in order to pool their grant money and share household responsibilities. Having a trusted adult in the household also provides Naledi with some peace of mind when it comes to managing illness.

Naledi: I told Mampho because maybe I will be sick so who will help give the baby treatment so she can help, you know.

Though Nonkululeko does not always speak of her husband very highly, she also comments on the help he provides when she is feeling ill.

Nonkululeko: You see in the morning the father puts the kettle on for the children so they can wash themselves. Sometimes if I feel sick, my husband gets the children ready.

The mothers also describe how much they depend on the older children, usually girls, to assist with household chores. Especially in the case of a mother's HIV illness, or the illness of an infant, the older children were increasingly relied upon for running errands and caring for the younger children.

D: What do the children do to help?

Nonkululeko: The children do everything, even with the [youngest] child. Almost everything. I can take a long time to walk, so if I need something there from the shop, if I want some milk for the child, the children go.

Pelisa: [The older child] knows that mommy is sick but she doesn't know with what. But she knows her sister must take medicine at 8 o'clock.

D: She knows how to take care of the baby?

N: Yah, but she doesn't know why, what's happening.

Pinky describes how Noluvuyo sticks to a daily routine in order to balance the needs of her healthy school-age child with the illness of herself and her youngest child. Thanks to the grants she receives, the house Philani built for her, and the treatment she takes, Noluvuyo's personal capabilities are becoming increasingly resilient.

Pinky: Ok, she gets up very early around 7 and prepares for the older child to go to school, then they walk her to school. Then they come back home and drink their

medicine and she and her youngest child go back to sleep until about 12. Then they get up and eat and clean and prepare dinner for the oldest child who gets home around 2.

Nonkululeko speaks of the domestic tasks she performs during the day to ensure that her children have a clean house and clothes:

D: And during the day, you are with the child? And what other things do you do during the day?

Nonkululeko: I wash the clothes, the shirts for school. I am supposed to clean everything in the kitchen.

Personal faith in God and an intense desire to care for their children were also recurring themes in this discussion on capabilities. Naledi speaks of her ability to stay positive despite the struggles in her life:

D: What gives you hope?

Naledi: God.

D: What are some things that Sivenathi does that make you happy?

N: When she is singing, I feel happy. Like when she is eating food nice, I am happy. When she is gaining weight, she is coming up right, I am happy. She's coming right again. She is taking the medicine, she don't refuse the medicine.

Nonkululeko also expresses her faith and the effect it has on her capabilities to care for her children:

D: So what keeps you with a big smile on your face? What are the things that make you so happy?

Nonkululeko: (laughing) I promise you, God. No one can help me but him. Before, if I am going to Red Cross [Children's Hospital] and I find my child is very bad and I say, why God didn't he take my child when she was in my stomach or when the time I was going to born. Now my child is three months now, I know my child is sick, I suppose to know it is not my problem. So when he [my husband] is doing the wrong thing, when he is not coming with me to check the baby, I don't mind. And I was so powerful and even here at home I've got the space. I am sleeping

here and I am sleeping there because I need my child, you know? I don't care about him [my husband]. I care about my child because it is my life. So after that everything has changed. Two months back he said maybe he will find a girlfriend because he said I don't know what's happening with you. And I said if you want. I don't have a life with you. But I want you to look after my child, so that is difficult.

Though the accounts of several women clearly show that HIV and AIDS significantly increases levels of anxiety, Nonkululeko speaks of personally coming to terms with her HIV status and allowing herself to focus on taking care of her children.

Nonkululeko: At that time that I found out, I was so worried, but now I have come alright. I have accepted for now. I know there are other people dealing with these problems. For now, I am right with myself. I know that it is not only me [who has HIV]. I just want to take care of my child. So when the time I was sad but now I don't think I like that. I want to have a chance to talk to my [9-year old] child. I don't want my child to know [about my HIV] from someone else.

When asked if she thought HIV infection makes it more difficult to be a mother, Pelokazi answered, “No, they [the women] are coping. They are strong.”

The coping mechanisms presented here involve both learned strategies and inner strength. Nokuthula's knack for household budgeting is a useful and transferable skill.

Nonkululeko and Naledi's faith in God and belief in their own abilities is less easily taught, but can be encouraged through peer-based programs like Philani. Involving children and family members in the household's poverty alleviation strategies is also a common practice among the women. These strengths can protect against depression and anxiety while also making a meaningful impact on the children's wellbeing despite the absence of financial stability or material assets.²⁶

Conclusion

This discussion on the way that mothers are mitigating the poverty experienced by their households has highlighted several key points as well as many areas for further study.

²⁶ This presentation of the resilience of some women is not an argument for withholding relief grants and other forms of social support. Rather, it is a discussion of the ways that mothers are in fact surviving through difficult situations.

With the exception of Nothemba, all of the mothers in the study access some government grants in order to alleviate their poverty. Of all of the grants offered by the Department of Social Development, only the Child Support grant, Disability grant, and Care Dependency grant are applicable to the situations of the women here. The most widely accessed grant among the mothers in this study is the Child Support grant. Few of the mothers meet the strict eligibility criteria to receive the other two illness-related grants. Nonkululeko's family may be able to access the Foster Care grant for their care of Mpumelelo's orphaned nieces, but this grant requires the intense involvement of a social worker. As demonstrated by the high caseload of Philani's only certified social worker (overseeing some 3,000 children), Foster Care grants are difficult to access.

The intention of social assistance grants are to target specific vulnerabilities as a result of sickness or age, yet these goals are undermined when distributed without other comprehensive support. The difference between the wellbeing of Noluvuyo's children (accessing a Disability grant and two Child Support grants) and Naledi's children (accessing one Child Support grant) is a scenario that should encourage a critical reevaluation of welfare policies. Naledi's story demonstrates that her wellbeing depends on the Child Support grant and that it is the only income in the household. Were she not to have a child, she would have no income whatsoever as an unemployed person. Child Support grants must be accompanied by long-term livelihood support for the other members of the household (Ewing 2006:92). A lack of such support also means that Naledi feels obliged to leave her youngest child in the Eastern Cape because his caregiver depends on the grant. Therefore, the child may be kept in the household most in need of the grant rather than the place best suited for him. Naledi's circumstances are a prime example of the serious need for comprehensive social provisions that support families rather than individuals.

The Disability grant has undoubtedly complimented Noluvuyo's medical treatment in assisting her to regain her health as a result of her increased nutrition, reduced stress, and more comfortable home environment. Noluvuyo was not working prior her illness and had been struggling with too little household income for many years, just like the other women. Therefore, that the grant targets people only when they are *unable* to work yet it poses a problem for Noluvuyo, whose improved health will mean the eventual termination of this support. The social assistance system assumes that she will reenter

the labour market at this time, overlooking the marginalization of the underclass to formal employment. It is unlikely that Noluvuyo will be unable to replace this lost income. This is evident in the unemployment experienced by all of the women in the study, regardless of their health status.

Nonkululeko describes how HIV infection and illness forced her to quit her job, she is not yet sick enough to access the Disability grant; she is therefore unemployed and with no supplementary income. The reality is that HIV infection contributes to poverty long before the onset of illness, so the appropriateness of targeting individuals only when they have become extremely sick overlooks the poverty of many others.

As seen in Noluvuyo's case, the Disability grant can serve as a lifeline to families. However, staff at Baphumelele were concerned that Nothemba received pressure from her family to return home once she began receiving the grant money. Returning home before she was well enough may have sped up the progression of Nothemba's illness. Further investigation needs to be made into the impact that Disability grants have on decisions made by individuals and their families.

Also seen in Nothemba's story is the effect that poor health can have on a mother's ability to access resources, care for children, and engage in income-generating activities or employment. Therefore, illness can be viewed as poverty in and of itself, but it also produces other forms of poverty by limiting the capabilities of people to ensure a basic quality of life for themselves. This story clearly portrays the effects that illness can have on a woman's capability to navigate within her vulnerability context, and illustrates the mutually reinforcing conditions of HIV/AIDS and poverty.

The problems that Nonkululeko described also clearly present the link between managing her and her child's HIV infection while living in a state of poverty. While her health problems may be HIV-related, she also identifies them as intensified by the family's lack of income and her lack of eating 'proper meals.' This mother is also frustrated with the clinic appointment system that does not enable her to be both a good mother and a responsible patient. Nonkululeko displays her resourcefulness in attempting to switch clinics to handle the problem of the staff and continue to look after her health, though her lack of income and ability to travel to the further clinic limits her choice in the matter.

When discussing the support the women requested and received from their community, they almost always did so in order to meet the needs of their children. However, each woman could only name one or two friends and neighbors to whom she could go to for help. This was attributed to the widespread stigma related to HIV. The women feared that their neighbors would gossip about them if they learned of their HIV status. This limited most of the women in reaching out to their community for support and amounted to a significant source of loneliness in the women.

Philani was discussed in depth in this chapter due to the extensive, and sometimes profound, impact it had on the mother's lives. The outreach program's aim of targeting malnourished children through developing the capabilities of their mothers was discussed as an effective intervention. However, the more nuanced effects of this program are what stimulated the most discussion. The significance attached to the emotional support the mothers receive from Philani outreach workers signaled a major form of previously unaddressed poverty. Especially in reference to the mother's HIV infection, their accounts of a lack of support by family and friends, either as a result of real or imagined stigma, implies that they receive little other emotional support.

Another response deployed by the mothers was to involve their school-aged children in domestic tasks and care. In support of this strategy, Bray & Brandt argue that caregiving must be seen as a two-way relationship that acknowledges the "potentially positive impact that children's input to these relationships has on adult wellbeing, and hence on adult abilities to continue caring and fulfilling other roles in the home and family" (Bray & Brandt 2007:11). Acknowledging a child's significant role in a family is therefore of great importance when making policies or decisions that affect them. "Children are not passive victims of the deadly triangle of poverty, unemployment, and HIV/AIDS, but are active in household coping strategies" (Ewing 2006:93). Children should therefore be active participants in decisions regarding their care and wellbeing.

These stories reaffirm that each family has a different way of coping with poverty on a daily basis. Although their poverty clearly still exists in varying degrees and forms, the women are responding to the best of their abilities. Philani's philosophy believes that "material provision alone does not determine care ideals or the nature of care practices in this resource-poor community... emotional and practical aspects [are] clearly

interwoven" (Bray & Brandt 2007:13). Embodying this quotation, the women in this study prove that they are able to maintain aspects of wellbeing despite the poverty they face. The final section of this chapter showed the impact that a mother's strength and positive outlook can have on her family's wellbeing.

Nokuthula is a prime example. She demonstrates that her wellbeing is not determined by income level alone, but is rather a function of multiple factors including the grants she accesses, the presence of a supportive husband, and her own capabilities of good health, budgeting skills, and a positive attitude. The lessons learned from these mothers may contain useful advice to other mothers coping in resource-poor circumstances and a difficult structural context. The potential in sharing their strategies and skills has already been demonstrated by the work of Philani outreach workers.

The women's mitigation of poverty would not be possible without the many forms of assistance discussed, yet it is the combination of such support with the mother's own strengths that result in the most meaningful outcomes. Evident throughout this thesis is how different each mother's "package" of services is, with some receiving more government support and others having stronger social networks, while others relying mostly on individual skills to mitigate poverty. Unfortunately, there are some women who have low levels of each of these, and whose poverty is the least mitigated. Recommendations will be made in the next chapter for targeting these women specifically while supporting the efforts of all mothers.

Chapter Six – Recommendations and Conclusion

This thesis has illustrated the experience of HIV-positive mothers in disadvantaged households, exploring the various ways that they are coping with poverty, childcare, and illness. Constrained by the structures that created and maintain the underclass, the women must respond to their family's poverty by creatively engaging with their environment and developing personal coping strategies. The *experience* of poverty has thus proven to be a useful concept, as it includes the process by which mothers move in and out of various deprivations.

As shown, the women access a number of resources provided by the government and community organizations. They also employ their social networks and personal skills when trying to ensure the wellbeing of their children. The women demonstrate that their unique capabilities help them to access resources, strategize within their households, and remain motivated. However, these capabilities can be diminished by a particularly difficult vulnerability context or by personal burdens like illness and childcare. The women received low-quality education as youths and have been marginalized from the labour market. The poor infrastructure in their areas does not provide them with the health care, work opportunities, or education that is needed to better their lives.

Ultimately this thesis has established that all of women's responses have served to mitigate poverty rather than eradicate it altogether. Unless something is done, their children will most likely grow up to be members of the underclass as well.

The government's response has been targeted at alleviating the poverty of children, the old, and the sick. Though these social assistance grants have made a difference in the lives of many, there is a huge gap in assistance for the unemployed. The stark differences in the experience of poverty among the mothers in this thesis can be partially attributed to oversights in the welfare system. The theory of the underclass has provided a deeper understanding to the chronic unemployment experienced by the mothers and demonstrated that the current welfare system is inadequate in addressing the needs of this population. The effectiveness of the current grants as supplementary support for especially vulnerable groups is therefore undermined without basic comprehensive protection for unemployed households.

Relevant to the stories of the women presented in this thesis is the criticism of social assistance grants that argues that they are primarily concerned with alleviating "... 'poverty proper' (i.e. resource adequacy) and not with the physiological, sociological, or political dimensions of poverty" (Case et al. 2004:5). The women have demonstrated this to be true, with their grants being directed at alleviating basic material deprivations. The government's system of grants should therefore be joined by support that addresses the more nuanced forms of poverty resulting from stigma, depression, and anxiety. Community-based organizations like Philani are currently attending to some of these issues. The government's increased support for these initiatives would mean that could make an impact on these kinds of poverty for many more people.

Gender emerged several times in this thesis as an element that influenced the women's experience of and response to poverty. The State's current welfare system presumes certain structures of male and female co-dependence. All of the women in this study discussed the burden of childcare, with some expressing their inability to engage in other activities as a result. That the current welfare system operates with such large gaps assumes that women have access to other sources of support or income. However, with two of the women single and two of the women receiving little to no support from their husbands, this is clearly an inaccurate assumption. Even so, the women place a high priority on caring for their children and this contribution to society needs to be acknowledged and supported by the government.

The intersection of HIV, childcare, and poverty also highlights the gender-specific experience of women suffering from illness. The care of children becomes an even greater burden when both mother and child are ill. HIV-positive mothers expressed feeling anxious, alone, and afraid. HIV-positive children also required a great deal of care from their mothers, increasing their daily responsibilities and maximizing upon their available capabilities, while simultaneously limiting their potential to engage in income-generating activities. As previously mentioned, none of the women were able to discuss their status with their male partners. Gender dynamics have proven significant to the experience and risk related to HIV and AIDS: "cultural prescriptions of masculinity and femininity – when they control and determine what men and women know, how they communicate with each other, and how they behave within their relationships – significantly affect not only men's and women's sexual behaviors and attitudes but also

their respective access to services and information and their ability to cope when ill" (Abdool Karim 2005:252-253). Addressing the HIV/AIDS epidemic therefore requires addressing the gender imbalances and expectations on women in society.

In order to effectively address the burdens resulting from these conditions, a number of gender-based interventions are necessary that confront the systems of privilege operating in society: "structural interventions that empower women and girls by increasing their access to the social and economic resources that in the long term protect women, men, and their families in the HIV epidemic, thereby also altering the economic and social dynamic of gender roles and responsibilities" (Abdool Karim 2005:259). Establishing a new structural environment in which women will be enabled to care for their children, look after their health, and be economically active involves addressing the gender inequality that sits at the root of HIV infection. Appreciating the care that women provide as well as implementing measures of support for their domestic work can begin to change the current constraints placed on them by a patriarchal culture.

The Philani Nutrition Center is making a substantial impact on the lives of the mothers and children in the outreach program by empowering mothers to ensure the health and wellbeing of their children, despite difficult circumstances. The outreach program, specifically, is also alleviating aspects of emotional poverty and HIV-related stigma and stress that other interventions and community structures have not addressed. More peer-based interventions like this can make a difference in mitigating the poverty within households in a way that complements state welfare payments.

The government should offer more support to community organizations that play this important role in vulnerable communities, particularly while state services are inadequate to meet the need. Government should also integrate lessons learned from the Philani model into their current programs. As stated, priorities must be placed on supporting the work of mothers and enabling them to care for their children. Extending greater access to psychosocial health services, emotional counseling, and support groups can achieve some of the same positive results in a family's health and wellbeing that Philani has achieved. Increasing the numbers of social workers would assist families in accessing protection and counseling services. The extension of home-based care services to address the needs of bed-ridden caregivers and their children is also a critical need.

Several specific recommendations can be made for ways that the government can support mothers in the context hitherto established. Free crèche facilities should be available to poor families, especially those headed by single mothers. These facilities would allow the mothers to engage in income-generating activities, attend school or skills training, or simply rest. This would dramatically relieve the mothers' burden of care and their entrenchment in their domestic roles. Additional services such as free laundry facilities and used clothes shops would further enable the mothers to meet their children's needs. Integrating mother and child health care services and providing free public transport would contribute to far fewer missed doctor's appointments.

For mothers with sick children requiring full-time care, the Care Dependency grant should be made more widely accessible. However, the problems of perverse incentives to stay sick related to the Disability grant and Care Dependency grant, can only be addressed through structural change. First, opportunities for work and schooling should be extended so that all people can engage meaningfully in society. These opportunities offer individuals a reason to get well. Second, a comprehensive system of social protection must be instituted, either as a basic income grant or as unemployment insurance, so that illness is not the only means of obtaining the income needed to survive in the underclass. Also, the grant application process must be streamlined so as to be easily accessible to homebound individuals, arguably those that need the grant the most.

These suggestions involve a profound re-conceptualization of the potential that members of the underclass hold. Creating a society in which the underclass can contribute and engage will instigate further motivation to get well and encourage individuals to pursue their goals. Put differently, society must *enable* mothers to transform their lives and the future for their children. To achieve this, serious investment needs to be made into the public education system in poor areas, for both adults and children. Multi-lingual education focused on developing the unique talent of the individual will foster creativity and increase capabilities. In the short-term, investment in creating low-skill jobs is needed to absorb the large number of unemployed. At the same time, the program to encourage small business development should be stepped up. These changes will enable people to meaningfully participate in the labour force.

This thesis has established the local vulnerability context present in the women's lives by presenting the challenges of living in Khayelitsha and their self-proclaimed anxieties and concerns. These frustrations need not be necessarily correlated to unemployment and lack of income. There are many ways that local and provincial government can intervene to raise a family's quality of life regardless of a family's employment status. The government must place high priority on addressing the levels of crime in poor neighborhoods. Safe play areas should be provided for children. Adequate sanitation and water services must reach even the most informal areas of the townships. Basic housing must be provided in order to ensure personal safety and health. It is unacceptable that in South Africa these basic aspects of wellbeing are currently unavailable to poor families.

As clearly shown, poverty alleviation must also be approached through a livelihoods frameworks that draw links between the cause and effects of poverty and evaluates a household's vulnerability context. The mothers' stories of their dynamic responses to poverty have provided useful insight into the effectiveness of poverty-alleviation interventions. Their experiences have also highlighted areas where structural change is needed to provide wider access to resources and reduced overall vulnerability.

Poverty is more than a just a lack of money or the presence of illness; it involves a number of factors, some of which can be addressed at a personal level and others that must be addressed in the policy environment:

Some of the appropriate policies will not be specific to households affected by HIV/AIDS but will be designed to reduce poverty in general by, for example, addressing contributory factors (e.g. low health status and low levels of education), providing protection against short-term shocks such as illness or retrenchment, and providing long term support to the chronically poor... it is important that mitigation strategies are based on the correct assessment of the progression of the disease within a household or community and that they reach and involve both infected and affected individuals and households (Nkurunziza & Rakodi 2005:26)

The current welfare system is focused solely on alleviating the daily experience of material deprivation. While this is a crucial short-term strategy, long-term solutions rely

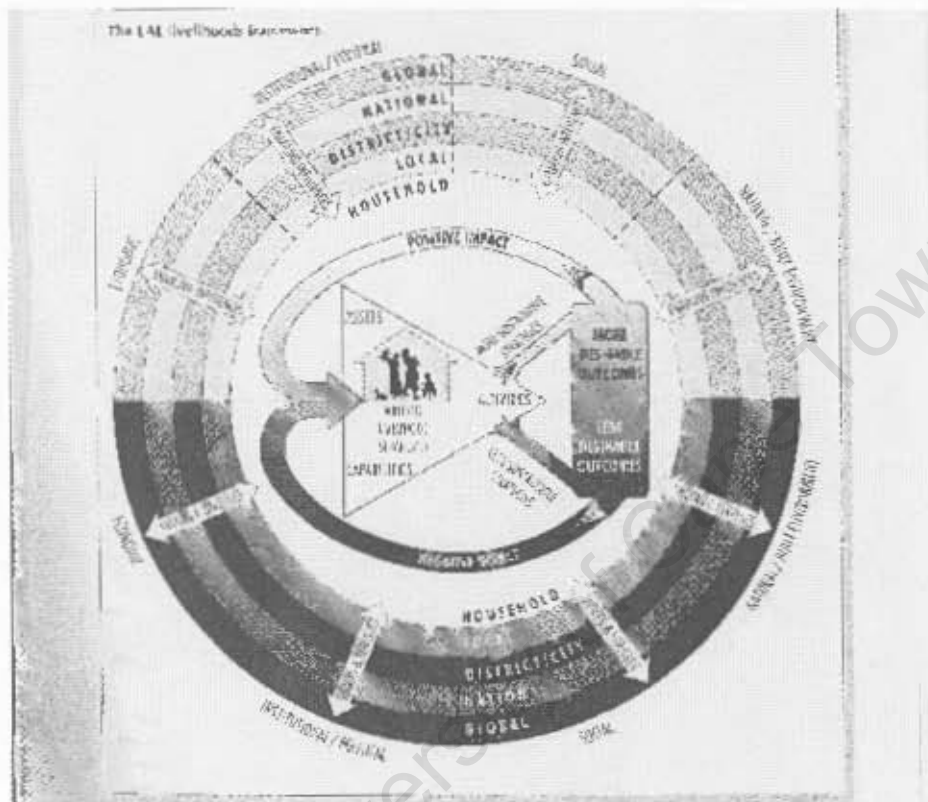
on enhancing household resiliencies through addressing multiple sources of vulnerability. This thesis has demonstrated that the mothers are taking action to reduce their own vulnerability and have highlighted significant sources of support that help them to do this. However, as argued by the theoretical frameworks of capitalism and the underclass, until the structural context is transformed, these responses will only be about *mitigating* poverty and will not achieve sustainable solutions. For poverty *eradication* to occur, the social, political, and institutional environment must change by implementing some of the recommendations raised here. Providing the members of the historically marginalized underclass with improved infrastructure, high quality education and skills training, meaningful work opportunities, entrepreneurship, basic social and health services, and a comprehensive safety net for those who are unable to support themselves, can begin to change the state of inequality in South Africa. Provided with an enabling environment, the mothers demonstrate that they are both willing and capable of ensuring wellbeing for their families. This should be the ultimate goal of structural change.

Appendices

Appendix 1: Livelihood Frameworks

Learning About Livelihoods Framework

(de Satgé et al, 2002:15)



Appendix 2: Maps

Map of Greater Cape Town

(X marking Khayelitsha)



Map of Khayelitsha, Site B

(X marking general locations of mothers' homes)



Maps obtained online at: <http://www.sa.c2a.co.za/>

Appendix 3: Photos of Housing in Khayelitsha

Typical zinc shack



A Philani shelter



Photos were taken by the author and may not be reproduced without expressed content.

Appendix 4: Interview Consent Form

Dear Outreach Workers & Caregivers of Philani Nutrition Outreach Program:

My name is Dianna Kane and I am a Masters student at the University of Cape Town. I have been working with Philani Nutrition Center for two years and have been inspired by the many mothers in the outreach program. I am now writing a paper about the ways that women are able to care for their children despite poverty and HIV infection. I would like to speak to 5 women in the Philani program who are dealing with these burdens. I will ask questions about your HIV status and how you think it has affected your ability to care for your children. I will also ask you what resources are helping you raise your children, whether it be a child support grant, disability grant, organizations and non-profits, or family and friends who offer support and friendship. You can also share with me other things that you are doing to keep your children safe and healthy. There are no right or wrong answers; I am just interested in how you take care of your children, including the struggles and the successes.

I am looking for 5 participants who are:

- women older than 18
- the primary caregiver of at least one child (does not need to be her own child)
- unemployed or without formal income
- HIV+ and comfortable speaking about this

You will receive no benefit from this interview other than to help me better understand your life and write a paper about it. I have no money to offer you or your outreach worker. I am just a student and our conversation will help me write a paper and get a degree. Your identity will be kept private and not shared with anyone at Philani Nutrition Center or any other people or organization. Your decision to participate will not affect your relationship with Philani Nutrition Center, either positively or negatively. I will ask your outreach worker to be present during the interview to assist in translating, or you can appoint another person who speaks both English and Xhosa if you prefer. The interview will last between 2-3 hours long. They will be tape-recorded if you are comfortable, or I can just take notes. At any point in the interview, you can refuse to answer any question or you can even end the interview. We can plan this meeting whenever is convenient for you and your outreach worker. Thank you for considering my request. Please let your outreach worker know if you have any questions before consenting to the interview. You would be doing me a great service by sharing your story of strength and resilience for my paper.

Enkosi kakhulu.

Dianna Kane

Name of Caregiver:

Signature of Caregiver:

Area:

Name of Outreach Worker:

Signature of Outreach Worker:

References

- Abdool Karim, Q 2005, 'Heterosexual transmission of HIV – the importance of a gendered perspective in HIV prevention' in *HIV/AIDS in South Africa*, Cambridge University Press, Cambridge, pp. 243-261.
- ANC 1994, *The Reconstruction and Development Programme*, African National Congress, Johannesburg.
- Babbie, E, Mouton, J, Vorster, P & Prozesky, B 2006, *The Practice of Social Research*, South African edn, Oxford University Press, Cape Town.
- Barnett, T & Whiteside, A 2003, *AIDS in the Twenty-First Century: Disease and Globalisation*, 2nd edn, Palgrave Macmillan, New York.
- ✓✱ Booyesen, F & Bachman, M 2002, 'HIV/AIDS, Poverty, and Growth: Evidence from a Household Impact Study conducted in the Free State province, South Africa', *The Annual Conference of the Centre for African Economies (CSAE)*, 18-19 March 2002, St. Catherine's College, Oxford.
- ✓✱ Booyesen, F 2003 'The Role of Social Grants in Mitigating the Socio-Economic Impact of HIV/AIDS: Evidence from the Free State Province', *Centre for Social Science Research Working Paper No.56*, University of Cape Town, Cape Town.
- Brandt, R, Dawes, A & Bray, R 2006, 'Women Coping with AIDS in Africa: Contributions of a contextually grounded research methodology', *Psychology, Health, & Medicine*, vol. 2, no. 4, pp. 522-527.
- ✓✱ Bray, R & Brandt, R 2007, 'Childcare and Poverty in South Africa: An ethnographic challenge to conventional interpretations', *Journal of Children and Poverty*, vol. 13, no. 1, pp.1-19.
- Budlender, D 2002, 'Women and Men in South Africa: five years on', Statistics South Africa, Pretoria.
- ✓✱ Camfield, L 2006, 'The Why and How of Understanding Subjective Wellbeing', *Research Group on WellBeing in Developing Countries Working Paper 26*, Economic and Social Research Council, Swindon.

- ✓ * Case, A, Hosegood, V & Lund, F 2004, 'The Reach and Impact of Child Support Grants: Evidence from Kwa-Zulu Natal', *Africa Centre for Health and Population Studies*, University of Kwa-Zulu Natal, Durban.

Chronic Poverty Research Centre 2007, *The politics of what works in tackling chronic poverty* [Policy Brief] no. 5, University of Manchester, Manchester.

- ✓ * * Davids, A, Nkomo, N, Mfecane, S, Skinner, D & Ratele, K 2006, *Multiple Vulnerabilities: Qualitative Data for the study of OVC in South Africa* HSRC, Cape Town.

de Satge', R, Hollway, A, Mullins, D, Nchabaleng, L, & Ward, P 2002, *Learning About Livelihoods: Insights from Southern Africa* PeriPeri & Oxfam, Cape Town & Oxford.

Delphy, C 1977, *The Main Enemy: a materialist analysis of women's oppression* Women's Research and Resources Centre Publications, London.

Department of Health 2005, *National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2004*, Department of Health, Pretoria.

Department of Social Development 2005, *SOCPEN Database*, Department of Social Development, Pretoria.

- ✓ * Department of Social Development 2006, *Strategic Plan 2006/7-2009/10*, Department of Social Development, Pretoria.

- ✓ * De Swardt, C, Puoane, T, Chopra, M & du Toitet, A 2005 'Urban Poverty in Cape Town' *Environment and Urbanization* vol. 17, no.2, pp.101-111.

Esplen, E 2007 'Women and Girls Living with HIV/AIDS: Overview and Annotated Bibliography', *BRIDGE Development-Gender and International Community of Women Living with HIV and AIDS Working Paper No.18*, Institute of Development Studies & University of Sussex, Sussex.

- ✓ * Ewing, D 2006, 'Children's Experiences of the Link Between Poverty and Unemployment in the Context of HIV/AIDS', in P Graham (ed.), *Inheriting Poverty: The Link Between Children's Wellbeing and Unemployment in South Africa*, Institute for Democracy in South Africa (IDASA), Pretoria & Cape Town, pp. 88-95.

* Gender Advocacy Programme 2001, *The child support grant: does it meet the sociological economic rights of the poor?* Gender Advocacy Programme, Cape Town.

✓ * Giese, S, Meintjes, H, Croke, R & Chamberlain, R 2003, *Health and Social Services to Address the Needs of Orphans and Other Vulnerable Children in the context of HIV/AIDS: Research Report and Recommendations*, Children's Institute, University of Cape Town, Cape Town.

✓ * Gillespie, S, Norman, A & Finley, B 2005, *Child Vulnerability and HIV/AIDS in sub-Saharan Africa: what we know and what can be done* International Food Policy Research Institute, Washington, D.C.

Hulme, D & McKay, A 2005, 'Identifying and Measuring Chronic Poverty: Beyond Monetary Measures' *The Many Dimensions of Poverty Conference*, Brasilia, Brazil. 29-31 August 2005, University of Manchester, Manchester & University of Bath, Bath.

Jacobs, M, Shung-King, M & Smith, C (eds.) 2005, *South African Child Gauge 2005*, The Children's Institute, University of Cape Town, Cape Town

Lewis, J 2001, 'Policies to Promote Growth and Employment in South Africa' Discussion Paper for The World Bank Southern Africa Department, Washington, D.C.

Lund, F 2006, 'Gender and Social Security in South Africa' in V Padayachee (ed.), *The Development Decade? Economic and social change in South Africa 1994-2004*, HSRC Press, Cape Town, pp.160-182.

Mackintosh, M 1989, *Gender, Class, and Rural Transition* Zed Books Ltd, London & New Jersey.

May, J 2006, 'Constructing the social policy agenda: conceptual debates around poverty and inequality' in V Padayachee (ed.), *The Development Decade? Economic and social change in South Africa 1994-2004*, HSRC Press, Cape Town, pp.143-159.

✓ * Meintjes, H, Budlender, D, Giese, S & Johnson, L 2003, *Children 'in need of care' or in need of cash? Questioning social security provisions for orphans in the context of the*

South African AIDS Epidemic, The Children's Institute, University of Cape Town, Cape Town.

Moser, C 1998, 'The Asset Vulnerability Framework: reassessing urban poverty reduction strategies', *World Development* vol. 26, no. 1, pp. 1-19.

Nattrass, N 2006. 'Disability and Welfare in South Africa's Era of Unemployment and AIDS', *Center for Social Science Research Working Paper No. 147*, University of Cape Town, Cape Town.

✓* Nkurunziza, E & Rakodi C 2005, 'Urban Families under pressure: conceptual and methodological issues in the study of poverty, HIV/AIDS, and livelihood strategies', *International Development Working paper 1*, University of Birmingham, Birmingham.

Payne, G & Payne, J 2004, *Key Concepts in Social Research*, Sage Publications, London.

Poggenpoel, S and Oliver, L 2004, 'Investigating the Implications of Ten Years of Democracy for Women: The Role of the Department of Social Development', from www.genderstats.org.za/documents/BudlenderReport3.doc

Preston-Whyte, E 2006, 'Framing the South African AIDS epidemic: a social science perspective', in V Padayachee (ed.), *The Development Decade? Economic and Social Change in South Africa, 1994-2004*, HSRC Press, Cape Town, pp. 361-380

✓* Richter, L & Rama, S 2006, 'Building Resilience: a rights-based approach to children and HIV/AIDS in Africa', *Focus on Africa* series, Save the Children, London.

Sachs, J 2001 'A new global consensus on helping the poorest of the poor' Keynote address in B Pleskovic & N Stern (eds), *Annual World Bank Conference on Development Economics*, The World Bank, New York.

Schwabe, C 2004, *Fact Sheet: Poverty in South Africa*, 26 July 2004, HSRC, Cape Town.

Seekings, J & Nattrass, N 2006, *Class, Race, and Inequality in South Africa*, University of KwaZulu-Natal Press, Pietermaritzburg.

Sen, A 1985, *Commodities and Capabilities*, Oxford University Press, Oxford.

Sen, A 1999, *Development as Freedom*, Knopf, New York.

Statistics South Africa 2007a, *Labour Force Survey March 2007*, Statistics South Africa, Pretoria.

Statistics South Africa 2007b, *Mid-year population estimates, South Africa: 2007*, Statistics South Africa, Pretoria.

✓* Statistics South Africa 2008, *Mid-year population estimates*, Retrieved 18 February 2008, from <http://www.statssa.gov.za>

✓* Steinberg, M, Johnson, S, Schierhout, G & Ndegwa D 2002, *Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic*, The Henry J. Kaiser Family Foundation, Washington, D.C.

Stillwagon, E 2002, 'HIV/AIDS in Africa: Fertile Terrain', *The Journal of Development Studies*, vol. 38, no. 6, pp.1-22.

✓* * Swartz, L 2005 'An Exploratory Study of the Impact of Primary Caregiver HIV infection on Caregiving and Child Development Outcome in the Era of HAART: Piloting the Methodology', *HSRC Child, Youth, & Family Development Working Group*, HSRC, Cape Town.

Taylor, V 2007, 'A Choice of Change: Social Safety Net or Comprehensive Social Protection', *New Agenda*, Issue 27, Third Quarter.

UNAIDS 2006, *UNAIDS/WHO AIDS Epidemic Update for Sub-Saharan Africa*, from <http://www.unaids.org>

UNDP 2008, 'Human and income poverty: developing countries', *Human Development Report* from <http://hdrstats.undp.org/indicators>

✓* UNICEF 2003, *Africa's Orphaned Generation* UNICEF, New York.

Whiteside, A & Lee, S 2006, 'Economic and development issues around HIV/AIDS', in V Padayachee (ed.), *The Development Decade? Economic and Social Change in South Africa, 1994-2004*, HSRC Press, Cape Town, pp.381-396.

Wolpe, H 1972, 'Capitalism and cheap labour power in South Africa: from segregation to apartheid', *Economy and Society*, vol. 1, no. 4, pp. 425-456.

Wolpe, H 1986, 'Class concepts, class struggle, and racism' in J Rex & D Mason (eds), *Theories of Race and Ethnic Relations*, Cambridge University Press, Cambridge, pp.110-130.

Wright, EO 1995, 'The Class Analysis of Poverty', *International Journal of Health Services*, vol. 25, no. 1, pp. 85-100.

Wright, EO 1996, 'The Class Analysis of Poverty: A Response to Tony Novak', *International Journal of Health Services*, vol. 26, no. 2, pp. 371-379.

Interviews

Philani mothers and outreach workers

Nonkululeko and Pelisa. 19 July 2007.

Naledi and Patience. 20 July 2007.

Nothemba and Phumla. 02 August 2007.

Noluvuyo and Pinky. 28 August 2007.

Nokuthula and Pelokazi. 05 October 2007.

Philani social worker

Nokwanele Mbewu. 23 August 2007.

Tapes, transcriptions, and notes of all interviews can be obtained by contacting the author at: dianna.kane@gmail.com