TOWARDS DEVELOPING AN UNDERSTANDING OF FACTORS INFLUENCING CARE GIVING PROVIDED TO CHILDREN BETWEEN BIRTH AND 6 YEARS WITHIN THE GROBLERSHOOP COMMUNITY.

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KEYWORDS

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ABSTRACT

Title: Towards developing an understanding of factors influencing care giving provided to children between birth and 6 years within the Groblershoop community.
By Faeza Khan

This thesis explores the personal, social and environmental factors of caregivers from the Groblershoop community to determine whether these factors influence the caregiver's ability to provide care to children from birth to six years. Using the Human Capabilities Approach and the Ethics of Care Perspective, this study seeks to examine the resources that are available for caring in Groblershoop. It also explores how the factors above (personal, social and environmental) play a role in how the resources are used by caregivers to increase the well-being of children under six years. The Human Capabilities Perspective purports that caregiving resources are not an end in itself. The resources are only as valuable as they are able to improve the functioning of the caregivers to provide care and assist in ensuring the well-being of the care receivers, namely the children. The Ethics of Care Perspective is used to examine the consequences of inadequate care by the State, community and caregivers themselves.

This study was conducted among caregivers from the community of Groblershoop, which is 150km from the main town of Upington in the Northern Cape Province. The town is rural in nature and unemployment, poverty and social ills such as substance abuse and teenage pregnancies are rife. Work is largely seasonal in nature and is found mainly on the surrounding grape and cattle farms. This study is qualitative in nature and used a purposive sampling method. Ten caregivers were selected using the criteria that they must reside in the community of Groblershoop and must be the primary caregiver to children from birth to six years of age, to participate in the semi-structured interviews. Seven other caregivers were also selected using the same criteria above to participate in a focus group interview using participatory action learning techniques. Participant Observation was conducted in the homes of three caregivers that participated in the individual interviews. Additionally, seven

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individual interviews were conducted with service providers that provide services to the community of Groblershoop.

The main findings of the study reflect that the personal, social and environmental factors do influence the caregiver’s ability to provide care to children from birth to six years among a small group of caregivers from the Groblershoop community. The personal factors explored in the study included the age, gender, health status, substance usage, educational level and income of the caregiver. Ill health was found to be a key factor which posed a challenge to caregivers in terms of being able to provide care to children. The World Health Organisation’s five key elements of care was used to provide a framework for assessing adequate caregiving. These factors were sustenance, stimulation, support, structure and surveillance. Factors such as educational levels were closely linked to income levels. The higher the educational level the better the income for the caregiver. The Child Support Grant was a major source of income for the majority of caregivers. Low levels of income also meant that the caregivers were unable to provide adequate nutrition to children.

The social factors focused on in this study was public policies which make provision for care resources, parenting practice, support systems, and the gender practices of caregivers. The consequences of inadequate care were examined through focusing on the children and the associated developmental delays experienced by them. The study found that while good public policies exists not enough resources were available to enable these policies to increase the well-being of people at community level. The lack of resources available for caring in the Groblershoop community impacted on parenting practices of caregivers. Caregivers in this study, due to the lack of resources as well as other factors such as limited knowledge of child care, resulted in care being considered inadequate using the World Health Organisation’s five elements of care. Gender practices among the caregivers are based on the stereotypical gender roles which sanction the ideology of patriarchy. Women are the primary caregivers and the biological fathers were absent from the caring process.

The environmental factors that were explored in this study were the climate, the physical home environment and the neighbourhood condition. Due to the excessive summer heat and

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the harsh cold of winter, physical activity and movement in the community is severely hampered. During summer, families sleep outside as the housing structures are built in a way that retains the heat and is freezing in the winter. Dwellings are small and typically compromises of a big room sub-divided by the family themselves. No ablution facilities are available inside dwellings and some homes still make use of chemical toilets and pit latrines. Crime and violence is closely linked to the alcohol usage at the local shebeens. These factors impact on caregiving as the environment with the lack of facilities and the harsh climate lends itself to fostering of illnesses amongst children.

The study concludes that the personal, social and environmental factors significantly influence the caregiver's ability to provide care to children from birth to six years in Groblershoop. To assist the development of children, it is essential that the above factors are considered as they influence the ability of the caregiver to use resources to achieve well-being. The findings of this study provides a good argument for an integrated coordinated approach to service delivery which takes into account the distinct challenges of rural communities, with regards to their distance from urban centres and the current lack of infrastructure within these communities. The study highlights the importance of focusing on how resources can effectively improve the quality of life of caregivers in communities as opposed to just making resources available and ensuring uptake. As this study demonstrates through the Human Capabilities lens, that resources alone do not result in people being able to live the lives they value. Ensuring that they are able to convert the resources into well-being should be the focus of how the State evaluates the effectiveness of programmes.

November 2009

DECLARATION

I declare that *Towards developing an understanding of factors influencing care giving provided to children between birth and 6 years within the Groblershoop community* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged as complete references.

Faeza Khan November 2009

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Signature:_______________________

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LIST OF ACRONYM

AIDS: Acquired Immune Deficiency Syndrome

CJCP: Centre for Justice and Crime Prevention

ECD: Early childhood development

FAMSA: Family and Marriage Association of South Africa

FAS: Foetal Alcohol Sydrome

HIV: Human Immune Virus

IDP: Integrated Development Plan

MRC: Medical Research Council

UNICEF: United Nations Children's Fund

UNIFEM: United Nations Fund for Women

WHO: World Health Organisation

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1 Chapter One: Introduction

1.1 Background to study

1994 marked South Africa's first democratic elections and previously disenfranchised people were given citizenship with the right to vote. South Africa had two challenges – the first being how to address the issue of racial discrimination, and second being how to address the accompanying political, social and economic discrepancies in an attempt to address these inequalities and afford those marginalised by Apartheid a set of rights. Women and children, who had played a pivotal role in the struggle for freedom, were placed at the core of this policy making process. A series of debates and discussions on gender ensued. These included how women were to be represented in the Government, what structures would be established to ensure that gender equality concerns would be addressed, and how gender would be mainstreamed throughout Government department's mandates.

However, fifteen years into a democratic dispensation (2009) very little has changed for women at a community level. In South Africa, women have been especially disadvantaged in the patterns of poverty and inequality. Households headed by young women in rural areas are amongst the poorest of all households (Lund, 2008:3). One in three women is abused by a man she knows intimately (Unifem, 2007). In South Africa a woman dies every six days at the hand of an intimate partner (MRC, 2008, quoted in www.iol.co.za, September 2009). In July 2006 2.8 million children were living in households where children were reportedly "sometimes, often or always" hungry. In the Northern Cape for the period 2000 – 2005 there was a steady increase in the number of women that were HIV positive during pregnancy. In 2006 in the Northern Cape 1.1 % of children are HIV positive (Child Gauge, 2008:60). One hundred and twenty two out of every thousand Grade 1 pupils in the Northern Cape have foetal alcohol syndrome (MRC, 2008). Women are not only subjected to perpetual violence perpetrated by male partners, they also bear the brunt of poverty, HIV/AIDS and are left to do the caring work.

Women are the major caregivers of children, the elderly and the sick in South Africa. Despite the progressive moves made to bring gender issues to the fore in the policy making process a significant disjuncture exists between policy and practice. Existing social welfare policy has been critiqued for its contradictory ways of portraying women. On the one hand, women are to be "fully integrated" into the economy, while on the other hand they are still responsible for the care and wellbeing of children (Sevenhuijsen, Bozalek, Gouws & McDonald, 2003). Nussbaum and Glover (1995) conclude that the unacknowledged position of women in a patriarchal society prevents women from reaching their full potential. This view is supported by Tronto and Fisher (1990) who also regard women to be both unacknowledged and restrained through the gendered experience of caring.. Tronto (1993) argues that adequate resources such as material goods, time and skill, needs to be made available for caregiving work, while Kittay (1999) also emphasises that dependency work also requires resources. This notion of adequate resources draws on the argument made by Sen (1984) and Nussbaum (1995) that resources have no value in themselves apart from their role in promoting human functioning. Sen (1984) further states that the ability to use these resources are further influenced by a person's personal, social and environmental factors. This approach acknowledges that some people may need more resources due to their personal, social and environmental factors to reach the same level of functioning. Caregivers in the rural areas of South Africa, marginalised by the distance to urban centres where large concentration of resources are available, require more resources to be able to achieve the same level of functioning than a caregiver who lives in an urban centre.

With regard to the notion of resource availability, the personal, social and environmental factors, according to Sen (1984) impact on the caregiver's ability to utilise the resources for the practice of caregiving. This is critical for the development and growth of children in the foundation years. According to Dawes, Bray and Van Der Merwe (2007) the early years of life are a particularly sensitive period for survival, growth and psychosocial development. If the contexts in which young children grow up are not supportive, their later participation in society is likely to be compromised. It is therefore imperative that an understanding of how the personal, social and environmental factors influence the caregiver's ability to provide care to young children is obtained so that strategies for early childhood development

programmes and welfare services account for these factors in the provision of resources. Currently there is a significant demand for service delivery to reach poor communities, driven by the Zuma administration, as part of delivering on the election manifesto. However there is little focus on how effective these services are in respect of access and availability, and what impact they have in contributing to the quality of life of South Africans. The government department's performance is measured on how many people were able to access a service as opposed to what difference the service made in the life of that person. This study seeks to explore the personal, social and environmental factors of caregivers in the community of Groblershoop, which is 150km from Upington in the Northern Cape Province of South Africa. It further seeks to explore how these aforementioned factors affect the caregiver's ability to provide care to children between birth and six years. For the purposes of this study the term personal will refer to the age, literacy level, educational level, physical, mental ability and the gender of the person. The term social will refer to social norms of a society, public policies and gender practices. The term environment will refer to the climate, infrastructure and material resources.

1.2 Statement of the Problem

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If the provision of services are to assist communities in reaching their full potential and enable them to do the things that are of value to them and their lives, then it is important that the impact of the personal, social and environmental factors are understood in relation to the person's ability to access and use services and resources. These factors may therefore facilitate or impede the ability of the person to engage in effective caregiving practice, which will have long term consequences for the development of children.

1.3 Personal Factors

Post 1994 the new democratic dispensation was faced with many challenges. During Apartheid[1] service provision was delivered along racial lines, with most service delivery going to the minority of the population; namely those designated as White under apartheid.

[1] Apartheid is an Afrikaans word meaning apartness or separation. In 1948 it was legalised in South Africa. This meant that people were discriminated against based on their racial grouping and the colour of their skin. In South Africa people were referred to as White, Indian, Coloured and Black.

The new administration was tasked with providing services and resources to **all** South Africans. An example of this was the overhaul of the social security system which resulted in the Child Support Grant being restructured so that all vulnerable children could benefit. In rural communities service delivery is generally problematic. In Groblershoop, access to health services is limited to the services of a primary health clinic which does not have the expertise of a medical doctor. Mental health services in this community are virtually non-existent. Schools are poorly resourced and as a result of the high levels of unemployment poverty is rife. This gives rise to numerous social problems such as teenage pregnancies, child abuse and neglect, and substance abuse. The lack of services in the community of Groblershoop leaves people vulnerable and affects the quality of their lives. The literature indicates that the educational level of parents influences parenting in that educated and literate parents seek knowledge on issues which are important in the caregiving of children. (Bray and Brandt, 2005; Sen, 2001) Depression also seriously affects a parent's ability to provide care and supervision of children which are important elements of caregiving. (Lange and Ybarra, 2008; Brandt and Bray, 2005) A parent with ill health's ability to parent is also severely hampered. Risk taking during pregnancy, such as the abuse of substances, may lead to problems for the unborn child which will manifest and have an impact later in their life (Soliday, 2008).

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1.4 Social Factors

Public policies provide the framework in which services are delivered. It is critical that public policies that govern child care reflect the needs of caregivers. In South Africa early childhood development cuts across the mandates of three departments, namely: social development, health and education. However there is currently no coordinated plan to work together to deliver a comprehensive service. This means that vulnerable caregivers fall through the gaps in the system. A way of illustrating this would be to offer an example of a young mother with a child under the age of 6 years in a poor community in South Africa. The mother could apply for a child support grant with the Department of Social Development. The child would also qualify for free health care and would be able to participate in a feeding scheme. However, in Groblershoop healthcare services are severely limited, so the only support the young mother would be able to access is the Child Support

Grant. In a community where the unemployment level is 76% (!Kheis Municipality IDP, 2008) and child care is largely the responsibility of the female members of the family, the Child Support Grant provides limited resources for caring. The literature on resilience indicates that parenting plays a very important role in preventing children from offending in later years (Farrington and Welsh, 2007, Sherman, Farrington, Welsh and MacKenzie, 2002). The ability to provide care to children is an important aspect of parenting and a contributing factor towards their healthy growth and survival (Dawes et al, 2007). Positive discipline, encouraging positive attachments to caregivers and stimulating cognitive development are essential parts of parenting (Kaplin and Ownens, 2008; Zevenbergen, 2008). Poverty also impacts on the development of children and denies children the opportunity for basic survival (Desai, 2005).

1.5 Environmental Factors

The physical environment plays an important role in the growth and development of the child. Access to water, recreational facilities and adequate safe housing has a critical impact on the child's development (Donald and Dawes, 2005). In Groblershoop the lack of a regular safe water supply plays an important role in the development and health of the child. As a result of the poor water supply diarrhoea is common in young children. Furthermore, there are no recreational facilities in the form of parks or playgrounds for children. Another important environmental factor in Groblershoop is the harsh climate. In summer the temperature soars to over 40 degrees Celsius and in winter temperature can drop to minus 1 degree Celsius. This study explores whether the climate affects the caregiver's ability to care for the child, as the excessive heat is known to cause drowsiness and dehydration.

1.6 Summary of Key Issues

The literature indicates that personal factors relating to physical and mental health, education and literacy levels; as well as the gender and age of the caregiver all have an impact on the caregiver's ability to provide basic care to children. Public policies according to Sevenhuisjen (2000) should not only determine the kind of interventions that will be

delivered to assist communities to meet their needs, but should also reflect the needs of caregivers. As women in the Groblershoop community provide the "taking care of" children, this needs to be reflected in social policy as care is central to society. This should be acknowledged and valued as work, given that everyone is dependent on care at some point in their lives (Kittay, 1999). The environment, which is so often ignored, forms an important part of the context in which children are reared. Not only does the environment affect the manner in which care is provided, an unsafe or under resourced environment may have a direct impact on the wellbeing of the child, thereby affecting its growth and development.

1.7 Identifying the Need

As care is so critical to everything we do, it is important that care as a normative framework be shifted from the private sphere of the family and the household into the realm of public policy (Ally-Schmidt, 2005). This shift would bring about a realisation that without care work, productive work would not be possible, and that seeing caring as a natural part of a woman's roles has added to women's burdens. Public policies assume that women will take on the caring role, without ensuring that their needs are taken care of and that sufficient resources exist for caring work. Care work should be valued and acknowledged and degendered so that it does not rely solely on women's willingness to perform it.

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1.8 Personal Factors

Literature posits that increasing the literacy levels of caregivers increases the chances of survival of children (WHO, 2004). Providing opportunities for caregiver's to develop their ability to read and write would improve their caregiving capabilities, as they would be better placed to make informed decisions about the health and nutritional options for their children (Sen, 1984). Giving teenage mothers the support to return to school after giving birth will improve their personal capabilities and thereby their functioning (UNICEF, 2008). The provision of mental health care services would provide assistance for caregivers that are suffering from mental health illnesses and would improve the quality of life and thereby improve their capacity to care for children. Depression, which is a common mental health

illness, is often undiagnosed and can be significantly debilitating (Lange etal, 2008). Support groups for parents who have suffered with post natal depression as well medication and assistance to cope with newborn children within the context of the home have shown to have worked to improve the capabilities of parents (Farrington etal, 2007).

1.9 Social Factors

Most of the carework literature pioneered by Tronto and Fisher (1990) refers to the importance of care as a normative framework, and argues for a movement away from the traditional functionalist role of men and women and their assumed responsibilities in a nuclear family set up (Kittay, 1999; Sen, 1995). By advocating for a normative framework, which places care at the centre of the political agenda, attention is drawn to the undervalued contribution of women who rear children and manage households. The market-based economy, with its dominant ideology of patriarchy, does not attach value to women's contribution (Ally-Schmidt, 2005). Engaging fathers in taking co-responsibility for child care work will start to shift the notion that care is part of the natural gender practices of women. By acknowledging the centrality of care within social policy frameworks and making a role for men within this framework, a change in the discourse that childcare is the primary responsibility of women may occur (Sevenhuijsen, 2000). The focus of parenting skill courses within the context of the home environment has shown to be an effective way of assisting parents learning new skills and dealing with the ever changing behaviour of young children (Sherman etal, 2002). It will also go some way to encourage the participation of male family members in the practice of child rearing.

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1.10 Environmental Factors

Understanding how the climate impacts on the daily lives of individuals will shed some insight into how to find mechanisms to operate within this environment. The importance of the creation of infrastructure in the lives of the caregivers in Groblershoop will provide much needed resources to facilitate child caregiving. The literature indicates (Donald etal, 2005; WHO, 2004) that a child who grows up within a home context that poses physical or health

threats will have their development impeded. Creating infrastructure would require that Government be lobbied to prioritise the community needs and the provision of safe, clean water; tarred roads; and adequate sanitation facilities. These are critical in improving the quality of life for children.

1.11 Gaps

It is evident that no literature exists about caregivers within the Groblershoop community. While it is important to understand what resources the caregivers have at their disposal for engaging in caring work, the availability of resources will not result in effective caregiving practice (Robeyn, 2003). What is needed is to examine the personal, social and environmental factors of the caregivers within the community of Groblerhoop and make practical recommendations as to what interventions would be needed to increase the capabilities and functioning of caregivers. While much is being written about understanding the process of carework (Tronto, 1996; Kittay, 2002), and its implications for public policy (Sevenhuijsen, 2000) very little is known about how this operates in the particular context of Groblershoop. The lack of basic service delivery, the harsh climate, the high level of unemployment and lack of job opportunities coupled with the limited resources available for caring makes this rural community a good case study for learning.

1.12 Purpose of the Study

The purpose of the study is to explore the personal, social and environmental factors impacting on caregivers and to examine how these factors influence their ability to provide care to children, from birth to six years, within the Groblershoop community.

1.13 Rationale for the Study

Groblershoop is 150km from the urban centre of Upington. The !Kheis Municipality's Integrated Development Plan (IDP, 2008) reported that the unemployment level was 76%. The community comprises of half tarred road, poorly constructed housing, lack of facilities

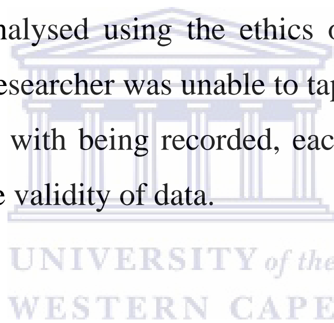
and a limited supply of clean safe drinkable water. Medical assistance is limited to the services of a nursing sister at the primary health care centre, and mental health services are non existent. Employment opportunities are severely limited and most available work is seasonal. Caregivers are expected to provide care within these circumstances. Men and women in the community perceive caregiving to be the sole responsibility of women, and men are regarded as the unchallenged head of the household. It is within this context that children are reared.

Tronto (1993) has identified four intertwining phases of caring. These phases which will be described in-depth in Chapter Two include: caring about, taking care of, caregiving and care receiving with associated moral values of attentiveness, competence and receptiveness. In order to provide care to children the associated value of competence is implied. The human capabilities perspective (Sen, 1984; Nussbaum, 2000) purports that in order to achieve competence or one's full capabilities it is important to acknowledge that the personal, social and environmental factors play a role in converting resources into functioning. In order to assist caregivers from the community of Groblershoop in providing adequate care to children it is important to understand how the personal, social and environmental factors affect their ability to care (this will be explored more fully in Chapter Two). This study will yield valuable information in terms of understanding care practice of a small group of caregivers in the Groblershoop community, while at the same time will shed light on how the personal, social and environmental factors influence the use of care resources to achieve functioning. This information will allow for recommendations to be made about interventions and strategies that can assist caregivers in the Groblershoop community to mitigate those factors and enhance their capabilities.

1.14 Description of the study

The study employed a qualitative methodology. Qualitative research according to Yeh and Inman (2007: 10) refers to "language versus numbered data in which the purpose is to build complex, holistic pictures and to describe and clarify human experience as it appears in people's lives." This study employed the use of semi-structured interviews using a semi-

standardised format, focus group interviews using participatory rural appraisal techniques, and participant observation. These methods are discussed at length in Chapter Three. Using a two phased data collection process the researcher spent a week in the community of Groblershoop conducting ten individual interviews with caregivers, and engaging in participant observation with three of the ten caregivers. During the second week the researcher conducted focus groups with seven other caregivers using the participatory rural appraisal technique of mapping, and conducted seven interviews with service providers. Purposive sampling method was chosen to identify participants. The Centre for Justice and Crime Prevention (CJCP) project officer in Groblershoop identified caregivers who had the responsibility of providing care to children, between birth and 6 years. The data was analysed using themes. Yeh etal (2007) describes qualitative data analysis as involving the reading and rereading of the data with the expectation of finding core ideal and deeper levels of meaning. The data was analysed using the ethics of care perspective and the human capabilities approach. As the researcher was unable to tape record the interviews because the participants felt uncomfortable with being recorded, each interview was typed up and read back to the participant to ensure validity of data.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1.15 Goal of the Study

The study will provide information on the personal, social and environmental factors and how this affects the caregiver's ability to provide care to children, from birth to 6 years. It will further make recommendations for interventions that could assist caregivers in Groblershoop to mitigate these factors and enhance their capabilities.

1.16 Research Questions

1.16.1 How do personal, social and environmental factors affect the caregiver's ability to give care to children from birth to 6 years in the Groblershoop community?

1.16.2 What resources are available for providing care to children in the Groblershoop community?

1.16.3 What are the consequences of inadequate care by the State, the community and the caregivers themselves for children from birth to 6 years?

1.16.4 What are the caregiving practices of a small group of caregivers who provide care to children from birth to 6 years in the Groblerhoop community?

1.17 Significance to the field

Limited literature and empirical research exists in South Africa on caregivers' needs and circumstances. This research is important in order to debunk the myth that equal resources produce equal care giving. Furthermore, the research demonstrates that programmes should not take a blanket approach but need to acknowledge the particular circumstances of the caregivers themselves who make use of the services. In addition to this, according to the capabilities approach, individual preferences are not reliable indicators of human needs, as those who are disadvantaged adjust their expectations and aspirations accordingly. In other words, the capability approach is not interested in finding out how satisfied people are with their circumstances or resources, but rather whether they find value in order to function in a fully human way (Bozalek, 2004:26). Resources are therefore a means to an end, rather than an end in itself (Robeyns, 2003). Furthermore, not enough political consideration is given to the concept of who cares and why caring is an important phenomenon in society, and hence resources allocated to caring work are often inadequate, not utilised in the best manner and further entrenched within stereotypical gender roles (Tronto, 1993; Sevenhuijsen, 2000). It is also important to contextualise the study within the geographical vicinity of Groblershoop which has limited resources, poor infrastructure and a particularly hot and arid climate. This qualitative study intends to provide an in-depth understanding on the diversity of

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programmes and services required to assist caregivers to care for children during their formative years.

1.18 Definitions

This study seeks to explore the personal, social and environmental factors of caregivers from the Groblershoop community and attempts to examine how these factors have an effect on their ability to provide care to children from birth to six years. According to the Human Capabilities approach (which will be explored in-depth in Chapter Two) these factors (personal, social and environmental) are called the conversion factors. The term conversion factors can be defined as the ability to transform resources into achievement of well-being. This means that two individuals will require a different amount of resources for the attainment of the same achievement of functioning due to the fact that they may have different personal, social and environmental factors which hamper or facilitate their ability to use the resources to obtain a lifestyle that they value (Deneulin and Shahani, 2009). The conversion factors interact with each other and the plurality of features will determine the rate of conversion of individual resources into achieved functioning. An example will assist to illuminate the concept: a bicycle can assist mobility as one is able to move around more rapidly than walking. However if a person is in a bad physical condition or disabled (personal conversion factor), or has never learnt how to cycle the bicycle will do little to enable the functioning of mobility. If there is a government or social constraint (social conversion factor) on women riding bicycles then it becomes even more difficult to use the goods (bicycle) for the functioning of mobility. If there are no paved roads (environmental conversion factor) then riding the bicycle will be virtually impossible and the functioning of mobility will still not have been achieved. Hence knowing that a person has the goods (in the example cited, the bicycle) is not sufficient to know which functioning the person would achieve, therefore it is imperative to know more about the person and the circumstances in which he or she lives (Robeyns, 2005).

1.19 Limitations and Assumptions

The study is limited to the caregivers in the community of Groblershoop and examines the care resources available in that particular community, which means that the findings of this study cannot be generalised. Another limitation of the study arose from the bias implicit in the nature of this study. While the researcher made every effort to ensure that the participants were comfortable and that a rapport was established, at times during the interview, there were silences and the researcher wishes to acknowledge that for these reasons the data collected is not as rich in direct quotations as it could have been if a tape recorder was used during the interview.

This thesis takes as a basic premise the notion that humans are "relational and interdependent" (Sevenhuijsen, Bozalek, Gouws and McDonald, 2003:315) and engages with the personal, social and environmental factors of caregivers as an example of this interdependence between the individual and the environment. It further assumes that the caregivers use the resources within the community for caring purposes. It also assumes that the caring work is done mainly by women.

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1.20 Ethical Considerations

To ensure that the research adhered to the strictest ethical principles as set out by the University of the Western Cape's Ethics Committee the researcher provided each participant with information about the study, prior to the interview in the form of an information sheet. The researcher then requested that each participant sign a consent form indicating their willingness to participate in the study (the consent form – appendix). The researcher also consulted with the Centre for Justice and Crime Prevention (CJCP) to ensure that the research was approved and the Groblershoop project officer could spend some time accessing participants for the researcher. The researcher conducted the study in the natural setting of the participants thereby ensuring that they are comfortable. Confidentiality was ensured and to protect the identity of the participant the researcher has used fictitious names in this report. The researcher was also careful to ensure that the information received from the participants was interpreted in an accurate manner. Taking cognizance of the South Africa Council for

Social Service Profession's Code of Ethics, the researcher also made every attempt to ensure that no physical or psychological harm was done to the participants in this research study and the researcher respected the participant when they indicated that they did not want to answer or elaborate on certain questions.

1.21 Thesis Outline

Chapter One locates the study within the context of Groblershoop and provides an overview of the problem, the research aim and assumptions underpinning the research.

Chapter Two outlines the theoretical framework and provides an explanation for the choice of theories chosen in this study. This study employs the Human Capabilities perspective and the Ethics of Care approach as a lens to analyse the data and findings. It explores existing literature on the personal, social and environmental factors and whether other studies indicate a correlation between these characteristics and the caregiver's ability to provide care. It also provides a framework in which to establish the essential elements of care to children. The literature also focuses on caring work and the gendered divisions of labour.

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Chapter Three details the methodology used for this research. The researcher writes in the third person and provides a qualitative account of the caregivers' experiences. It also elaborates on the research instruments, sampling techniques, as well as data collection and data analysis. The chapter outlines any biases which may arise in the research to ensure validity of information. It lists some of the limitations of the study and provides a discussion of the ethical considerations.

Chapter Four presents the data and the interpretation of the results. The first section of the findings chapter provides descriptive data about the participants. The second section sets out the research findings and provides discussion around each identified theme. The last section summarises the main findings of the study.

Chapter Five provides commentary on the findings draws conclusions and makes

recommendations for practice and policy with specific reference to the community of Groblershoop.

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2 Chapter Two: Literature Review

Introduction

This Chapter is divided into three main sections. Section One outlines the theoretical framework, describing both the Human Capabilities approach and the Ethics of Care approach. It also demonstrates how these theoretical approaches will assist in examining the personal, social and environmental factors and the caregiver's perceptions of how these factors affect their ability to provide care to children, from birth to 6 years.

Section Two examines literature on caring and the notion of the family. It also focuses on the location of caring as part of women's work and explores the gendered division of labour.

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Section Three focuses on personal, social and environmental factors and their effects on the caregiver's ability to provide care to children. It also explores South African policies and programmes directed at early childhood development, and discuss the literature relating to social assistance to children and families as an important resource needed for the provision of care to children.

2.1 Section One: Theoretical Approach

2.1.1 Human Capabilities Approach

The Human Capabilities approach has been pioneered by Amartya Sen and later by Martha Nussbaum, as well as many subsequent contributors. In his book "Development as Freedom" Sen (2001:3) argues that "development can be seen as a process of expanding the real freedoms that people enjoy". The core characteristic of the capability approach is its focus on what people are effectively able to do and to be, that is, on their capabilities. The approach defines capabilities "as a set of vectors of functioning, reflecting the person's freedom to lead one type of life or another."(Robeyns, 2003:5) Functioning is described as

the person's ability to do and be and is an achievement. A commodity can aid a set of functionings and is "a means to an end rather than an end in itself."(Robeyns, 2003:5) Commodities refer to goods and services.

The capabilities approach to well-being and development therefore seeks to evaluate policies according to their impact on people's capabilities. Knowing that commodities are available for use by a person is not enough to ensure well-being, as the person may not have the necessary functioning to convert those goods and services into an improved quality of life. The Human Capabilities approach posits that the relation between the goods and the functioning to achieve certain things is influenced by three conversion factors namely personal characteristics, social characteristics and environmental characteristics. (Robeyns, 2003) These three factors therefore interact and affect the person's ability to achieve functioning. Robeyns (2003:18) cites the example of a man and woman who have equal access to higher education and receive the same scholarship. Both eventually receive the same degree and both want to use their degree to achieve some kind of functioning. Since women are discriminated against in the labour market, it will be more difficult for the women to use her degree to enable functioning, compared to the man who has the same degree. Gender discrimination, which is a social factor, impedes the achievement of the same level of functioning for both the man and the woman.

Nussbaum (2002:3), in support of Sen's idea of development, recognises that equality of resources fall short because it fails to take account of the fact that individuals have differing needs for resources it they are to equate to the same level of capability to function. They also have differing abilities to convert the resources into actual functioning. Nussbaum (2002:8) also argues that the capabilities approach has a further advantage in that, by focusing from the start on what people are actually able to do and to be, the ability to address inequalities that women suffer inside the family: inequalities in resources and opportunities, educational deprivations, the failure of care work to be recognized as work and assaults to bodily integrity can be realized and addressed.

One of the strengths of the capabilities approach is that it does not assume that all human beings are the same, thus the acknowledgement of human diversity is a key concept. The capabilities approach acknowledges that two people may have exactly the same resources at their disposal but have different capabilities to turn these resources into functioning that can improve their well-being. Sen (2001) rejects the exclusive focus on well-being and suggests that information on people's agency should also be taken into account. Agency is defined as the ability to set and pursue one's own goals and interest, of which the pursuit of one's own well-being may be only one (Peter, 2003). Sen (2001) postulates that by focusing on women's agency and capability rather than their disadvantaged levels of functioning (being oppressed or violated) will contribute towards women's liberation. Paid work is a critical element in women becoming financially independent and increasing their self esteem, dignity and autonomy (Gasper & Van Staveren, 2003).

Central to Sen's theory of development is his view of people as agents of development and processes, rather than patients of development. (Koggel, 2003) Sen (2001) distinguishes between strategies that promote women's well-being from strategies that promote women's agency. The former approach treats women as passive recipients of policies and programmes that are designed to remove inequalities and achieve better conditions. The agency approach takes women to be active agents who can themselves promote and achieve social and political transformation that can better the lives of both men and women. Sen acknowledges that the two approaches overlap since agency strategies have the goal of removing inequalities that affect women's well-being, and well-being strategies are needed to draw on women's agency to affect real change (Koggel, 2003). Sen (2001) views the promotion of women's agency as critical for improving economic and social power, as well as for challenging deep-rooted values and social practices that support gender bias in the distribution of basic goods such as food and health care and in the treatment of women and girls within families. He makes a strong claim that changing the agency of women is one of the major mediators of economic and social change. This idea is supported by Peter (2003) who also acknowledges that active women's agency can bring about social change.

2.1.2 Ethics of Care Approach

The Ethics of Care approach recognises that the concept of care, while integral to our everyday lives, have significant implications for policy and politics. Caring as defined by Joan Tronto is "a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life – sustaining web" (Tronto, 1993:142). Caring work is often undervalued, unpaid and unappreciated. Historically, caring has been the work of slaves, servants and women in Western history. It is usually conducted by the least affluent members of society.

Caring has four phases and are all interconnected. They are: caring about, taking care of, care giving and care receiving (Tronto, 1993:18). Caring about recognises the importance of caring and notes that a need exists and should be met. Caring about is individually and culturally shaped suggesting that some issues may be more important to address for some people than for others (Tronto, 1993:18). Taking care of refers to responding to the need that has been identified. This involves doing something to meet unmet needs. Care giving involves the direct work of caring or meeting the need. It means doing the physical work and almost always means that the carer comes into contact with the person needing care. Care receiving is the final phase of caring and recognises that the object of care will respond to the care it receives and that the identified needs have been met (Tronto, 1993:19).

The notion of power is also closely associated to the notion of caring. "Taking care of" and "caring about" are the duties of the more powerful. "Care giving" and "Care receiving" are the duties of the least powerful (Tronto, 1993:22). Thus "taking care of" is more associated with public roles and with men, while" receiving care" and "care giving" is often less visible and associated with women. Care is often associated with the emotional rather than the rational, and is further devalued by being connected to the private sphere. This perception increases the burden of care upon women as the practice of care is not only seen as part of the gender roles that women have been socialised to embrace, but the notion that it is an emotional process further prevents men from entering the caring realm. Care receivers are viewed as helpless as they have a need. Neediness is feared rather than seen as an important

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part of human life, and is regarded as a barrier to independence and autonomy. The care receiver is seen as less capable and less powerful. This results in society seeing care receivers as being pitiful and their needs do not receive any acknowledgement. In South Africa caring has been shaped by the system of Apartheid, which differentiated the quality of care received based on ethnic and racial lies. According to Bozalek (2004) the majority of South Africans were excluded from access to resources and services. This has now formally changed with an attempt on the part of the State (since 1994) to redistribute resources and provide access to basic facilities to those people who were formally excluded. Bozalek (1999) further reported that the Apartheid regime created an unequal system of welfare benefits. The system largely excluded Black South Africans and concentrated resources primarily on White and to a lesser degree on Indian and Coloured South Africans.

The four phases of caring gives rise to the four ethical elements of care namely: attentiveness, responsibility, competence and responsiveness. Attentiveness refers to our ability to recognise the needs of others in our communities. If the needs of others should be ignored then we are failing in our moral duty to assist. The second dimension of care refers to responsibility, which seeks to define the levels of obligation people have for meeting the needs of others. This also allows us to examine the responsibility the State has in relation to meeting the needs of those who find themselves in poverty stricken situations. The third element of care refers to competence in care-giving as a moral notion. Intending to provide care, even accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met (Tronto, 1993:18). The fourth moral element that arises from care is responsiveness. In communities we endeavour to be responsive to the needs of vulnerable groups, to ensure that we meet real needs of people. Often policy makers speak on behalf of the vulnerable group without adequate consultation and listening to the real needs of those they say they seek to assist.

2.1.3 Framework for Assessing Care

In her unpublished article on the care ethic and welfare policy, Joan Tronto presents a set of questions relating to the elements of care. This will assist this study in assessing the

adequacy of care in relation to the care giver, the context in which the care takes place, as well as the resources required for caring. The questions are presented in the table below:

Table 1: Framework for Assessing Care

Attentiveness:	What care is necessary? What types of care now exists? How adequate are they? Who gets to articulate the nature of needs and to say what and how problems should be cared about?
Responsibilities:	Who should be responsible for meeting the needs for care that exists? How can and should such responsibility be fixed?
Competence:	Who are actually the caregivers? How well can they do their work? What resources do caregivers need in order to care completely?
Responsiveness:	How do care receivers respond to the care that they are given? How well does the care process as it exists meet their needs?

Taken from: J.Tronto (undated) The Care Ethic and Welfare Policy

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2.1.4 Suitability of the theoretical approach to the Study

The Human Capabilities approach allows one to examine the care given to children from birth to six years by examining the extent to which the caregiver was able to mitigate personal, social and environmental factors to achieve well-being. The Ethics of Care approach allows for the quality of care to be examined by assessing the context of care and care resources required for caring to take place.

2.2 Section Two: Literature on Caring

Introduction

In many countries women are dying of famine and widespread hunger, their rights are being violated and they are robbed of their political and civil freedoms (Sen, 2001:1). Even though women make up just over half the population of the world, their voices are conspicuously silent. Despite the prevailing human rights rhetoric and the pursuit of gender equality, millions of women remain bound by cultural and traditional stereotypes that dictate their diminished status in society. In South Africa, 1994 marked the beginning of a new era, not only in relation to the dismantling of the Apartheid system of government, but also with regards to making strides to achieve gender equality. The ratification of international treaties in the form of the Beijing Platform of Action, Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the United Nations Declaration of Human Rights placed women's rights at the centre of the Government's agenda. The 1996 Constitution enshrines the notion of gender equality and contains a Bill of Rights for all South Africans (Constitution of the Republic of South Africa, No.108 of 1996)). The South African Constitution is hailed as being the most progressive in the world with regards to the protection of human rights. The promulgation of various pieces of legislation and policies that aim at providing women with freedoms and protection against gender violence indicated the newly elected government's commitment towards achieving gender equality. The Domestic Violence Act No.116 of 1998, the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007, the Maintenance Act No.99 of 1998 as well as the Children's Act No. 38 of 2005 are a few examples of the State's commitment towards gender equality.

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2.2.1 Women as Carers

According to UNICEF, the status of women and the well-being of children are deeply intertwined (UNICEF, 2007:2). Child survival is dependent on the survival of women as women are in almost all cases the primary caregiver. Healthy, empowered and educated women will more likely have healthy, educated and confident children. There is

considerable evidence that women's education and literacy tends to reduce the mortality rates of children (UNICEF, 2007:2). The influence works through many channels, but perhaps almost immediately it works through the importance that mothers attach to the welfare of their children (Sen, 2001:195). Women have been socialised into taking on the caring roles, both in the household and the community. Caring activities for many women also include having to walk long distances to fetch water and firewood. Young girls are often forced to drop out of school due to child marriage and violence. Often in situations of poverty, women and girls are more likely to give scarce food resources to men and boys at their own expense (UNICEF 2007:9). Women fulfill a key care giving role in society but receive no care in situations of violence, and instead have their human rights violated. In South Africa as in most places in the world, the burden of caring is often left to women. Women not only care for the children and the family, but for the sick, frail and those affected by disease and other social ills.

2.2.2 Gender Inequality – a Social Justice Issue

Inequality between men and women is entrenched in all institutions in society by the ideology of patriarchy, which according to Anthony Giddens (1990:101) is the dominance of men over women. Inequalities between men and women raise the issue of gender justice in society, which in effect is a question of social justice. Amartya Sen, in his Human Capabilities approach "focuses on what people are effectively able to do and be, that is, on their capabilities. The core element of this approach is that people have the freedom (capability) to lead the kind of life they want to lead. Once they effectively have these freedoms they can choose to act on these freedoms in line with their own ideas of the kind of life they want to live" (Robeyns, 2003:7). Using the capabilities lens, one can see how the notion of growth is a poor indicator of quality of life as it does not tell us how and what deprived people are doing. Approaches that measure well-being purely in terms of the provision and access of goods and services do not help us understand the real pressing issues of gender injustice. This is because women frequently exhibit adaptive preferences which suggest that they have adjusted to their second class status. A major concern for gender justice is the issue of care because, as has already been pointed out, most caregiving is done by women across the world. This impact on what they can do and be – i.e. on their

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capabilities. John Rawls defines justice in terms of the distribution of "primary goods" predominantly meaning wealth and income. His theory is based on the understanding that all parties are roughly equal and not dependent on each other (Patricia McGrath Morris, 2002:3). His theory of justice is critiqued by both care and Human Capabilities theorists who acknowledge that people begin their lives as helpless infants and remain in a state of extreme, asymmetrical dependency, for a large proportion of their lives (Tronto, 1993; Kittay, 2002; Sevenhuijsen, 2000; Robeyns, 2003). They make the point that any society is a caregiving society and a care receiving society, and must therefore discover ways of coping with these facts of human neediness and dependency that are compatible with the self respect, and do not exploit the care givers (Nussbaum, 2002:23). Kittay (1999), a prominent care theorist, criticises Rawls for his failure to take into account dependency concerns. Kittay goes further to suggest that a universal compensation called a doulia, for dependency work, will ensure that those who engage in caring work do so themselves, not become vulnerable to abuse or dependency, their work being valued and improving their ability to do what Kittay terms 'dependency work' (Kittay, 1999).

2.2.3 The Changing Nature of the Family

With the changing structure of the family "the concept of "household" has been critiqued as being inadequate to describe the complexities of relationships and responsibilities and the traditional nuclear family with a breadwinner husband, stay at home wife who provides for biological children is not a viable construct"(Sevenhuijsen, 2000:2). This notion of the family being perceived as a natural institution is considered by Bren Neale to be a myth. Family life can now be understood in ways that do not emphasise the centrality of the conjugal bond or insistence of co-residence, which may not be organized around heterosexuality, conventional divisions of labour or ethnocentric notions of family structures (Neale, 2000: 2). The need to deconstruct the notion of the family in the South African context was also supported by Sunde and Bozalek (1995). They purported that the understanding of the complexity of familial forms in South Africa is required if policy is to address the welfare needs of the country. Silva and Smart (1999) concur that it is relatively easy for policy makers to define the family in conventional conjugal units which are based on marriage, co-residence and heterosexuality, however the way families organise themselves

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represents a different reality. To account for the changes in the notion of the family, Morgan (1996) has proposed a focus on family practice. This concept implies that individuals are doing family and not simply passively residing within a pre-given structure. (Silva and Smart, 1999). Morgan (1996), seeks to express the regularity, fluidity and multi-facetedness of what occurs within families through the use of the term family practices. These practices are also located within a historical, social and cultural context which provides legitimisation of choosing one set of practices over another. The work of Margo Russell (2003) in attempting to understand Black households in South Africa foregrounds the diversity of family practices in households and examines the range of individuals who may constitute a part of the family across racial, class and urban/rural divides.

Tronto (1996) also acknowledges that families have changed in their composition. She notes that divorce rates around the world are high. More children are being born out of wedlock and fewer people are marrying and having children. Tronto postulates that the notion of the family as a conjugal unit as the best care giver has come under serious attack. The modern family has turned out to be a realm of great inequality, danger and unhappiness (Tronto, unpublished manuscript). The number of female headed households are growing in South Africa and Budlender (2003) posits that female headed households are often poorer than other households. Rawls on the other hand sees the family as a decision unit with a head who decides altruistically for all members of the family, thus making the assumption that the family is a just institution (Knobloch, 2002:8). Iversen (2003:94) differs from Rawls and explores how domestic power imbalances, often with a gender connotation, generate inequality and mediate opportunities to achieve well-being among household members. Folbre in Iversen (2003) further argues that the impression that women and female children voluntarily relinquish leisure, education and food would be plausible if they had the power to demand their fair share. Women lack economic power and have an unequal distribution of household resources at their disposal (Iversen, 2003: 96).

2.2.4 Gendered Division of Labour

Knobloch identifies that the gendered division of labour is a special type of social division that is not limited to the market sector, but also exists within the subsistence part of the

economy and is steeped in inequality. She distinguishes between three kinds of gender-division of labour:

1. Gender-based division of labour between market and subsistence economy: this refers to the traditional distribution of work with men engaging in more of the paid work while women do more of the unpaid work.
2. Gender-based division of paid work in the market place: Many jobs are either predominantly male or female. For example women tend to become nurses, dieticians and teachers while men do jobs like engineers, architect, and doctors. The jobs done by men often have more status and are paid more than the jobs done by women
3. Gender- based division of unpaid work in the non-market economy: This refers to the fact that often women work in the formal market economy during the day and come home to the caring activities of the household at night. Men's activities in the domestic sphere are different as they tend to do more of the work that involves repairing and maintenance (Knobloch, 2002: 3).

Knobloch emphasises through the identification of the three kinds of gender-division of labour that even though more women are working in the market place, their work is still considered less important than men. They are paid less than men and they are still expected to fulfill the gender stereotypical roles of a woman in society. For women who are not part of the formal economy, the caring work done is largely unrecognised, unpaid and therefore invisible in terms of the benefit it adds to maintaining the formal economy. Mohanty in Koggel's (2003:173) article on Globalization and Women's Paid Work, differs with Sen and says that paid labour will not change the status of women or give them freedom, while Lim in Iversen (2003) points out that even though women may be forced to work in appalling conditions, the change for each individual woman in respect of the home and community can transform and challenge traditional gender stereotypes. Nussbaum (1995; 2000), Fraser (1997) and Tronto (1993) using social justice and political Ethics of Care approaches, all concur that as a result of the gendered division of labour women work a "double day" and the concept of "universal caregiver model" argued for by Fraser will ensure that men take equal responsibility for caring work (Knobloch, 2002:15). Rawls's theory of justice does

not take into account the gendered division of labour (Knobloch, 2002:8). Implicit in the family structure are gender roles which find its roots in the ideology of patriarchy. The Rawls's theory of justice does not see the problem of injustice in the family and the household, and therefore he does not apply his theory to either of them (Knobloch, 2002: 8).

2.3 Section Three

2.3.1 Personal Characteristics of the Care giver

It has been well established that "the care that children receive has powerful effects on their survival, growth and development" (WHO, 2004:5). Some of the important developmental milestones for children between birth and six years are the child's cognitive development, language acquisition skills, emotional development and physical development. Central to the child's development is adequate and appropriate nutrition, proper health care, immunisation, safe environment, developmentally appropriate stimulation and nurturing caregivers. Young children are dependent on the care they receive from others. All the child's physical and psychological needs must be met by one or more persons who understand what infants need and want. The early years of life are a particularly critical period and if the context in which young children grows up in is not supportive; their later participation in society is likely to be compromised (Dawes etal, 2007:20). The World Health Organization (2004) indicates that the quality of infant-caregiver relationship is a major determinant of psychological adjustment and subsequent personality development. Caregiver – child interactions occur within a framework of care giving and parenting, which is influenced by both cultural and sub-cultural practices. The World Health Organization (2004) has identified five primary care giving functions that cannot be separated from one another, and are universal across cultures:

1. Sustenance – to promote biological integrity through the provision of food and shelter
2. Stimulation – to engage attention and provide experience and information that is neither incomplete nor excessive or disorganized
3. Support – to meet social and emotional needs and to reinforce goal-directed behaviour.

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4. Structure – to differentiate inputs to the child according to the child's needs and capabilities.
5. Surveillance – to keep track and monitor the child's activity. This is imperative to the child's safety and wellbeing (World Health Organization, 2004:34).

The above set of functions is deemed as necessary requirements for care of a young child. Literature indicates that the personal characteristics of the care giver may impact on his/her ability to provide the above functions in an adequate manner. The World Health Organization (2004:47) describes the personal characteristics of caregivers to include, amongst others, "age, knowledge, educational level and mental state, physical ability and sex". Bray and Brandt (2005:21) also point out the mental state of carers has important implications for their capacity to provide emotionally responsive care to their children. Research convincingly indicates that poor psychological functioning in mothers, including depression, predicts poor monitoring of children and other adverse impacts on children's emotional and intellectual development (Brandt & Bray, 2005:22). Post-natal depression can adversely impact on the mother-child attachment and other family interactions. Depression during pregnancy can lead to physiological effects that are detrimental to prenatal development and are associated with low infant birth weight and prematurely (Lange and Ybarra, 2008). Richter and Kvalsvig (2007:181) also concede that maternal health, depression, stress, mood and emotional state can influence the quality of the caregiver – child relationship. They also state that the caregiver's education levels are strongly associated with children's survival and development. Sen also emphasises that female literacy was found to have an unambiguous and statistically significant reducing impact on under – five mortality (2001:197). An informed and empowered care giver is more likely to understand any health risks for the child and will be in a position to have more knowledge about the child nutritional, emotional and developmental needs. This is further supported by Soliday (2008) as she purports that higher levels of maternal education have been associated with higher levels of pediatric outpatient clinic use and higher rates of preventive health measures, such as immunization. Risk taking practices of mothers during pregnancy may also have an adverse effect on children in later years. Alcohol abuse during pregnancy poses unique risks to the foetus and may result in foetal alcohol syndrome in children. This causes significant

developmental delays and permanent brain damage which will affect the quality of life of the child in later years (www.fasfacts.org.za/fasinfo.htm).

2.3.2 Social Factors

2.3.2.1 Parenting

When children are born they are entirely dependent on their care givers for survival. The human infant is a particularly vulnerable creature, unable to look after itself until well into its middle childhood. The primary task of parenting therefore is to ensure the survival and wellbeing of children (Hoghughi and Long, 2008). Parenting may be defined as purposive activities aimed at ensuring the survival and development of children. Bronfenbrenner (1986), Belsky (1984) and Furstenberg and Nord (1985) have attempted to identify the theoretical elements of parenting (Zevenbergen, 2008).. Their work gives rise to a conceptual framework of parenting which defines its core activities into three groups namely care, control and development. Each of these activities have two facets namely, the prevention of adversity or anything that may harm the child, and the promotion of positive development or anything that may help the child. Care comprises of a cluster of activities aimed at meeting the survival needs of children. Children have physical, emotional and social care needs. Control comprises the range of activities concerned with setting and enforcing boundaries for the child in an age and culturally appropriate manner. Development activities are concerned with those aspects of the child's life that will enable them to fulfill their potential in all areas of functioning (Hoghughi, 2008). This conceptual framework posits that in order to provide care to a child the care giver requires knowledge and understanding of the child's needs motivation to meet the needs of children and resources for caring. It goes further to state that the core resources for caregiving are not only finances, but also include qualities, skills, social networks and material resources.

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According to Burton, Leoschut and Bonora (2009) there are a number of factors which contribute towards developing resiliency which occurs at the level of the individual, the family, the school and the community. This is supported by Farrington etal (2007) and Sherman etal (2002) who further emphasise the importance of parenting factors at a family

level and the role that this plays in mitigating the potential of the child for offending in later years (Farrington etal, 2007; Sherman etal, 2002). Kaplin and Owens (2008) goes further to state that children raised by nurturing, responsive care givers are less likely to present disturbances, whereas children raised by emotionally cold caregivers are more likely to have an insecure attachment to their caregiver. Positive forms of discipline, those aimed at increasing the frequency of desired behaviours, include attention, praise, privileges and concrete rewards. Punishment, which is aimed at decreasing the frequency of unwanted child behaviours is frequently associated with physical punishment. Harsh discipline and punishment of children is one of the predictors of offending in later life (Zevenbergen, 2008).

Researchers in education and psychology agree that the home environment is a significant factor in the intellectual development of children. In Piagetian theory of childhood cognitive development, children actively construct knowledge as they manipulate and explore their surroundings. Emphasising the biological nature of cognition, Piaget's cognitive developmental theory suggests that children adapt to the eternal world as the structure of their mind develops, just as the structures of the body are adapted to fit with the environment. This adaptation is innate and inevitable and is augmented with a need to maintain a balance between child's internal structures and information they gather in their everyday environment. While this theory does initiate some debate about the importance of the environment as a critical factor in the development of the child's cognitive skills, it does support the notion that cognition is affected by biological factors and hence excessive use of substances during pregnancy is likely to affect the brain of the child, and thereby their ability to develop a full set of cognitive skills.

Vygotsky's (1992) theory of cognitive development addresses the importance of the environment in the development of children. In Vygotsky's sociocultural theory of development, the values, beliefs, customs and skills of a social group affects development. Social interaction, such as co-operative dialogue between children or adults, is seen as necessary for the development of cognitive skills. As children learn new skills they are supported by a care giver who allows the child to perform the task in increasingly more complex ways. Once the child has mastered the task support is decreased. This process,

which Vygotsky described as scaffolding, has a major influence on cognitive development. Like Piaget, Vygotsky believed that children are active, constructive learners constantly exploring and making sense of their environment. However, Vygotsky asserted that cognitive development is also a socially mediated process, dependent on the support of adults (Wade, 2008). This theory supports the concept of the importance of parenting in a social context which influences the development of cognitive skills within children.

2.3.2.2 South African Policies and Programmes directed at ECD

1994 marked the end of an era of Apartheid and with this came the birth of a new democracy. South Africans were filled with hope and excitement of the promise of political freedom and the fulfillment of basic human rights, regardless of race. Women and children played a significant role in the long struggle against racial oppression, and many lost their lives in this process. This young democracy held significant promise for securing the rights of women and children. South Africa became a signatory to a number of international treaties to ensure the protection of children's rights and their well-being. The United Nations Convention on the Rights of the Child and The African Charter on the Rights and Welfare of the Child spoke to the democratic government's commitment to the development of its children (Lund, 2008:5). The South African Constitution was aligned to the Convention and recognised the need to secure the well-being of all children. The Bill of Rights in the Constitution acknowledges the need to secure the wellbeing and the development of all children and makes specific mention of basic nutrition, shelter, health care and social services as well as education as rights for all children in South Africa (Constitution of the Republic of South Africa, No. 108 of 1996)). The Children's Act, which was promulgated in 2008, replaced the Child Care Act No. 74 of 1983 and outlines the minimum standards for early childhood development services that apply to facilities that take care of children. It also provides for the registration and regulation of Early Childhood Development (ECD) services and partial care for children (Children's Act No. 38 of 2005). Early Childhood Development programmes and policies cut across three departments in South Africa, namely, Department of Health, Social Development and Education. While these departments are represented at the national sphere of government the function of social development, health care provision

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and education are all provincial competencies. This means that different provinces allocate and prioritise different resources to these three departments based on their assessment of need. It also implies that the three departments have to work together to spend their budgets more efficiently and to make sure that there are no gaps in the system. However, intergovernmental relations have not worked in South Africa, and in many provinces the departments do not communicate with each other, much less decide how to spend their resources more effectively.

2.3.2.3 Social Assistance

One of the major challenges to the democratic government was the integration of all welfare departments, especially those from the former homelands[2]. In 1995/96 financial year 85% of the welfare budget was spent on social assistance. South Africa had the following grants available:

1. Elderly Pension
2. Foster Care grant
3. Care dependency grant
4. Disability grant
5. State Maintenance Grant

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At the end of 1995 racial parity had been achieved in all grants, except the State Maintenance Grant. This grant was introduced in the 1930's to White families, specifically but was later rolled out to Coloured and Indian Families and some African families. It was much more difficult for African families to obtain the grant. It was clear that the State would not be in a position to finance this grant to all those who may need it. The Lund Commission (1998) was established to find solutions to address this issue. It was decided that the grant would be phased out and the Child Support Grant would take it place. This grant was phased in and was only available to children up to seven years of age. Each new financial year the State has increased the age of children who may receive this grant. The amount of the grant, however, was substantially reduced from the State Maintenance Grant of R537 to the Child Support Grant which is now only R270 (Lund, 2008). Lund concludes that it is still too

[2] Homelands in the Apartheid era in South Africa were separate settlements created for Black people.

early to measure the impact of the new system of social assistance to children, but some anecdotal evidence indicate that there is an increase in enrollment of children in schools and some benefits to the family as a whole as the grant provides a limited form of buying power. The school feeding schemes, free healthcare to children under 6 years, and other social development programmes were aimed at providing poor families with a package of services in addition to the Child Support Grant to alleviate poverty. However, each of these services and programmes have their own problems and their effectiveness has been questioned by many practitioners and community alike, and have not alleviated the plight of the poorest of people.

In South Africa social development policy has focused on the building integrated and sustainable caring communities, through the eradication of poverty and various social ills. While the rhetoric about caring communities suggest that government policy is in line with the expressed needs of vulnerable communities, practical interventions are more removed from this reality. As Tronto (unpublished) asserts, the state is focused on understanding human needs from an economic perspective presenting an image of those that are not self sufficient as being irresponsible and relying on welfare benefits as opposed to engaging in the work ethic. The focus on the "preservation of families" does not tell us what family forms the State is seeking to preserve, given the diversity of family practices in South Africa. The norms and perceptions around caring work and who does this are important social factors that affect the caregiver's ability to provide quality care. Another factor is the way in which the State supports caring through its policies and programmes. In South Africa, the Constitution provides for education as a right, as well as the need to secure the well-being and future of all children through the Grant System (Biersteker & Louw, 2006:15). The State has for all intents and purposes taken for granted the fact that caring will be done by women, and have made insufficient attempts to meet people's basic needs through programmes that reflect their needs. This view is supported by Tronto (1993:2) and she states that "privatising care is an insidious way to reduce the State's level of accountability for its citizen's welfare."

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2.3.2.4 Poverty

Poverty is a "condition characterised by severe deprivation of basic human needs including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income, but also on access to social services (Ally-Schmidt, 2005:55). In South Africa, at least 50% of the population has monthly incomes whose levels are too low to sustain a decent lifestyle. Six out of ten children in South African live in poverty, where poverty is defined as the poorest 40% of the households (Biersteker etal, 2006:27). Millions of people, especially in the urban areas, live in shacks that are inadequate while in the rural areas, millions live miles from clean water. The collapsing health care system and a large number of dysfunctional schools is another challenge facing communities (Desai, 2005:11). Female headed households are over-represented among the poor "some of the factors underpinning these gendered differentials include the greater probability that female-headed households are rural based, where poverty is concentrated, with fewer adults of working age in female headed households, high female unemployment rates and persisting wage gap between male and female." (Desai, 2005:47). Poverty impacts on the development of children by exposing them to a number of "risk" factors. These risk factors include the lack of adequate nutrition, employment opportunities, inadequate social security system, shelter, basic health care and access to equal services. Violence, alcohol and drug abuse and other social ills are often present in poor communities, but not limited to them. These risk factors have a detrimental outcome on the overall well-being and safety of the child. Poor communities make use of State provided services which are often insufficient, effective or regular. This deepens the cycle of dependency.

2.3.3 Environmental Factors

Climate, infrastructure and material resources are environmental factors that play a role in the conversion from the characteristics of the goods to the individual functioning (Robeyns, 2003:13). Knowing the person owns the resources or can use it is not enough to know if the person can achieve a level of functioning. More knowledge about the person and the circumstances in which they live in is required. Donald etal (2005:5) state that the physical characteristics of a child's context, for example, whether they have access to water, recreational facilities, housing etc has an impact on a child's development. This is significant

as it outlines the fact that the caregiver mitigates the environment on behalf of the child, as part of the caring practice to ensure the child's well-being.

2.4 Outlining the Importance of the Study and identifying the gaps

In 2005, Ally-Schmidt undertook a study in the community of Ceres in the Western Cape, examining the needs of caregivers in poor female headed households. This study highlighted the fact that women were caught in the paradoxical bind of being responsible for caregiving and acquiring resources, but limited structurally through being marginalized and exploited workers. The human capabilities perspective takes this argument a step further and advocates for the agency of women who are able to decide for themselves what they find valuable in their lives. In order for this to occur, the gender division of labour needs to be unpacked and care which is seen as women's natural role and burden must be brought to the centre of political debate. Kittay (2002) states that everyone experiences some form of dependency in their lives and therefore the caring work done by women must be acknowledged and valued. Providing resources to engage in caring work is extremely important. Resources alone, however, will not ensure quality care. The capabilities perspective acknowledges that the personal, social and environmental factors impact on a caregivers ability to provide that care. Understanding what the impact is and how it affects the development of children in the long term will enable policy makers and the Centre for Justice and Crime Prevention to establish programmes and strategies which will assist caregivers to care for children in the formative years.

2.5 Conclusion

This chapter has drawn on the Human Capabilities approach and the Ethics of Care literature to provide the theoretical underpinning for this study. It also focused on national and international literature drawing on women's experiences in relation to the gender roles, gender division of labour and the practice of caring. It specifically examines literature which has looked at the personal, social and environmental factors and how this affects the functioning of caregivers in relation to the caring of children. It also explores literature on caring and the notion of family and outlines a framework by which to assess the basic

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elements which outline how adequate care could be understood. It also explores public policies and social assistance and how these present as caring resources.

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3 Chapter Three: Methodology

3.1 Introduction

This Chapter outlines the aims and objectives of the research. It also discusses and describes the research approach and process, the data collection method and the research tool. It addresses the ethical concerns which arose during the research process. Finally it describes the data analysis process as well as some of the limitations of the study.

3.2 Research Aim

The aim of the study was to explore personal, social and environmental factors that affect the caregiver's ability to provide care to children from birth to six years within the Groblershoop community. The researcher's involvement with Centre for Justice and Crime Prevention's (CJCP) youth resiliency project means that rapport with the community had already been established. By engaging with caregivers and understanding their own limitations and the limitations resulting from the environment and social arrangements it was hoped that a better understanding could emerge with regard to what may be needed to create a healthy, stable environment in which young children can grow and develop in the poorly resourced area of Groblershoop.

3.3 Research Objectives

The objectives of the research study are as follows:

- To explore the influence that personal, social and environmental factors have on care giving for children between birth and six years, within the community of Groblershoop.
- To investigate what resources exist for caregiving within the Groblershoop community, and how they are used by care givers to provide care to children between ages birth to six years.

- To establish what mechanisms need to be established to mitigate the limitation created by personal, social and environmental factors to ensure that children between birth and six years benefit from care that promotes their healthy growth and development.

3.4 Qualitative Research Approach

Qualitative research considers reality to be subjective, constructed, multiple and diverse. It assists the researcher to interpret and understand, first the actors' reasons for social interaction, and the way they construct their lives and the meaning they attach to them (Sarantakos, 2005:37). According to Welman, Kruger and Mitchell (2005) qualitative research covers an array of interpretive techniques which seek to describe, decode, translate and otherwise come to terms with the meaning of naturally occurring phenomenon in the social world. Leedy and Ormrod (2005) posit that the researcher's ability to interpret and make sense of what he or she sees is critical for understanding any social phenomenon, and the researcher is seen as the instrument of the research. Qualitative research is also strongly associated with induction and exploration. Induction and exploration allows for a degree of openness in the research design, and seeks to be sensitive to the priorities held by those who will be interviewed or observed (David & Sutton, 2004:77). The qualitative research design offers a guide that directs the research action, and helps to introduce a systematic approach to the research operation, thereby guaranteeing that all aspects of the study will be addressed and executed in the right sequence (Sarantakos, 2005:106).

3.5 Qualitative Research Process

This study, qualitative in nature, will employ a series of methods which will include in-depth interviews, focus group interview using participatory learning and action techniques and participant observation. A qualitative methodological approach is a particular style of social research which is employed to describe, interpret and reconstruct the subjectively meaningful words of people (David etal, 2004). It sets the researcher close to reality and has the potential to capture the world in action. For this particular study a qualitative design enabled

the researcher to record the voices of the caregivers and document their experiences as it relates to their life conditions. Qualitative research also allows for a flexible research design. The design is appropriate for this study as it yielded a rich array of data from the personal experience of caregivers, which could be used to gain insight into the dynamics of childcare and caregiving. A qualitative methodology is thus the most appropriate approach to use in a study of this nature, as it is important to begin to grapple with the complex issues emerging from the caregiving process, and its impact on the relationship between caregiver and child and the quality of care giving.

A two-phased data collection process was conducted. In the first phase the researcher spent a week in Groblershoop interviewing caregivers and engaging in participant observation. During the second phase the researcher conducted a focus group, and used the participatory rural appraisal method to enable a group of care givers to map their care giving resources in the community. During this phase semi-structured interviews were conducted with service providers in the community. The goal was to gather their opinions of caregiving and resources available for children from birth to six years old. The researcher also spent a week in the community to complete the second phase of the data collection process.

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3.6 Data Collection

3.6.1 Population and Community Demographics

The Centre for Justice and Crime Prevention, the organisation which the researcher works for, conducts a youth resilience project in the community of Groblershoop. This provided the motivation for the researcher to choose this community within which to conduct this research. One of the intentions of conducting this research study was to provide direction to the project activities and to ensure that the organisation would be better able to meet the felt and expressed needs of the community. The community of Groblershoop is about 150 km from the major town of Upington in the Northern Cape Province.

The town of Groblershoop is very small and the first sign of the community from the main road is the sight of the police station and magistrate's court. According the !Kheis

Municipality's Integrated Development Plan (2008) the town is occupied mainly by White inhabitants. The Coloured community is hidden behind dunes of sand. The general lack of infrastructure in both the town and the community is evident, and sandy gravel roads are the norm, rather than an exception. The sharp contrast in the community is very evident. As one enters the community, the only built up formal housing structures can be seen in a small cluster – this is called "Die Wit Blokke" as most of the houses here are painted White. The drive starts out on a tarred road but quickly becomes gravels about a kilometer from the entrance. The rest of the community comprises of informal dwellings as well formal structures of an inferior quality. The sight of children playing in the road, men sitting alongside the street and women clustered together talking makes one realised that one has arrived in the community of Groblershoop.

3.6.2 Context of Groblershoop: Using the CJCP Baseline Information

In 2007 the CJCP conducted a baseline study in Groblershoop. The purpose of this study was to obtain a picture of the community of Groblershoop, identify the resources in the community as well as obtain a sense of projects and interventions operating in the area. The baseline study was completed by conducting a community household survey, as well as interviews with a range of service providers. The baseline study (Sharp, 2007) revealed the following:

The community of Groblershoop has a combination of formal and informal housing structures. One in four households uses a pit latrine or portable chemical toilet while one in six households has no toilet. Most households have no ablution facilities inside the dwelling, and use a bucket to wash outside. Approximately one third of the community collects their water from a tap in the community. The formal housing structures are made of brick and corrugated iron roofs which increase the temperature in summer and make the houses cold in winter. The informal housing structure comprises of bamboo wreaths and is kept together by mud. In summer most families sleep outside as it is impossible to sleep indoors in the heat.

Figure 1: Informal Dwelling in Groblershoop

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Figure 2: Inferior Formal Housing Structure in Groblershoop – No Tarred Roads

The climate is dry and arid and temperatures can rise up to 40 degrees Celsius during the

summer months and drop to minus 0 degrees in the winter. The roads in Groblershoop are untarred. Very few people are fortunate enough to have the use of a car, and most people use taxis as a form of transport. It is a common site to see people hiking or walking long distances to reach places. The clinic is located in the town of Groblershoop and most people have to walk quite far to access services. The clinic is staffed by five nursing personnel and there is no doctor in Groblershoop. If there is a serious medical issue, patient have to wait to be transported to Upington Provincial Hospital which is 150km away.

Figure 3: Open Spaces in the Community often used as a Playing Field

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The picture above shows a typical space in the community where children play. Along this field runs a proportion of the only tarred road in the community. Shebeens[3] are one of the only recreational spaces in the community where people meet. Below is a picture of one of the larger shebeens in the area.

[3] Shebeen is used to describe a community based tavern where alcohol is sold. Most times these shebeens are illegal operating without any liquor licences.

Figure 4: Shebeen in the Community of Groblershoop

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There are two schools in the community, one primary school and one high school, and three crèche facilities. The CJCP baseline study (2007) indicated that education levels were relatively low. Most of the people interviewed in this study reported that they did not complete their schooling because they could not afford to, or needed to find work to support their family. Only one is six adults had received any kind of informal skills development. Of those who received training, most of this was computer related training.

Figure 5: Children at the Creche

People in the community of Groblershoop are poor. The 2008 Integrated Development Plan (!Kheis Municipality) document states that the unemployment level is 76% . Hunger is a significant issue for members of the community and almost half of the 634 people interviewed in the community survey stated that they often went to bed hungry. Social issues arising from poverty include child abuse, domestic violence, teenage pregnancy, overcrowding and ill health amongst others.

3.6.3 Sampling Method and Recruitment

The purposive sampling method was chosen to identify participants. The project officer who works within the Youth Resiliency Project identified participants who in her opinion met the criteria set out by the researcher. The researcher stipulated that the participants who could be included must live in the community of Groblershoop and must be responsible for providing care to children between birth and 6 years. As Sarantakos (2005) points out, the choice of respondent is guided by the judgement of the investigator, in this case the project officer, and there are no particular procedures involved in the actual choice of subjects.

Individual interviews were conducted with ten caregivers and three of these ten caregivers gave the researcher permission to engage in participant observation in their home environments. Seven other care givers were identified and they participated in a focus group in this study. Seven interviews were also conducted with service providers to ascertain the nature of services that were being provided to the community of Groblershoop.

In the community of Groblershoop caregiving is the responsibility of the women, and therefore all the caregivers interviewed were female and Afrikaans speaking. The ages ranged between 18 and 49 years, for all that participated in the study. All the caregivers were the biological mothers of the children, except one who was the grandmother. Fifty percent of the women that were interviewed were involved in an intimate relationship with a partner while only one caregiver was married. With the exception of the woman that was married the current partners of the other women were not the biological fathers of the children. Fourteen of the caregiver's community of origin was Groblershoop, and they had lived in this community all of their lives. Two of the remaining three women came from other parts of the Northern Cape and the other woman was born in Vredenburg in the Western Cape. All seven care givers that participated in the focus groups were also originally from Groblershoop.

3.7 Data Collection Instruments

The following instruments were used to collect data for this study:

3.7.1 Individual Interviews

Semi-structured interviews using a semi-standardised format were conducted in the natural settings of each participant. David etal (2004) posits that an interview is a conversation with a purpose. The purpose is clarified in the act of setting out themes and sub-questions which provides guidance to the interview and allows for flexibility in its approach. Welman et al (2005) state that the semi-structured interview offers a versatile way of collecting data as this method can be used with all age group and with subjects of a sensitive nature. Interviewing, according to Yanos & Hopper (2008), requires a total display of attention to the person being

questioned, to develop a complete attunement to the participant's world in order to avoid pitfalls such as thinking that the researcher has heard it all before.

Trust is a mandatory issue in all research ethics (Ryen, 2008:460). The researcher thus undertook to build a rapport with the participants and in so doing the researcher was able to ask more probing questions. The researcher requested permission to record the interviews, while each of the women interviewed gave their permission, they were unresponsive at the beginning of the interview and focused largely on the tape recording device. Whilst the researcher spent the first few moments of the interview attempting to make the participant comfortable and explaining the anonymity and confidentiality of the interviews, this did little to distract the participant's attention away from the recording device. In an attempt to make the respondent's feel more comfortable and to allow a conversation to develop where it was possible to ask more probing and clarifying questions, the researcher did not tape the interviews and instead took detailed notes at each interview.

A group of ten caregivers was identified from the Groblershoop community. Using the semi-structured interview guide as a tool the researcher explored personal, social and environmental circumstances of the caregivers as defined in this study, to establish if these factors influenced care giving of young children. The perceptions of the caregivers about how their personal, social and environmental circumstances may influence their ability to care was a critical component of the study, and has assisted to make valuable suggestions for ways of mitigating limitations resulting from these factors so that young children could be better cared for.

3.7.2 Focus Groups using the Participatory Learning and Action Technique

According to Welman etal (2005) a focus group can also be described as a group in-depth interview. This group consists of a small number of interviewees that are drawn together for the purpose of expressing their opinions on a specific set of open questions. David etal (2005) state that the purpose of a focus group is to use the interaction between a group of interviewees to generate discussion about a topic. This discussion would be more detailed and wide ranging than a one on one interview. Additionally, the researcher employed the

technique of mapping which forms part of the Participatory Learning and Action Research Paradigm. Mapping according to Chambers (2007) is a participatory learning and action technique that allows the participant to use visual symbols and diagrams to depict a picture of the community. According to O'Brien (2001) action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. According to Bozalek and Biersteker (2009) the community mapping exercise is useful for participants to indicate their homes, neighbourhoods, and available resources. The mapping technique highlights the different circumstances in which the caregivers live and different caregivers place different values on resources (Bozalek etal, 2009).

The researcher gathered seven caregivers in a focus group interview. By using the participatory learning and action technique of mapping the community resources for caring were identified and discussed along with an identification of barriers which may exists in relation to accessing these resources. The researcher also wanted to understand how these resources were used in providing care to young children. Using this PRA technique of mapping in a group environment enabled those members in the group who may not have knowledge of certain resources to become familiar with ways of accessing them. These techniques, according to Chambers (2007) allows respondents to use symbols, words and diagrams to express realities that are cumbersome or impossible to express verbally. Getting people together in a group was an effective method of encouraging a support system and sharing ideas and thoughts.

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3.7.3 Service Provider Interviews

Semi-structured interviews were conducted with seven service providers that offered services to the Groblershoop community. The service providers were largely professional or semi-professional individuals who were either social workers, educators, nursing personnel or early childhood practitioners. This enabled the researcher to ascertain what resources were available for caring in the community. This was very important as it provided understanding of whether caregivers are aware of all services that exist, and also obtain the perspective of the services providers who may be offering services that may not be used optimally. This

has also provided valuable information as to what is needed in the community, to not only provide services but ensure that issues of access to services are also addressed. The individual interviews with service providers assisted in establishing what programmes and interventions are currently taking place in the community, which act as a resource to the caregivers, whether any interventions are planned, and identify what the gaps exist.

3.7.4 Participant Observation

According to Welman etal (2005) participant observation requires the researcher to take part in and report on the daily experiences of the members of a group, community or organization. Sarantakos (2005) states that the participant-observer-researcher may bring "fresh eyes" into the situation and thus notice potentially important aspects of the situation that subjects who are immersed in it might miss or take for granted. Because of one's 'newness' to the setting, the researcher may more easily pick up on little nuances that have become comfortable old habits - and thus sublimated to the subconscious - to the subjects in the field. The researcher chose to engage in participant observation because it provided an opportunity to observe first hand the interaction between the caregiver and the child, and provide insight into the parenting style as well as the disciplinary practices employed by the care givers.

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From all the individual interviews conducted the researcher requested permission from those who were comfortable to engage in participant observation. Only three participants were comfortable being observed. While the association between the participant and the youth resiliency project made it possible for the identification of participants, the need to maintain a sense of privacy and separate the project from their home environment was present. Even though the researcher was known to the community, she was still regarded as an outsider. This could be another reason for the majority of the participants refusing to allow the researcher into their homes. While all the individual interviews were conducted at the homes, it was interesting to note that when the researcher explained that she would like to spend some time with the family, just observing what happens in the family setting and learning more about the family practices, most caregivers immediately said they were not comfortable with this.

During participant observation the researcher observed the interaction between the caregiver and child, and also attempted to observe whether the child's responses were developmentally appropriate. In order to support the participant observation process the researcher developed a check list that guided what the researcher would observe during the participant observation process. The researcher also endeavored to keep notes that documented all experiences that occurred during participant observation. The researcher was able to complete participant observation for one afternoon (three hours) at each caregivers home. The researcher acknowledged the fact that the participant observation provided the researcher with a glimpse into the real lives of the caregivers, and this provided a good opportunity to observe what the caregiver may not be able to articulate in the individual and group interviews. Participant observation has assisted to the yielding of data that would be instrumental in providing insights into all the research objectives outlined for the study.

3.8 Phases of the Research Process

The researcher gathered data in two phases. As the researcher is based in the Western Cape and chose to conduct the study in the Northern Cape, it was more cost effective to travel to Groblershoop and then stay in the community for a week at a time.

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3.8.1 First Phase

The researcher traveled to the community late January 2008. The Centre for Justice and Crime Prevention (CJCP) has a satellite office in the community. The project officer, who has lived in the community for most of her life, assisted the researcher in identifying caregivers that have children from birth to six years. The researcher provided the project officer with an information leaflet about the study before arriving so that she could provide it to the participants so that they could be aware of the nature of the study and why it was being conducted. The interviews were largely scheduled for the morning as this is the best time for most caregivers, as the temperature was still bearable. The researcher conducted the participant observation during the afternoons. All the interviews were conducted in the homes of the participants. The researcher took a small food parcel compromising of fresh brown bread, peanut butter, some fruit and milk to each interview, as a way of thanking the

care giver for their time. She also hoped that the content of the food parcel would encourage healthy eating especially for the children.

3.8.2 Individual Interviews with Caregivers

As noted in the previous section the researcher conducted ten individual interviews with care givers who provided care to children from birth to six years old. All the participants were requested to sign a consent form. The researcher gave the participant a copy of these consent forms and also left the information leaflet providing more information about the research. Due to the difficulty in recording information the researcher transcribed the interviews at the end of every day to ensure that all the information was captured. The researcher also gave the completed interview back to each participant, and went through their responses with them to ensure that it was accurately captured. In a semi-structured interview the researcher focuses on the participants first hand experience of their life-world rather than on their interpretation or speculative explanations of it. (Welman et al, 2005:196) The interview with the caregivers covered the following areas:

- Demographic information – this section allowed for the researcher to establish information on the age, marital status, whether the participant has a partner, community of origin and why they moved to Groblershoop.
- Personal Information – this section explored their income levels, whether they received any State grant, how this money was spent, whether they were searching for employment and how this process was going. It also explored their educational level.
- Family – this section gathered information about who their family members were and what their relationship was like, examined whether their parents and grandparents were still living and what kind of relationship they shared with these family members.
- Personal characteristics – this section explored the health status of the participant: physical ability, mental health, and sexual health including HIV status, whether they or their partner used any substances like alcohol of drugs currently or during pregnancy, explored significant life changing experiences which they may have had.
- Social Factors – this section explored the support base of the participants. It focused on who the participant would speak to about person problems and who supports child

care. It also looked at the role of religion, gender, peer support and feelings about their community.

- ♦ Environmental factors: this section covered access to services in the community, assessed the impact of the climate on the activities of the participant, looked at the participant's perceptions of crime and the availability of alcohol, drugs and weapons in the community. It also looked at the physical structure of their house.
- ♦ Parenting – this section focused on the participants daily activities and how time is divided for child care. It also focused on parenting styles, disciplinary processes in the home, who does most of the caring of the children, what support base the participant has for child care within the family and the community. It also looks at access to services and whether the respondent used any of the resources available in the community and why or why not.
- ♦ Developmental checklist – During the last part of each interview the researcher went through the developmental checklist with the participant. In almost all the cases the care giver did not know whether the child could achieve certain milestones. When the child was present, the researcher proceeded to check with the child whether the developmental milestones where possible.

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3.8.3 Participant Observation

Participant observation formed part of the first phase of the research. Participant observation requires the researcher to take part in, and report on, the daily experience of the members of a group, community or organisation or the people involved in a process or event. (Welman etal, 2005:194) In order to be unobtrusive in the lives of the care givers (three respondents), the researcher only spent one afternoon with each caregiver and her children. When the researcher arrived at the home of the participant she made sure that the participants was comfortable with being observed. The researcher also explained that she would be making notes which she would share with them and explained why the participant observation was being conducted. The researcher spent approximately three hours at each of the three participant's homes. The researcher made notes and wrote a commentary after each session of participant observation. The researcher also got a sense of how the caregiver used the resources at their disposal, including self, to provide care to the young child. The participant

observation provided an opportunity to ascertain how personal, social and environmental factors came into play during the interaction between child and care giver.

The researcher documented:

- Activities/Events
- Environment
- Housing structure
- How climate affects behaviour
- Behaviours and interactions (with whom)
- What was said in conversation
- Where people position themselves in relation to each other/ issues of space
- Physical gesture
- Discipline
- Verbal behaviour /communication and interaction (tone of voice, effectiveness of communication)
- Physical behaviour and interaction (body language to communicate)
- Personal space
- People who stand out in interaction

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3.8.4 Second Phase

The researcher returned to the community about a week after the first visit. Due to the fact that travel costs to the Northern Cape Province are expensive, the researcher stayed in the community for a week to complete the second phase. During the second phase the researcher conducted interviews with service providers, as well as facilitated a focus group interview.

3.8.5 Individual Interviews with Service Providers

Seven interviews were conducted with service providers. Using a semi-structure interview guide with service providers the researcher gathered information about their organisation, its mission and vision, the services they provide, the target beneficiaries, the areas covered, their practical operation at satellite offices, whether they provided services to children under six, whether they thought that there were gaps in service delivery in the community, policy gaps

that could be addressed and finally whether they had any recommendations as to how to improve service delivery to care givers and children 6 years and younger.

3.8.6 Focus Groups Interview

The researcher conducted a focus group interview with seven caregivers that have children between the ages of birth to six years old. These caregivers were not the same caregivers that participated in the individual interviews. In a focus group the researcher directed the interaction or inquiry to gather information. During the focus group the researcher used the Participatory Learning and Action technique of mapping to allow the participants to map out the caring resources within their community. Adebo (2003) states that the purpose of community sketch maps is a visual representation of what the community perceives as their community space. This method takes into account that the community members are the experts in their area. The focus group proceeded in the following manner:

The focus group started off by the researcher making the participants feel comfortable. An ice breaker was conducted and allowed each person to introduce themselves. The researcher explained the purpose of the research and what was going to happen in the focus group. The first activity of the focus group was asking the group to draw a map of their community and where they thought the caring resources were located. After this process was completed these services were discussed, as well as barriers to accessing these services being identified. The gaps in service delivery were also discussed and the group prioritised what they perceived as most to least important. The group also discussed and depicted graphically who the support systems were that helped them to care for their children. The role of men and religion was also discussed to in relation to them being a resource for caring.

3.9 Difficulties Encountered during the Research Process

The distance from the researcher to the participants as well as the expensive travel costs from the Western Cape to the Northern Cape Province resulted in the researcher having to complete the entire field work process during a two week period. The distance between the community of Groblershoop and Upington also meant that a significant proportion of time was spent traveling, especially during the week when interviews with service providers was

conducted. This limited the amount of time the researcher spent engaging in participant observation.

When the researcher realised that she would not obtain sufficient information if she continued to tape the interviews, another plan of capturing data had to made. The researcher also had to think about how to verify the data that she was capturing, post the interview, and therefore reading back the interview to the participant proved to be an important method of verification of data captured.

3.10 Data Analysis

Since this is a qualitative study data was analysed simultaneously with data collection. Data was collected, coded, conceptually organised, analysed and evaluated (Sarantakos 2005:344). The semi-structured interview guide was structured according to broad themes and sub-themes, which assisted the researcher in the analysis of the information. The researcher consistently reviewed the data to ensure that it is within the context of the setting of the research purpose and employed a basic descriptive content analysis. Sections of data were identified that demonstrated some commonalities and then coded. Patterns and themes was identified and consistently refined as more data was revealed. Notes from participant observation were also analyzed and coded in the above way.

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The first step in the process of data analysis for the researcher was to transcribe all the interviews at the end of the day. The researcher then sought to validate the information by asking the participants to verify the transcript as a true account of the interview. Following the verification process the researcher started by grouping together similar responses from each interview. In this way potential broad themes were developed. The researcher then examined the research objectives and started organising the data in response to the objectives outlined for the study. The themes that emerged were examined thoroughly and interrogated against the literature review, as well as the theoretical framework. The Ethics of Care approach presented a framework against which to determine the adequacy of care given to children. The Human Capabilities Approach provided a theoretical framework against which

to analyse the social, personal and environmental factors of the caregivers, and how they perceive this influencing their ability to care for children.

3.11 Validity and Reflexivity

Validity refers to the measure of precision, accuracy and relevance of the research study (Sarantakos, 2005:434). The researcher ensured that the data received was accurate by going back to participants and checking relevant themes and patterns that were emerging to ensure that what was captured was what was intended by the participant. Another important factor which was taken into account when conducting research is reflexivity which is important in the process of ensuring validity. The social researcher is not a mere medium through which knowledge is discovered. He or she is a "constructor of knowledge" and therefore it is important to examine how the researcher's personal and social worlds lead to these constructions and how these constructions are subsequently used in the social world (Plummer, 2001:206). It was thus important for the researcher to reflect on the research process in relation to her own personal, academic, cultural and social space to ensure the validity of my findings. Plummer (2001) has identified three areas of bias which could arise during the research process - (a) the subject of the research, (b) the social spaces in which the research knowledge is produce, (c) the personal, cultural, academic, intellectual, historical factors of the researcher in actually building the research knowledge. This will be discussed below:

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3.12 The Researcher

As an experienced social worker, the researcher had the opportunity to work with women who were survivors of domestic violence. Through this time, the researcher was frustrated with the limited resources available to assist women and their children. For many people, including the researcher, who grappled with understanding of why these women do not leave these abusive relationships, the researcher was able to see how limited resources impacted on their decision to stay or leave through her work with these women. This initiated the researcher's interest as she realised that women largely assume the caring role in society and have the responsibility of the children, whether this is their choice or not.

As a child growing up the researcher's father developed cancer and was sick for most of her childhood years. The experience of working with survivors had awoken her memories of her own childhood as her mother looked after her sick father, and all of the six children. The researcher remembered how her mother had to hold down a job, see to her husband and his health care needs as well as to six children who were at various developmental ages. Growing up was about meeting basic needs and luxuries were a rare treat. Although the researcher did not understand the stress of the whole situation at the time for her mother, she remembers how difficult it was for her mother and how worried she always was. This meant that she never really had much time for play and as a child. The researcher always yearned for her mother's undivided attention.

When the researcher started conducting community work in the town of Groblershoop, she identified with the plight of the women in the community as they struggled to care for their children. She also started realising that there are various factors that affect a person's ability to care. Working in the community where the climate is excessively humid made the researcher feel consistently tired and she realized that it must be difficult to still have the responsibility for caring for children. She also started wondering whether her own mother suffered from depression, and often was just too emotionally burdened by her own feelings to cater for the needs of the researcher as a child.

By virtue of the fact that she worked within the community for a long time before undertaking this study, the researcher had already established a rapport with the women. This helped them, to some degree, to share their stories with her. The researcher was always aware of her cultural differences and was careful not to judge the community from her cultural perspective. The researcher was raised in a conservative Indian family that practiced Islam as a religion. The practice of Islam forbids having children and sexual contact outside marriage and the researcher became aware of the differences in culture where it was apparent that having children out of wedlock was common in the Groblershoop community. During the research process the researcher made extensive field notes to guard against becoming "too familiar" and taking information or experience for granted or as "normal".

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3.13 The Subject of the Research

As the researcher is not a parent herself, the researcher had to guard against making assumptions about parenting, as well as judging the participants if they do not conform to the researchers own understanding of the issues being studied. The researcher did however know what it was like to be cared for and in this way could relate to the participants being studied. The researcher also had to guard against the participants providing her with "expected" answers to her questions which may not necessarily reflect the reality of the participant's life. Initially, when the researcher attempted to record the interviews, the answers that she received were superficial and mono worded. Deciding to abandon the recording device changed the dynamics of the interview and allowed the participants to open up. The participant observation process enabled the researcher to pick up on cues which may not have been apparent during the individual interviews. It also helped the researcher to check for congruency between what the participants had said in the individual interview around social, personal and environmental factors, and how this plays itself out in their interaction with the children.

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3.14 The Social Spaces in which the Research took Place

All the interviews took place in the homes or just outside the homes of the participants as it was too hot to sit inside. While this was advantageous, as it helped the participant to feel safe and comfortable, there were numerous distractions in the environment. The children themselves were present in all the interviews, and often this meant that they would be jumping over the researcher, trying to look into the researcher's notes or crying to write with her pen. At some point during the interview the researcher gave the children paper and pencils to draw with. This seemed to make the mother more comfortable and the children were less distracting. Focusing on the child's ability to draw also assisted the researcher in making an assessment about the child's developmental milestones. The interviews took approximately an hour and a half, and the researcher realised that she could not push the participants beyond this as they became restless and less willing to engage. Keeping the interview within the agreed upon one and a half hours prevented boredom by the participants.

3.15 Ethical Considerations

The research complied with the strictest ethical standards as per the South Africa Council for Social Service Profession's Code of Ethics as is commonly used within the discipline of social work. The research abided by the following ethical practice:

- The research will do no harm. Its intention is to achieve an understanding of the context in which caregivers provide care to young children in order to ensure that interventions remain relevant, and takes into account the diversity of each caregiver. The researcher did not exploit the situation of any of the respondents in any way, and conducted herself in a manner that ensured her professional integrity.
- Confidentiality was assured as the study was conducted with participants who were willing to participate. The anonymity of the participant was protected and no real names were used when documenting the interviews. The participant was requested to give signed informed consent around whether they will allow the researcher to record (manual recording) the interview. All raw data was stored in a locked cabinet. All computer files were protected by passwords.
- Participants were told that they could withdraw at any stage, or ask that certain information not be used.
- The researcher referred the participant to the relevant community resource, when the need arose during the research process.
- The researcher was open and upfront with all participants and the research process was honest, transparent and ethical.
- The researcher has protected and respect the privacy of the participant at all times by ensuring that their personal information is protected and confidentiality is assured.
- The researcher has also provided those caregivers who participate in the research process with parenting skills training which was be provided by the Centre for Justice and Crime Prevention. The results of the research will also be fed back to the relevant role players and will be considered when the CJCP conceptualised programmes aimed at care givers.

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4 Chapter Four: Findings and Discussion

4.1 Introduction

In Chapter Three, the researcher presented the research design which was employed to gather data. In Chapter Four the findings of the research are presented and discussed. Chapter Four draws on information from the interviews with the ten caregivers during Phase One of the research process and the information obtained is arranged around the key themes that evolved from the semi-structured interview guide. Where appropriate and to provide a richer perspective, the results also refer to the information obtained from the interviews with service providers, the focus group with caregivers and the participant observation process which formed part of Phase Two of the research. The reporting of all these findings enables the researcher to provide the reader with a composite picture of the factors which influence care giving from the perspective of the caregiver to children from birth to six years within the Groblershoop community. To ensure confidentiality the full identifying details of participants are not used in this study to protect identity of the respondents.

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4.2 Chapter Outline

The aim of the study was to explore the caregiver's perceptions of personal, social and environmental factors that influence their ability to provide care to children from birth to six years by exploring the:

- Physical and mental health, gender, educational and literacy levels of the caregiver
- Social norms of society, public policy and gender roles taken on by the caregiver
- Climate, infrastructure and material resources available for caring in the Groblershoop community
- Use of resources that are available to caregivers to provide care to their children
- The needs of caregivers to enhance their ability to provide care

This chapter consists of two sections. The first section will provide a description of the key informants (ten caregivers) by building on the information presented in Chapter Three. In the second section the results of the study will be presented, showing the main trends, patterns and connections. The discussion is presented according to the themes identified, and draws on the different participants who were interviewed to substantiate the findings. Thus, the findings as stated by Yeh et al (2007) take the form of a presentation of themes which provide meaning to the data which was collected. In this chapter, the researcher intersperses the arguments presented with verbatim quotes from the participant, to provide corroborating evidence. The data presented will be analysed using the Human Capabilities approach and the Ethics of Care perspective as a lens to make sense of the emerging themes and patterns. The findings of this study are limited to caregivers from the community of Groblershoop and cannot be generalised.

4.3 Section One

4.3.1 Biographical Information of Key Participants (ten caregivers)

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In this section an overview of the biographical details of the ten caregivers will be presented using tables and graphs for ease of reference. This section will provide a description of the caregivers, the children six years and below, as well as the caregivers' household type. The caregivers that were interviewed were all female and Afrikaans speaking. Their ages ranged between 18 and 49 years old. All the caregivers were the biological mothers of the children, except for Johanna who was the maternal grandmother. The table below depicts the age of the caregiver and the number[4] and ages of children six years and below, in their care.

Table 2: Demographics of Caregivers involved in the Study

Name of Caregiver	Age of Caregiver	Name of Child	Age of Child
Francina[5]	32 years	Dalyn	5 years
Charmaine	25 years	Shannon	5 years

[4] Only the children 6 years and below are listed in the Table 2. Some caregivers have more children but they are older so will not be listed as part of Table 2.

[5] All the participants and their children have been given pseudonyms.

Linda	42 years	Clivano Macnic	4 years 6 years
Leana	24 years	Elvino	2 years
Getruida	38 years	Tasleemah Shumeez	5 months 4 years
Mellisa	19 years	Kaitlin	2 years
Heidi	18 years	Jaselin	2 years
Johanna	49 years	Jovani Jasmine Ignasius	4 months 2 years 4 years
Vinta	24 years	Madelaine	5 years
Rochell	31 years	Xander	2 years

Two of the caregivers were young mothers, which is a typical phenomenon in the community of Groblershoop. Johanna is grandmother to three children below the age of six. Her daughter was 18 years old when she gave birth to Ignasius. Six of the ten mothers were 20 years and below when they gave birth to their first child. Linda has two other children older than six years, with her eldest daughter being 22 years old. The nursing sister at the local clinic cited teenage pregnancy as one of the major reasons why young girls leave school, and do not return (personal interview). This was supported by respondents from FAMSA and Child Welfare Groblershoop.

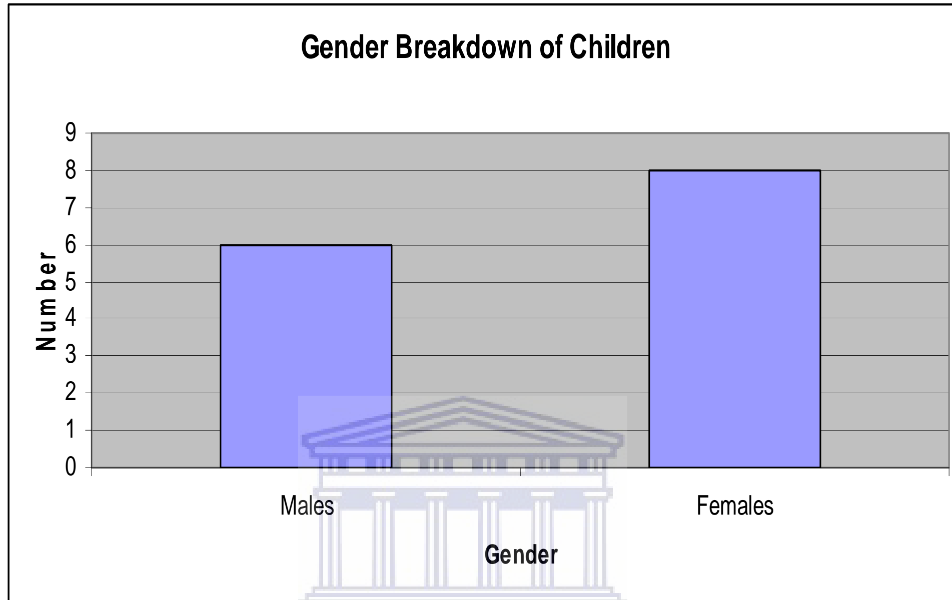
> *"Many young girls engage in sexual relationships with older men in the community. The reason for this I think is that the older man is able to entice these young girls with money or promises of clothes and nice things. When the girls get pregnant however the men are nowhere to be found"*
> (Personal interview with FAMSA social worker)

> *"One of the big problems facing our youth in Groblershoop is the thing about teenage pregnancy. So many girls get pregnant before they reach matric and then*

they don't go back to school. The girls then leave the babies with their mothers and are forced to look for work."

(Personal Interview with Child Welfare Groblerhoop community worker)

Figure 6: Gender breakdown of children



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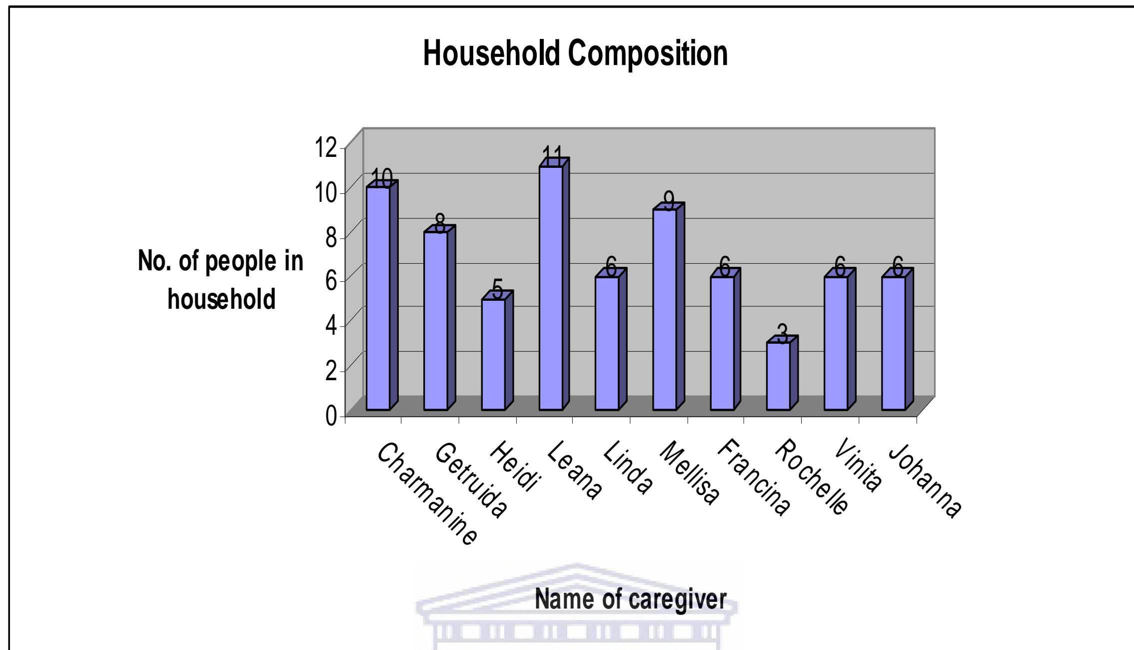
Only three of the ten caregivers had more than one child in their care. Six of the children were males and eight were females. The youngest child in this study was four months old and the oldest was six years.

4.3.2 Household Composition

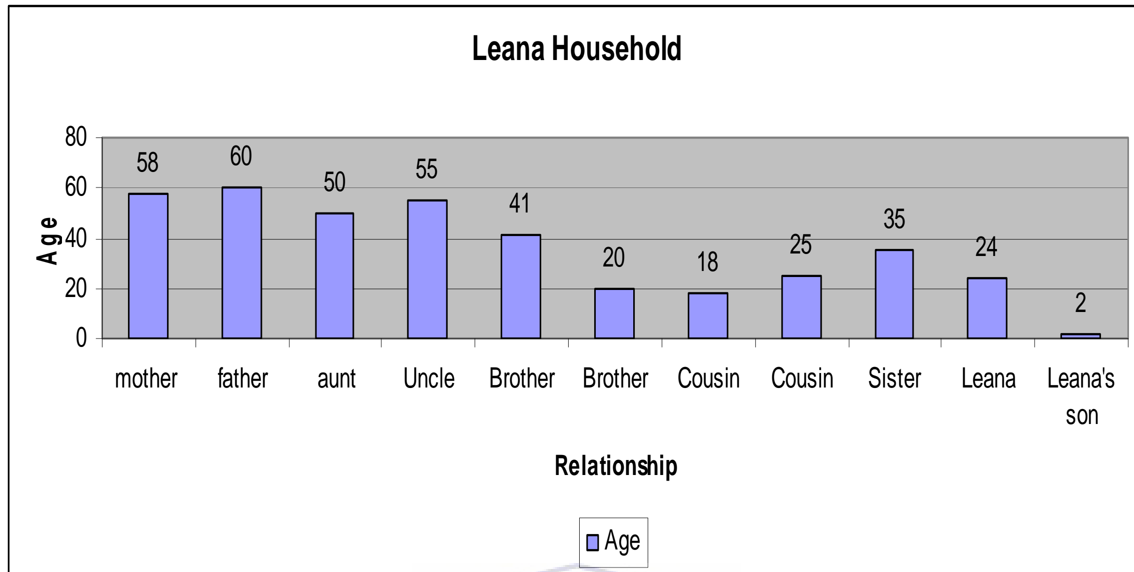
The graph below depicts the number of people who live in the household, including the caregiver and the children.

Figure 7: Household Composition of Caregivers



Given the size and type of housing structures, as depicted in Chapter One, the number of persons in the household suggests that overcrowding is a problem for many families in Groblershoop. The largest household size amongst the caregivers compromises eleven persons, while the smallest household size compromises three persons. All the caregivers interviewed stated that due to the extreme heat in summer, beds and mattresses are placed outside, while in the winter due to the extreme cold, families huddle together inside and virtually "sleep where they find a space". This raises other issues for children including those affecting their health and developmental growth.

Figure 8: Leana's Household



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The graph above depicts a typical household. Most households included extended family members e.g. brothers, sisters, aunts, uncles and children of siblings. In eight out of the ten households the maternal mother lived with the family, while in four households only the maternal father was present in the household. In only two households, the caregivers shared the household with their live in boyfriends. The phenomenon of leaving children with grandmothers is a typical situation in Groblershoop. Maternal grandmothers are left to provide care to young children as work within the community is scarce, and most of the biological mothers go out in search of work. This often means that they would need to move to the larger towns i.e. in Upington, Kimberly or Bloemfontein.

4.4 Section Two

This section will present the findings of the study in a thematic manner and will offer an analysis drawing on the Human Capabilities Approach and the Ethics of Care perspective, as a lens in which to consider and explore the data. Sen (2001), using the Human Capabilities Approach, has identified three factors namely the personal, social and environmental, which interact and affect the person's ability to achieve functioning. These factors according, to

Sen (2001) determine how the person will be able use resources to develop their capabilities. While the Ethics of Care perspective emphasises that resources are critical to be able to provide care in a competent manner, the capabilities approach states that resources in themselves cannot bring about quality of life (Nussbaum, 2000; Sen, 1984). The personal, social and environmental factors influence how an individual consumes resources. This would further imply that some individuals would require additional resources to reach the same level of functioning (Sen, 1984).

4.5 Personal Characteristics of Caregivers

This section will explore the physical, sexual and mental health of the caregiver; including substance usage, educational levels and income, and spending patterns.

4.5.1 Physical Health

The World Health Organization, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) estimate that 529,000 maternal deaths occurred globally in the year 2000, with the highest number of death occurring in Africa and Asia (Lange etal. 2005). According to Kaplan in Moghughi and Long (2008) parental illness appears to be a risk factor that makes the child more vulnerable to developing emotional and behavioural problems. The way that this risk operates may be direct (for example, a genetic predisposition for an illness) or indirect, through the effects of parent's illness on their behaviour towards their children; or the complication that can arise as a result of parents' hospitalisation. None of the caregivers interviewed in the study had any physical disabilities. Four caregivers reported poor health and cited hypertension, back problems, arthritis, low blood and asthma as the reasons for this condition. Two of caregivers' condition were considered to be chronic, and both currently have been medically boarded (and declared unable to work) and are in receipt of a disability grant. All of the caregivers stated that they treated their conditions with regular daily medication. The caregivers who experienced asthma and arthritis said that their condition became increasingly chronic and painful during the winter months (due to the cold).

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"During the winter I am always sick. My chest troubles me so much because it is so cold in these houses and sometimes it even leaks when it rains. I cough the whole night long and get no really help from the clinic. So what can I do I have to just live with this condition?"

The caregiver who has arthritis said that some mornings she experiences painful joints in her finger, and she is unable to do anything. She has to plan her day based on how she feels and can only tackle housework when her pain is not as acute and she has the full use of her hands.

"My arthritis is so bad that some days I can't do anything in the house or for the children. I have to use the days when I feel okay and can use my hands to do the washing and cleaning. It is very hard"

The caregiver with the back problem also said that she is limited in terms of the amount of housework she can do in a day. Her back condition stemmed from her work at the local abattoir. The cold conditions in her workplace aggravated her condition, and she later had a back operation followed by a full hysterectomy, due to the problems experienced with the back. She is now experiencing menopause and states that the hot flushes and mood swings significantly affects her and she struggles to sleep so feels more agitated and exhausted.

"Some days I wake up and feel like I don't want to face the day. My back gives me lots of trouble and there are days when I can't do anything. I hate this menopause. I feel moody and depressed and get such hot flushes that I can't sleep at night making me feel even worst during the day."

The caregivers' who reported that they had poor health, were asked whether they thought that their illness affected their ability to care for their children. They indicated that the way they feel physically affects their ability to look after their children. This was due to not feeling well, and the children are left to fend for themselves.

"On the days that I don't feel well the children just play around outside and my neighbour will watch out for them. When they are hungry, the oldest boy makes jam and bread sandwiches for the two younger ones."

Research indicates that when parents experience chronic physical ill health there is a risk that the child becomes the carer. As stated by Kaplan (2008), when a child takes on age-

inappropriate responsibility, the boundaries of who manages who may be broken down. There is often a role reversal to a major degree in the burden of care and the child may have few opportunities to enjoy the normal activities of childhood and to receive the kind of care that the child needs.

4.5.2 Sexual Health

The sexual health of the caregivers is of significance and can have long term effects on their quality of life, and their ability to care for children. According to the latest (2008) WHO and UNAIDS global estimates, women comprise 50% of people living with HIV. In sub-Saharan Africa, women constitute 60% of people living with HIV. Eight of the caregivers reported having been tested for HIV/AIDS. All the caregiver's result was reported to be negative. Only two caregivers had been tested for a sexually transmitted disease, one caregiver tested positive and underwent treatment for the disease. When asked whether the caregivers practice safe sex, all the participants said that they knew about HIV/AIDS, but were unable to insist on condom use.

> *"My boyfriend doesn't use a condom. When I ask him to he says it's my responsibility to take care of the contraception."*
>
> *"My boyfriend says that I am having an affair if I insist on him using a condom, so now I just don't ask anymore because I am tired of convincing him that I am faithful."*
>
> *"People die of this AIDS sickness. I know that there is no cure, so the sisters at the clinic says you must be careful"*

Violence against women (physical, sexual and emotional), which is experienced by 10 to 60% of women (ages 15-49 years) worldwide, increases their vulnerability to HIV (WHO, 2008). Forced sex can contribute to HIV transmission due to tears and lacerations, resulting from the use of force. Women who fear or experience violence lack the power to ask their partners to use condoms or refuse unprotected sex. Fear of violence can prevent women from learning and/or sharing their HIV status and accessing treatment. Women may face barriers due to their lack of access to and control over resources, child-care responsibilities, restricted mobility and limited decision-making power. Socialisation of men may mean that they will

not seek HIV services due to a fear of stigma and discrimination, losing their jobs and of being perceived as "weak" or "unmanly".

When asked what they knew about HIV/AIDS and sexually transmitted diseases the caregivers demonstrated limited knowledge about their sexual health, and the long term consequences of contracting HIV/AIDS. The caregiver who had contracted a sexually transmitted disease was unable to demonstrate an understanding of what the implications of the disease meant for her, her partner or her relationship.

> *"I got herpes and got treated by the clinic. I am not sure why one gets this disease. The sister at the clinic just told me not to have sex until it clears and asked me to ask my boyfriend to come to the clinic. I am not sure if he went or not. But I am fine now."*

Gender inequality is a key driver of this HIV epidemic. Gender norms related to masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women. In some settings, this contributes to higher infection rates among young women (15-24 years) compared to young men (WHO, 2008). Norms related to femininity can prevent women – especially young women – from accessing HIV information and services. Only 38% of young women have accurate, comprehensive knowledge of HIV/AIDS according to the 2008 UNAIDS global figures. In South Africa, across age groups and sexes less than half of all people knew of both the preventative effect of condoms and that having fewer sexual partners could reduce the risk of becoming infected. (www.avert.org/aidssouthafrica)

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4.5.3 Mental Health

According to Bray etal (2005) the mental state of carers has important implications for the caregiver's emotional responsiveness to their children. Four of the caregivers stated that they were depressed, with two of the caregivers having experienced post natal depression. Of the two caregivers that experienced post natal depression, only one was treated professionally for their condition.

> *"I felt terrible after my pregnancy and hated my child and myself. I just couldn't cope with the crying baby and myself."*

Only two of the caregivers reported having difficulty sleeping, with one woman stating that she suffers from insomnia. Six caregivers stated that they either overeat or have no appetite. For most of these women this is a regular feature of their lives. For those caregivers that said that they overeat, they stated that they feel comforted by food and therefore overindulged.

> *"When I feel sad eating makes me feel good. I have this hole in my stomach when I feel sad and I am driven to eating to make me feel better. I will start to think about food all the time."*
>
> *"When I am sad I lose my appetite and then I have no energy"*

Nine caregivers reported that they were consistently anxious, while seven stated that they regularly feel like they have no energy to the point that they do not want to get out of bed. Feelings of anger (most of the time) were common for eight caregivers and they cited reasons relating to children, family members, self-anger, financial and social circumstances as the causes for feeling angry. When asked to describe their personality, two of the caregivers described their personality as being aggressive, while two other caregivers described themselves as" *introverts, withdrawn, worrier*." A number of caregivers described themselves as "*hardworking and responsible*." Six caregivers stated that they feel confused on a regular basis because they often feel like things are beyond their control; while two of the caregivers said that they feel lonely and unsupported.

> *"Some nights I wake up sweating and feeling so scared and anxious, I cannot go back to sleep. I start to think about my life and my family and I become even more afraid."*

An interesting observation is that all caregivers admitted to experiencing signs of depression and anxiety, even though when asked directly if they were depressed only four caregivers were able to identify with this condition. Depression according to Lange et al (2008) is a major health issue and burden among women and appears to be especially prevalent in women, during pregnancy and in the post partum period. Depression following pregnancy can adversely impact the mother-child attachment and other family interaction. Depression during pregnancy can lead to physiological effects that are detrimental to prenatal development and are associated with low infant birth weight and prematurely.

4.5.4 Coping with Emotions

All the caregivers interviewed said that they felt hopeful for the future, and listed the following reasons for this:

"Serious about building a future. I registered at the DoE for part time studies"

"I must make a life, I have a child"

"Things can change"

"I am young and going back to school to get matric and have a future"

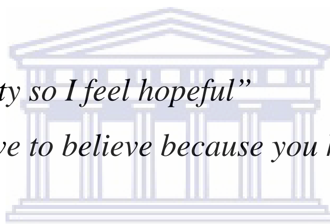
"Life gives me hope and my children give me hope"

"I feel hopeful because the doctor is looking after me but I must look after myself. Looking after my grandchildren is important. They only have me as their mother drinks a lot"

"I want to become a nurse and help people. I got a second chance and I decided to use it to make my life better"

"Getting work is a possibility so I feel hopeful"

"If you have a child you have to believe because you have to look after him"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Many of the caregivers cited that their children provide them with a sense of hope and the motivation to carry on with their lives, despite their difficult social circumstances. According to Lange (2008) having hope for the future as well as being able to employ coping strategies when feeling depression, are important determinants in ascertaining whether clinical depression has set in.

When asked about how the caregivers coped with their feelings of sadness the following responses were recorded:

"I talk to someone – other people company helps"

"I must admit that when I feel this way I become argumentative with my family"

"I take a walk – need to have some time to myself"

"I sit quietly to calm down"

"I am unable to take action – I isolate myself and then call my mother"

"I talk to my sister- she gives me advice."

"I cry and then go talk to my friends"

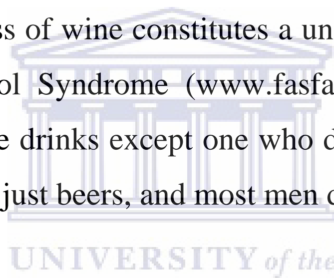
While it is clear that a significant number of caregivers have signs of depression, their ability to cope with the feelings of sadness is not in anyway self destructive. Each caregiver appears to have some means of coping with the way they feel. It is clear that family and friends play a very important role of providing emotional support. All the caregivers interviewed indicated that they had friends. When asked if they have any influence in the lives of friends and family, three caregivers reported that they felt like they had no power to influence anybody. The remaining seven caregivers stated that they had the power to *"influence friends. My friends respect me"*. One woman also stated that friends do not always positively influence ones life "*My friends don't always positively influence me. Sometime they want you to do something that is wrong for you"*. Many of the caregivers were also able to provide a source of support to their friends, *"I have a great influence in their lives – everyone talks to me about their problems"* while it was clear that for most women friends was also a great source of support, "*Friends play a very important role – they provide support and I can rely on them"*.

Family is also an important source of support and a very critical caring resource. Many of the women said that their family assists them "*not only financially but provides support and relief with regards to child care."* Many care givers rely on sisters and mothers to assist them in providing care to their children. *"I love my family – they are important and I consider them in all my decisions"*. *"My family helps me when I am troubled"; "my family gives me advice."* The support systems of caregivers will be explored in more detail later in this chapter.

4.5.5 Alcohol Consumption

A serious consequence of alcohol use by pregnant women is that it may lead to Fetal Alcohol Syndrome (FAS). This disorder - the impact of which stays with affected children their whole lives - is solely attributable to the harmful effects of drinking alcohol during pregnancy. And its consequences are severe: the alcohol a mother consumes during her pregnancy damages the developing brain, resulting in mental retardation. Children with Foetal Alcohol Syndrome struggle to learn and reason. It also causes abnormalities in the

nervous system, organs and limbs, and leads to characteristic facial features. According to the Medical Research Council (2008) the impact of Fetal Alcohol Syndrome seems to be the highest in the Northern Cape Province. Results from a study in the town of De Aar showed that 122 out of every thousand children starting school were affected - officially the highest frequency yet reported in one population in the world (www.fasfacts.org.za). Five of the caregivers interviewed in this study stated that they drink alcohol. When asked how much they drink many women say they are *"social drinkers"*. However, this term varies in terms of the actual quantity of alcohol consumed. The women stated that they *"drink between 3 -6 beers on a Friday and Saturday"*. Three of the caregivers stated that they consumed alcohol during their pregnancy. When asked how much they consumed many said a *"couple of beers*", some said that they drank *"6 beers"* over a weekend. According to FAS FACTS, a non governmental organization working with Foetal Alcohol Syndrome, 3 to 4 units of alcohol per time (1 beer or glass of wine constitutes a unit) during pregnancy can lead to the development of Foetal Alcohol Syndrome (www.fasfact.org.za). All the partners of the caregivers drank more than five drinks except one who did not drink. The women also said that they drank hard liquor, not just beers, and most men drank over weekends.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An interesting observation was noted by the researcher. When asked about the coping strategies for dealing with feelings of depression, all the caregivers reported that they rely on the support of family and friends. However, when asked why alcohol is consumed the women said the following:

"Alcohol helps me forget when I am feeling sad"

"I drink alcohol because it is common practice in the community and it is the way to socialize"

"I drink alcohol because it helps me to forget my problems and then I feel as if I can deal with anything."

It was evident from above that alcohol is also used as a mechanism to cope with difficult life situations, and help the caregivers to forget their problems. Of concern is the consumption of alcohol during pregnancy. This could account for some of the developmental difficulties experienced by children, which will be covered later in this chapter.

4.5.6 Income and Employment Status

Of the ten caregivers interviewed only three women were employed, and only one woman was employed fulltime. Of the remaining two caregivers, one woman did part time domestic work and one stood in for teachers who were absent from school. Two of the caregivers interviewed were young mothers aged 18 and 19 respectively, and both returned to school after giving birth. When asked what the impact of unemployment was on their lives, the women listed the following responses:

> *"Can't meet all the needs of the child. Can only give bare essentials and nothing else".*
>
> *"I am dependent on my mother. Even though I get a child support grant, I still can't manage to see to all my needs and the needs of my child"*
>
> *"It has a "huge impact on my life"*

Two of the caregivers that were unemployed received a disability grant and some money from their partners. They said:

> *"I receive a disability grant and my partner gives me money. I am better off than most families here financially"*
>
> *"It doesn't have a huge impact on me, I receive a disability grant"*

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One of the woman said that *"my family sees to my needs"* so unemployment doesn't affect her significantly.

4.5.6.1 Grants

Of the ten women interviewed seven currently receives the Child Support Grant. Two of the women receive a disability grant for themselves and one of the participant's mothers receives an Old Age Pension (which contributes to the family's monthly income).

4.5.6.2 Spending Patterns

The table below indicates the household income and expenditure of each respondent per month.

Table 3: Household Income and Expenditure of Caregivers who are unemployed

Respondent	**Household income per month**	**Source of Income**	**Expenses**
Johanna	R2490	R840 – DG R150-daugther R1100 – Boyfriend R400 - CSG	R205-Water & services R250 – Furniture account R100 –Electricity R1935 - food
Vinita	R300 + dad income?	R300 – maintenance from child father Father is an educator – Respondent not sure how much he earns	R20 – school fees R100 – clothes R180 – give for food and electricity to dad
Leana	R800	R800 – maintenance from child father	R800 – Food and toiletries for child and her
Getruida	R600	R600 – CSG *When she gets a contract she earns R8000 per month but she is currently unemployed.*	R200 – water R200 – electricity R100 – foschini R100 – Truworths R2000 – Food
Heidi	R1270	R200 – brother R200 – CSG R870 – old age pension	R50 electricity R150 – Food Not sure what mom does with the rest of the money
Mellisa	R700	R200 – CSG R500 - sister	Not sure what the mom spends money on
Moeksie	R1840	R600 –CSG R400 – maintenance R840 – disability grant	R150 Water R300 Furniture R100 electricity R1290 Food

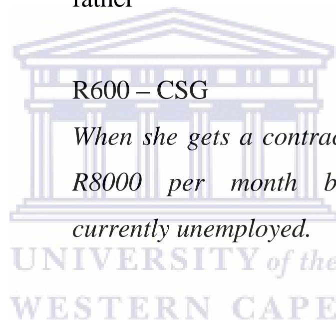
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Table 4: Household Income and Expenditure of Employed Caregivers

Respondent	Amount per month	Source of Income	Expenses
Charmaine	R680	Does part time work as a relief at school. R200 – CSG R280 – payment from school R200 – maintenance(not regular)	R20 school fees R100 -Blanket account R50 electricity R510 - food
Linda	R530	Does part time char work R130 – Char work R400 - CSG	R40 Water R40 Electricity R450 - Food
Rochelle	R8800	Works as a project officer at an NGO R8800	R800 rent Car – R2400 R100- School fees R1500-Petrol R4000 – food and clothing

Only four of the women receive maintenance from the biological father of their children. The highest income per month amongst the employed women is R8800, while the lowest income is R530. The highest income received by women who are unemployed is R2490, while the lowest income received is R300. The caregiver who is in receipt of a disability grant has a substantially higher income and even more than the women who is part time employed as a domestic worker. The old age pension of the mother of one of the care givers also substantially raises the income of the family per month. When asked what the women spent the child support grant on many participants said food, electricity and when it is really necessary clothing. An interesting observation made is that even though many participants admitted to taking a "*social drink*," this was not listed as part of the expenditure. When the researcher asked those women who said that they drink they were reluctant to be more specific about how or what percentage of the money is actually spent on alcohol.

"I spend very little money on alcohol"

"I go to the shebeen and then see who will buy me a drink"

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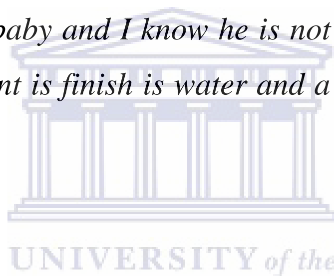
It was apparent that the women did not engage in a budgeting exercise and spent the money based on what they thought was needed at the time. The researcher was told that when the food money was finished, the children just have to wait until more money comes in.

> *"When the money for food is finished, I see what I can do to feed the children. Sometimes we just have to wait until we get money again"*
>
> *"My children get some food at school and then when the money is scarce we just eat bread and jam all the time"*

Many children survive on the food received at school through the school feeding scheme, and when the money is scarce continue to eat bread for supper. The younger children who are at home often breast feed until four years old, and the caregiver would often sacrifice their food to ensure the child has something to eat. Breast feeding is also difficult when the caregiver has not eaten, and so the child is often not satisfied after having being breast fed.

> *"Sometimes I feed the baby and I know he is not getting enough. All I live on when the money from my grant is finish is water and a slice of bread if there is. It is very difficult"*



4.5.6.3 Educational Level

The following table shows the educational level of each respondent and sites the reasons for leaving or not completing secondary school.

Table 5: Educational and Literacy Level of Caregivers

Respondent	Highest Std. Achieved	Grade left school	Reasons for leaving/ not completing	Literacy levels	Further Education/ courses
Johanna	Grade 7 (STD 5)	Grade 8	*"Parents could not afford to send me to school"*	Can read and write	None
Vinita	Completed Matric	completed	*"Did not complete university education*	Can read and write	B(ed) – HDE Kimberly – completed

			because I could no longer afford it.”		2 years
Leana	Grade 10	Grade 11	*“lazy to learn”*	Can read and write	Yes – IEC course – voting process
Getruida	Matric	Completed matric	*“wanted to study further but had no money”*	Can read and write	Yes – Pre school course in Kimberly
Heidi	Grade 9	Grade 10	*Got pregnant*	Can read and write	Back at school completing matric
Mellisa	Grade 11	Grade 10	*Got pregnant*	Can read and write	Back at school completing matric
Moeksie	Grade 9	Grade 8	*I got pregnant*	Can read and write	none
Charmaine	Grade 11	Grade 12	*“ I failed grade 12 and didn’t want to go back to school”*	Can read and write	Yes – governance board training
Linda	Grade 7	Grade 8	*“ just didn’t want to go back to school”*	Can read and write	none
Rochelle	Completed matric	Matric	*n/a*	Can read and write	BA (social science)

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Three of the ten caregivers had matriculated, while two of the caregivers were currently completing grade 12. Only two of the ten caregivers had tertiary education, with only one participant being able to complete a full degree. It is important to note that this participant's place of origin is Vredenburg in the Western Cape, and she cited her move to Groblershoop because of work purposes. Three of the caregivers stated that they got pregnant while at school. This is an indication of the broader problem of teenage pregnancies in the community. The motivation for girl children to complete school appears to be low and three participants said they *"just didn't want to go back to school"*. Financial reasons were another factor that contributed to girls having to drop out of school. Three caregivers said that their parents could no longer afford to keep them at school. There is also very limited opportunity for people to do additional courses. Five of the caregivers stated that they had no exposure to opportunities for further skills development. The educational levels of the caregivers are very closely tied to their employability and income levels. Employment is dependent on the opportunities available within the community. Presently employment opportunities within the community are very limited. The local abattoir, the municipality, small businesses and the surrounding farms are the major employers in the community. The farms surrounding the communities are largely grape farms and the work opportunities are seasonal and unemployment is rife.

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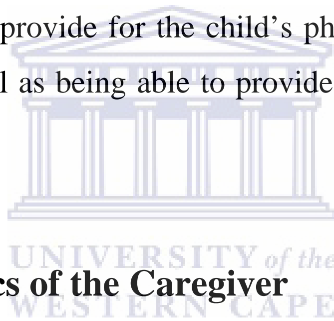
For the caregivers interviewed in this study, the personal circumstances have affected their ability to provide care to their children. Caregivers who were experiencing poor health were unable to effectively look after their children as their quality of life was poor, because they felt ill most of the time. The lack of education, severely limited the caregivers ability to earn an income. It was apparent in this study that the more educated the caregiver was the better the opportunity for employment. Household income was also dependent on who lived in the household at the time. The findings from this study corroborates with the study conducted by Ally-Schmidt (2005) among poor female headed households in Ceres who also concluded that the household income was dependent on the number of inhabitants at the time. The researcher does not wish to suggest that this is the fault of the caregivers that they were unable to change their personal circumstances, but in fact blame could be laid at the doors of the State who failed to make services available and accessible to those communities who are

not only poor but marginalised (by distance to urban centres). The distance to a medical facility in Upington is one such example where inhabitants from Groblershoop had to travel to reach an essential service. Exploring this argument further, the political ethics of care as espoused by Tronto (1993), Sevenhuijsen (2000), Kittay (2002) foregrounds the provision of services and conducive social policy as being central to the adequacy of care in a society. The lack of job opportunities, poor health provision within the community and the lack of services in relation to mental health all have negative consequences for caregivers in this study. Social security is available to caregivers. However it does not adequately provide for the needs of those who do the care and those whom they care for. Using the Human Capabilities lens one can identify that the functioning of the caregivers has been severely limited by the personal factors relating to their health, educational levels and ability to earn income, as well as their substance usage. This further implies that elements of the caregiving process, such as being able to provide for the child's physical needs, being able to monitor and supervise the child, as well as being able to provide structure and routine to the child's day is severely impacted.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4.6 Social Characteristics of the Caregiver

The political ethics of care perspective as outlined by Tronto (1993) posits that caring has four phases and corresponding values attached to each phase (this has been elaborated on in Chapter Two). The four phases as developed by Tronto (1993) refer to i) identifying the care needs ii) taking responsibility for those needs that are identified iii) doing the actual caregiving work and iv) receiving care. For each phase a corresponding value has been identified, namely: attentiveness, responsibility, competence and responsiveness. Tronto (unpublished) has presented a set of questions which are useful in assessing the adequacy of care in relation to the caregiver, the context of caring as well as the resources available for caring. In the following discussion the researcher will present the data in response to some of the questions developed by Tronto (unpublished) to assess the adequacy of care. The questions are outlined below:

- What care is necessary? This question seeks to establish what minimum standards of care are required to ensure the survival and development of the child.

- What types of care currently exist? This question seeks to unpack the levels of support and services available to caregivers in Groblerhoop.
- How adequate is the available care? Here the researcher using the gaps outlined by various service providers attempt to assess how adequate are the care resources.
- Who articulates the needs and what problems should be cared about? In this section the researcher unpack public policy as it relates to the provision of caring resources.
- Who are the caregivers? The researcher looks at who the caregivers are in relation to the gender practices and parenting undertaken.
- What is the impact of the caregiving on the care receiver? The researcher seeks to unpack what effect the caregiving has on the children.

4.6.1 What care is necessary?

According to Bray etal (2005) the significance of the quality of early caregiver relationships to children's social and emotional development is well established. UNICEF diagramatically proposes the following model of care represented below:

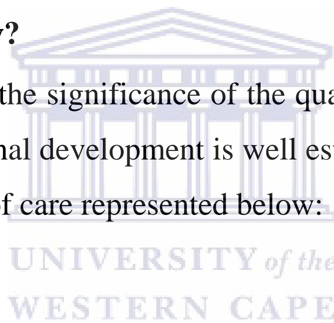
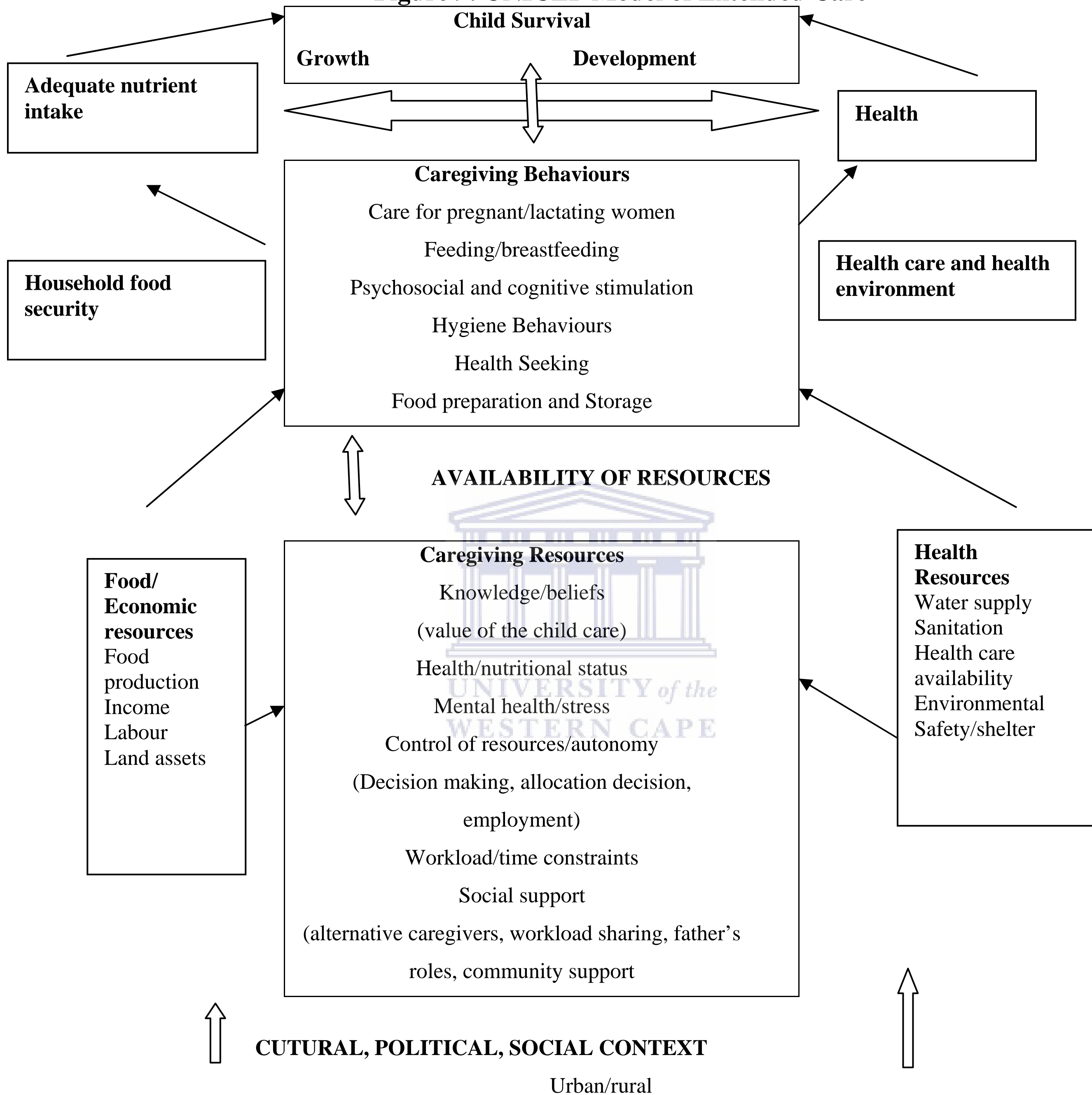


Figure 9: UNICEF Model of Extended Care



Source: World Health Organization. 2004 The Importance of Caregiver-child interaction for the survival and health development of young children.

In the UNICEF model, caregiving behaviours are mediators between the social, health and caregiver attributes and the child's survival growth and development. Caregiving is also a

key determinant of the quality of the environment provided for children. The World Health Organization (2004) goes further to identify five primary caregiving functions that cannot be separated from one another, and deemed as the necessary requirements for care of young children from birth to six years old i)Sustenance, ii) Stimulation iii) Support iv) Structure, and v) Surveillance. Taking these five functions into account the researcher will reflect on the data to establish what care is necessary.

4.6.1.1 Sustenance

According to the literature (WHO, 2004) sustenance refers to the provision of food and shelter. This is important for the physical and developmental growth of the child and lays the foundation for which social and cognitive development will take place. Seven of the caregivers were recipients of the Child Support Grant. When analysing the expenses of the caregivers a large proportion of the income was spent on food for the household, however there appeared to be a disjuncture between what they say they spend the money on and the social activities they participate in for example drinking at the local shebeen. Many of the caregivers stated that their children participated in the school feeding schemes.

> *"At least my child gets food at school. Then if there is no food at home they had one meal per day at school."*

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Many of the caregivers also stated that feeding the family was their major concern, and when the money is depleted, they have to make a plan to feed the children. This often means that they themselves eat no food and have to proportion food for children.

> *"When the money runs out, I wake up every morning worrying about how I am going to put food on the table. Sometimes there is nothing to eat and my neighbours give the children bread if they have"*
>
> *"I feel very bad when the children tell me they are hungry and there is no money. I give them something to drink, like black coffee and hope it will fill their stomach. It is really hard."*
>
> *"I try to make my money last but everything is so expensive. Sometimes we use candles so that I can have money for food. I will give my food to the children. I can cope with being hungry."*

It is evident that many of the families in this study do not have adequate nutrition. If it was not for the nutritional schemes at pre-schools and primary schools, the children would have very little nutritious food to eat. Most meals consist of bread and jam and this meal in itself does not provide the nutrients that are needed for proper physical and mental growth and development.

4.6.1.2 Stimulation

According to the World Health Organization (2004) stimulation is to engage the attention and provide experience and information that is neither incomplete nor excessive or disorganized. Stimulation is critical to the child's development and involves a range of behaviours on the part of the caregiver that exposes the child to various experiences, which facilitate physical growth and encourages cognitive and intellectual development. Evidence shows that one parenting practice repeatedly found to influence the cognitive development of children is the emotional and verbal responsiveness of the parent or caregiver (Wade, 2008). Emotional and verbal responsiveness is characterised by a range of activities and ploys in which the parent communicates with the child, either in response to the child's curs or spontaneously. A second aspect of parenting found to have a significant impact on the cognitive development of children is the amount of cognitive stimulation a parent provides within the home environment. During infancy, cognitive stimulation encompasses the full range of activities that take place between parents and children, from touching, gazing and smiling, presenting toys and making cooing noises. As the child grows older and becomes more aware of the environment, toys and reading materials, visual and auditory stimulation, encouraging and playing with the child, and later reading and talking to the child about, his or her day become important.

Evident from the field notes of the participant observation process, the researcher noted that not much interaction in the form of play or learning was present between the caregivers and the children. In the case where babies were present (as was the situation with two caregivers) the children would only draw the attention of the caregiver when they cried. Once their immediate physical needs were taken care of, the caregiver continued to carry on with her business. No attempt was made to initiate play, or to engage in any "baby talk" with the

babies. The older children were constantly told to go and play and even though the children demanded attention by engaging in behaviour that was unacceptable to the caregiver, the attention given was through the caregiver shouting at the children or physically hitting them.

4.6.1.3 Support

Support refers to assisting the child to meet the social and emotional needs and reinforce goal directed behaviour (WHO: 2004). Assisting the child to try new behaviour is a critical tool for encouraging and stimulating physical, emotional, cognitive and intellectual growth. Supporting the children to learn new behaviours is a critical part of socialization. The field notes gathered during the participant observation process showed evidence that the support to learn new and socially acceptable behaviour was lacking from the side of the caregivers. The only attention that the children received was negative and in the form of shouting. "No, don't do that" "stop that…" was common words shouted at the children very often.

4.6.1.4 Structure

Structure refers to the different input to the child according to the child's needs and capabilities (WHO: 2004). Structuring the child's day is of the utmost importance. Through structure the child learns boundaries and feels contained. This is important to the child's development as the child is able to internalise new behaviours that is socially acceptable. The children of the caregivers in this study had very little structure. During the interviews the children were engaged in their own aggressive play. Fights were common among the children and this was observed during play. The children's time was unstructured and they engaged themselves in self play or with other children. This was often done without any supervision by the caregivers.

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4.6.1.5 Surveillance

Surveillance makes reference to the ability to track and monitor the child's activity. Resiliency literature (Sherman etal, 2002; Farrington etal, 2007) indicates that parental monitoring and supervision of children is critical and is a significant factor in predicting offending in later life. During the participant observation process the researcher noted that often the caregiver did not know the whereabouts of the children. The children were allowed

to run down the road freely. The caregivers were not alarmed if they discovered that the children are no longer on the home property.

In summary, considering the five elements of quality care which is essential for the survival of children according to the WHO (2004), the caregivers in this study fall short of provision of quality care. The caregivers ability to provide care to children in this study, if one considers this using the human capabilities lens, is lacking and more resources is required to reach the level of functioning as set out by the WHO framework of minimum care to children.

4.6.2 What types of care currently exist?

In response to this question the researcher will reflect on the existing care resources available for caring to the caregiver.

4.6.2.1 Support Systems as a caring resource

The caregivers cited friends, extended family, neighbours and religion as important sources of support that assisted them in their caregiving functions. During the focus group interview the participants also confirmed that their support system compromises of friends, family and neighbours. Below find an example of how a participant depicted their support system graphically:

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Figure 10: Focus Group Interview – Support System of Participant

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Figure 11: Focus Group Interview – Support System of Participant

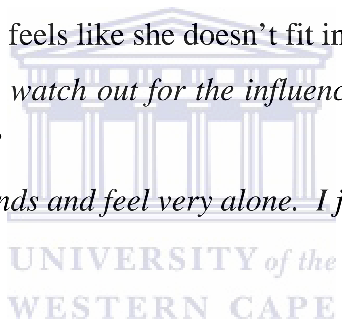
4.6.2.2 Friends

When asked who the first person they would talk to about a personal problem was, four of the participants said they would talk to their mother. Three of the participants said they would talk to a friend and the rest of the sample said they would talk to their daughter, aunt or oldest sister. Trusting the person, feeling comfortable, knowing that the person is able to provide advice and the length the time the person is known to the participant was cited as reasons why they would choose to speak to that person.

> *"My friend makes me feel comfortable and I know I can trust her as she always gives me good advice. I know her for a long time and this helps to speak to her."*

All the participants stated that they have friends. Four participants said that they do not have many friends and cited the fact that friends could be "trouble" and influence one negatively. Loneliness was also reported as a reason for not having many friends, as well as the fact that one of participants said that she feels like she doesn't fit in.

> *"Sometimes one has to watch out for the influence of friends in ones life. They can also just mean trouble."*
>
> *"I don't have many friends and feel very alone. I just don't fit into here and therefore have nobody"*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4.6.2.3 Extended Family

Six out the ten households consist of brothers and sisters who also form part of the family structure. Seven of the caregivers live with either parents, or a mother as part of the household. Two caregiver's parents are deceased, while one caregiver's parents live in the Western Cape. Five caregivers have maternal and paternal grandparents that are deceased. Three caregivers only have a paternal grandmother and two care givers have only paternal grandfathers. Only two caregivers grandparents live in close proximity of the family. One grandmother lives in Upington and the other grandmother also lives in Groblershoop. Eight of the caregivers said they have a very good relationship with their family in general. One caregiver "*did not get along*" with her uncle and one caregiver refused to comment on her relationship with her family. When asked about the relationship the caregivers' have with their family they offered the following:

> *"Very good relationship we don't fight"*

“Good relationship with most of my siblings. I have no contact with my younger brother... I am not sure what happened between him and my parents”

“Very close family we keep regular contact”

“Very good relationship with family. We can talk to each other and support each other during a crisis”

“Very good relationship with my family and they help me and advise me. My mom helps me to look after my child. I couldn’t go to school if it wasn’t for her.”

“Good relationship with my family. We can talk to when I have a problem”

Yes I can communicate with my family”

4.6.2.4 Relationship with the Church

Religion plays an important role in the lives of the participants. Everyone agreed that religion provides “spiritual motivation” and one participant said:

” *when I go to church I feel satisfied and have hope again”*.

Only one of the participants stated that she does not go to church regularly because her

“Grandfather’s death affected [her] relationship with the church”.

Most participants’, go to church at least twice a month, and four respondents reported that they attend church every Sunday of the month. Of the participant that said they could not go every Sunday, the reasons cited was that they had to alternate with other family members as the children did not sit still in church, and the adults took turns looking after them. During the focus groups the participants felt that the church could play a larger role in terms of providing material assistance to destitute families.

“The church only really provides spiritual guidance. What the church needs to do is assist the congregation with food and clothing for our children. Also community work projects will help the families.”

4.6.2.5 Relationship with Neighbours

All the participants, except one said that they knew their neighbours on both sides of their home. The one participant that did not know her neighbour had recently moved to the house and was still in the process of getting to know them. When asked to describe their relationship with their neighbour, all the participants, except one, said that they had a very

good relationship with their neighbour. When asked, however, if they would allow the neighbour to look after the children for extended periods of time only six caregivers said that they would do this.

4.6.3 Local Resources available to Caregivers

During the focus groups interview, the technique of mapping was used and the participants were asked to map out the community resources in Groblershoop. The pictures bellows represent the community maps of three of the participants:

Figure 12: Community Map 1

Figure 13: Community Map 2

Figure 14: Community Map 3

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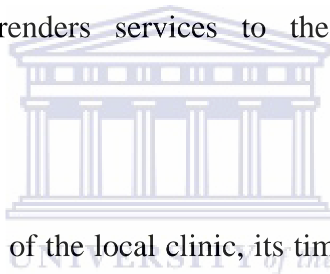
The maps outlined the church, the shops, the police station, the old people community centre, municipal payment office, clinic, stadium, school and the shebeen as facilities present in the community. After discussion in the focus group interview, the participants identified that the police, clinic, church and school were the only resources that were helpful to them for caring. They stated that the only form of recreation in the community was the stadium which was only used for school sports or soccer matches. The shebeen was also seen as a place where socialization takes place. The maps also give a sense of the landscape of the community and the clinic is removed from the residential part of the community, meaning that participants either have to take a taxi or walk. It is interesting to note that none of the community maps showed the existence of any of the other services such as Child Welfare or the early learning centres which exists in the community.

The following organisation renders services to the caregivers in the Groblershoop community:



4.6.3.1 Local Clinic

All the participants were aware of the local clinic, its time of operation and had made use of its services. The researcher spoke to the Nurse at the local clinic. She confirmed that the clinic serviced Groblershoop and all the surrounding farms and smaller towns. The clinic operates from 7h30 am until 4pm from Mondays to Fridays. Two nursing sisters are on standby for emergencies after hours. The clinic is in the town of Groblershoop and the people who live in the location have to take a taxi which can cost between R4 and R6 to per trip to get to the clinic. This presents a significant problem to the people who live in the location because when they do not have money they have to walk. Accompanied by the harsh climate this can be exhausting for someone who already feels ill. The services offered by the clinic are child immunisation, family planning, treatment of chronic illnesses, Tuberculosis treatment, anti-retroviral treatment and a maternity unit. The service is open to all people from all population groups from birth to old age. The clinic provides specific services to all children from birth to 6 years. These services include immunisation, feeding scheme for vulnerable children (low birth weight, TB, HIV infected children), and weighing and monitoring children until school going age. On Thursdays a dietician, speech therapist,

physiotherapist and occupational therapist visits the clinic. The clinic does not enjoy the services of a medical doctor. If there is any condition that cannot be dealt with by the nursing sister the patient is transported by ambulance, or own transport, to Upington hospital, which is 150km away.

4.6.3.2 Northern Cape Department of Social Services

The researcher interviewed the social worker at the Department of Social Development in Upington. All the participants knew about the existence of the Department of Social Development, but associated the services with the administration of the child support grant. The Department of Social Development has a satellite office in Groblershoop and services the entire Siyanda district. They provide a number of services including social welfare services, probation services, statutory and prevention work, welfare financing and monitoring. There services are targeted at children, senior citizens, disabled, families and the support of NGOs'. There services are extended to all population groups. The Department does not render any direct services to children in the early childhood development phase, except for the provision of social grants but subsidises other NGO's who do render these services. The social worker hours in Groblershoop are from 8am to 4pm Monday to Fridays. At present services are being rendered to the senior citizens only.

4.6.3.3 Department of Education

The Department of Education's offices are based in Upington. In Groblershoop itself there are two primary schools and one high school. All the participants knew that these facilities existed within the community. The Department of Education defines their services more broadly as the monitoring, support and training of schools and educators. They also have a role to play in educational development. With regards to ECD the department defines their services as providing guidance and support to grade R educators, monitoring of compliance of ECD facilities, and the provision of support and training of ECD practitioners. The Department of Education admits that their service operates quite irregularly. They only manage to visit schools in Groblershoop twice a year.

4.6.3.4 FAMSA

Famsa is based in Upington. Due to the lack of funding FAMSA no longer has a satellite office in the community of Groblershoop. Their social worker travels from Upington to provide the necessary services. They provide services to most of the Siyanda district. Their services are directed at the family, and seek to strengthen relationships through family and couples counselling. The organisation also has a poverty alleviation project, community violence and trauma project, therapy, counselling, life skills, and marriage counseling. The organisation is also involved in community development projects and volunteer training, provides life skills for youth and conduct workshops and seminars. They target all population groups and mainly provide individual therapy. The population they serve in Upington is mainly White citizens, who have the resources to seek the services of the organisation in terms of being able to pay for the service as well travel to where the organisation is situated. They render general support to crèches, run teenage parent groups and prenatal classes. These services are not specifically delivered in Groblershoop. There is one development worker that renders support bi-monthly services in homes and communities. The local clinic makes the appointments and services are rendered from the clinic. While the NGO offers dynamic services it was clear that since the closure of the satellite office, not much of those services are taking place within the Groblershoop community.

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4.6.3.5 Child Welfare

Child Welfare has a satellite office in the town of Groblershoop and is an important service provider to children and families. The organisation services Groblershoop and its surrounding communities. Their operating hours are from 8am to 4pm, Monday to Friday. They also have community volunteers who are available 24 hours in case of an emergency. They do statutory work and manages cases where children are abused or in need of care. They are also engage in prevention work, specifically around alcohol abuse and child abuse. The organisation also provides support to parents and offers parents guidance on how to manage the growth and development of their child. The organisation also conducts community volunteer training to assist in the caring of vulnerable children and those children, who have been abandoned as a result of HIV. As most grandparents are involved in

the caring of children, the organisation works with the senior citizens at the Centre for Senior Citizens in the community. The services of Child Welfare are offered to all population groups. The target groups are children under 18 years old, senior citizens and families. The organisation renders specific services to children from birth to six years. The Asibavikele (Let's Protect Them) project offers family support services to parents from birth to 6 years. Eye on the Child is an intervention programme aimed at the child protection in cases of neglect. This project is also involved in providing safe houses to children that are neglected. The organisation also provides material assistance to vulnerable families. They also render support services to Roosknoppies, which is a crèche facility for children from 3 – 6years. The organisation has identified alcohol and poverty as key issues which impact on caregiving.

4.6.3.6 Lieflike Geur Day Care

There are three crèches in the community of Groblershoop – Roosknoppies run by Child Welfare, Lieflike Geur and Kwetterkousies. Only five participants were aware of the presence of a crèche and after school care service in the community. Lieflike Geur Daycare Centre is located in the Wit Blokke[6] in the community. The facility provides daycare and pre school facilities to children between birth and 6 years. The crèche currently has 33 enrolled children. This crèche is in the process of registration with the Department of Social Development. Their fees are R100 per month per child. The ECD practitioners who manage this facility have no formal ECD training and they rely on their self knowledge, and previous experience of working with children. The children who attend this crèche are mainly "Coloured "children from the surrounding community. This crèche also has a small number of children in after school care. They operate from 6h30am until 17h15, Monday to Friday.

4.6.3.7 Kwetterkouseis Crèche

This crèche is based in the town of Groblershoop. It services the surrounding farms as well as the community of Boegoeberg. The early childhood development practitioner, stated that they uses the Montessori approach and the ECD practitioners are formally trained in this

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[6] This part of the community has formal housing structures and is considered to be the more affluent side. People who live here have properly constructed houses with bathrooms inside the dwelling.

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practice. The early learning centre focuses on helping the children to become school ready and takes children from ages two to seven years old. The racial categories of the children that attends the school is mixed – White, Coloured and Japanese (one child). The early childhood development practitioner stated that the early learning centre focuses on the development of the whole child and uses art and music to support the children develop and learn. The crèche operates from Monday to Friday, from 7am to 13h30.

In summary, it is evident that there are some services which are key caregiving resources to caregivers. However, access to these services, especially around child care is limited to those who have money to pay for the services. According to the Human Capabilities Approach these caregivers are unable to reach their full level of functioning as they are unable to mitigate the social factors that prevent them from accessing child care resources. Sen (1984) postulates that people should have the agency and freedom to choose what resources they wish to use to create value and meaning to their lives. Resources are only as valuable as they allow the caregiver to achieve their full capabilities (Robeyns, 2003). The Human Capabilities Approach seeks to judge development by the expansion of substantive human freedom not just by material resource (Dreze & Sen, 1989). When caring is still largely seen as women's work and gender relations are still based on patriarchal notions of male power, then the Human Capabilities Approach allows the researcher to conclude that substantive human freedom has not been achieved.

4.6.4 How adequate are the care resources?

The services that exist within the Groblershoop community are not deemed adequate as services are few and not regularly available to caregivers to access when the need arises. In order to use some of the key services the caregivers have to spend money and time in order to access the resources. During the interviews with service providers the following gaps were identified:

4.6.4.1 Clinic

During the focus group the participants listed the need to have the services of a doctor as the first priority for the community. Alcohol abuse was listed as a key issue that needs to be addressed among caregivers of young children. The nursing sister also felt that care givers needed more information and education around child development. Education around family planning was also seen as a need, as well as the involvement of men in family planning and parenting. The nursing sister identified the fact that care givers need more information on the importance of immunization, as the child is often not brought into the clinic in time. The access to the clinic in terms of its location from the community could account for this difficulty. The nursing sister also felt that the feeding scheme currently only provides food to children up to one year. This needs to be extended.

4.6.4.2 Northern Cape Department of Social Development

The social worker identified the lack of infrastructure, poverty of families, low salaries of care givers, and low educational levels of ECD practitioners as some of the issues that could be addressed to provide assistance to care givers. For the Department of Social Development the lack of staff to monitor subsidised services and the lack of services for those who need it the most, is the critical gap in service delivery in the area of ECD. The Department of Social Development also stated that there is no consistent coordination with the Department of Education, who also has a role in the ECD sector. This creates confusion between the departments. She felt that more training could be done with ECD practitioners, better coordination between departments, and clarification of roles would go a long way in improving services.

4.6.4.3 Northern Cape Department of Education

The Department of Education identified some of the key issues that need to be addressed to assist caregivers in improving caregiving as follows:

- Foetal Alcohol Syndrome
- teenage pregnancies
- knowledge about parenting
- alcohol abuse

- young parents

The official from the Department of Education felt that there should be more emphasis on life skills in grade R, instead of innumeracy and literary.

4.6.4.4 Child Welfare

The gaps in service delivery regarding early childhood development were identified by the organisation as:

- Lack of day care centres
- Lack of day care and after school facilities for seasonal workers
- Services to address issues with regards to care giving i.e. parental support
- Lack of capacity in terms of specialization
- Cost of providing services in terms of the distance between communities.
- ECD day care management lacks the capacity to deal with finances and develop business plans
- Lack of training for ECD management committees

The organization feels that some of the ways to address the above gaps would be to:

- Ask grant recipients to contribute extra towards the development of the facilities, as parents must also be responsible. The researcher is not sure that this is possible. There is a strong feeling from the social worker that the CSG is being abused.
- More support from Government in terms of capacity building around financial systems, nutrition and menus etc
- Increase subsidies
- Do away with the volunteer system and pay them a living wage to ensure better service delivery and sustainability.

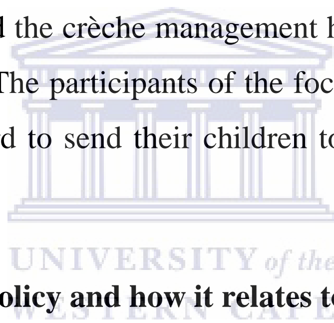
4.6.4.5 Lieflike Geur Day

The crèche identified poverty, lack of knowledge about nutrition and alcohol abuse as some of the key social issues that parents are faced with. The crèche recognises the fact that after school care is a significant gap as children have no place to go when there parents are at

work. The crèche stated that they need more support from the Department of Social Development so that they can offer a more holistic service.

4.6.4.6 Kwetterkousies Crèche

Staff at the crèche felt that there was a lack of knowledge around safety and first aid, and recognised that alcohol abuse is rife. The Early Childhood Development practitioner stated that the gaps in service delivery around ECD is the lack of recreational facilities for young children, no after school activities, no play parks/areas, information and education around parenting is also lacking. Poverty is a significant issue and the early childhood development practitioner feels that the State should provide more subsidies. Fund raising is also necessary to subsidise disadvantage children. She said that more children must get access to free ECD services. The crèche operates for half day only and their fee is R100 per month. The facilities are more effective and the crèche management has a better sense of how to manage the development of children. The participants of the focus group said that many families in the community could not afford to send their children to the day care facilities or the after school care facility.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4.6.5 The Power of Public Policy and how it relates to the provision of caring resources

This section will discuss the current policies in relation to their facilitation of resources for caregiving. It will also attempt to define who articulates the nature of needs and problems and who should be responsible for meeting those needs (Tronto, 1996).

According to Tronto (unpublished) care presumes that humans are engaged in each other's lives. Kittay (2002) takes this notion further and posits that all humans are dependent at different points in their lives and that this dependency is seen as a normal part of human existence. Care, as stated by Sevenhuijsen (2000), has recently grown into a major policy issue for many Governments. In 1994, South Africa was challenged with reforming the Social Welfare policy to become inclusive and provide services to all South Africans regardless of race, ethnicity, gender or class. In January 2000, the Minister for Social Development launched a ten point action programme to address South Africa's most pressing social problems. In his first point he makes reference to the "restoration of the ethics of care

and human development into all our programs. This requires the urgent rebuilding of family, community and social relations in order to promote social integration." (Sevenhuijsen et al, 2003) The point of entry for providing services is focused on the family.

Sevenhuijsen et al. (2003) analysed South African Welfare policy using an Ethics of Care perspective and found that contradictions in relation to women are evident in the policy. On the one hand the policy advocates for women's' integration into the economy, meaning entering the paid labour market while on the other hand the burden of care in respect of children, the elderly, the sick and dependent is also placed on women. The policy further implies that women are responsible for the well-being of children and youth in respect of showing them the appropriate direction in life. Men are not addressed in the policy in relation to the caring responsibilities. As early as 1995, with the advent of a new democratic dispensation, the notion of family was at the heart of the development of social policy. Sunde and Bozalek (1995) noted that the concept of familism was implicit in existing social policies in South Africa. Familism as defined by Sunde etal (1995) as an ideological construction which emphasises the naturalness of the nuclear family as a unit. Bozalek (2004) also defines the term familism to mean that the nuclear family is considered to be the norm.

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This is further entrenched in the current child and family programme of the Department of Social Development which has a focus on "family preservation". Family preservation as defined by the Department is an approach which implies that families should be strengthened and supported in order to keep them together as far as possible. (Department of Social Development, 2008) While the Department recognises the diversity of South African families in its policy, it still views the family as a unit that should be kept together at all costs, with interventions focusing on shifting families from a state of dysfunction to a state of functionality. A significant percentage of the Department of Social Development's budget is spent on supporting the work of NGO's in as far as it fulfills the objectives of the Department. In this way Government makes sure that service delivery occurs within the parameters established by the Department.

The welfare policy also emphasises the need for an integrated and intersectoral approach. This acknowledges that in order to improve the lives of disadvantaged people, Government departments must coordinate services and work together to provide public policies that can improve the capabilities of the most disadvantaged. Services targeting children in the early childhood development phase are located within the mandates of three Government departments namely Health, Social Development and Education. During the interviews with officials from these departments it was clear that there was no coordination of services at service delivery level. In fact officials to ascribed blame and responsibility to the other department for service delivery issues.

> *"it is not our role to provide ECD services that is the role of the department of social development. We are only concerned with children in grade R."*
> *(Interview with Education Department official)*
> *"We only deal with providing subsidies to early childhood centres and help them get registered and accredited. The education department must also do their job"*
> *(Interview with social Development official)*

Public policy is determined by politicians who are governed by political manifestos. This results in a disjuncture between policy and the real felt needs of the people.

> *"Government uses consultants to write implementation plans and these consultants do not always understand the needs of the community." (Interview with FAMSA officer)*

This translates into poor service delivery. Vulnerable communities are further spiraled into the trap of poverty. In every society it is the responsibility of the State to assist the vulnerable through the development of public policies which enable each person to reach their full potential or capabilities. These public policies reflect the paradigm of the State which will directly impact on the way services are rendered. The revision of the social security system after the advent of a new democratic political dispensation, attempted to make provision for all children within South Africa and the State Maintenance Grant was replaced by the Child Support Grant. Seven of the caregivers in this study were recipients of the Child Support Grant. Although the grant was only R200 at the time, it assisted in feeding families and provide for basic needs. The State, at the time of passing this legislation, envisioned that the grant would be supplemented by the feeding schemes, free health care to

children under six, and access to public works programmes which was a poverty relief programme (Lund, 2008). In the community of Groblershoop the lack of adequate service provision is a serious issue which impacts on the quality of life of its inhabitants. The reasons for poor service delivery can be contributed to the fact that there is no deliberate plan to roll out essential services. Furthermore the distance from one town to the other in the Northern Cape is extremely vast, thereby making service provision a costly exercise. In fact the researcher was told by an education official that a significant proportion of the Departments budget is spent on transport as there are huge costs involved in getting from one place to another.

4.6.6 Who are the Caregivers? - A look at the gender practices

The community of Groblershoop is traditional in respect of the roles adopted on by men and women. According to the participants women typically are the "*problem –solvers, the carers, community workers, housewives*." Women are expected to be "*submissive*" while men are "*the breadwinners, the providers, and heads of the household.*" Men are involved in "*work (outside the home), they play sports, sleep, drink alcohol, abuse women and children, watch soccer and do things in the yard.*" Women "*cook, clean, look after the children, do volunteer community work, is involved with the church, look after the husband or boyfriend and also work outside of the home*". Women "*support each other*" and are concerned with the uplifting of the community. Men *"tend to the cattle"* and are not involved in any community or family work.

The roles of men and women in the home reflect the roles of men and women in the community. All the caregivers except for two, said that the father/ brother / boyfriends were the head of the household. The remaining two participants said that their mother and female cousin was the head of the household. In the one instance the mother was the head of the household because there were no men in the home, and she was the eldest. In the other instances the cousin worked and provided for the family, making her the head of the household. All the caregivers said that the men are the *"natural heads of the household"*. They must be *"respected because they earn the money and because the bible said so"*. This view was corroborated in the focus group. The caregivers stated that *"women and men are*

seen as not being equal. Women are involved in community activities, church organizations and child rearing. The men go to the tavern and makes debt on the women's names. The women work and men play soccer".

The caregivers in the focus group expressed that the church reinforces the traditional teachings and views the men as being the head of the house and the mother does the caring work. There was a strong sense from all the caregivers (those interviewed in the focus group as well as in the individual interviews) that these roles cannot be shifted as the participants of the focus group were adamant that this was part of the teachings of the scripture. They said that if one was to go against this idea of the man as the head of the household one would be "*ostracised and isolated in the community."* The men would also not allow it. So even if the man is unemployed and an alcoholic it is his right to be head of the household and dictate the family rules. This perception is intrinsically believed by men and women in the community. Only three caregivers felt displeased with this reality and stated that "*men should be educated to provide women with more than just financial assistance."* One caregiver stated that she has *"made peace with the way things is"* and another said that "*if men have an important role they must take the leadership role"*. It was interesting to note that those caregivers that were unhappy with the current status were the younger caregivers. The older caregivers did not want to change anything. When asked what some of the consequences are in respect of changes to the current status quo all the respondents agreed that this would not be acceptable by family or society. "*we don't speak back to my father – its his house- he is the man of the house, we were not raised to challenge him"*

Morgan (1999) introduces the notion of family practice rather than simply referring to gender roles and functions. This approach implies that families are fluid and flexible and reflects a sense of agency within family practice (Bozalek, 2004). Morgan's approach reflects a sense of doing family and gender, so conveys a sense of everyday routine that people perform in the process of living. Morgan sees caring as one of the family practices i.e. one way of doing family. In this study it is clear that the women are involved in the caring activities of cooking and cleaning and looking after children. All the caregivers also relied on other females like their mothers, grandmothers, aunts, sisters and female friends to stand in for them when they

are either sick or needed to be away from the home. The caregivers in both the focus group as well as those interviewed individually stated categorically that the men are the heads of the household. Bozalek (2004) found a similar pattern in the study she conducted in 2004, through examining the family in community profiles of students at University of the Western Cape. Most of these men were either seasonally employed or unemployed, were absent from the home environment and were uninvolved in the raising of their children. Despite this, the institution of the Church, the focus on providing services to the family by State Departments as well as the way children were socialised reinforced this ideological paradigm of patriarchy.

4.6.7 Parenting Practices

Nine caregivers stated that they hit their children as a means of disciplining them. Many of the women said that they first attempted to talk, then shout and then hit if the child still does not listen. "First *I talk to him then I hit him with a wet cloth"; "I first ask what happened then I hit"; "I talk to him, explain the consequences but then shout and hit him if he does not listen"*. Only one caregiver said that she "*comforts the child and talks nicely"*. All the participants expressed said that discipline was necessary every day, and often more than once. The researcher also engaged in participant observation and observed that the way the caregiver spoke to the child was to shout and then physically hit if the child's behaviour persisted. All the children that the researcher observed lacked the necessary discipline and pushed the care giver to the point where the next step would be a physical beating. The behaviour would stop only for a short time and then continue or a new behaviour that annoyed the care giver would be started. The cycle of shouting and then spanking would be resumed.

During the participant observation exercise the researcher noted a few important points. The children were largely left to their own devices and there was no consistent parental monitoring taking place. The children were left to play unsupervised in the street and then just wander off with older children. During the interviews most participants expressed a concern about the older children molesting the younger children, but even those caregivers that had this concern allowed their under 6 year olds to wander off into the streets, following

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a crowd of older children in most cases. All the care givers indicated that they sleep in the afternoon as it is too hot. The children then often left the yard and went off into the streets. The care givers accepted that the children will return home. There was also no attentiveness in the way that the care giver dealt with the child. During the participant observation exercise no caregiver actually spent time playing with the child, or attempted to develop their motor, sensory or intellectual ability. The children were left to play on their own. The level of care that the children receive is also a concern. During the observation exercise at one home, the caregiver made no attempt to clean the baby even though the baby had passed a stool in his/her nappy. The baby blanket was dirty and crawling with big red ants. No attempt was made to get rid of the ants that were clearly troubling the baby. In another home the child got hurt and scraped his/her knee. The sore knee was not cleaned or tended to and flies settled on the child's sore. At the last home that the observation exercise was carried out the little girl had wet her pants and even though she attempted to alert her mother to this fact, nothing was done to clean the child. Eventually the child fell asleep with the wet pants. The children played very aggressively and boys and girls played through means of fighting and pushing one another. The caregivers reported having very little energy to run after the children or stop the fights. They wait until things got to a point where they are really angry and then shouted and hit the children. The researcher also observed very little obvious acts of love which is normally given by a parent to a child. In the home where the caregiver was going through menopause it was clear that the care of the children "was too much for her." She allowed the children to go ahead with very little attempt to control them or look after them, if they played too aggressively.

4.6.8 Daily Care Practices

The following information boxes provide a glimpse into the daily practice of three of the caregivers interviewed:

I wake up at 5am, wash myself and then start to clean the house. At 7am I get my child up and help her get ready for school. By 7h30 I walk my child to school. When I go home I finish clean the house. Some days when I have a piece job I drop my child then go to work. By 12pm the child must be fetched at school. I come home and if there is food I give them something to eat. Then I sleep as the afternoon is very hot

here. I wake up 5pm, then I make something to eat for supper. Sometimes my daughter sleeps otherwise I walk down the road to see where she is playing and bring her home. I then wash her and make her ready for bed. We then watch some TV and then by 9pm I go to sleep so that I can get up again at 5am.

I get up at 5am and go outside to fetch water from the tap and then prepare it so that I can wash. I then start to clean the house before my daughter goes to work and I have to take over the looking after the children. By 8am the children start to wake up and then I prepare water to wash them. I feed them and then let them play. I then clean the house. By 11am the baby falls asleep and I then do the washing or whatever ironing I have to do. Then at 1pm I give all the children lunch. After lunch the children go and play in the street and then I sleep. I wake up at about 5pm then I make supper. Some nights my daughter comes home late because she goes to the shebeen then I look after the children, give them supper, wash them and put them to sleep. We all sleep outside because it is very hot now and I am struggling with menopause so then I sit up until late at night.

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I wake up at 5h30 and then prepare water so that I can wash. I then wake up my daughter and get her ready for the day. I feed her and then I start to clean the house. I get ready for school at about 7am. School starts at about 7h30am. My mom looks after my daughter while I am at school. At 1pm the school comes out. I go straight home, feed my child lunch, then tidy the house again- wash dishes. I sleep normally between 3 and 4 in the afternoon. I wake up then do my school homework and help my mom make supper. I then wash my child, feed her and then either go to a prayer meeting three nights a week or finish up my school projects. When I go to the prayer meeting I get home at 8h30 pm then I wash myself, watch some TV, while I put my child to bed and go and sleep around 10pm.

The above are typical examples of the caring tasks fulfilled by the caregivers. The caregivers feel a sense of responsibility towards the children and care about their well-being which is

the first phase of the caring. They therefore engage in a process of taking care of their needs through the practice of caregiving, which is the second and third phase of caring. The children are the receivers of these care and during the early childhood development phase is dependent on the care for survival and are considered to be the care receivers, which is the final phase of caring. The values allow us to assess the care given, while at the same time acknowledging that each caregiver needs certain conditions to be met to provide quality care, as outlined early in this chapter. Responsiveness is the value that allows us to assess the adequacy of care. If the care is not adequate, the care receivers would not experience care in a way that compromises their well-being. These conditions are different for each caregiver and lay the foundation for the quality of care received on the part of the child. The care is dependent on the family practices, so whose responsibility it is to provide care as well as what resources are available for care and how the caregiver uses the resources for caring competently. This competency is dependent on how best the caregivers are able to mitigate the personal, social and environmental factors to utilise the resources that are available to its maximum. As has been demonstrated in the earlier section of this chapter, this is not solely dependent on the individual caregiver, but how best their needs have been met by the State, whether services have been provided and what access mechanism to those services have been put in place by the policy makers. At the same time the attitudes of what caregivers or women (as in this study all the caregivers are women) are entitled to is dictated by the dominant ideology of patriarchy. This plays a role in respect of how their capabilities such as "being able to live one's life in one's own surrounding and context" as one of the capabilities set out by Nussbaum (2000), is being fulfilled.

4.6.9 Impact of Caregiving on Care Receivers

Using a checklist developed by the Personal Touch Early Intervention Programme – Early Childhood Centre New York (2006), the researcher assessed the developmental milestones of the children. Initially the researcher intended to ask the caregivers about the child's developmental milestone achievements, but all the caregivers were unable to answer the questions with any amount of certainty. This assessment tool was fairly simple and the researcher then conducted the assessment with each of the child. The table below describes the developmental delays present in each of the children.

Table 6: Developmental Milestones of the Children

Child	Age	Developmental delay
Dalyn (Francina)	5	Cannot print some letters Cannot recall part of a story Does not understand the concept of time Very withdrawn child Does not want to be with friends
Clivano (Linda)	4	Cannot go up and down stairs without support Cannot use riding toys Cannot copy square shapes Cannot draw a person with 2 to 4 body parts Cannot use scissors Cannot copy capital letters Is not really interested in new experiences Cannot dress or undress himself Grandmother doesn't know if child can distinguish between fantasy and reality and whether she has any imaginary friends or sees monsters
Macnic (Linda)	6	Cannot tell jokes or riddles Very withdrawn child
Elvino (leana)	2	Cannot pull toys behind him while walking Cannot build block towers or put 4 blocks on top of one another Cannot use two word sentences Begin to sort shapes and colours Does not make believe play Not becoming gradually more independent Very withdrawn and passive Very anxious child
Tasleemah (Getrudia)	5 mths	Cannot push up on extended arms Pull to sitting position with no head lag Does not respond to other peoples expression of emotion
Shumeez (Getrudia)	4	Cannot hop or somersault Can copy triangles and other geometric patterns Cannot print some letters Cannot go to toilet on her own

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		Cannot say name and address Cannot understand the concept of time Very aggressive
Kaitlin (Mellisa)	2	Cannot build block towers of pile up 4 blocks on top of each other Very attached to her mother not independent
Shannon (Charmaine)	5	Child cannot stand on one foot for more than 10 seconds Cannot copy triangle and other geometrical patterns Cannot draw person with body Cannot use spoon and fork Tell long stories Speak in the present Does not understand the concept of time Doesn't obey rules
Jaselin (Heidi)	2	Cannot carry large toys behind him while walking Cannot scribble spontaneously Turn over container to pour out its content Build a block tower or pile block on top of one another Cannot point to objects or picture that are named for her Cannot use two word sentences Cannot follow simple one step instructions Cannot find objects even when hidden under 2 or 3 covers Cannot begin to sort shapes and colours Cannot begin to play make believe Does not imitate behaviour of others Not very independent child Separation anxiety
Jovani (Johanna)	4mths	Cannot transfer an object from one hand to the other Does not look for toys that have fallen Does not use voice to express joy or sadness Child cries a lot
Jasmine (Johanna)	2	With great difficulty pull large toys behind her while walking With great difficulty carry large toys while walking Still have difficulty running Struggles to get on and off furniture Needs help to go up and down stairs Does not recognize the name of known people of body parts

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		Does not yet do forms and sort colours Does not engage in imaginary play Still very dependent
Ignasius (Johanna)	4	Need help to go up and down stairs Cannot draw four sided forms Cannot use scissors Cannot do a circle and square Cannot start to write capital letters Can eat with great difficulty with a spoon Doesn't understand the concept of the same and different Does not have basic grammar Does not really tell stories No concept of time Follow 3 part instructions Cannot dress and undress
Madelaine (Vinita)	5	Does not go to toilet on her own Can only say name not address Does not understand the concept of time Does her own thing – no rules
Xander (Rochelle)	Almost 2	No developmental delays except he is very hyperactive Doesn't not sit still for very long

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All except one child experienced developmental delays. The caregivers reported that this was the first time anyone had done these assessments with their children. The caregivers said that the clinic only weighed the babies and provided immunisation, but none of the children were assessed for age appropriate development. The risk of these developmental delays not being addressed by the health care system could have long term impacts on the child's development and quality of life, as well as the life opportunities that would be available to him/her. Possible causes for the developmental delays could be the lack of appropriate stimulation, the lack of adequate nutrition, the social conditions in which these children are raised and the alcohol usage of the mothers during pregnancy. Using the Human Capabilities lens the caregivers' inability to mitigate the personal, social and environmental factors impacted on their ability to provide care to the children. The researcher did not have the medical skills to diagnose Foetal Alcohol Syndrome in any of the children, nor was this focus

of this study, but most caregivers spoke of "drinking socially" during pregnancy and were unable or unwilling to explain this behaviour.

4.7 Environmental Factors

Climate, infrastructure and material resources are environmental factors that play a role in the conversion from the characteristics of the goods to the individual functioning (Robeyns, 2003:13)

4.7.1 Climate

All the caregivers described the climate as being" *very hot*". Six of the caregivers stated that the excessive heat*" makes them tired."* One caregiver stated that she "s*leeps after school"*. Another caregiver admitted that "*I sometimes feel like doing nothing because it is too warm."* The children are also affected by the heat and one participant said "It *affects the activities and it is too hot for the children who struggle to play sport."* The caregivers stated that one needs to adapt to the environment but in doing so one becomes much slower in completing tasks.

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4.7.2 Neighbourhood Conditions

All the caregivers, with the exception of one stated that they enjoy living in the community. Six caregivers reported that crime is high in the community and stated that the reason for this is that the "police *don't come, there is no work so people drink and then commit crime, People steal because they are poor, children steal because they come from broken homes and men fight when they abuse alcohol."* Violence is also a problem in the community and all the caregivers except one agreed with this statement. The caregivers attributed the high levels of violence to the amount of alcohol consumed in the community. There are four shebeens in the small community. All the caregivers confirmed that alcohol is easily accessible in the community, while dagga but not other drugs are accessible. Knives are a huge problem and are easily accessible according to all caregivers while guns are not easily accessible. Only three caregivers stated that they knew someone who made a living from

crime in the community. Four caregivers felt that this community of Groblershoop was safe to raise children in.

4.7.3 Physical Home Environment

Seven caregivers live in a dwelling that ranges from having 2 – 4 bedrooms with a lounge and kitchen. These dwellings have no bathroom but have an outside flush toilet. The caregivers use buckets or basins to wash in. The house structures are made of brick wall with metal roof, making it retain heat even more. The caregivers said that in summer it is excessively hot in the houses and in winter it is very cold. While there may be up to 4 bedrooms in a dwelling, the rooms are very small and often sub-divided by the owner him/her self. Only three caregivers live in houses that had bathrooms and toilets inside the house. This facility was installed by the owners themselves. All the caregivers had running water and electricity. The water, however, is problematic and cannot be drunk without boiling. At the time of collecting the data the children was struggling with diarrhea due to the problems with the water. None of the caregivers had access to their own Telkom landline and pay phones were available at some points in the community. Most caregivers had access to cell phones but never had any money to buy airtime.

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4.7.4 Resources Identified by Caregivers to Support Caring

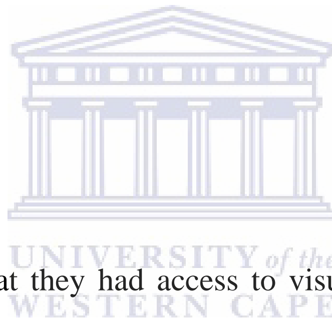
The caregivers listed the clinic, the child support grant, the crèche, the church and the family (mother specifically) as support resources that assist in caregiving. When asked what happens when their child/ren are sick, all the caregivers stated that they take the child to the clinic, but attempt home remedies first before going to seek outside help. Five of the caregivers said that they do not know what community resources are available to help them with child care. All the participants including those who participated in the focus group agreed that the children need more support. When asked what support they needed the following was listed by both groups:

- Parenting programme
- A place where you can leave your child when you go to work
- Broaden the feeding scheme
- Need financial help – need jobs

- More recreational facilities
- Parks with swings, play areas
- Doctors, local community clinic
- After school care facilities
- Provide motivation talks to children and parents
- Infrastructure to assist daycare – more Early Childhood Development Centres
- Raise the amount of the child support grant

All the participants said that they have access to the following services in the community:

- Free health care
- Immunisation
- Nutritional information
- Child support grant
- Healthcare – HIV +
- Weighing of baby
- After birth care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Only four caregivers stated that they had access to visual testing, hearing tests and motor development for their children, yet the clinic nursing sister said that these services were routine for all babies who attended the clinic. Six caregivers reported that they knew their rights with regards to services that could assist their children.

4.8 Overview of Main Findings

This research study reveals that personal, social and environmental factors do have an impact on the caregiver's ability to provide care. The caregivers who displayed signs of physical illness and mental distress, either through depression or experiencing anxiety, reported that this impacts on their physical ability to provide care to their children. The research findings also suggest that the level of education achieved determines the type of employment that the caregiver is able to access and therefore the amount of material resources that is available for caring. In Groblershoop employment opportunities are limited to the grape or cattle farms, the abattoir and the local small businesses. The competition for employment is significant.

With an excess of cheap labour available to the business sector, salaries are not competitive, fair labour practices are not upheld as there is no enforcement and workers are almost exclusively at the mercy of their employers.

The study revealed that the women are the primary caregivers in the Groblershoop community. This is reinforced by the Church, the family and the greater community. Men are seen as the "natural head of the household" while it is the women who do the caring practices within the family in relation to child care, as well as household maintenance. It is the responsibility of the women to seek for the next meal when the money is depleted. The women also have to ensure that the men are fed. Due to the lack of recreational facilities within the community, as well as the acceptability of alcohol as part of the social space, men and women frequent the shebeen. The shebeen is often a site where most of the incidences of domestic violence and assaults starts, and is then continued in the home.

Violence is seen as an acceptable means of dealing with conflict and as an effective tool for discipline. As observed during the participant observation process as well as the testimonies of the caregivers themselves, hitting and spanking is seen as the only way to bring about change in behaviour. The interesting phenomenon is that this seldom changed the child's behaviour in any significant manner and before long the child was seeking for attention again. Another important finding is that due to a number of factors cited by the caregivers, including the excessive hot climate, feelings of depression, lack of knowledge on parenting and lack of parenting skills supervision and monitoring of children which is an activity very critical to parenting is absent from all the caregivers repertoire of care in this study. No stimulation activities could be observed during the participant observation process, neither was this reflected by the caregivers themselves. The children were left to play with each other in the streets. When the researcher reflects on the five key functions which the World Health Organization (2004) identifies as core caring functions namely Sustenance, Stimulation, Support, Structure and Surveillance; then the caregivers in this study fall short. Sustenance is an issue for all the caregivers due to the high levels of unemployment and poverty in the area. There was no or very little observation of stimulation, support and structure from caregivers to their children and surveillance was distinctly absent.

Using Tronto (1993) ethics of care perspective and the phases and values of caring, the care provided to children could be assessed. Attentiveness is which the corresponding value of the first phase of caring about requires that the needs of the other be recognised and considered to be important. While the caregivers definitely cared about the children they were less attentive to their needs. The second dimension of care refers to responsibility which defines the level of obligation to meeting the person's need and forms the value of the second phase of taking care of. The caregivers take responsibility for taking care of most of the physical needs of the child in relation to hygiene, feeding, clothing and sheltering the child. However, the need for play and stimulation both emotionally and cognitively was absent from the care given to children. The third element of care, refers to the competence in care-giving. This value corresponds to the third phase of caring which is caregiving and speaks to the actual practice of care. The monitoring and supervision of children, which is an important element of care, is absent from the caregiving practice, as children are left to run in the streets. The fourth phase is care receiving and its corresponding value is responsiveness. The developmental milestones are one marker of judging the responsiveness of children to the care received. Based on the data, only one child suffered no developmental delays, while all the other children in the study were not developmentally on par.

When this was explored further in the study the researcher found that factors such as the lack of infrastructure, the lack of service delivery in the community as well as placing the burden of care solely on the female caregivers with the biological fathers or male role models largely absent from the caring relationship. This coupled with the lack of programmes that provide knowledge and skills around parenting as well as providing assisting to teenage parents create a further reason for poor parenting functioning.

The inability to translate Government policy into implementable service deliver, particularly for the more rural areas, has a serious impact on the lives of the caregivers in this study. In order to access some of the services, a taxi to Upington is required and in the climate where resources are few and far between this is a luxury that most of the caregivers cannot afford. The living conditions also aggravate childhood illnesses like diarrhea and chest illnesses.

The excessive heat makes productivity very difficult and changes family practices in the Groblershoop community, attesting to the fluidity and flexibility of the concept of the family.

The study clearly demonstrates that for the caregivers in this study to achieve their capabilities more has to be done to enhance the functionings of the caregiver. The Human Capabilities approach acknowledges that some people need more resources than others to achieve the same level of functioning. In a community where resources are scarce, the caregivers need to be assisted to better enhance their ability to mitigate their personal, social and environmental factors which could assist to provide care to children. However, in this community a greater emphasis needs to be placed on attempting to engage men in the caring process. Creating awareness about fatherhood and the importance of a positive male role model in the life of the child could be a starting point to engaging men on issues of care. The women also need to be empowered to widen their understanding of their role in society more broadly. While it would seem as if the caregivers in this study have a sense of agency, this is very limited as most caregivers have been socialised to accept that they have no choice but to do the caring work, and that men are heads of the household without interrogating what this means. The women were willing to relinquish the power to the men in their families and in their community, rather than understand the power that they have as caregivers, and women in society.

5 Chapter Five: Conclusions and Recommendations Chapter

5.1 Introduction

In this Chapter the findings of this study are reviewed, the implications are discussed, and broad recommendations for interventions as well as future research are presented.

The Human Capabilities Approach and the Ethics of Care perspective were used to analyse the findings and make sense of the information. The Human Capabilities Approach places emphasis on what the caregiver is able to do and to be i.e. what capabilities they have for caring and as caregivers. This perspective goes further to say that their capabilities is influenced by three factors namely the personal, social and environmental factors and depending on how the caregiver is able to mitigate these factors their level of functioning will be affected. These caregivers may need more resources to achieve the same level functioning as other caregivers in a similar community who have managed to mitigate their personal, social and environmental factors. These caregivers have been marginalised through the provision of poor health care, and had their physical and mental health care needs compromised.

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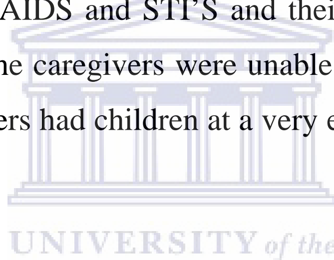
The provision of adequate community based health care would improve the personal factors of the individual caregiver. Provision of alcohol campaigns and services to children who may suffer from Foetal Alcohol Syndrome would assist the caregivers to not only help themselves, but assist the children who may suffer from this syndrome. The Ethics of Care perspective is useful in that it allows the researcher to unpack some key questions to assess the adequacy of care and identify how the caring agenda is determined in the community of Groblershoop. The phases of caring as well as the moral values associated with each phase assisted the researcher to gain a full understanding of care as a practice should be similar. This is the integrity of care Tronto (1993) argues for when the phases and moral values of attentiveness, responsibility and competence are integrated which constitute care as practice

and therefore provides service delivery with a 'standard' for an 'integrated well-accomplished act of care' (Tronto, 1993; Sevenhuijsen, 1998 and Fraser, 1997).

5.2 Personal Characteristics of the Caregiver affecting Caregiving

This study found that personal characteristics have a significant impact on the caregiver's ability to provide care to their children in the early childhood development phase. Caregiver illness plays a significant role in the ability of the caregiver to care for the children. In this study the caregivers reported that when they felt physically ill, they were unable to respond to the needs of the children and that their quality of life was poor as they generally suffered from chronic pain. None of the caregivers in this study disclosed that they were HIV/AID positive. Only one caregiver was treated for a sexually transmitted disease. There was limited knowledge about HIV/AIDS and STI'S and their consequences for health, lifestyle and impact on their family. The caregivers were unable to demand safer sex practices with their partners and most caregivers had children at a very early age, with two of the caregivers still school going.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Most of the caregivers suffered from some form of depression, while only one caregiver was diagnosed and treated for postnatal depression. All caregivers, however, reported some signs of mental distress. With medical services being limited in the community, mental health services are virtually non-existent. Substance abuse, particularly alcohol abuse, was common. This factor however was underplayed by the caregivers. Most caregivers said that they are social drinkers and most of them said that they had a drink or two during pregnancy. Alcohol abuse is common in the community of Groblershoop with both men and women frequenting the shebeens. Alcohol usage also results in the caregivers not being able to give any quality time to the children and prevents families from spending quality time together. Physical assault is common at the shebeens.

The physical health, mental health, at-risk sexual practices combined with the use of alcohol are significant factors which prevents the caregivers from providing care, according to the five element of quality care defined in this study. The at-risk sexual factors will have an

effect on the longer term for the caregivers and their children, as the health of the caregiver will suffer and impede caregiving. The other factors also had a definite impact on the caregiver's ability to provide the necessary stimulation, structure and surveillance and these impacts on the development of the children and have a direct bearing on the associations that they make. The lack of knowledge on the part of the caregivers around HIV/AIDS and their current at-risk sexual practices will have significant consequences for the caregiver herself, as well as the wellbeing of the children.

In this study, educational levels were clearly linked to income levels and employment. The unemployment levels in the community were 76% according to the IDP documents (!Kheis Municipality, 2008). Given the limited opportunities for employment in the community, reliance on social security was the primary means of survival for many caregivers. Those households who had more members in it that were either employed or receiving another form of grant or were receiving some form of maintenance contribution from a biological father, had more resources for caring. The majority of caregivers had to make ends meet with very limited resources. Most caregivers reported that it was their responsibility to provide food for the family. This often meant that when there was no more money to buy food, it was the caregiver who had to find a domestic job or borrow food from the neighbours. All caregivers reported that there were times when there was just no food and they learnt how to get by without eating. Food was given first to the men in the household (irrespective of who he was in relation to the caregiver), then to the children, and lastly the caregivers themselves would eat.

5.3 Social Characteristics of the Caregiver affecting Caregiving

The social factors that this study explored were limited to the resources available for caring, support systems, gender practices and parenting. The developmental milestones of the children were also assessed as one of the measures that looked at the development of the children within their environment.

A key finding of this study was that the social factors had an impact on the caregiver's ability to provide adequate care. The Ethics of Care approach argues that if a caregiver is to be able

to engage in caregiving then adequate caring resources should be available to ensure competency of care. Public policy provides broad guidelines for service delivery at a local level. While the focus of this study was not to analyse public policy discourse or the effectiveness of policy, this study merely looked at what provision public policy makes for caring and at points offered a commentary on how the policy could be interpreted. However both the Ethics of Care and the Human Capabilities Approach emphasise the importance of social policy in being able to adequately provide for care. There were limited physical resources available for caring in the community of Groblershoop. Those that were available to caregivers were the local clinic, social development office to apply for a child support grant, child welfare that provided statutory services, FAMSA who provided family services but who had offices in Upington and three crèches. Early Childhood Development services cut across three departments namely, Departments of Health, Social Development and Education. No coordination of services occurs at this level, and this is problematic for service delivery. The Department of Education and Social Development officials define their role very narrowly in Early Childhood Development. The Department of Education only views their role as managing Grade R and maintains that it is the job of Social Development to audit, train and assists early childhood centres. Social Development merely assists with foster placements of children, works with the elderly and facilitates the process of accessing a child support grant.

Services for children in the early childhood development phase are severely limited, uncoordinated and piece meal. Studies measuring the effectiveness of these services are also lacking. Organisations working in the community are attempting to provide as much as they can with the limited resources available. This does not always translate into a quality service.

Another important resource for caring is the support system that is available to caregivers. The caregivers reported that the female members of their family in the form of their mother, grandmother, aunt, sister or cousin were seen as important sources of support if they needed assistance, or someone to watch over the children when they were ill or needed someone to run errands. Their female friends were also seen as important in this respect. The sense of

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community support is alive in Groblershoop and even though there is a greater awareness of issues around child abuse most caregivers said that they would allow their neighbours to care for their children. Religion also played an important role in the lives of the caregivers. Most caregivers said that the Church could do more to assist the poor. Religion also plays a key role in reinforcing the ideology of patriarchy. The idea of the man being the head of the household is fully supported by the church and preached from the pulpits.

Women do all the caring work within the community as reflected by their daily caring practices. Not only are they the sole caregivers of children, they take on further caring roles of home maintenance such as the cooking, cleaning and doing the washing and ironing. Most caregivers in this study also have to seek work so that they could ensure the survival of the children and the family. When there is no food or money to buy food, it is the responsibility of the caregiver to ensure that everyone eats. It is also the caregiver's responsibility to seek assistance if the children are sick. In the community of Groblershoop men do not take responsibility for fathering. Not much thought is given by men as to how they participate in the lives of their children. It would seem as if sex is the right of men and women are left with no choices about whether to be a parent of not. If the caregiver is unable to provide care, the next female within the household (normally the mother of the caregiver) would be required to fulfill this role. This finding was corroborated by Ally-Schmidt study (2005) where the oldest girl child takes over the caregiving role in the absent of the primary caregiver.

Women do all the caring so they also do all the parenting and disciplining. The study demonstrated that there was a lack of knowledge and skill on how to parent and discipline children. Apart from feeding, clothing and sheltering children, very little else was done to encourage growth and stimulate development or form attachments with the children. The caregivers themselves appeared to be weighed down by their circumstances that the ability to form attachments and play with children in a meaningful way was severely hampered. Children were constantly receiving negative attention from caregivers and were left mostly to their own devices. Most times parents had very little idea of where their toddlers had run off to, and did not show any concern with regard to this. There was a general ethos that very

little cares and value was given to this community where people lived in extreme poverty and where employment was difficult and services few. This ethos continues and is reflected in how these caregivers provide care to their children. Discipline equated with physical punishment and verbal reprimands. For these caregivers parenting under these conditions is extremely challenging.

The lack of services, coupled with the lack of stimulation and necessary attachment as well as other biological conditions which the researcher was unable to assess, resulted in significant developmental delays in all the children except one. The caregivers were unable to identify problems with the children and when the researcher asked about the child's abilities none of the caregivers could give an account of this. The researcher thus tested each child using the simple assessment form which is attached. The caregivers said that the children were not tested at the clinic and it appeared that the clinic services were limited to the weighing of babies, provision of immunisation and treatment of serious illness on presentation. Some children had facial features suggesting that they had Foetal Alcohol Syndrome, according to the literature, but the researcher was not in a position to confirm this. Given the levels of substance abuse in the community services raising awareness, diagnosis and treatment of Foetal Alcohol Syndrome and rehabilitation units are almost non-existent.

This study thus concludes that the social factors play a major role in the kind of care that the caregiver is able to provide to the child. None of the resources that are available to caregivers acknowledge that these caregivers need more support in terms of learning parenting skills, and more about the development of children to better build their capabilities to provide care. The social circumstances where women are relegated to do all the caring work as well as provide for the family and often live below the breadline, implies that they need more resources to be able to achieve functioning. This should be acknowledged by public policies and reflected in the types of interventions and resources made available at community level.

5.4 Environmental Factors of the Caregiver affecting Caregivers

The environmental factors that were considered in this study included climate, physical home environment, neighbourhood conditions and resources identified by the caregivers as needed for caring. The key finding of this section reflects that the environment does affect the caregiver's ability to care for children.

The climate in Groblershoop is very harsh; incredibly hot in summer with temperature reaching almost 40 degrees Celsius and very cold in winter. Rain is very scarce in this region and the ground consists of red clay, which is very dry. The caregivers reported that the heat makes it impossible for caregivers to do much in the afternoons and all the caregivers except those that are employed said that they sleep when it gets very hot. Most families sleep outside in the summer and when one walks through the community one can see the beds placed outside. When the caregivers sleep during the afternoons the children are left to wander around in the community and play outside.

The physical home environment is also challenging for the caregivers. There are some homes where families still use the pit latrine system. All the caregivers in this study had access to a flush toilet; however, the toilets were situated outside of the home. There was no bathroom in the housing structures and the caregiver had to heat water to bath and bathing was done outside, behind the toilets for privacy. The provision of water is also a problem and on certain days the water is not fit for human consumption. Caregivers either buy water or are forced to boil it before drinking. Diarrhea is very common among children and can be attributed to the problems with the water.

Crime in the community was largely alcohol related and violent assaults are common. There are no recreational facilities in the community and drinking at the shebeen is seen as a social space where people come together. The caregivers clearly requested more recreational facilities as a means of taking care of themselves. Self-care is also very critical as outlines by Tronto (1996). Other services that the caregivers saw as gaps in the system was around teaching them parenting skills, establishing more early learning centres, creating employment opportunities, providing a doctor in the community, broadening feeding schemes and

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provision of aftercare facilities for children. What was interesting is that none of the caregivers stated that they needed better housing and infrastructure, proper lighting and roads in their community or better provision of water. The Human Capabilities perspective recognises that people become accustomed to less and adjust their lifestyle accordingly (Sen, 1984; Nussbaum, 2000). This, however, does not respect people's basic human rights and need for dignity and respect which is enshrined in the South African Constitution.

The environment and other social factors described above portray an uncaring stance or attitude toward the inhabitants in this community by the part of the Government, as the provider of services and securer of basic human rights. Not only are they marginalised by distance to urban centres and the facilities that are available there, they learn to live with less and this becomes acceptable and a measuring stick of what it is that they deserve and how they are valued as citizens.

5.5 Reflections on this study

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This study has challenged the researcher in that the data collection took place in the height of summer and this took its toll on the researcher. In retrospect what would have been interesting for this study would have been to consider the impact the climate had on caring during the winter months, when it was extremely cold. If the researcher had the opportunity to repeat this study or build on its findings she would also interviewed men to understand more about their concept of fatherhood, and also attempt to explore more their absence as fathers in the lives of their children.

The researcher also valued the opportunity to engage in participant observation. This process provided insight into what the caregivers were unable to articulate about their parenting practices. The participant observation process, however, only happened with three of the caregivers for a limited space of time. What would have been more useful is to have done participant observation over a period of time. The researcher also had difficulty using a tape recorder and the responses of the women were not as rich as they could have been. If the researcher could repeat the study she would focus on breaking up the individual interview so

that each theme could be dealt with in greater depth, while at the same time building a much stronger rapport with the caregivers themselves. The researcher wrote up each interview and allowed the caregiver to go through the response again, making notes for clarity, and therefore feels as that the information received is accurate, even though it may not be as detailed as the researcher would have desired. The initial baseline report that was conducted by the CJCP provided critical information about what exists in the community and what resources were available. This report was used to provide background information in this study, and was considered to be useful by the researcher.

The research process taught the researcher much more about the fieldwork and data collection and challenged the researcher to learn more about the data through the use of a theoretical framework. The research process enabled the researcher to get a glimpse into the lives of the caregivers who were challenged by circumstance, mostly beyond their control and learnt about the resilience and tenacity of the human soul.

5.6 Recommendations

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The research findings raise pertinent issues which need to be considered so that people are able to achieve functioning. The Human Capabilities Approach emphasises a focus on what a person is able to do and be; on the quality of their life and on removing obstacles in their lives so that they have the freedom to live the kind of life they find valuable (Robeyns, 2003:6). This kind of approach does not measure development in terms of numbers or commodities, but in terms of what value people have and what agency they acquire to achieve the value. Personal, social and environmental factors influence how a person can convert the characteristics of the commodity into a functioning. It would therefore be essential to assist an individual to mitigate these factors so that functioning can be achieved. This study set out to explore how these factors influence a particular kind of capabilities that is the ability to care for children in the early childhood development phase. Based on the findings presented in the study the researcher seeks to make the following practical recommendation:

An integrated coordinated approach to service delivery is required. The problem presently is that services are fragmented and offered in a piece meal fashion. Basic service delivery is also seriously lacking. Water provision and community infrastructure is poor. The integrated approach should focus on providing a holistic service to children and caregivers and all services should compliment each other. Services delivery should focus on providing services in the following areas:

- A programme aimed at providing parenting skills. The parenting skills that are needed include having knowledge about the development of children, how to stimulate development and form attachments with children, nutritional information, health information on childhood illness, positive discipline of children, how to develop routine and structure, and the importance of monitoring and supervision of children. These programmes should target both males and females and provide support to fathers to fulfill their caring responsibilities.
- Additional Early Childhood Development centres should be established and existing Early Childhood Development centres should be audited and upgraded. It is also recommended that the existing childhood centre should have trained educators who are familiar with child development, positive discipline and how to develop activities that will stimulate growth and development of children.
- Mental health services should also be provided as this these issues were largely undiagnosed and untreated.
- Substance abuse programmes should also be made available. This should address rehabilitation as well as awareness and behaviour change through cognitive behavioural programmes.
- A broader programme focusing on promoting dialogue in the community about issues of gender, gender based violence and caring practices is imperative if men are to be engaged as active fathers and take on the responsibility of fathering. This would also involve engaging in dialogue with the Church, which presently plays a significant role in shaping the thinking of the men and women in Groblershoop.
- Existing services should be evaluated for their effectiveness and usage by caregivers. One of the issues that were evident from the caregivers was the fact that they did not know what services existed, implying that the few services that are available are

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under utilised or under marketed. Perhaps issues of access to these services need to be addressed.

- Employment opportunities focusing on the existing environment needs to be considered. Skills building programmes which focus on addressing the local demand as well as teaching business skills to create markets for new opportunities should be considered. Government public works programmes could be utilised and the local community could be employed in the upgrading of community facilities such as improving the water provision, building roads and recreational structures.

5.7 Concluding Remarks

Despite the debates globally and in South Africa about gender practices and gender equality very little has changed in the lives of women from rural communities such as Groblershoop. Care work is still considered to be the responsibility of women. Women have no choice about being a caregiver and in these communities men enjoy privileges. Even where resources are scarce, men take away from the family the material resources that could be used in caring albeit they themselves have not contributed towards those resources. Women shoulder these burdens in silence and remain voiceless.

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Public policies such as the White paper on Social Welfare, and the Integrated Social Service delivery model which have been developed should be properly implemented to assist the vulnerable. Presently there is limited assistance to caregivers, and there is the assumption that women will take on the work of care and that they are in a position to provide this care. With the advent of democracy in 1994, South Africa promulgated many progressive policies and legislation. However the disjuncture between the policies and implementation has resulted in the provision of paper rights for many South Africans. Poverty, poor health, violence, substance abuse and the lack of basic infrastructure and service delivery continues to be the reality for many poor communities. The lack of adequate monitoring and evaluation of programmes and interventions has contributed to poor service delivery. The State's focus on the number of people using a service as opposed to the quality of services prevents an assessment of how the service has enabled the person to improve their lifestyle and feel a sense of well-being.

This study has highlighted that development is not solely about the provision of resources but about a complex array of factors which must be considered if sustained change is to occur in people's lives. Development is about people and in the words of Amartya Sen "allowing people to live the kind of life that they have reason to value". Development in its real sense is accompanied with values of freedom, justice, equality and democracy and the acknowledgement and celebration of the diversity of the human race. This approach to development which is encapsulated in the Human Capabilities framework, values differences as opposed to pathologising them and set about in the pursuit of building equality and real freedom.

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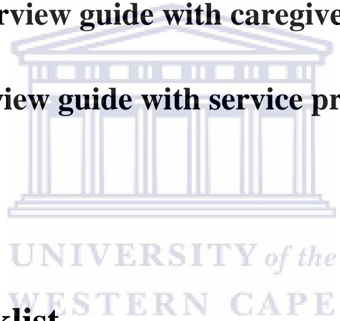
6 Appendices

6.1 Map of Northern Cape

6.2 Map of Groblershoop

6.3 Research instruments:

6.3.1 Semi – structured interview guide with caregiver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6.3.2 Semi-structured interview guide with service provider

6.4 Information leaflet

6.5 Consent form

6.6 Developmental checklist

Semi - Structured Interview Guide

Interview with Caregiver

Conducted by: Faeza Khan
Date:
Place of Interview:

Thank you for your time. We are inviting you to participate in this research project because you have a child 6 years or younger and have been identified as being the caregiver of the child. The purpose of this research project is to make sure that projects that are established in your community will better assist you in caring for your children. The information obtained from this interview will be kept confidential and we will also seek to protect your identify by ensuring anonymity. If you do not feel comfortable with any questions, please feel free to say so. If you do not want to continue with the interview at any point, please feel free to say so.

The interview will be structured and will cover 7 areas

- Demographic details
- Personal information
- Information about your family
- Information about your social networks
- Information about the environmental factors that influence your life
- Access to services
- Parenting and your child

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I am going to start by asking a few questions about you.

1. Name
2. Age
3. Sex
4. Home Language
5. Marital status
6. Do you have a partner?
7. Do you live together?
8. What community do you live in?
9. What community were you born in?
10. Why did you come to live here?
11. How many children do you have?
12. How old are they and what is their sex
13. Are Any of them adopted? Who?

INCOME AND EDUCATONAL LEVEL

1. Are you employed? Full time or part time
2. What kind of work do you do?
3. If unemployed are you seeking employment currently?
4. What impact does unemployment have on your life and that of your children?
5. If employed how long have you been working for this company?
6. What is your household income per month?
7. please breakdown your monthly income sources
8. Does anyone in your home receive a grant? What grant and how much?
9. What is the grant money spent on?
10. What is the highest standard of education that you have obtained?
11. Did you complete grade 12?
12. If not what grade did you leave school?
13. Are you able to read fluently?
14. Are you able to write?
15. Have you had the opportunity to complete any short courses or workshops? Name them

FAMILY STRUCTURE

1. How many people live in you household – please describe them in terms of name, sex, age, their relationship to you and how long they have lived with you?
2. How many brothers and sisters do you have? Where do they live and how often do you see them?
3. IS you mother still alive?
4. Is your father still alive?
5. Are your maternal grandparents alive? Where do they live
6. are you paternal grandparents alive? Where do they live
7. Do you have a good relationship with your family – please explain

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PERSONAL CHARACTERISTICS

1. Do you have any disabilities? Describe them.
2. Do you suffer from any illnesses? Describe the condition.
3. Have you ever been tested for HIV?
4. Have you ever been tested for STI"S
5. Do you feel comfortable to disclose your status? If yes what is it?
6. Have you ever suffered from depression or has there ever been a time in your life when had been very sad
7. How often has this happened?
8. Do you have difficulty sleeping?
9. How often does this happen?
10. DO you ever feel like not eating or do you overeat?
11. How often does this happen

12. Do you ever feel like you have no energy and do not want to get out of bed in the morning?
13. How often does this happen
14. DO you feel hopeful about the future Why or why not?
15. Do you feel anxious about things you cannot control?
16. If yes how often?
17. Have you ever felt angry
18. Have you ever felt mixed up and confused about your life?
19. Do you ever feel lonely and unsupported?
20. How often do you feel the above?
21. How do you cope with the above
22. Using three words describe you personality?
23. Why do you think these words best describe who you are?
24. what influence do you think you have in the lives of your friends and family
25. Do you use alcohol – how often- did you use during pregnancy
26. On average how much do you drink in a week/on weekends?
27. Does your partner drink- how much
28. On average how much do you think he drinks during the week and on week ends
29. Have you ever used drugs
30. Did you use drugs during pregnancy – please explain
31. does your partner use drugs – How often
32. Has there been any other significant event in the last 5 years that may have an impact on your life.

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SOCIAL CHARACTERISTICS

1. Who do you speak to first when you have a personal problem?
2. Do you have many friends? What role do they play in your life
3. How often do you visit them?
4. What role does religion play in your life
5. How often do you go to your place of workshop?
6. Do you know the name of your neighbours?
7. Describe your relationship with you neighbours
8. Would you let them look after your child for a night?
9. Do you feel safe in your community – what makes you feel safe
10. What roles do men and women play in your community?
11. What role does men and women play in your home?
12. who is the head of the household
13. Are you happy with the role that men and women take on in your community?
14. What are the consequences of not following the roles in your family?

ENVIRONMENTAL CHARACTERISTICS

1. What services exists in your community and how often do you used them

2. describe the climate that you live in?
3. How does it affect your daily activities
4. Do you enjoy living in your neighbourhood? Why
5. is crime a problem in your community? Explain
6. is alcohol easily accessible?
7. are drugs easily accessible?
8. Are guns and knives easily accessible?
9. Do you think your community is a safe place to raise children? why
10. Please describe the structure of your home (how many rooms, formal structure etc)
11. Do you have a toilet inside the house, ablution facilities inside the telkom landline, cell phone, useable running water, electricity

PARENTING

1. Who is involved in taking care of your children most of the time during the week?
2. who is involved in taking care of your children most of the time during the weekend?
3. please describe a typical day in your life from the time you wake until you sleep?
4. how do you deal with your child when he/she has done something wrong?
5. How do you discipline you child?
6. Who takes care of your child when you are not feeling well?
7. What happens when your child is sick? Does anyone assist you?
8. What support networks do you have to help you with parenting?
9. What resources are available in your community to help with caring?
10. DO you need more resources that can assist you to look after your child? W hat would these be?
11. How can the State go about helping caregivers to provide care to children
12. Did your newborn child have access to:
    - Free health care
    - Immunization
    - Nutritional information
    - Child support grant
    - Baby weighing
    - Auditory testing
    - Visual testing
    - Motor development
13. did you have post natal care?
14. do you know if the above is available in your community?
15. Are you aware of your rights with regards to receiving these services
16. Complete developmental checklist with child and caregiver
17. Has anyone asked you similar questions in relation to the development of your child?
18. If yes when

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19. IF there is a problem with the child's development has anyone provided you with any assistance – explain

Thank you for participating.

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Structured Interview Guide with Service Providers

Date:
Place of interview:
Conducted by:

Thank you for participating in the research. We are conducting research into the factors that influence care giving to children between birth and 6years. As part of this process we are interviewing service providers to gain an understanding of what services exists for children this age and how care givers can access these services.

1.1.	Name:	
1.2.	Organisation name Address	
1.3.	Do you have a satellite office in the groblershoop community?	
1.4.	What areas do you service?	
1.5.	Can you describe the mission of your organization?	
1.6.	What services broadly does your organization render?	

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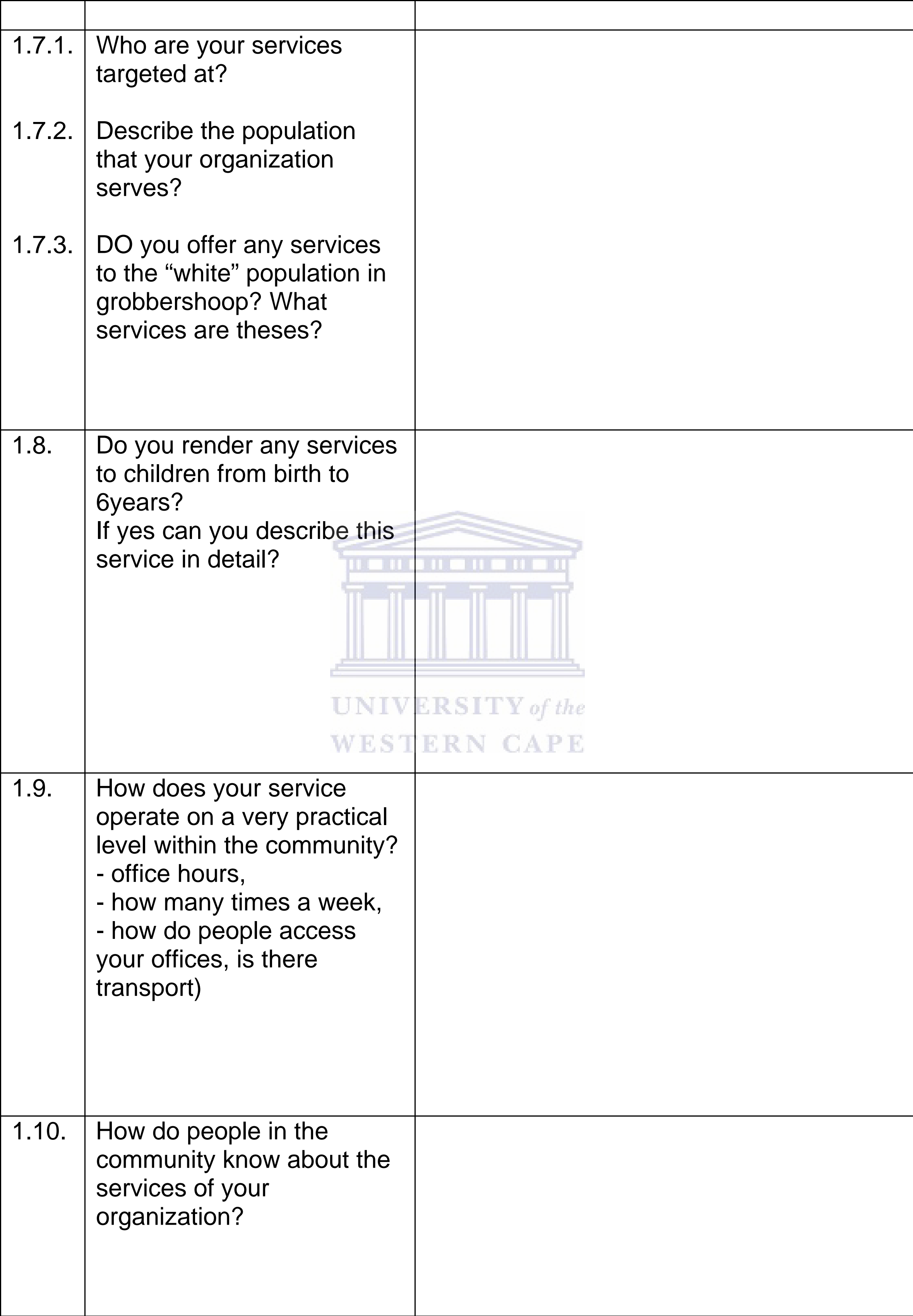

1.7.1. 1.7.2. 1.7.3.	Who are your services targeted at? Describe the population that your organization serves? DO you offer any services to the “white” population in grobbershoop? What services are theses?	
1.8.	Do you render any services to children from birth to 6years? If yes can you describe this service in detail?	
1.9.	How does your service operate on a very practical level within the community? - office hours, - how many times a week, - how do people access your offices, is there transport)	
1.10.	How do people in the community know about the services of your organization?	

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1.11.	What do you think are some of the key issues that need to be addressed to assist care givers to care for children between birth and 6 years?	
1.12.	What do you think are the gaps in service delivery particularly around early childhood development services within the Grobblershoop area?	
1.14.	What is your organizations approach to providing services. Is your work underpinned by any ideological principle, approach, theory?	
1.15.	What is in your opinion are some of the gaps in policy around early childhood development?	

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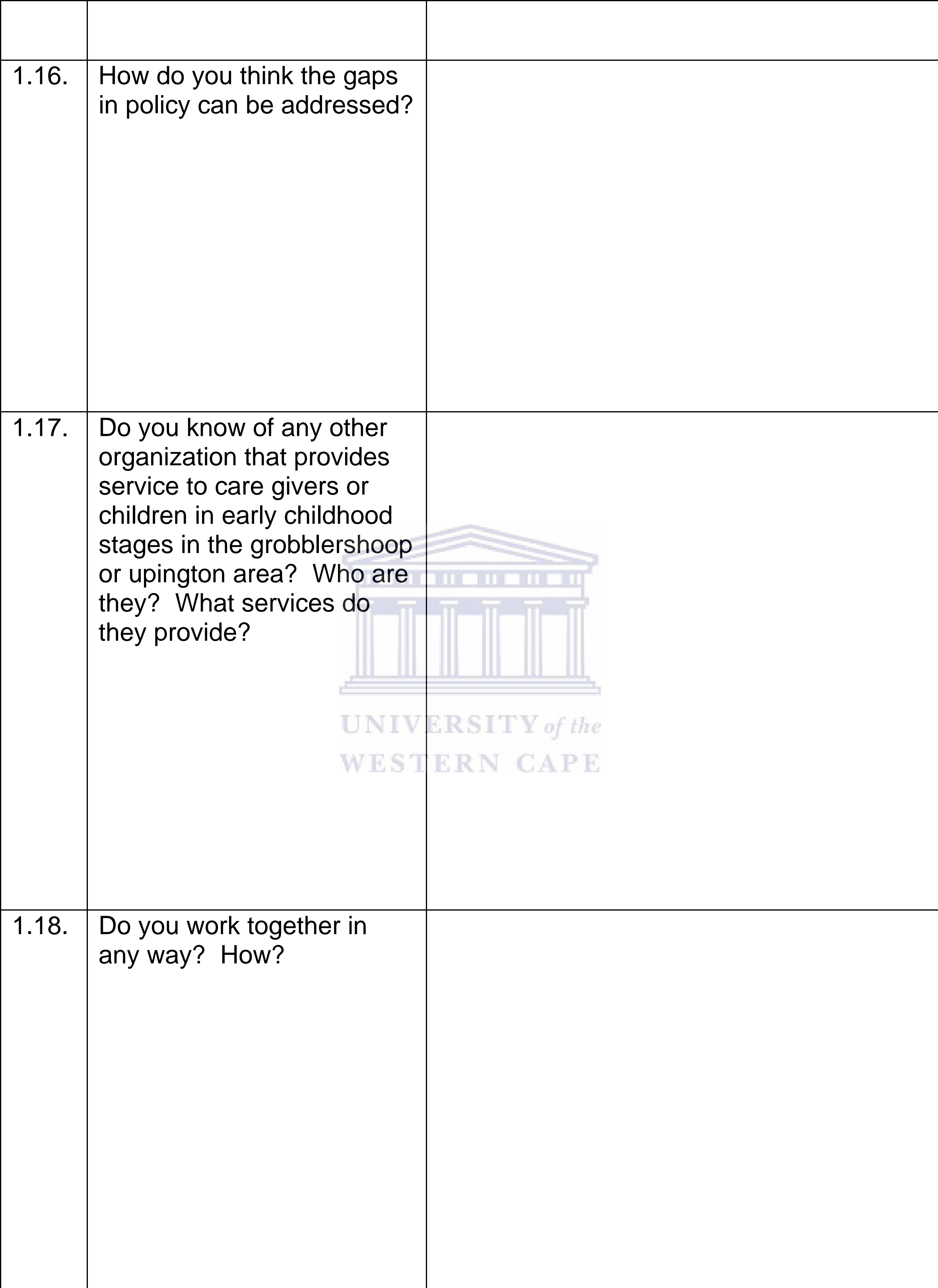

1.16.	How do you think the gaps in policy can be addressed?	
1.17.	Do you know of any other organization that provides service to care givers or children in early childhood stages in the grobblershoop or upington area? Who are they? What services do they provide?	
1.18.	Do you work together in any way? How?	

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Thank you for taking the time to complete this interview with me.

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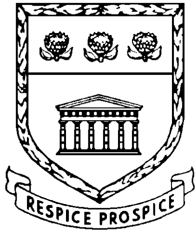

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Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592277, Fax: 27 21-959
E-mail: training@cjcp.org.za

INFORMATION SHEET

Project Title: Towards developing an understanding of the conversion factors and its impact on care giving of children between birth and 6 years from the Groblershoop community.

What is this study about?
This is a research project being conducted by Faeza Khan, from the social work department at the University of the Western Cape. We are inviting you to participate in this research project because you have a child 6 years or younger and have been identified as being the caregiver of the child. The purpose of this research project is to make sure that projects that are established in your community will better assist you in caring for your children.

What will I be asked to do if I agree to participate?
You will be asked to participate in an individual interview or a group interview. These interviews will take place in Groblershoop at a venue that is convienant for you and will be approximately an hour long. You may also be asked if I could come to observe you and your child in your home environment. If you participate in the individual interview, I will ask you questions about yourself in terms of your age, your educational level, whether you can read or write and find out more about a typical day in Groblershoop. I will also ask you about what resources you have to help you look after your child. If you participate in the group interview I will ask you to draw a map showing me where the resources are in your community and we will have a discussion as a group about the resources that have been identified. If you are comfortable to invite me into your home, I will observe the interaction between yourself and your child for short periods of time and may need to come back to your home a few times to assist me to understand your challenges in caring for your child.

Would my participation in this study be kept confidential?
We will do our best to keep your personal information confidential. To help protect your confidentiality, we will not record your name during any of the interviews or the observation process. All the information collected during the research process will be stored in a locked cabinet and passwords will be used for any computer files. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There may be some risks from participating in this research study. You may feel uncomfortable or embarrassed to have me come to your home to observe you with your child. It may also be exhausting emotionally to have the presence of a stranger in your home. Telling a stranger about your life may also not be easy and you may find that you do not speak easily about yourself.

What are the benefits of this research?
The results of this research hopes to ensure that future programmes that will be established in the Groblershoop community will understand the different needs of caregivers and can assist you in accessing resources so that you can better look after your children.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?
Counselling and workshops on parenting will be provided to you if you require them. If there are any other issues which may arise the researcher will in as far as possible ensure that you are referred for assistance.

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What if I have questions?
This research is being conducted by Faeza Khan from the Social Work Department at the University of the Western Cape. If you have any questions about the research study itself, please contact Faeza Khan at: 0833877102 or write to me, 98 Jupiter Street, Surrey Estate, Cape Town.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Head of Department:
Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
Private Bag X17
Bellville 7535
This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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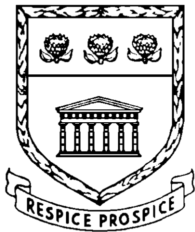

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CONSENT FORM

Title of Research Project: Towards developing an understanding of the conversion factors and its impact on care giving of children between birth and 6 years from the Grobblershoop community.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.
This research project involves making tape recording the interviews between you and the researcher. The tape recordings are made so that the researcher can correctly record what your responses to the questions are. The tapes will be transcribed and then destroyed. Your identity will be kept confidential and will not be mentioned on the transcriptions.

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___ I agree to be audio taped during my participation in this study.

___ I do not agree to be audio taped during my participation in this study.

Participant's name………………………..

Participant's signature……………………………….

Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Faeza Khan

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959- 2277

Cell: 0833877102

Fax: (021) 6853284

Email: training@cjcp.org.za

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(this list has been adapted from the Personal Touch Early Intervention Programme – Early childhood centre New York)

DEVELOPMENTAL CHECKLIST - 1 TO 3 MONTHS

CHILD'SNAME:____
DOB:____
PARENT OR
GUARDIAN:____

MOVEMENT DATE OBSERVED:

☐ RAISES HEAD AND CHEST WHEN LYING ON STOMACH (3 MOS.) __________

☐ SUPPORTS UPPER BODY WITH ARMS WHEN LYING ON STOMACH (3 MOS.) __________

☐ STRETCHES LEGS OUT WHEN LYING ON STOMACH OR BACK (2-3 MOS.) __________

☐ OPENS AND SHUTS HANDS (2-3 MOS.) __________

☐ PUSHES DOWN ON HIS LEGS WHEN HIS FEET ARE PLACED ON FIRM SURFACE (3 MOS) __________

VISUAL

☐ WATCHES FACE INTENTLY (2-3 MOS.) __________

☐ FOLLOWS MOVING OBJECTS (2 MOS.) __________

☐ RECOGNIZES FAMILIAR OBJECTS AND PEOPLE AT A DISTANCE (3 MOS.) __________

☐ STARTS USING HANDS AND EYES IN COORDINATION (3 MOS.) __________

HEARING AND SPEECH

☐ SMILES AT THE SOUND OF VOICE (2-3 MOS.) __________

☐ COOING NOISES; VOCAL PLAY BEGINS AT 3 MOS. __________

☐ ATTENDS TO SOUND (1-3 MOS.) __________

☐ STARTLES TO LOUD NOISE (1-3 MOS.) __________

SOCIAL/EMOTIONAL

☐ BEGINS TO DEVELOP A SOCIAL SMILE (1-3 MOS.) __________

☐ ENJOYS PLAYING WITH OTHER PEOPLE AND MAY CRY WHEN PLAYING STOPS (2-3 MOS.) __________

☐ BECOMES MORE COMMUNICATIVE AND EXPRESSIVE WITH FACE & BODY (2-3 MOS.) __________

☐ IMITATES SOME MOVEMENTS AND FACIAL EXPRESSIONS __________

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DEVELOPMENTAL RED FLAGS

1 TO 3 MONTHS

DOESN'T SEEM TO RESPOND TO LOUD NOISES

DOESN'T FOLLOW MOVING OBJECTS WITH EYES BY 2 TO 3 MONTHS

DOESN'T SMILE AT THE SOUND OF YOUR VOICE BY 2 MONTHS

DOESN'T GRASP AND HOLD OBJECTS BY THREE MONTHS

DOESN'T SMILE AT PEOPLE BY 3 MONTHS

CANNOT SUPPORT HIS HEAD WELL AT 3 MONTHS

DOESN'T REACH FOR AND GRASP TOYS BY 3 TO 4 MONTHS

DOESN'T BRING OBJECTS TO HER MOUTH BY 4 MONTHS

DOESN'T PUSH DOWN WITH LEGS WHEN HIS FEET ARE PLACED ON A FIRM SURFACE BY 4 MONTHS

HAS TROUBLE MOVING ONE OR BOTH EYES IN ALL DIRECTIONS

CROSSES HER EYES MOST OF THE TIME (OCCASIONAL CROSSING OF THE EYES IS NORMAL IN THESE FIRST MONTHS

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DEVELOPMENTAL CHECKLIST - 4 TO 7 MONTHS

CHILD'S NAME:____

DATE OF BIRTH:____

PARENT OR GUARDIAN:____

MOVEMENT DATE OBSERVED:

☐ PUSHES UP ON EXTENDED ARMS (5 MOS.) __________

☐ PULLS TO SITTING WITH NO HEAD LAG (5 MOS.) __________

☐ SITS WITH SUPPORT OF HIS HANDS (5-6 MOS.) __________

☐ SITS UNSUPPORTED FOR SHORT PERIODS (6-8 MOS.) __________

☐ SUPPORTS HIS/HER WHOLE WEIGHT ON HIS/HER LEGS (6-7 MOS.) __________

☐ GRASPS FEET (6 MOS.) __________

☐ TRANSFERS OBJECTS FROM HAND TO HAND (6-7 MOS.) __________

☐ USES RAKING GRASP (NOT PINCER) (6 MOS.) __________

VISUAL

☐ LOOKS FOR TOY BEYOND TRACKING RANGE (5-6 MOS.) __________

☐ TRACKS MOVING OBJECTS WITH EASE (4-7 MOS.) __________

☐ GRASPS OBJECTS DANGLING IN FRONT OF HIM (5-6 MOS.) __________

☐ LOOKS FOR FALLEN TOYS (5-7 MOS.) __________

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LANGUAGE

☐ DISTINGUISHES EMOTIONS BY TONE OF VOICE (4-7 MOS.) __________

☐ RESPONDS TO SOUND BY MAKING SOUNDS (4-6 MOS.) __________

☐ USES VOICE TO EXPRESS JOY AND DISPLEASURE (4-6 MOS.) __________

☐ SYLLABLE REPETITION BEGINS (5-7 MOS.) __________

COGNITIVE DATE OBSERVED

☐ FINDS PARTIALLY HIDDEN OBJECTS (6-7 MOS.) __________

☐ EXPLORES WITH HANDS AND MOUTH (4-7 MOS.) __________

☐ STRUGGLES TO GET OBJECTS THAT ARE OUT OF REACH (5-7 MOS.) __________

SOCIAL EMOTIONAL

☐ ENJOYS SOCIAL PLAY (4-7 MOS.) __________

☐ INTERESTED IN MIRROR IMAGES (5-7 MOS.) __________

☐ RESPONDS TO OTHER PEOPLE'S EXPRESSION OF EMOTION (4-7 MOS.) __________

DEVELOPMENTAL RED FLAGS
4 TO 7 MONTHS

SEEMS VERY STIFF, TIGHT MUSCLES
SEEMS VERY FLOPPY, LIKE A RAG DOLL
HEAD STILL FLOPS BACK WHEN BODY IS PULLED TO SITTING POSITION (by 5 months stills exhibits head lag)
SHOWS NO AFFECTION FOR THE PERSON WHO CARES FOR HIM/HER
DOESN'T SEEM TO ENJOY BEING AROUND PEOPLE
ONE OR BOTH EYES CONSISTENTLY TURN IN OR OUT
PERSISTENT TEARING, EYE DRAINAGE, OR SENSITIVITY TO LIGHT
DOES NOT RESPOND TO SOUNDS AROUND HIM
HAS DIFFICULTY GETTING OBJECTS TO HER MOUTH
DOES NOT TURN HIS HEAD TO LOCATE SOUNDS BY 4 MONTHS
DOESN'T ROLL OVER (STOMACH TO BACK) BY SIX MONTHS
CANNOT SIT WITH HELP BY SIX MONTHS (NOT BY THEMSELVES)
DOES NOT LAUGH OR MAKE SQUEALING SOUNDS BY FIVE MONTHS
DOES NOT ACTIVELY REACH FOR OBJECTS BY SIX MONTHS
DOESN'T FOLLOW OBJECTS WITH BOTH EYES
DOES NOT BEAR SOME WEIGHT ON LEGS BY FIVE MONTHS

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DEVELOPMENTAL CHECKLIST - 8 TO 12 MONTHS

CHILD'S NAME:____

DATE OF BIRTH:____

PARENT OR GUARDIAN:____

MOVEMENT DATE OBSERVED:

- ☐ GETS TO SITTING POSITION WITHOUT ASSISTANCE (8-10 MOS.) __________
- ☐ CRAWLS FORWARD ON BELLY __________
- ☐ ASSUMES HAND AND KNEE POSITION __________
- ☐ CREEPS ON HANDS AND KNEES __________
- ☐ GETS FROM SITTING TO CRAWLING OR PRONE __________
- ☐ (LYING ON STOMACH) POSITION (10-12 MOS.) __________
- ☐ PULLS SELF UP TO STANDING POSITION __________
- ☐ WALKS HOLDING ON TO FURNITURE __________
- ☐ STANDS MOMENTARILY WITHOUT SUPPORT __________
- ☐ MAY WALK TWO OR THREE STEPS WITHOUT SUPPORT __________

HAND AND FINGER SKILLS

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- ☐ USES PINCER GRASP (7-10 MOS.) __________
- ☐ BANGS TWO CUBES TOGETHER __________
- ☐ PUTS OBJECTS INTO CONTAINER (10-12 MOS.) __________
- ☐ TAKES OBJECTS OUT OF CONTAINER (10-12 MOS.) __________
- ☐ POKES WITH INDEX FINGER __________
- ☐ TRIES TO IMITATE SCRIBBLING __________

COGNITIVE DATE OBSERVED

- ☐ EXPLORES OBJECTS IN MANY DIFFERENT WAYS (SHAKING, BANGING, __________ THROWING, DROPPING (8-10 MOS.)
- ☐ FINDS HIDDEN OBJECTS EASILY (10-12 MOS.) __________
- ☐ LOOKS AT CORRECT PICTURE WHEN IMAGE IS NAMES __________
- ☐ IMITATES GESTURES (9-12 MOS.) __________

LANGUAGE MILESTONES

- ☐ RESPONDS TO SIMPLE VERBAL REQUESTS __________
- ☐ RESPONDS TO "NO" __________
- ☐ MAKES SIMPLE GESTURES SUCH AS SHAKING HEAD FOR NO (8-12 MOS.) __________

☐ BABBLES WITH INFLECTION (8-10 MOS.) __________

☐ BABBLES “DADA” AND “MAMA” (8-10 MOS.) __________

☐ SAYS “DADA” AND “MAMA” FOR SPECIFIC PERSON (11-12 MOS.) __________

☐ USES EXCLAMATIONS SUCH AS “OH-OH” ________ __

SOCIAL/EMOTIONAL

☐ SHY OR ANXIOUS WITH STRANGERS (8-12 MOS.) __________

☐ CRIES WHEN MOTHER OR FATHER LEAVES (8-12 MOS.) __________

☐ ENJOYS IMITATING PEOPLE IN HIS PLAY (10-12 MOS.) __________

☐ SHOWS SPECIFIC PREFERENCES FOR CERTAIN PEOPLE AND TOYS (8-12 MOS.) __________

☐ PREFERS MOTHER AND/OR REGULAR CARE PROVIDER OVER ALL OTHERS (8-12 MOS.) __________

☐ REPEATS SOUNDS OR GESTURES FOR ATTENTION (10-12 MOS.) __________

☐ FINGER-FEEDS HIMSELF (8-12 MOS.) __________

☐ EXTENDS ARM OR LEG TO HELP WHEN BEING DRESSED __________

DEVELOPMENTAL RED FLAGS
8 TO 12 MONTHS

DOES NOT CRAWL
DRAGS ONE SIDE OF BODY WHILE CRAWLING (FOR OVER ONE MONTH)
CANNOT STAND WHEN SUPPORTED
DOES NOT SEARCH FOR OBJECTS THAT ARE HIDDEN (10-12 MOS.)
SAYS NO SINGLE WORDS (“MAMA” OR “DADA”)
DOES NOT LEARN TO USE GESTURES SUCH AS WAVING OR SHAKING HEAD
DOES NOT SIT STEADILY BY TEN MONTHS
DOES NOT SHOW INTEREST IN “PEEK-A-BOO OR PATTY CAKE” BY 8 MOS.
DOES NOT BABBLE BY 8 MOS.
DOES NOT BABBLE BY 8 MOS. (“DA DA,” “BA BA”, “MA MA”)

DEVELOPMENTAL CHECKLIST - 12 TO 24 MONTHS

CHILD'S NAME:____

DATE OF BIRTH:____

PARENT OR GUARDIAN:____

MOVEMENT DATE OBSERVED:

☐ WALKS ALONE (12-16 MOS.) __________

☐ PULLS TOYS BEHIND HIM WHILE WALKING (13-16 MOS.) __________

☐ CARRIES LARGE TOY OR SEVERAL TOYS WHILE WALKING (12-15 MOS.) __________

☐ BEGINS TO RUN STIFFLY (16-18 MOS.) __________

☐ WALKS INTO BALL (18-24 MOS.) __________

☐ CLIMBS ONTO AND DOWN FROM FURNITURE UNSUPPORTED (16-24 MOS.) __________

☐ WALKS UP AND DOWN STAIRS HOLDING ON TO SUPPORT (18-24 MOS.) __________

HAND AND FINGER SKILLS

☐ SCRIBBLES SPONTANEOUSLY (14-16 MOS.) __________

☐ TURNS OVER CONTAINER TO POUR OUT CONTENTS (12-18 MOS.) __________

☐ BUILDING TOWER OF FOUR BLOCKS, OR MORE (20-24 MOS.) __________

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LANGUAGE

☐ POINTS TO OBJECT OR PICTURE WHEN IT'S NAMED FOR HIM (18-24 MOS.) __________

☐ RECOGNIZES NAMES OF FAMILIAR PEOPLE OBJECTS, AND BODY PARTS (18-24 MOS.) __________

☐ SAYS SEVERAL SINGLE WORDS (15 TO 18 MONTHS) __________

☐ USES TWO WORD SENTENCES (18 TO 24 MONTHS) __________

☐ FOLLOWS SIMPLE ONE STEP INSTRUCTIONS (14-18 MOS.) __________

☐ REPEATS WORDS OVERHEARD IN CONVERSATIONS (16-18 MOS.) __________

COGNITIVE DATE OBSERVED

☐ FINDS OBJECTS EVEN WHEN HIDDEN UNDER 2 OR 3 COVERS __________

☐ BEGINS TO SORT SHAPES AND COLORS (20-24 MOS.) __________

☐ BEGINS MAKE-BELIEVE PLAY (20-24 MOS.) __________

SOCIAL

☐ IMITATES BEHAVIOR OR OTHERS, ESPECIALLY ADULTS AND OLDER __________ CHILDREN (18-24 MOS.).

☐ INCREASINGLY ENTHUSIASTIC ABOUT COMPANY OR OTHER CHILDREN (20-24 MOS.) __________

☐ DEMONSTRATES INCREASING INDEPENDENCE (18-24 MOS.) __________

☐ BEGINS TO SHOW DEFIANT BEHAVIOR (18-24 MOS.) __________

☐ EPISODES OF SEPARATION ANXIETY INCREASE TOWARD MIDYEAR, THEN FADE ___

DEVELOPMENTAL RED FLAGS
12 TO 24 MONTHS

CANNOT WALK BY EIGHTEEN MONTHS

FAILS TO DEVELOP A MATURE HEEL-TOE WALKING PATTERN AFTER SEVERAL MONTHS OF WALKING, OR WALKS EXCLUSIVELY ON HIS TOES

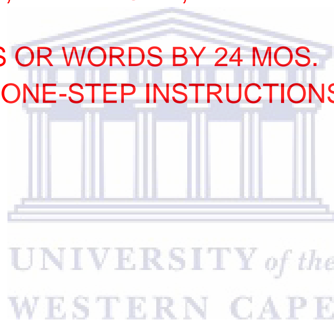
DOES NOT SPEAK AT LEAST FIFTEEN WORDS BY EIGHTEEN MONTHS

DOES NOT USE TWO WORD SENTENCES BY AGE TWO

BY FIFTEEN MONTHS DOES NOT SEEM TO KNOW THE FUNCTION OF COMMON HOUSEHOLD OBJECTS (BRUSH, TELEPHONE, BELL, FORK, SPOON)

DOES NOT IMITATE ACTIONS OR WORDS BY 24 MOS.

DOES NOT FOLLOW SIMPLE ONE-STEP INSTRUCTIONS BY 24 MOS.



DEVELOPMENTAL CHECKLIST - 24 TO 36 MONTHS

CHILD'S NAME:____

DATE OF BIRTH:____

PARENT OR GUARDIAN:____

MOVEMENT DATE OBSERVED

☐ CLIMBS WELL (24-30 MOS.) __________

☐ WALKS DOWN STAIRS ALONE, PLACING BOTH FEET ON EACH STEP (26-28 MOS.) __________

☐ WALKS UP STAIRS ALTERNATING FEET WITH SUPPORT (24-30 MOS.) __________

☐ SWINGS LEG TO KICK BALL (24-30 MOS.) __________

☐ RUNS EASILY (24-26 MOS.) __________

☐ PEDALS TRICYCLE (30-36 MOS.) __________

☐ BENDS OVER EASILY WITHOUT FALLING (24-30 MOS.) __________

HAND AND FINGER SKILLS

☐ MAKES VERTICAL, HORIZONTAL, CIRCULAR STROKES WITH PENCIL OR CRAYON (30-36 MOS.) __________

☐ TURNS BOOK PAGES ONE AT A TIME (24-30 MOS.) __________

☐ BUILDS A TOWER OR MORE THAN SIX BLOCKS (24-30 MOS.) __________

☐ HOLDS A PENCIL IN WRITING POSITION (30-36 MOS.) __________

☐ SCREWS AND UNSCREWS JAR LIDS, NUTS, AND BOLTS (24-30 MOS.) __________

☐ TURNS ROTATING HANDLES (24-30 MOS.) __________

LANGUAGE

☐ RECOGNIZES AND IDENTIFIES ALMOST ALL COMMON OBJECTS AND PICTURES (26-32 MOS.) __________

☐ UNDERSTAND MOST SENTENCES (24-40 MOS.) __________

LANGUAGE DATE OBSERVED

☐ UNDERSTANDS PHYSICAL RELATIONSHIP (ON, IN, UNDER) (30-36 MOS.) __________

☐ CAN SAY NAME, AGE, AND SEX (30-36 MOS.) __________

☐ USES PRONOUNS (I, YOU, ME, WE, THEY) (24-30 MOS.) __________

☐ STRANGERS CAN UNDERSTAND MOST OF HIS/HER WORDS (3-36 MOS.) __________

COGNITIVE

☐ MAKES MECHANICAL TOYS WORK (30-36 MOS.) __________

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☐ MATCHES AN OBJECT IN HIS HAND OR ROOM TO A PICTURE IN A BOOK (24-30 MOS.) _________

☐ PLAYS MAKE BELIEVE WITH DOLLS, ANIMALS, AND PEOPLE (24-36 MOS.) _________

☐ SORTS OBJECTS BY COLOR (30-36 MOS.) _________

☐ COMPLETES PUZZLES WITH THREE OR FOUR PIECES (24-36 MOS.) _________

☐ UNDERSTANDS CONCEPT OF "TWO" (26-32 MOS.) _________

SOCIAL/EMOTIONAL

☐ BY THREE, SEPARATES EASILY FROM PARENTS _________

☐ EXPRESSES A WIDE RANGE OF EMOTIONS (24-36 MOS.) _________

☐ OBJECTS TO MAJOR CHANGES IN ROUTINE (24-36 MOS.) _________

DEVELOPMENTAL RED FLAGS
24 TO 36 MONTHS

FREQUENT FALLING AND DIFFICULTY WITH STAIRS
PERSISTENT DROOLING OR VERY UNCLEAR SPEECH
NABILITY TO BUILD A TOWER OF MORE THAN FOUR BLOCKS
DIFFICULTY MANIPULATING SMALL OBJECTS
INABILITY TO COPY A CIRCLE BY THREE
INABILITY TO COMMUNICATE IN SHORT PHRASES
NO INVOLVEMENT IN PRETEND PLAY
FAILURE TO UNDERSTAND SIMPLE INSTRUCTIONS
LITTLE INTEREST IN OTHER CHILDREN
EXTREME DIFFICULTY SEPARATING FROM PRIMARY CAREGIVER

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DEVELOPMENTAL CHECKLIST - 3 TO 4 YEARS

CHILD'S NAME:

DATE OF BIRTH:

PARENT OR GUARDIAN:

MOVEMENT (BY THE END OF AGE 3) DATE OBSERVED

- ☐ HOPS AND STANDS ON ONE FOOT UP TO FIVE SECONDS ____________
- ☐ GOES UPSTAIRS AND DOWNSTAIRS WITHOUT SUPPORT ____________
- ☐ KICKS BALL FORWARD ____________
- ☐ THROWS BALL OVERHAND ____________
- ☐ CATCHES BOUNCED BALL MOST OF THE TIME ____________
- ☐ MOVES FORWARD AND BACKWARD ____________
- ☐ USES RIDING TOYS ____________

HAND AND FINGER SKILLS (BY THE END OF AGE 3)

- ☐ COPIES SQUARE SHAPES ____________
- ☐ DRAWS A PERSON WITH TWO TO FOUR BODY PARTS ____________
- ☐ USES SCISSORS ____________
- ☐ DRAWS CIRCLES AND SQUARES ____________
- ☐ BEGINS TO COPY SOME CAPITAL LETTERS ____________
- ☐ CAN FEED SELF WITH SPOON ____________

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LANGUAGE MILESTONES (BY THE END OF AGE 3) DATE OBSERVED

- ☐ UNDERSTANDS THE CONCEPTS OF "SAME" AND "DIFFERENT" ____________
- ☐ HAS MASTERED SOME BASIC RULES OF GRAMMAR ____________
- ☐ SPEAKS IN SENTENCES OF FIVE TO SIX WORDS ____________
- ☐ ASKS QUESTIONS ____________
- ☐ SPEAKS CLEARLY ENOUGH FOR STRANGERS TO UNDERSTAND ____________
- ☐ TELLS STORIES ____________

COGNITIVE MILESTONES (BY THE END AGE 3)

- ☐ CORRECTLY NAMES SOME COLORS ____________
- ☐ UNDERSTANDS THE CONCEPT OF COUNTING AND MAY KNOW A FEW NUMBERS ____________
- ☐ BEGINS TO HAVE A CLEARER SENSE OF TIME ____________
- ☐ FOLLOWS THREE PART COMMANDS ________ ____

☐ RECALLS PARTS OF A STORY ___________

☐ UNDERSTANDS THE CONCEPT OF SAME/DIFFERENT ___________

☐ ENGAGES IN FANTASY PLAY ___________

☐ UNDERSTANDS CAUSALITY ("I CAN MAKE THINGS HAPPEN") ___________

SOCIAL MILESTONES (BY THE END OF AGE 3)

☐ INTERESTED IN NEW EXPERIENCES ___________

☐ COOPERATES/PLAYS WITH OTHER CHILDREN ___________

☐ PLAYS "MOM "OR "DAD" ___________

☐ MORE INVENTIVE IN FANTASY PLAY ___________

☐ DRESSES AND UNDRESSES ___________

☐ MORE INDEPENDENT ___________

EMOTIONAL MILESTONES (BY THE END OF AGE 3) DATE OBSERVED

☐ OFTEN CANNOT DISTINGUISH BETWEEN FANTASY AND REALITY ___________

☐ MAY HAVE IMAGINARY FRIENDS OR SEE MONSTERS ___________

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DEVELOPMENTAL RED FLAGS
3 TO 4 YEARS

CANNOT JUMP IN PLACE
CANNOT RIDE A TRIKE
CANNOT GRASP A CRAYON BETWEEN THUMB AND FINGERS
HAS DIFFICULTY SCRIBBLING
CANNOT COPY A CIRCLE
CANNOT STACK FOUR BLOCKS
STILL CLINGS OR CRIES WHEN PARENTS LEAVE HIM
SHOWS NO INTEREST IN INTERACTIVE GAMES
IGNORES OTHER CHILDREN
DOESN'T RESPOND TO PEOPLE OUTSIDE THE FAMILY
DOESN'T ENGAGE IN FANTASY PLAY
RESISTS DRESSING, SLEEPING, USING THE TOILET
LASHES OUT WITHOUT ANY SELF-CONTROL WHEN ANGRY OR UPSET
DOESN'T USE SENTENCES OF MORE THAN THREE WORKS
DOESN'T USE "ME" OR "YOU" APPROPRIATELY

DEVELOPMENTAL CHECKLIST - 4 TO 5 YEARS

CHILD'S NAME:

DATE OF BIRTH:

PARENT OR GUARDIAN:

MOVEMENT (BY THE END OF AGE 4) DATE OBSERVED

- ☐ STANDS ON ONE FOOT FOR 10 SECONDS OR LONGER ___________
- ☐ HOPS, SOMERSAULTS ___________
- ☐ SWINGS, CLIMBS ___________
- ☐ MAY BE ABLE TO SKIP ___________

MILESTONES IN HAND AND FINGER SKILLS (BY THE END OF AGE 4)

- ☐ COPIES TRIANGLE AND OTHER GEOMETRIC PATTERNS ___________
- ☐ DRAWS PERSON WITH BODY ___________
- ☐ PRINTS SOME LETTERS ___________
- ☐ DRESSES AND UNDRESSES WITHOUT ASSISTANCE ___________
- ☐ USES FORK, SPOON ___________
- ☐ USUALLY CARES FOR OWN TOILET NEEDS ___________

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LANGUAGE MILESTONES BY THE END OF AGE 4

- ☐ RECALLS PARTS OF A STORY ___________
- ☐ SPEAKS SENTENCES OF MORE THAN FIVE WORDS ___________
- ☐ USES FUTURE TENSE ___________
- ☐ TELLS LONGER STORIES ___________
- ☐ SAYS NAME AND ADDRESS ___________

COGNITIVE MILESTONES BY THE END OF AGE 4 DATE OBSERVED

- ☐ CAN COUNT TEN OR MORE OBJECTS ___________
- ☐ CORRECTLY NAMES AT LEAST 4 COLORS ___________
- ☐ BETTER UNDERSTANDS THE CONCEPT OF TIME ___________
- ☐ KNOWS ABOUT THINGS USED EVERY DAY IN THE HOME (MONEY, FOOD, ETC.) ____

SOCIAL MILESTONES BY THE END OF AGE 4

- ☐ WANTS TO PLEASE AND BE WITH FRIENDS ___________
- ☐ MORE LIKELY TO AGREE TO RULES ___________
- ☐ LIKES TO SING, DANCE, AND ACT ___________

☐ SHOWS MORE INDEPENDENCE ___________

DEVELOPMENTAL RED FLAGS

4 TO 5 YEARS

EXHIBITS EXTREMELY AGGRESSIVE, FEARFUL OR TIMID BEHAVIOR

IS UNABLE TO SEPARATE FROM PARENTS

IS EASILY DISTRACTED AND UNABLE TO CONCENTRATE ON ANY SINGLE ACTIVITY FOR MORE THAN FIVE MINUTES

SHOWS LITTLE INTEREST IN PLAYING WITH OTHER CHILDREN

REFUSES TO RESPOND TO PEOPLE IN GENERAL

RARELY USES FANTASY OR IMITATION IN PLAY

SEEMS UNHAPPY OR SAD MUCH OF THE TIME

AVOIDS OR SEEMS ALOOF WITH OTHER CHILDREN AND ADULTS

DOESN'T EXPRESS A WIDE RANGE OF EMOTIONS

HAS TROUBLE EATING, SLEEPING OR USING THE TOILET

CAN'T DIFFERENTIATE BETWEEN FANTASY AND REALITY

SEEMS UNUSUALLY PASSIVE

CANNOT UNDERSTAND TWO PART COMMANDS AND PREPOSITIONS (EX: "PUT THE CUP ON THE TABLE")

CAN'T GIVE HIS FIRST AND LAST NAME

DOESN'T USE PLURALS OR PAST TENSE

CANNOT BUILD A TOWER OF 6 TO 8 BLOCKS

SEEMS UNCOMFORTABLE HOLDING A CRAYON

HAS TROUBLE TAKING OFF CLOTHING

CANNOT BRUSH HIS TEETH OR WASH AND DRY HIS HANDS

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DEVELOPMENTAL MILESTONES – 6YEARS

Child Name: ____

DOB:____

Parent/Guardian____

Physical Movement: Date Observed
- ✓ Able to do handstands_______
- ✓ Hit a ball_______
- ✓ Ride a two wheeler bike fast_____
- ✓ Able to draw a picture of a house and it will include a garden and sky_______
- ✓ Like to climb, run, jump, skip, ______
- ✓ Be able to throw and catch a ball_______

Speech and Language Development
- ✓ Child knows the different tenses and is able to use the correct tenses in sentences________
- ✓ Able to tell jokes or riddles______
- ✓ Begin to enjoy a book on their own_____
- ✓ Speak fluently___
- ✓ Read out loud_______

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Social Emotional Development
- ✓ Beginning to be more responsible______
- ✓ Understanding of what rules are________
- ✓ Like to win at games________
- ✓ Bit bossy or still very shy______
- ✓ May tell lies or take thing that don't belong_______
- ✓ Like going to school unless problems at school___
- ✓ Have an understanding of money___
- ✓ Know left from right______

DEVELOPMENTAL DELAYS OR RED FLAGS
- ✓ Your child has a problem making friends_____
- ✓ Regularly being aggressive or a bully______
- ✓ Frequently lying or stealing_____
- ✓ Child has difficulty separating from you_____
- ✓ Unable to keep up with other children______
- ✓ Have problems with bowel or bladder and no physical cause____