

# Negotiating the care of children and support for caregivers

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All children need care to survive, thrive and grow to adulthood into adulthood. Decisions about childcare are not always straightforward. According to the Children's Act,<sup>1</sup> such decisions ought to be made with the "best interests of the child" in mind. But what the "best interests of the child" means is not always the same for different people and stakeholders.

There are a variety of care options available, ranging from care within the child's biological family to care in state institutions. Irrespective of the form or place of childcare, two issues remain constant in all arrangements: First, care for children is usually provided in families and households where women are the main caregivers, and second, decisions about childcare are rarely made by an individual but involve negotiations within families, between families, and at times between families and the state.

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*Survival pressures and livelihood needs impact deeply on what families can do to provide care.*

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In South Africa, the decisions, opportunities and resources available for caring for children are rooted in – and deeply intertwined with – systems of inequality that are experienced along the lines of race, gender and class. The apartheid regime's deliberate and systematic incursion into family life has meant that the contexts in which children are cared for – and the ability of families to secure care – are often circumscribed by variables beyond the control of the family. Indeed, the formation and composition of families is not simply a logical outcome of biological reproduction or marriage. Historical and social processes weave into how families are constituted and are at the centre of decisions and practices surrounding childcare. As noted in the introduction, families are varied, fluid and flexible – at times, resilient and at other times, fragile. Families also change over time and as they change, so too do configurations of care. This essay focuses on childcare and children's caregivers and aims to

address the following questions:

- Who provides care for children?
- How does the state support or undermine care choices?
- Why and how should the state support caregivers?

## Who provides care for children?

Care work is physically demanding; it may include growing, harvesting, purchasing and preparing food, cleaning and home maintenance, assisting with transport, medical appointments, liaising with government staff and others, and assisting children with social interactions, as well as personal tasks such as lifting, carrying, washing, going to the toilet, and feeding. It is also emotionally demanding.

## Negotiating care

In most families, the willingness to provide care to others flows from the quality of relationships. To a large extent, in "primary" relationships, people care for the people that they have affection for. However, the capacity to care and the decisions about who undertakes care go beyond the quality of relationships and are influenced by normative expectations, and social and economic factors including who is available to provide care and who needs to earn money.

Children's experience of care is inextricably woven into the social fabric. For most families in South Africa, childcare arrangements are made in a context of low rates of marriage and cohabitation, and high rates of HIV, poverty and unemployment. Survival pressures and livelihood needs impact deeply on what families can do to provide care. Those who face hardship are likely to have limited choices about how to respond to child-care demands.

For example, a comparative study examined the role that fathers and paternal family play in acknowledging and caring for children born outside of recognised unions in rural Lesotho and urban South Africa. It noted that despite similarities between the two communities (high HIV, high unemployment and a decrease in marriage rates and the payment of damages), there were important differences in how and when the mother's family made claims on the family of the biological father.<sup>2</sup> In

## Case 8: Negotiating care at the intersection of intergenerational fertility

Alison Swartz

Mambele was born in rural Tarkastad in the Eastern Cape in 1944. She married in her late teens and although she did not want children yet, she had the first of her seven children at 19. Ntombi, her second last child, was born in 1979 when she was 35 years old. By the time her last child, a son, was born in 1985, Mambele's childbearing period spanned a total of 21 years. Mambele moved her family from Tarkastad to Khayelitsha in 1985 when Ntombi was a little girl. Ntombi discovered that she was pregnant when she was 16 and had just started Grade 11. When the father denied paternity, Ntombi dropped out of school, hoping to find work to support herself and her baby. Despite her efforts, she was unable to find employment. She struggled to care for her daughter, Zabi. To help her daughter,

Mambele became Zabi's primary caregiver. Ntombi had two more daughters, Sindi and Londiwe. In 2013, when Zabi was 16 and her mother was 33, Zabi found out she was pregnant. Sandile denied paternity at first, but after seeing the child his family verified that he was the father. He made little contribution towards caring for his daughter, Thandiwe, financially or otherwise. When Thandiwe was almost two years old, Ntombi, Zabi's mother, had another child – her fourth daughter.

This case illustrates intergenerational patterns of fertility, and the ways in which female relatives share childcare responsibilities across generations, particularly when mothers are young and fathers are absent, unable to provide support or deny paternity.

Mokhotlong, Lesotho, women refused to acknowledge their partner's claim to paternity, while in Nyanga East, South Africa, cultural norms were disregarded to allow fathers and paternal families access to a child. Yet despite these different outcomes, the decisions families made around childcare were based on similar factors: geography, availability of kinship networks, education and employment opportunities.

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In resource poor settings, aspirational, economic and social forces push working-age adults to migrate for work, leaving children in the care of elderly kin. The deaths and illnesses of working age adults from HIV in previous decades contributed to older people assuming the role of caregiver for their co-resident grandchildren and for these children themselves to perform care work when elders could not. Today, increased access to antiretrovirals allows women, who might have previously needed care, to make decisions about work and having children. Such biomedical advances are affecting the negotiation of care within families, and this is particularly so within "young families".<sup>i</sup> In such situations, when decisions about childcare are made, education opportunities for

young mothers are often weighed up against employment opportunities which could bring much needed income into the household. This is particularly challenging for younger teenaged parents or heads of child-headed households as caregivers of children can only qualify for the Child Support Grant (CSG) from the age of 16.<sup>3</sup>

### Women providing care

Demographic and other data about co-residence and care arrangements make it clear that women (particularly unemployed women) are the main caregivers for children. Women, as mothers, sisters, daughters and so on, are expected to provide childcare and other forms of routine care such as cleaning and cooking. Since care is deeply gendered, the health and well-being of the mother and the reproductive aspirations of other female kin are also important considerations.

To some extent decisions about care begin while the child is *in utero*. For example, how and when a pregnancy is announced impact on subsequent decisions about where a child belongs and who will care for the child. Teenage girls often report that they only realised that they were pregnant five or six months into the pregnancy.<sup>4</sup> For many, the pregnancy was unplanned and they wished that they could delay motherhood, but late discovery of the pregnancy made legal termination impossible. Once the pregnancy was reported, an entourage from the girl's family could seek the payment of damages from the alleged father and his family. In some cases, the late request for damages was used by the

<sup>i</sup> "Young families" is a term used to describe families that are formed when a teenager gives birth to a child. The term acknowledges that not only is the mother of the child young, but the grandmother of the child is often also young and therefore likely to be of reproductive and working age.

**Table 7: Children with absent parents**

Age	Total number of children	Mother absent		Father absent		Both parents absent	
		%	Number	%	Number	%	Number
0 – 5 years	6,978,000	15	1,070,000	61	4,223,000	13	909,000
6 – 11 years	6,815,000	26	1,781,000	62	4,275,000	23	1,548,000
12 – 17 years	5,786,000	32	1,869,000	64	3,724,000	28	1,631,000
<b>Total</b>	<b>19,579,000</b>	<b>24</b>	<b>4,721,000</b>	<b>62</b>	<b>12,223,000</b>	<b>21</b>	<b>4,089,000</b>

Source: Statistics South Africa (2018) *General Household Survey 2017*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.  
 Note: Absent parents may be dead, unknown or living elsewhere.

father's family to delay payment until the baby was born and seen to resemble the alleged father. In other cases, the father acknowledged paternity.

The practice of paying damages allows paternal kin to acknowledge the child belongs to the patrilineage – giving the child an ancestral line of care – and creating the potential for the father and his family to provide care and support. However, as with any cultural practice, the payment of damages is complex, contested and changing in response to larger changes in society.

In South Africa children are more likely to live with their mothers than with their fathers and with maternal rather than paternal kin. As illustrated in Table 7, only 38% of children live with their biological father.

There is little difference in co-residence of children and fathers across the age groups, while co-residence of children with their mothers declines sharply with the age of the child. Only one in six young children (0 – 5) do not live with their mother, compared to one in three older children (12 – 17 years). Although children may not live with their fathers, the father's absence does not necessarily mean that fathers do not care for their children in other ways.<sup>5</sup>

### Fathers and men providing care

Fatherhood in South Africa, as in other African contexts, is often a collective responsibility.<sup>6</sup> When biological fathers are unable to meet the needs of children, their own fathers, brothers or maternal grandfathers and uncles often step in to help.<sup>7</sup> Children are thus exposed to multiple adult male figures who may participate in raising the child.<sup>8</sup>

Men's relationships of care for children may vary according to residential proximity.<sup>9</sup> For example, men may live with their biological children or be fathers to biological children living elsewhere (possibly with the children's mother in a separate home) or they may live with a woman who has children from a previous partner. If they live close to where their children stay, they may be in regular contact.

Men's relationships of care for children may also vary according to the childrearing roles, activities, duties and responsibilities that older men as father-figures are expected to perform and fulfil regardless of their biological connection to a child.<sup>10</sup> These social fathers may include the mother's partner, patrilineal and matrilineal uncles, grandfathers and brothers, friends, teachers, religious and community leaders.<sup>11</sup>

However, women continue to carry the burden of childcare even when fathers are present. For example, results from the 2010 Time Use Survey indicate that mothers spend much more time than fathers on childcare, even when fathers are co-resident.<sup>12</sup>

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The assumption that the biological mother will be – and should be – the primary caregiver of her infants and young children is embedded in understandings of gender that are common across different populations in South Africa. The willingness, capability and capacity of mothers to provide care to infants and small children is generally taken for granted, with an assumption that new mothers will also be supported by older and experienced kin or by the woman's partner. State structures, legislation and grants provide supplementary assistance, but also assume that those who are vulnerable will be cared for within a safety net provided by kin. While family members are more likely than the state to intervene, this is not always the case. Accordingly, in both urban and rural settings, the care of children born to young mothers is often undertaken by their grandmother, or is shared by women who are not related but form a support network.<sup>13</sup>

Shared or delegated childcare arrangements have been an important strategy for women in the context of AIDS, and also when women need to work. When women are labour migrants, there may need to be decisions about whether the child can stay with the mother at all, or whether it is better for the child to be cared for by family members elsewhere.<sup>14</sup> Often families need to privilege employment and income generation opportunities over the relationship between a particular caregiver and child. If possible, families will call on people who cannot engage in wage labour at the time, such as a mother with young children or an elderly person, to help with childcare.

### Informal kinship care and foster care

Extended families continue to play a significant role in the care of children in South Africa, and the majority of children not living with their parents in South Africa live with their grandparents or other relatives, as illustrated in Table 8.

**Table 8: Relationship of household head to child if child is not living with mother**

Grandparent / great-grandparent	65%
Aunt / uncle / in-laws / other relative	17%
Parent / step / foster / adopted	10%
Sibling / step sibling	6%
Self / partner	1%
Unrelated	1%

Source: Statistics South Africa (2018) *General Household Survey 2017*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Of the four million children who are cared for by relatives in the absence of their parents, just over one million are maternally orphaned, while close to three million have mothers who live elsewhere. It is important to distinguish informal kinship care from foster care. Kinship care is widespread, historical and negotiated within the family. Foster care is a form of alternative care provided by the state where children are found by a court to be in need of care and protection (because of abuse, neglect, abandonment or orphaning) and are placed with a foster family rather than in institutional care. Technically, they are wards of the state, whose placement is considered to be temporary, subject to review every two years, and in the case of children who have been removed from their family, the ideal outcome is eventual family reintegration.

In 2002, in response to rising orphaning rates, the Minister of Social Development encouraged relatives caring for orphaned children to apply for foster care so that they could access the Foster Care Grant (FCG) – which at the time was

nearly triple the value of the CSG. The number of foster care placements escalated rapidly – from around 50,000 children to over 500,000 by 2010 – placing an overwhelming demand on social workers and the children's courts. Nearly 90% of children who were reported to receive FCGs in 2017 were maternally orphaned. Over half (56%) were living in households headed by a grandparent, while another 32% lived with aunts, uncles, siblings or other relatives.<sup>15</sup> In other words, the vast majority lived with extended family.

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Civil society groups have repeatedly questioned this shift in policy.<sup>16</sup> The main concern is that the administrative process of placing children in formal foster care depletes the time and resources of social workers and courts to deal with urgent matters of child abuse, neglect and exploitation. A second concern is that, for most of the families who apply for foster care placement of orphaned children, the main incentive is a larger grant. This could easily be provided through a top-up of the CSG, which is much quicker and easier to apply for, and does not require social workers and courts to make the initial placement or to periodically review placements. The underlying issue is the question of whether families can be trusted to make decisions about care arrangements and provide the same quality of care for orphaned children as they would do for children who are not orphaned.

### How does the state support or undermine care choices?

According to the Children's Act<sup>17</sup> the "best interests of the child" should inform decisions about care arrangements for all children – and especially those who are orphaned, abandoned or vulnerable. The care arrangements available to such children include kinship care, foster care, cluster foster care and adoption. Generally, a family context is considered the best place for children, rather than institutional care.

### Abandonment, abortion and adoption

Most children live with parents or other relatives, but in some cases families are not able to care for children. The law provides for abortion when a pregnant woman chooses not to keep the unborn child, and abortion services are meant to be freely available in the public health sector. The mother may

also choose to give a child up for adoption. Abandonment is illegal but may be a last resort if a child is unwanted and the family has failed to access either abortion or adoption services.

Research by the National Adoption Coalition of South Africa indicates that child abandonment appears to have declined marginally, with estimates just below 3,000 children per year. Social workers say that it is often impossible to find the parents or family of children abandoned into their care. This highlights the importance of alternative child-care solutions, given that formal adoptions continue to decline with only 1,349 adoptions taking place in the 2016/2017 period.<sup>18</sup>

Research conducted in 2013 found that rather than supporting adoption as a form of alternative care, government officials are actively preventing adoptions from taking place.<sup>19</sup> This starts in state hospitals where the option of adoption is, in most instances, not communicated to women experiencing a crisis pregnancy, and when actively sought, it is often denied to them. State employed nurses, social workers and police officers all voiced cultural concerns around adoption, believing that it is not the role of the state to create families and kinship connections, but rather that of family, ancestors and/or God. The mothers also feared “punishment” for “giving their child away” which could range from personal and familial suffering to long-term infertility.

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These cultural concerns are compounded by restrictions in legislation. A girl of any age can request an abortion in a state clinic, however, she must be over the age of 18 years to consent for her child to be adopted, ensuring that this becomes a familial decision rather than an individual choice. And despite progressive legislation, health care providers’ resistance to abortion has made it difficult for women to access abortion services in practice.<sup>20</sup>

The Birth and Deaths Registration Act enables social workers to apply for registration of the birth of an abandoned or orphaned child.<sup>21</sup> The law provides that where the details of the parents are available, these should be provided and will be included on the birth certificate.<sup>22</sup> If there is a notice of birth (a document issued by the hospital where the child

was born) which makes it apparent that the child is a non-South African citizen (for example, because their parents are recorded on the notice to be citizens of other countries), then the child will be issued with a birth certificate without an ID number.<sup>23</sup>

In practice there are cases where Department of Home Affairs officials request social workers to find the parents in order to prove the nationality of the child, before they will register the birth. This is not a legal requirement as the law only stipulates that the parent’s details be provided “where available”.<sup>24</sup> This is often done in cases where Home Affairs suspects that the child is a non-South African citizen. This practice unlawfully discriminates against children based on their assumed nationality (with the risk of racial or ethnic stereotyping if the parents are not known) and results in delays or denial of birth registration for abandoned children. The lack of a birth certificate or an ID number on the certificate affects children’s chances of finding permanent family-based care and renders many stateless. The absence of an ID number is also likely to result in a range of exclusions, including from social grants, schools and certain health services.

### **Why and how should the state support caregivers?**

Caregiving is essential to sustain human life and development. Care work is physically and emotionally demanding, and it intensifies the economic pressures on the household. Yet, caregivers’ efforts go largely unrecognised and unsupported. In this section, we therefore consider the forms of care that caregivers, especially grandmothers and parents, may need and the ways in which the state can provide this support.

### **The importance of caregiver support**

Caregivers support children’s well-being and development by responding to their needs and ensuring that they are safe, stimulated and receive nurturing care. Children who receive care in a consistent, sensitive and responsive manner – who are fed when they’re hungry and comforted when they cry – are likely to develop confidence, healthy relational skills and empathy for others. Similarly, by establishing routines, modelling social behaviour, and using positive, non-violent forms of discipline, caregivers promote children’s social-emotional development, helping them learn how to plan, focus attention and regulate their own behaviour.<sup>25</sup>

A mother’s capacity to manage early infant care is affected by her mental health. Yet caregivers provide care amidst physical and psychological pressures, including their own, tiredness, stress and anxiety. They may also face poverty and unemployment, social isolation, interpersonal and

**Table 9: Policies and programmes to support parents and caregivers**

<b>Material support</b>	<p><b>Social assistance:</b> 12 million children benefit from the child support grant (CSG), yet an estimated 1.8 million eligible children are not receiving the grant – many infants under one year. For this reason, the National Integrated ECD Policy recommends pre-birth registration for the CSG. In addition the value of the grant remains below the food poverty line and does not cover the costs of a child.</p> <p><b>Maintenance:</b> Recent amendments aim to strengthen enforcement of maintenance orders.</p> <p><b>Job creation and skills development:</b> Unemployment remains stubbornly high at 27% and increases to over 52% of youth aged 15 – 24,<sup>26</sup> greater effort is needed to ensure the efficacy and reach of job creation and skills development programmes.<sup>27</sup></p> <p><b>Birth registration and identity documents:</b> Access to most services depends on birth certificates and identity documents. While birth registration has increased, access remains challenging especially for children living in rural areas.<sup>28</sup></p>
<b>Child care</b>	<p><b>Parental leave:</b> Working mothers are entitled to four months unpaid maternity leave, and the Labour Laws Amendment Bill introduces 10 days of parental leave for the other parent, and 10 weeks leave for adoptive parents.</p> <p><b>Child care and education services:</b> School attendance is high (97%), but there are very few after-school and holiday programmes, so families need to find ways to care for children and keep them safe when they are not in school. No-fee schools have made basic education affordable from grade R onwards, but early learning programmes are not fully funded, with many ECD centres charging fees. Child-care services for young children, such as day mothers and child minders, are not subsidised at all. Child care is therefore not an option for those who cannot afford to pay.</p>
<b>Parenting support</b>	<p><b>The National Intergrated ECD Policy<sup>29</sup></b> provides for: Public information campaigns; the provision of parenting support through the health services – with potential to build on the new Road-to-Health book and Side-by-Side campaign, and the WHO Care for Development module; parenting programmes provide more targeted support, though currently these have limited reach, and greater investment is needed to take these to scale.</p>
<b>Health care</b>	<p><b>Early antenatal and postnatal care:</b> Visits early in pregnancy are important because they provide opportunities for support, screening and referral. Early antenatal visits have increased: 65% of pregnant women attending antenatal clinics had their first visit within the first 20 weeks of pregnancy in 2016/17<sup>30</sup> – up from 31% in 2005. Postnatal care enables further screening<sup>31</sup> and support, yet it is not always easy for women who have recently given birth to get to health services, and nearly 30% of new mothers do not do so within the recommended six days after birth.<sup>32</sup></p> <p><b>Risk screening and referral:</b> Maternal depression and anxiety can compromise child care and development – especially during the first 1,000 days.<sup>33</sup> Further risks include substance abuse, violence and adolescent caregiving. While clear systems for risk identification and referral are proposed in the NIECD policy, they have not yet been implemented, and allied health and social services remain limited.</p> <p><b>Sexual and reproductive health services:</b> Access to quality reproductive health services, including family planning, is an important area of support. Plans to provide discreet access to condoms through schools and incorporating youth friendly services into the Ideal Clinic initiative may help address adolescents’ dissatisfaction with public health services.<sup>34</sup></p>

community violence, physical and mental health conditions, and poor access to support services. Excessive caregiver stress and adversity can hinder the provision of supportive, responsive care – and may contribute to toxic stress – the chronic or excessive activation of the child’s stress response system – that, particularly in the early years, may damage the developing brain and compromise children’s physical, cognitive and emotional development.<sup>35</sup> Yet the presence of caring and responsive adults can buffer the damaging effects of toxic stress, and enable children to cope with adversity.<sup>36</sup> It is therefore essential that parents and caregivers also receive care and support, starting early in the antenatal period and continuing through to adolescence. This includes:

- **Material support:** including social assistance, maternity benefits, maintenance, and access to adult education, skills development and work opportunities, and poverty alleviation programmes

- **Child-care support and services:** including parental leave for those who work, child minders, day mothers, early childhood development play groups and centres, and after-school and holiday programmes
- **Parenting support services:** including information to help carers promote child development and provide responsive caregiving, positive discipline and healthy family relationships
- **Health care:** including early antenatal care, identification of mental illness, substance abuse, domestic violence and/or food insecurity, and referral to support services.

#### Examples of state support to caregivers

While there are a number of policies and programmes designed to provide support for caregivers, coverage and quality varies both within and across programmes, as illustrated in Table 9.



Women's presence in the workforce has increased, and alongside this is the growing importance of women's role as contributors to the economy and as financial providers in their own families. But labour participation comes at a cost in an environment where employers do not support the role of women as caregivers of children.

Only mothers can breastfeed but both the state and employers have an important role in supporting working mothers to do so. Breastfeeding is ideal for infants for the

first six months of life, as it boosts immunity, growth and development. It is also good for the mother and promotes bonding. Rates of exclusive breastfeeding in children under six months increased significantly, from 7% in 1998 to 32% in 2016.<sup>41</sup> But structural and personal barriers continue to make exclusive breastfeeding difficult. It is a challenge to breastfeed or express milk at work, whether in the informal sector or in contract employment. The Basic Conditions of Employment Act allows for only four months of maternity leave for women

### Box 9: Women informal workers call for quality public child care

Rachel Moussié

The complex relationship between children, families and the state cannot be fully understood without also considering women's working conditions. In many low-income households, women are both primary care providers and income earners. Their working conditions affect the time and resources they have to care for children living in their homes. Across sub-Saharan Africa, more women than men find employment in the informal economy.<sup>37</sup> In South Africa, informal employment makes up 29 and 23% of female and male urban employment respectively.<sup>38</sup> For instance, of the 530,000 street traders recorded in the South African Quarterly Labour Force Survey (Second Quarter, 2010), 70% were women.<sup>39</sup>

Conditions of work in the informal economy are characterised by low earnings, limited or no access to social security benefits, and insecure employment. In South Africa, women informal workers with young children do not have access to maternity benefits and their earnings may be too low to pay for child-care services, even when supplemented by a Child Support Grant. Women often choose more flexible work or reduced working hours leading to lower earnings so that they have time to look after their children.

In focus group discussions conducted by Women in Informal Employment: Globalizing and Organizing (WIEGO) in 2016, women street traders in Durban's Warwick Junction Market said that they were unable to sell their goods when it was too hot, rainy or windy as they did not want to expose their young children to the bad weather. This meant that they would lose out on a day's earnings.<sup>40</sup> Women traders were also concerned that the market, located at the intersection of busy city roads, is not a safe space for children. Some traders relied on family members – mothers, aunts and sisters – for child

care, but this often came with the expectation of financial support and was an additional burden of care, particularly for ageing grandparents.

The traders also used informal child-care centres though they complained that they found that their children were neglected, there were too few child-care workers to provide quality care, and the costs were high. Costs became even higher when the centres were not designed to cater for the needs of working people. For example, if centres opened after work started, workers would have to pay someone to look after their child until the centre opened, as well as for transport if the centre was located far from home.

Calls for quality public child-care services by women informal workers is changing the way the state, including local municipalities, considers women's role in care provision and as workers. Rather than assuming families and kinship networks can take on child care while women work, the state must see that it has a role to play in the provision of child care, and not just in the regulation of private child-care centres.

In 2017, WIEGO launched a global campaign for public child care based on demands emerging from women informal workers in Brazil, Ghana, India, South Africa and Thailand. In Warwick Junction market, informal organisations are negotiating with the municipality for space to set up child-care centres for traders. These efforts delineate new spaces for collaboration and contestation around child care between women, workers organisations and the state.

For more information on the campaign and to see the demands signed by informal workers organisations and global trade union federations go to: <http://www.wiego.org/wiego/wiego-child-care-campaign>

in formal employment, whereas the guidelines recommend six months of exclusive breastfeeding. The same Act allows women two breaks a day to express milk, but this provision is not widely known or implemented. In addition, the absence of private and clean spaces in which to express milk at work makes it extremely difficult for working women to sustain exclusive breastfeeding.

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Lack of awareness may also prevent exclusive breastfeeding. Evidence from a study in Soweto found that the health workers at community clinics frequently understood the advice about exclusive breastfeeding to be an HIV preventive strategy only, and so gave little attention to women who were HIV negative.<sup>42</sup> It is important that service providers in the civil service are properly informed so that they in turn can advise and support mothers appropriately.

Accessing safe, quality childcare can be difficult for mothers and other caregivers who also need to work, and particularly so for those who do not earn enough to pay for child-care services. Even low-cost and unregulated child-care services may be unaffordable, and the cost and time of travel may be prohibitive if the caregiver also needs to get to work. Here again, the state and employers have roles. Some employers provide free or subsidised crèche facilities or nursery schools for the children of their staff in recognition that this improves productivity, advances gender equality in the workplace and contributes to the well-being of employees and their children. But the provision of childcare is not required by law and very few employers offer it.

Different approaches to child care at work include:

- an on- or off-site company child-care centre
- a facility in the community which is linked to the workplace
- financial support (e.g. child-care vouchers, funds or subsidies)
- advice and referral services to help employees find childcare facilities and support.

In addition, employers can make childcare easier by:

- allowing flexi-time so employees can come and go at more convenient hours for childcare.
- allowing work-from-home options.<sup>43</sup>

The South African government has developed guidelines for the establishment of child-care facilities for its own employees in the public service.<sup>44</sup> The guidelines give a detailed rationale and a step-by-step overview of the procedures to be followed when establishing child-care facilities, and note that the costs of developing and running these facilities would be borne by the relevant department.

For women who work in the informal sector, the challenges are even greater, as described in Box 9:

### **On-the-ground and responsive services**

Responsive services are necessary to provide support to caregivers as and when needed – for example, during periods of unemployment or teenage pregnancy – and to respond to the changing needs of families over time. Support needs to be provided in ways that promote caregivers' ability to cope with stress and strengthen their support networks.

Caregivers and children often experience multiple and linked forms of deprivation and adversity. For example, depression in pregnant women is associated with food insecurity.<sup>45</sup> It is therefore important to strengthen referral systems to ensure a smooth and seamless transition between different services, and to respond to families' complex and changing needs. A number of programmes have been developed to link social services and income support – and two are illustrated by the Isibindi and Sihleng'imizi case studies on pages 78 and 79.

The Isibindi intervention is designed as a community-based intervention that can be scaled up and replicated across the country. Almost 300 Isibindi projects serve over 100,000 children. At the same time as providing a child protection response, which includes both practical assistance and therapeutic elements to support children and families, the design of the Isibindi model aims to develop the child and youth care workforce. The Sihleng'imizi programme implemented by the City of Johannesburg links cash transfers (though the CSG) with a programme to support better care in families, as a protective measure for children. It also has the potential to strengthen welfare services in South Africa which are currently poorly funded, largely based in urban areas, and primarily treatment-focused.



**Case 9: Isibindi**

*Debbie Budlender and Zeni Thumbadoo*

Isibindi is a community-based intervention developed by the National Association of Childcare Workers (NACCW) to provide prevention and early intervention care for children in poor communities. Child and youth care workers (CYCWs) are recruited from the communities in which they work, receive training in an accredited qualification, and deliver services under the supervision and guidance of mentors. Isibindi therefore not only provides services to children, but also provides training and creates jobs in poor communities.

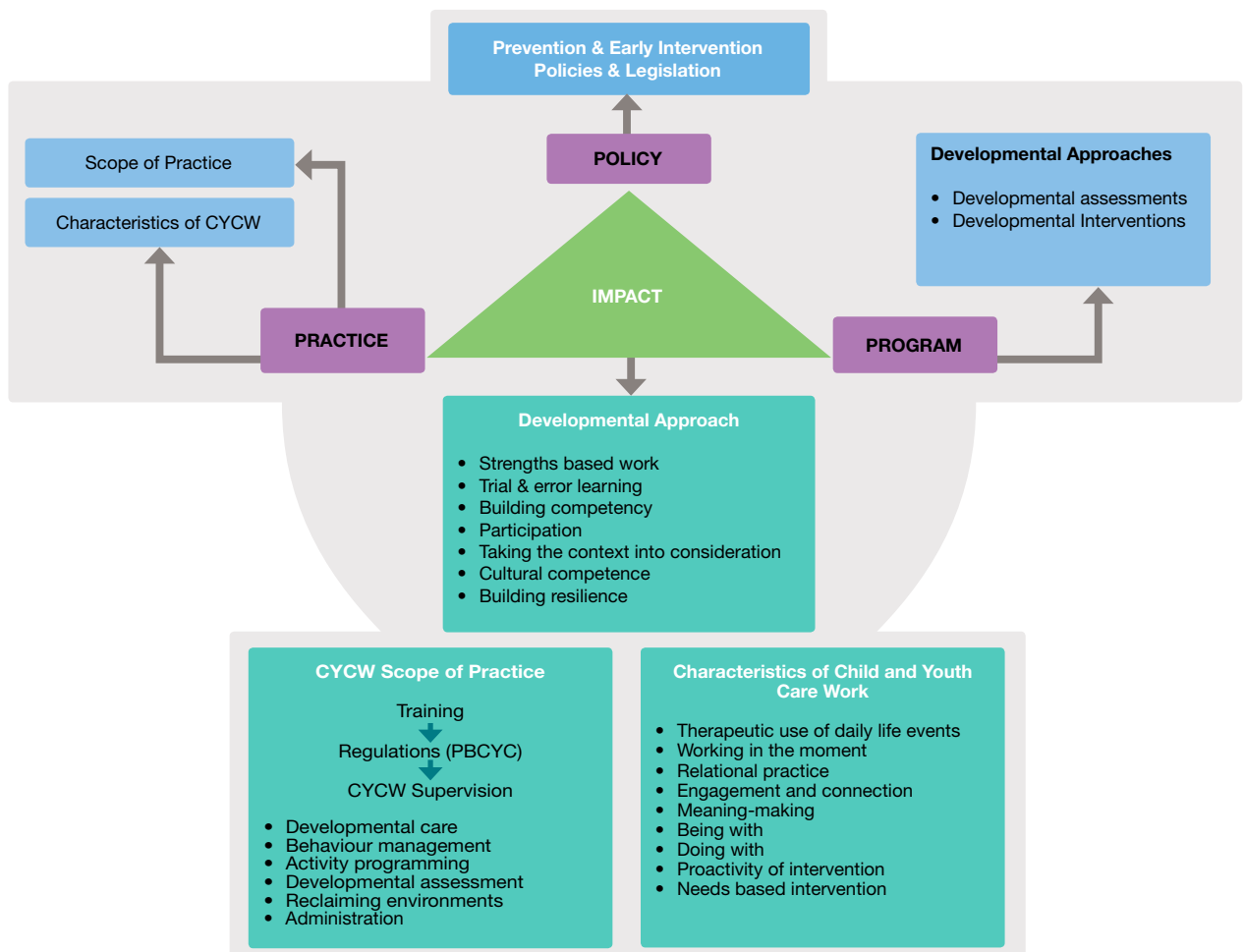
CYCWs use a strength-based approach and work with families to improve areas that need attention, such as domestic violence, abuse of money and alcohol, poor communication and parenting skills.

By working in the “life space” of the child, CYCWs visit families and children in their homes, helping with household chores and educating the family about general hygiene, gardening, health and nutrition. They cook

together with children, teach basic life skills and use ordinary human interaction as a context and means to go beyond basic care and meet the emotional needs of children. They draw up an individual development plan for each child as well as a family development plan to promote the family’s resilience.

CYCWs also help families access other services helping families apply for identity documents, birth certificates and social grants, engaging with schools to facilitate school admission and fee exemption, referring family members for HIV counselling and testing and other health services, helping families access food parcels, seeds and skills for food gardens, and referring child protection cases to social workers. CYCWs also work in multi-disciplinary teams with other professionals helping to address more difficult cases. In these ways CYCWs help bridge the knowledge and information gaps within communities and strengthen linkages between services.

**Figure 7: Isibindi: Core for conceptual coherence**



## Case 10: Sihleng'imizi

Tessa Hochfeld and Leila Patel

Sihleng'imizi (we care for children) aims to build family strengths and prevent social problems associated with income poverty. It recognises that families living in difficult circumstances may need more than just the Child Support Grant (CSG) to ensure child well-being. Sihleng'imizi is designed to strengthen families and the care they already provide to children, based on research that demonstrates how a warm and caring family environment,<sup>46</sup> social and community supports, and access to responsive services, all have an important protective effect for disadvantaged children.

The 14-week group-based programme is facilitated by trained social workers and supported by qualified ECD workers. Families who receive a CSG for a child in grade R or grade 1 are randomly selected via primary schools. Weekly group sessions are fun and participatory focusing on social education and skills development in areas that can have a substantive effect on a child's well-being, such as nutrition and child health; cognitive and educational development; caregiver stress; family communication;

management of behavioural problems and alternative forms of discipline; social relations and access to community resources. Between sessions, families try out new skills and meet each other to offer social support.

Following an initial pilot study, advanced testing and evaluation was conducted in 2017 in 10 of most deprived wards in Johannesburg, using the city's social workers and infrastructure, and results will be released in late 2018.

A programme of this nature is time- and labour-intensive, but the 2017 pilot demonstrates that it is possible to integrate Sihleng'imizi into municipal social work services. While trade-offs have to be made in relation to time and resources, this intervention has the potential to reduce demand for therapeutic services. As municipal social workers do not undertake statutory work, the programme would not erode resources for those with acute child protection needs. Scale-up will require an organisational mandate and political will from local government to enable a shift from the current focus on treatment to preventive and promotive services.

Comparing the two programmes, Isibindi is an established programme that has been designed, tested and is currently being taken to scale. The Child and Youth Care workforce has been recognized by the Council of Social Services Professionals and the model addresses many priorities set out in the National Development Plan. The Sihleng'imizi programme is relatively new. It demonstrates an alternative approach to linking cash and care. Both programmes are focused on supporting the child in the context of the family or, in the terminology used by Isibindi, "in the life space of the child". Both programmes have already proven to deliver good results for children including improved learning outcomes, youth development, food security, dietary diversity and reduced levels of violence and abuse.

### Conclusion

Care is negotiated within families, between families and between families and the state. Care is also highly gendered

and women, more than men, are expected to provide care. When families make decisions about who will provide care, factors such as the quality of relationships between carer and the recipient of care, potential educational and work opportunities, the health and well-being of the carer and the reproductive aspirations of female kin are important considerations. Decisions about who provides care are often weighed up against social and economic factors in the interests of household survival.

Government agencies and service providers need to recognise that child-care arrangements are family strategies. Furthermore, caring for children is demanding and can be stressful, particularly when carers are also coping with other stressors such as poverty, violence and mental illness. Carers therefore need to be given support and such support programmes need to be attuned and respond in coordinated ways to the varied needs of caregivers.

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