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Multi-Dimensional Forms of Poverty Experienced by Unemployed HIV-positive Mothers Living in Khayelitsha

Dianna Kane

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Dianna Kane graduated in June 2008 with an MPhil in HIV/AIDS & Society from the University of Cape Town. She has been working with community-based organizations on issues of poverty reduction, with a focus on women and children, for the past four years. She now lives in San Francisco.

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Abstract

For the millions of unemployed South Africans, poverty is a daily experience. However, traditional economic measures of poverty are failing to provide policy makers with a full picture of the lived experience of poverty. Through two years of participant observation at Philani Nutrition Center, conversations and home visits with local outreach workers, and in-depth interviews with five HIV-positive unemployed mothers in Khayelitsha, this paper explores the multiple dimensions of poverty experienced by these mothers and their children. Using class and gender-based theories of structural oppression, this paper argues that these mothers are marginalised from the labour market and are members of a distinct unemployed underclass. Three main findings emerged from this study. One, the state of chronic unemployment has profound effects on both the material and emotional wellbeing of these women and their families. As a result of the years of race- and class-based discrimination, their opportunities to improve their situations are minimal. Two, the presence of HIV illness serves to reinforce the continued reproduction of this disadvantage through its debilitating physical and social effects. The mother's own HIV illness, as well as the intensive care required by HIV-positive children, limits a mother's ability to work and ensure the child's wellbeing. Three, the structure of patriarchy further ties mothers to their domestic and childcare responsibilities, often without the support of their partners. Unemployment and insufficient social assistance increases their pressure to earn an income in addition to fulfilling daily household responsibilities. It is important to understand how poverty manifests itself in the lives of these women and their children in order to design poverty reduction strategies that address the many dimensions of their experience. The structural causes for their poverty need to be recognised in order to motivate meaningful changes in our society, with the goal of creating an enabling environment for these mothers. This will then provide the mothers with the space in which to transcend their current position in the underclass and ensure the many aspects of wellbeing for themselves and their children.

Introduction

South Africa is a highly unequal society, comprised of a small wealthy, elite class and a large population living in deep, chronic poverty plagued with unemployment. International economic measures of poverty deem that at least 45% of South Africans are living in absolute poverty[1] (Meintjes et al. 2003: 14). Those experiencing the greatest poverty in South Africa are unemployed, black[2] women and their children[3]. In March 2007, 36.4% of black women were unemployed (Statistics South Africa 2007a: xvi), and 80% of female-headed households reported no wage earners at all (Budlender 2002; Gender Advocacy Programme 2001). The role of unemployment is a major factor in the high rates of inequality in South Africa and there is a proven positive correlation between unemployment and poverty (Seekings & Nattrass 2006: 12). In addition to these income-related challenges, women are also commonly the primary caregivers of children, often with little help from their husbands or partners. The time and resources needed to raise children present substantial challenges to women who are faced with the double burden of managing and mitigating structural economic and gender inequalities in South Africa (Brandt, et al. 2006: 523).

In the midst of widespread unemployment, structural inequality, and poverty in South Africa, HIV prevalence is concentrated in the poorest areas and among the most vulnerable populations. Young South African women are especially affected, and are four times more likely to be HIV-infected than their male counterparts (UNAIDS 2006: 10-13). Compared to a national prevalence rate of 11%, women between the ages of 20-64 years have an overall prevalence rate of 18.1%, and it is as high as 40.7% among women in some provinces (Statistics South Africa 2007b: 1-2; Department of Health 2005: 8). As demonstrated in

[1] Set at US$2 per day.

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

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

this paper, the poverty experienced by women and children in South Africa is exacerbated by HIV/AIDS, creating yet another burden and challenge in their lives.

While some approaches to analysing poverty generalise the experience of the poor, this paper aims to explore some specific forms of poverty experienced by women caring for children, while also coping with HIV infection and unemployment. The findings of this research demonstrate that the experience of poverty is related to a number of factors in the mothers' lives, such as stage of HIV-related illness, number of children, presence of a partner, and housing situation. The research was conducted with five mothers[4] enrolled in the Philani Nutrition Center program in Khayelitsha[5]. Through in-depth interviews, it aimed to provide a forum through which women could voice their greatest concerns and anxieties, thus moving away from simplistic notions of poverty to an understanding of the multidimensional forms that poverty, inequality and illness take on in these women's lives. This paper refers to existing literature that illustrates the heightened vulnerability of HIV-positive and unemployed mothers in order to contextualise the findings of the Philani mothers' experiences. The structural causes of poverty and inequality in South Africa will frame this discussion and contextualise the constraints faced by the women who participated in this study.

Conceptualising Poverty and Wellbeing in the Context of Class and Gender

While traditional measures of poverty, commonly set at an internationally defined monetary amount such as the World Bank's "$1 a day" income-based poverty line, the actual experience of poverty encompasses a myriad of deprivations (UNDP Human Development Report 2003: 43). As argued by

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

[5] A black township 30 kilometers outside of Cape Town's city center, created in the 1980s under the height of apartheid violence.

Amartya Sen, an exclusively income-centred view of poverty does not reveal the ways that poverty limits people's freedoms to live their lives the way they choose (Sen 1985). Poverty is therefore intrinsically linked to the concept of overall wellbeing, incorporating "material (having a secure livelihood and fulfilment of your basic needs), physical (health, strength, and appearance), security (including peace of mind), freedom of choice and action (including self development and mobility), and social wellbeing (constructive family and community relationships)" (Camfield 2006: 7).[6] This approach looks beyond economic deprivation to understand how fear, insecurity, hopelessness, and powerlessness are also indicators of poverty. These experiences in turn impact upon an individual's independence, confidence, agency, and mobility (Camfield 2006: 8). Overall health, for example, is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). Wellbeing therefore refers to a state of active participation and empowerment. While economic poverty can be both a cause and a result of these other forms of poverty, it should be seen as only one of the many deprivations experienced by the poor. Additionally, Hulme & McKay make a strong argument for including a time dimension in any analysis of poverty, claiming that *chronic* poverty, as opposed to transient poverty, is a distinctly different experience (2005). This approach provides a wider lens through which to define people's needs and the responses required to alleviate and eradicate poverty.

South Africa operates under a capitalist economic system, which, by definition in Marxist theory, depends upon the exploitation of the labourer for the profit of the capitalist (Wright 1995: 91-95). A long history of racial discrimination in South Africa under apartheid allowed whites to build assets and achieve high-ranking positions, which placed them in a favourable position to control the means of production. At the same time, the proletarianisation of the peasantry in South Africa, alongside the limited educational opportunities for blacks, left most of the African population to depend on wage labour for income, and ultimately, survival (Wolpe 1972). The creation of this structured dependence on white capitalists left the African population with so few other options for livelihood that "when employment slowed and stagnated from the mid-1970s onward, open unemployment was inevitable" (Seekings & Nattrass 2006: 16).

Marxist theory of capitalism and exploitation has been specifically applied to contexts of chronic unemployment by academics such as Wright (1995) and

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

Seekings & Nattrass (2006). Based in Marxist theory, the concept of the "underclass" was developed to refer specifically to a population that is not only unemployed, but actually marginalised from engaging with the means of production (Wright 1995: 96). The cumulative disadvantage that results from being denied the opportunity to accumulate human capital, social capital, and financial capital further entrenches this group in poverty (Seekings & Nattrass 2006: 280-286). These disadvantages are then reproduced within neighbourhoods and social groups and transferred through generations, justifying their recognition as a distinct class that cannot be categorised with other disadvantaged workers (Seekings & Nattrass 2006: 275-276).

The existence of an underclass in South Africa is the resulting legacy of discriminatory apartheid policies. The de-racialisation of policies following the disintegration of apartheid governance had the effect of transferring privilege from race to class. Individuals are no longer discriminated against based on race, but rather experience opportunities and wellbeing as members of stratified classes (Seekings & Nattrass 2006: 273). In South Africa the underclass experiences chronic unemployment given its position as a group that is both socially and geographically marginalised from the labour market. Evidence of this can be found in statistics stating that eighty-three percent of the unemployed in South Africa have been so for more than 6 months, while nearly two-thirds have *never* worked (Seekings & Nattrass 2006: 278-279). In a society structured on capitalism "where unemployment means poverty," the underclass experience many forms of poverty and deprivation. Underclass households experience a distinctly low quality of life, with their income almost entirely dependent on public welfare and remittances, with survey results demonstrating that most members of this class live in informal dwellings without basic sanitation and cleanliness. Additionally, this class often experiences emotional poverty related to anxiety and depression (Seekings & Nattrass 2006: 289-295).

Within the contexts of poverty described above, the South African government has yet to adopt a sufficient pro-poor response. The primary focus has been on offering social "safety nets" in the form of cash grants to especially vulnerable populations. However, the vulnerable are defined as *unable* to work, rather than those who have not been able to find employment. The system therefore offers limited support to the young, the old, and the sick, and provides no financial support to unemployed adults. These social safety nets

> 'seek to ameliorate the difficulties of those who cannot get paid work because of ill health, disability, or other factors not related to structural conditions… [yet,] growing unemployment and

> casualisation of work, deepening and widening poverty, macroeconomic shocks and financial volatility, the HIV/AIDS crisis and other disasters require more than a social safety net' (Taylor 2007: 12-13).

These interventions do not adequately address the needs of the underclass because they overlook the primary problem of unemployment among adults of working age. This lack of support for unemployed adults presents yet another structural challenge for the underclass. The impacts of the current system's gaps will be highlighted by the stories of poverty experienced by the women presented in this paper.

Even within the underclass exist varying levels of privilege and opportunities, with women being the most vulnerable and exploited members, suffering "from the additional burdens imposed by gender-based hierarchies and subordination" (Sen & Grown 1988: 23). The system of patriarchy that exists in South Africa operates in a similar way to capitalism, relying on the oppression of one gender (women) for the benefit of the other (men) (Delphy 1977). The exploitation of women through patriarchal structures has also been linked to the development of capitalism. Sacks & Brodkin argue that in tribal societies, women took on the role of "sister" and engaged with men as equals, but the "rise of states or class societies… destroyed the possibility of sister relations and hence of equality of women and men, particularly in the underclasses" (1982: 7). As the family unit began to lose its own productive capacity to industries and corporations, women were transformed from sisters to wives and became subordinates to men, restricted from the means of production. Their relationship to their partners "went from a relationship of adulthood to one of dependency" (Sacks & Brodkin 1982: 7) as women's domestic duties were no longer viewed to hold economic value.

However, the role that women's domestic labour played in supplementing their husband's participation in low wage migrant labour also allowed for the exploitation of their husbands to persist. Women were expected to maintain households that provided childcare, retirement, and health care for migrant workers, allowing employers to pay very low wages (Wolpe 1972). However, with the growing numbers of the unemployed and the increasing number of female-headed households, women feel increasing pressure to earn an income, while maintaining their domestic duties. Women therefore constitute a distinct, super-exploited class, marginalised from the means of production by both the capitalism and patriarchal systems (Mackintosh 1989:163; Delphy 1977:16, 33,

Sacks & Brodkin 1982:12). Due to the structural discrimination of these two systems, women have not been given the opportunity to access education, accumulate capital, or find employment, positioning them to be likely members of the underclass.

The high rates of HIV infection among members of the underclass, and women in particular, are rooted in inequalities replicated by both the capitalist and patriarchal systems that dictate power relations within class and gender. Women's dependence on men and their lack of economic and sexual independence not only places them at higher risk of infection but also makes them more vulnerable to the social and economic effects of AIDS illness. It is a well-documented trend that "poverty deepens the effects of HIV/AIDS on households and HIV/AIDS in turn aggravates already existing poverty" (Jacobs, Shung-King, & Smith 2005: 22). As women assume the burden of care of sick family members, they are also more vulnerable to impoverishment and loss of employment as a result. The income of HIV-affected households is nearly half that of non-affected households (Booysen & Bauchman 2002: 10). Furthermore, Swartz comments on the social stigmatisation of the disease, stating, “HIV positive women have also been found to experience significantly less socio-economic, spiritual, and family support than HIV negative women. Many infected mothers are either reluctant to, or desist altogether, from seeking assistance” (2005: 21). HIV and AIDS are therefore limiting a woman's ability to depend on her community support networks, and hence her access to social and material assets. For women living in poverty, this often results in a lower state of overall wellbeing.

This discussion has established the disproportionate impacts of HIV infection and poverty on the wellbeing of women and children and the structural causes for such disadvantage. This is the reason why HIV-positive women, and mothers in particular, have been selected as the primary focus of this research. The connections between the structures that make women vulnerable to HIV infection with those that lead to unemployment and economic oppression will be discussed in relation to the participants of this study and the many forms of poverty they experience. The social and psychological aspects and processes of poverty will be explored with special emphasis, with an ultimate goal of outlining a path to achieving holistic wellbeing in the mothers' lives.

Methodology

A case study was undertaken during the period of July to September 2007 on five women who all meet the following criteria:

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

These criteria relate to the *context* that unifies all of the women in the sample group and grounds them as examples of mothers experiencing unemployment, HIV-infection, and childcare. This small study does not claim to be representative. However, as this paper illustrates, their experiences may yield important insights for those working in the field of HIV/AIDS, policy, and poverty reduction. The following section introduces the women who participated in this study and contextualises them within the above-mentioned criteria. Though Philani mothers are the focus of this research, their Philani outreach workers were integral and involved participants in the research process and are introduced here as well.

Background of Participants

As stated, the mothers' experience of poverty is not unique. Living in Khayelitsha not only predisposes them to poverty as a result of the structural disadvantage of the area, but also reinforces their existing poverty by providing them with little opportunities for personal advancement. Hosting even more discouraging statistics than the national averages, 72% of women in Khayelitsha report having no paid work and 22% of Khayelitsha residents are estimated to be HIV-positive (De Swardt 2005:103; 110). Illustrating the legacy of discriminatory apartheid policies and lack of investment in black areas, 51% of Khayelitsha residents receive water from a tap outside their house and only 60% have access to a flush toilet. Additionally, high levels of food insecurity exist and only one-third of Khayelitsha residents completed secondary school (De Swardt 2005: 104). De Swardt states, "this nexus of poor living conditions related to shelter, sanitation and water, geographic location, insufficient access

to electricity, low incomes and low educational levels seriously aggravated the problems related to ill-health and morbidity" (2005: 110).

Philani Nutrition Center was established in Khayelitsha in the early 1980s, to address the needs of malnourished children. The intervention is structured on a community-health model, operating both drop-in centers as well as an extensive home-based outreach program. The outreach program currently has 80 local outreach workers and serves 3,000 children in Khayelitsha and surrounding townships. The outreach workers are all mothers that come from similar backgrounds to the women enrolled in the program, allowing them the unique ability to offer personal advice and experience. A Philani outreach worker has an average of 34 children in their caseload, though since their intervention addresses the entire household, they often reach many more children and women than this.

As stated above, the five Philani mothers participating in the study all met the criteria outlined in the methodology. All five women are residents of a particular area of Khayelitsha and reside in informal settlements and dwellings. Four of the women live in shacks made of corrugated zinc sheets and other discarded materials, while one woman lives in a simple shelter built by Philani. The conditions of their dwellings ranged from very poor to fairly good, based on local standards.

Three of the five women were living with partners at the time of the study and two were married to their partners. Another woman was living with a family member, with the last woman living as the only adult in the household. All of the women are biological mothers (though having biological children was not part of the criteria); though two provide care to non-biological children as well. The age of the children ranged from six weeks to 12 years, with most of the children being between the ages of four and six. The number of total people in the household ranged from three to six. All five women are HIV-positive, with four of the women having an HIV-positive child in the household as well. The women and children were at varying stages of HIV illness, ranging from no symptoms to advanced AIDS. Two women were on ARV treatment at the time of the study. All of the HIV-positive children in the study were on ARV treatment, though were at varying stages of health. All of the women learned of their HIV status during a doctor's visit for their children, either during pregnancy or at some point shortly after birth. None of the women is aware of their partner's HIV status and the men refuse to discuss this with them.

All five women have been unemployed for at least a year prior to the study, though the two that had worked previously were employed as unskilled labourers with little job security. Of the women living with other adults, only two of these adults were bringing in income, and only one of these was consistent. Several of the women expressed having only primary school education, though they did not go into depth about this.

Two of the women were comfortable speaking English in the interview, while three of the women used the help of a translator. This difference is reflected in the empirical data where some women are quoted directly more often than others.

All of the women were receiving some sort of governmental social assistance, though the type and amounts of grants accessed ranged dramatically, from R200 per month to R1170. One of the mothers is also receiving from a special fund at Philani. Only one child was receiving the Care Dependency Grant as a result of her mental and physical disabilities.

Table 1 summarises the mothers' situations, organised by some key pieces of information that illuminate their personal circumstances and impact upon the forms of poverty they experience.

Table 1: Summary of mothers' biographical information

Mother	*Philani Outreach Worker*	*Total # people in house-hold*	*# total children in house-hold*	*# children HIV-positive*	*Married?*	*Household Income*[7]	*Health Status*	*Type of Housing*	*Last Work Experience*	*Translator for Interview*
Nonkululeko	Pelisa	6	2 biological + 2 non-biological	1	Yes	R200 CSG + husband's income (R355/wk)	HIV+; Some illness, not on ARVs	Three-room shack; average condition	Cleaner in cape town	None
Naledi	Patience	4	1 biological + 1 non-biological	1	No	R200 CSG (x2)	HIV+; Healthy; not on ARVs	One-room shack; poor conditions	Unknown	None
Nothemba	Phumla	3	1 biological	1	No	R870 DIS	HIV+; AIDS illness/on ARVs; passed away	Shack; poor conditions	Unknown	Yes; Themba
Noluvuyo	Pinky	3	2 biological	1	No	R870 DIS + R200 CSG (x2) + R300 DT	HIV+; Healthy; On ARVs	One-room Bungalow; good condition	Never worked	Yes; Pinky
Nokuthula	Pelokazi	4	2 biological	0	Yes	R200CSG + husband's income(+/- R500/pm)	HIV+; Healthy; not on ARVs	Two-room shack; good condition	Domestic worker in cape town	Yes; Pelokazi

[7] CSG=Child Support Grant; DIS=Disability grant; DT=Desmond Tutu grant (Philani)

Data Collection Methods

Qualitative methods were used in the research, with the primary source of data collection being in-depth, semi-structured interviews and participant observation in order to capture the complexities of their lives (Payne & Payne 2004: 131). A consistent semi-structured interview schedule was employed throughout the interviews to provide consistency of theme and topics, and to allow the women's unique experiences to emerge. The women were also given the opportunity to introduce topics of importance to them. In-depth interviewing was also applied in order to understand why the women feel and act the way they do, establishing linkages to other issues in their lives (Babbie, Mouton, Vorster and Prozesky 2006). This was the preferred method for the study (as opposed to focus group or survey) due to the very private and personal nature of the topic and the importance of understanding the individual circumstance and capabilities of each woman.

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

Numerous interviews, both formal and informal, were held with Philani's head social worker, who monitors all of the 3,000 people in the outreach program. Additionally, countless informal conversations have been had with numerous Philani outreach workers about their work with women like those in these case studies. I have accompanied these outreach workers on countless home visits over the past two years to mothers in the outreach program. This experience of participant observation[8] has significantly contributed to my understanding of the issues affecting mothers in Khayelitsha and has been a great source of information and inspiration.

[8] Participant observation is the act of simultaneously being both a member of a group and a researcher. It allows for an insider's perspective to a group and allows the researcher to experience first-hand what the members of the group experience, rather than solely through stories describing their experience (Babbie et al 2006:293).

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

In order to maintain the integrity of the research and minimise ethical issues related to coercion, pressure to participate, and discussing sensitive information, the outreach workers approached the mothers privately to present the research and request their consent. That their participation would receive no material benefits was continually stressed throughout the process and the mothers and their consent was consistently reconfirmed. The mothers were also given the choice of time and venue to conduct the interview to make them as comfortable as possible.

Additionally, all names have been changed to maintain the privacy of the women, their children, and their outreach workers. For the reader's ease in distinguishing between mother and outreach worker, all mothers have been designated a name beginning with "N" while outreach workers' names all begin with "P." Philani's social worker has chosen to keep her own name, as she is a representative of the organisation.

Empirical Findings: Household Vulnerability and Challenges

Through the in-depth interview techniques described above, the mothers discussed the particular struggles and deprivations in their lives. The issues they raise speak to the multi-dimensional nature of poverty and how the structures in society have contributed to their limited ability to transcend their class. The mothers express an intense frustration with being unable to prevent transferring their poverty to their children. Unemployment, lack of income, poor housing, and illness emerged as factors that significantly contribute to their vulnerability and poverty, presenting a myriad of challenges that serve to limit their capabilities and reinforce their poverty. Within these broad categories, the mothers describe the various forms of poverty they experience, from material deprivation, lack of security, emotional anxiety, poor physical health, and unreliable social support. Childcare and HIV infection are consistent motifs

throughout these broad topics that serve to put additional pressure on a mother, limiting her ability to engage in paid activities as a result of care responsibilities or illness, and adding to the internal anxiety she experiences. The empirical findings presented here will later be discussed in the context of the class and gender-based theories, which offer structural causes for their marginalisation and potential solutions for removing some of the constraints in their lives to enable them to achieve greater wellbeing.

Unemployment & Household Income

All of the mothers interviewed describe suffering from economic poverty as a result of their unemployment. With no assets to generate income for themselves, no income coming from wages, and the absence of a comprehensive system of social protection, unemployment usually means there is very little money in the household. Seekings & Nattrass describe this as a common experience for underclass households in South Africa (2006: 289-291). The women express their anxiety about their financial insecurity and the effects this has on the poverty experienced by their households. Pinky states, "the biggest problem in this area is unemployment, it affects the children's lives and you see so many malnourished children. Even if you come into the house, hey, there's no life in this house.[9]"

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

> 'Dianna: What are other things that make you stressed?
> Naledi: Because I am not working. I can't afford to support my child because I have this R200 [Child Support grant] and I have to buy everything for this child… and I have these other three children [in the Eastern Cape] and I didn't buy anything for them since 2001. So I am stressed with that.

[9] As described in the methodology section above, each of the interviews quoted in this paper took place in 2007.

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

The three other children that Naledi refers to here are staying with a family friend in the Eastern Cape. Only one of these children is young enough to receive the Child Support Grant, which she gives to the woman caring for them. However, Naledi still laments about not being able to provide more support to these children as a result of her unemployment.

Pelokazi translates for Nokuthula, expressing similar concerns:

> 'D[10]: What are any things that you worry about? What causes stress?
> Pelokazi: The children. [Nokuthula] would like to give everything, but it's not easy to do that, because she is not working and the father is depending on [his informal and unpredictable] business [for money].'

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

> 'Nonkululeko: On Monday I was going to Groote Schuur [hospital] for my appointment but I didn't go because I don't have money for the taxi. I try to, you know, I'm not working so it's difficult… My husband is drinking so sometimes he cares, sometimes he don't care… I know [my husband] don't give me some money for me because I'm not working, but [he's] just supposed to support [his] child. Even Pelisa, I told her, I've got a problem. I don't have a problem for his money, but try to support the children. My brother sometimes he give me the money so I don't mind. If [my husband] just give me the money for the child I don't mind.'

As a result of a lack of income discussed above, the mothers express anxiety over providing even the most basic provisions for their children. This material

[10] This abbreviation refers to "Dianna," the interviewer. Thereafter the first letter of the respondent's name is listed in the dialogue.

deprivation is possibly the most tangible aspect of economic poverty, yet the compromised emotional health of the mother is evident here as well. The responsibility of caring for children clearly results in a heightened sense of anxiety among the mothers, who are frustrated with their inability to provide for the basic needs of their children.

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

Nonkululeko describes the relative needs of her two children, according to their age. She struggles with the additional needs of her 9-year old daughter because she perceives these needs to be more difficult to satisfy than those of her youngest child are. "D: Do the children have everything they need? Nonkululeko: No, even my child hasn't got clothes. I just went last week for the shoes. I don't mind about the little one. She has got everything." Here Nonkululeko reflects on the differing needs of her two children, with her older child requiring an increasing amount of financial support. Nonkuleleko feels able to satisfy the needs of her youngest, which mostly relate to care that she can provide as a mother, but when it comes to shoes, clothes, and school fees for the older child, Nonkululeko is concerned that she cannot give this to her daughter.[11]

Caring for children is a significant commitment for the mothers and requires a good portion of their day. Some of them equated this care to that of a full-time job. Nonkululeko tells of her daily routines caring for children and the energy that it requires of her. The women rarely mentioned their partners when discussing childcare and it is clear from this next story from Nonkululeko that she is the primary caregiver in her household.

> 'Nonkululeko: Like my older one, neh? For now, I've got a problem because most of the time I'm looking after the little one, but the older one... [sometimes she can't wash herself so] I wake up and then I wash

[11] The expenses related to caring for the younger, disabled, HIV-positive child, may also limit the resources available to provide for the older, HIV-negative child. The allocation of resources among children based on their HIV status is not discussed in depth in this paper, but is highlighted as an area requiring further study.

her, because she is still young… Every time I do this. I am working every morning. Then I am going to sleep. I am the same as somebody [who is] working. Because I do everything everyday. This morning she didn't see the shoe. I can try to look, where is the shoe, you know? And then I, oh it's difficult, she don't want to eat in the morning. Only the amasi[12], but you can't force her.'

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

Housing & Neighbourhood

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

'Naledi: I'm worried about… the food, clothes, and the place to stay. We've got no toilets, no water, the place is dirty. And this is a child, so if she wants to play, she just goes outside to play and it is dirty. So you know, you can't see her all the time what she is playing with, but when you see, you say don't play with that, so if I can stay in the right place with her.
D: In your community, do you feel safe there?
N: No. Maybe she can be raped, or maybe stealed by someone. She is not safe, and I am not safe. And the house I am staying is not safe. It's just a shack. So if someone wants to get in, they can just get in. Not safe at all, but I am staying there… [The shack] was two rooms, then

[12] Yogurt-like soured milk.

> it was burnt, all of the two rooms. Then I started fresh, I took those zinc [walls] that were burnt and I put them back up.
> D: Do you all stay in the same bed?
> N: We don't have [a] bed. We just put the crates and put the mat on the crates. Mampho is putting the crate on that side and I am putting my crate on this side [and we are sleeping with our children].'

The mothers link housing to serious concerns for their child's safety. Nonkululeko also identifies inadequate housing as a primary form of poverty and one that she feels will affect her child's future:

> 'D: What are other problems? Is there a lot of crime? Do you feel safe?
> Nonkululeko: It's not the safest. Even I pray everyday, I want my own house, the right house for me. And I pray god, don't take me because I want my child to have a house, to leave my child with a nice place. And I take my sister to stay with her. I don't have mother, I don't have father, so where must my child stay? You know the family is difficult now.'

Another reality in Khayelitsha is that of alcohol abuse. Nonkululeko's outreach worker, Pelisa, commented that Nonkululeko's 9-year old daughter is scared of her father when he comes home drunk. This alludes to the possibility that the child has witnessed or experienced violence or abuse by adults under the influence of alcohol, though the conversation with this mother did not explicitly state this.

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

The mothers are describing a specific experience of poverty here: that of feeling insecure, unsafe, and unable to protect their children. They blame the high levels of crime in their neighbourhood, the alcohol abuse of both husbands and neighbours, and poor quality of their shelters with these feelings of fear and disempowerment. The mothers express feeling trapped in their situation and without the resources to improve their living conditions or move to a safer neighbourhood.

Illness

As previously discussed, illness is another factor that makes households vulnerable to poverty, as well as intensifying existing poverty due to its impact on the mothers' capabilities. Nonkululeko was affected by an increasing number of HIV-related opportunistic infections. As a result, she needed to resign from her job as a cleaner. This has limited her ability to provide for her children's material needs. Her child's health status has also declined in this period, which in turn has limited Nonkululeko's capacity to work outside the home even if she were well enough to do so. Additionally, both Nonkululeko and Nothemba describe how their illness and compromised mobility restricted them from applying for social assistance grants in their time of need.

> 'Nonkululeko: So I was sleeping there at Somerset [Hospital] and I didn't have a chance to come to do the grant because I'm sleeping with my child. After that a new doctor said, I'm right now. She says I'm well for working. I said I can't work because I've got a problem with the child. So if I get another person to look after my child, that money I supposed to make something for my child, I'm supposed to pay somebody else to look after my child. But I want to work if I find something, but it's difficult for now.
> D: Do you feel like you're well enough to work?
> N: No, when I use the water [to wash], I feel cold and I feel sick. Just now I'm using the [washing] machine because I can't use my hands, even the nappies I buy the disposable. Even now, I don't know what's happening. I lose weight, I've got the arthritis. I am sick most of the time.'

Nonkululeko's illness has also had a direct effect on her 9-year old daughter's education. While she was working in the center of Cape Town, her child was able to attend a multi-lingual and well-resourced school there; however, when she needed to quit her job as a result of her illness, her daughter had to transfer to a low-quality Khayelitsha school, a clear point of frustration for Nonkululeko, expressed by her outreach worker.

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

There is also a clear connection here between the mother's employment status and the quality of education of the child. As a result of the mother's progressing illness and associated unemployment, her child no longer has the opportunity to attend a middle-class school in the center of town.

Nothemba's advanced AIDS illness placed a significant strain on her physical ability to care for her child and even constrained her access to health care. Nothemba describes the double burden of mother and child HIV infection, translated and retold by Themba, a worker at the Respite Care facility where Nothemba was staying at the time of the interview.

> 'Themba: [Nothemba] is sick and the child is sick… that's why she doesn't have grant. The child was supposed to start ARVs last August but she couldn't get her to clinic because [the mother] was sick. Until the child was here at Baphumelele, she just started the ARVs at Red Cross [Children's Hospital].
> D: What is the most difficult thing about being a mother and how does being HIV-positive add to the difficulties?
> T: She's saying it's really, really difficult especially being a mother and the child is also positive. It would have been better if she was a mother who is not positive because she would also be strong enough to carry the child.
> D: What are some of the things that she is able to do even though she's sick and what are the things that she's proud of?
> T: (Nothemba cries) She's saying that there wasn't much she could do, all she could do was love the child. It was tough.
> D: Themba, would you ask [the outreach worker] how she thinks [Nothemba's] situation compares to the other women she works with?
> T: [Phumla] says [Nothemba] was struggling the most, with the conditions of the house, and the extent of the illness.'

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

> 'Naledi: yah I want to take care of her, but just if I could get something for staying with her without working.
> …Philani gives me milk [for the baby] and they say I [should] come to do the work, make some things in the shop to make money. But the

only thing is my baby is not well. [She's only been well for two days now and I usually have to] stay with her to take care of her.'

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

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

Many of the outreach workers reaffirmed the hardships faced by mothers of sick children, implying that this is a predicament faced by many mothers in their caseloads. Sick children require more care and attention than healthy children do and it may not be possible to place them in local daycare facility. In a context of capitalism, where adult household members must work for wages in order to survive, mothers now have to choose between providing physical and emotional care for their children and working to meet their material needs. Again, the mothers do not mention their partners regarding the topic of childcare. This absence speaks to the mother's primary responsibility for the children.

Accessing health care services also presents a veritable challenge for mothers of sick children, who struggle to make their appointments when their children have coinciding appointments at different facilities.

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

Additionally, the mothers complain of the bureaucratic system of the clinics that does not allow them to attend a neighbouring clinic when their designated clinic is closed after hours.

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

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

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

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

> 'Pelisa: So, Dianna, not everyone is supportive. They gossip around about your problems. So it's not so easy to talk to anyone.
> Nonkululeko: If you say, I've got a problem, then they tell everyone. But I'm not scared now because Jesus knows what's happening with me.
> N: We are having a lot of people who are having the problem, but nobody can talk.
> P: You see, many people are not supportive. These people gossip around and they call it "this thing."
> N: ...And then, you can't eat with this plate and so my child is eating with separate plate. These people is wrong. I tell myself everyday it's better; I know I'm sick, but it's difficult because they may say you have this thing and you are going to be dead now, but me, maybe I'm still I have time, I have a long time.'

The outreach workers spoke a great deal about the effect of HIV infection in their Philani mothers' lives. Patience comments on the additional stress that HIV has on Naledi's life:

> 'D: Do you think that other [mothers in the community] [have these problems]?
> Naledi: They might. I'm not sure.
> Patience: Sometimes I am not feeling right because her problems are difficult… to me… more than the other people.
> D: What is it about being HIV-positive that makes it more difficult?

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

Pinky offers her perspective on how HIV should be viewed within the community and Noluvuyo's experience as a HIV-positive person.

> 'Pinky: It’s changing a bit now that there’s treatment. The way the people were told is not right. They should be told that it’s like any other chronic illness. She [Noluvuyo] can't hide that she is ill although she never talk about it except that friend, who also is HIV-positive and asked her to go with her to the clinic.'

During the interviews with the women, none of them seemed to perceive HIV as a death sentence or a source of shame. Rather, what was expressed was a fear of gossip and humiliation from the community that kept them from disclosing their status publicly. This was an experience shared by all of the women in the study. The interview material illustrates that the women were limited in their access to social support due to their attempt to conceal their status.

Goals & Aspirations

Even in the context of the many different aspects of poverty and extreme anxieties in their lives, the women expressed hope in a better future for their children. An understanding of the mothers' wishes contributes to the understanding of their poverty, as this offers another form of insight on what is lacking in their lives and how far they are from achieving or obtaining these goals.

Noluvuyo speaks of her wish to provide her children with more than the absolute basics. "Pinky: To be a good mother, [Noluvuyo] likes her children to be happy, eat food [like] meat, veg, and rice. She is trying to satisfy her children, buy them toys, money for chips."

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

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

Pelokazi (translating for Nokuthula): Education.
D: Does she think she will be able to give them that?
P: She thinks so.'

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

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

Naledi also expresses the things she must do to ensure her child's safety and happiness, now and in the future.

'Naledi: I must love her, take care of her, feed her all the time, make sure she is clean, she is playing nice.
D: When you think about your daughter and the future, what do you hope for her?
N: I want her to be at school, to be right, to be healthy. For instance, if I can die, I would not like her to be taken by the family because they are not good. So maybe she be taken by the foster care or whatever, you know, because my family is not right.'

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

Understanding Multi-Dimensional Poverty: From Theory to Reality

The women's self-identified vulnerability context encompasses factors related to unemployment and a lack of income, poor housing, high crime levels, and illness in themselves and their children. Within these broad categories emerged experiences of many forms of poverty, including material deprivation and a lack

of basic necessities, emotional stress and anxiety, poor health, and minimal opportunities for work or quality education. Strongly expressed in the interviews were the mothers' concerns over the safety of their children. They expressed a profound inability to protect them. Not only do their stories speak to dismal living conditions but of a neighbourhood wrought with crime. This context seriously impacts upon a family's wellbeing and sense of security. These stories contribute to the understanding of poverty in South Africa and highlight the various interventions and structural changes needed to eradicate it. The structural causes of poverty in South Africa are theorised above; this section considers the theory in relation to the reality of multidimensional poverty faced by mothers in Khayelitsha. Their experiences illuminate the theories of racial-, class-, and gender-based oppression, highlighting the layers of disadvantage behind their poverty.

Assigning this group to the ranking of underclass emphasises that access to (or, rather, lack of access to) employment was a key factor in their experience of poverty. The impact of unemployment on living conditions, indicators of health, and education for children was highlighted in several of their stories. The mothers felt constrained by the effect that their lack of income had on their ability to raise their children in a safe neighbourhood with a good school system. Both Nonkululeko and Naledi blame their unemployment as a cause of this poverty and powerlessness. They also refer hopefully to a day when they might have work and can begin to change some of these circumstances. In Nonkululeko's case, her illness had a direct impact on her ability to work. Her resulting unemployment had the consequence of removing her child from a good school she was attending in Cape Town near the mother's place of work. As Seekings and Nattrass pointed out, underclass households usually cluster together, serving to reinforce their disadvantage. During the time that Nonkululeko was employed, she was interacting with other members of the working class and had access to better schools in town. Returning to the ranks of the unemployed, her child has lost this opportunity for education and eventual class mobility.

These stories demonstrate the ties between income and wellbeing and reinforce the theoretical explanations of the reproduction of poverty and the underclass over generations. Through the lack of access to education and proper healthcare and housing, the children in these households are inheriting their mother's underclass status. Growing up in a community of underclass individuals is unlikely to provide these children with the social capital and education needed to connect them to job opportunities in the labour market. The urban and social

fragmentation that characterises the underclass communities in which these women live are a result of mass numbers of people who have been systematically and historically marginalised from the formal economy without adequate housing, education, and opportunities for personal and professional development (Seekings & Nattrass 2006: 276). Nonkululeko's story is a prime example of the various opportunities that her previous employment status held for herself and her children. Now that she is unemployed, such opportunities are no longer within reach.

Due to the many ways that HIV and AIDS is affecting society, illness is both a factor in the women's greater vulnerability context as well as an aspect of their personal struggles. In nearly all of the narratives, the women describe how their HIV infection affects their emotional and psychological health. Many of the mothers expressed feeling alone and unsupported by their community, a form of poverty in and of itself, but also a contributor to other forms of material poverty that could otherwise be mitigated. None of the mothers described feeling personally shameful of their HIV status, but instead, it was the fear of gossip and stigmatisation that prevented them from disclosing their status, forming friendships, and reaching out for help. The resulting isolation that many of the mothers described has reinforced their vulnerability and position in the underclass, characterised by a lack of social capital and poor emotional health. Therefore, the fear of HIV stigma prevents the mothers from fully engaging with their community, reinforcing and, at times, exacerbating their current experience of poverty.

HIV is presented strongly in the narratives as an aspect of personal struggle for the mothers, the effects of which are multi-dimensional. The empirical findings of this study are supported by literature documenting how HIV and AIDS weaken household structures and are often the "tipping point from poverty to destitution" (Steinberg et al. 2002: i), as economic resources are directed towards medical costs and social resources are focused on caring for the sick person. In particular, the study highlights how HIV and AIDS reduced the mother's capabilities to engage in employment or seek social assistance in the form of community-based care or financial support through government welfare programs. Nonkululeko, Nothemba, and Noluvuyo identified their own illness as one of many factors keeping them from finding work. However, Nonkululeko's ineligibility for the grant highlights the gaps in the social welfare system. Her progressing illness is still not deemed serious enough to qualify for the grant, leaving her unemployed and without support. Severe illness, which resulted in hospitalisation, also prevented Nothemba from accessing her grant when she

was most in need, resulting in the extreme poverty of herself and her child. When HIV has infected the caregiver, especially among the female-headed households in this study, the health and wellbeing of the children may also become compromised as a result of the mother's diminished capacity to care for them (Richter & Rama 2006: 17). Conversely, the health status of the children also affects a mother's capacity to meet their needs. Naledi describes how the responsibility of caring for her HIV-positive child limits her ability to engage in income-generating activities. Nonkululeko concurrently expresses exhaustion from the full-time commitment of caring for her disabled child. These various experiences all speak to the way that HIV serves to entrench the mothers in poverty and contribute to the reproduction of poverty within their households.

The mothers' experience of being HIV-positive came through in their stories as a gender-specific experience. Consistent across the stories is the women's lack of knowledge of their partner's HIV status. Their partners refused to discuss this with them so the women do not know if their partners have tested or if the men know their own results.[13] Nonkululeko spoke of her deteriorating relationship with her husband after she disclosed her status to him. The literature has established that gender dynamics are significant in the experience of and risk related to HIV and AIDS:

> 'cultural prescriptions of masculinity and femininity – when they control and determine what men and women know, how they communicate with each other, and how they behave within their relationships – significantly affect not only men's and women's sexual behaviors and attitudes but also their respective access to services and information and their ability to cope when ill" (Abdool Karim 2005: 252-253).'

Preston-Whyte's findings that the HIV is often attributed to female promiscuity are seen in the mothers' experience of shame and neglect from their male partners (Preston-Whyte 2006). Their partners refused to discuss HIV with them, likely fearing their own infection yet wanting to deny and avoid this possibility. Since the women acknowledged their HIV infection to their partners, while the men's status remained unknown, the women experienced shame from their husbands, under the assumption that the women had brought this disease into the family. Nonkululeko states that she and her husband now live "like

[13] The gender dynamics between partners concerning the decision to test and disclose their HIV status is a topic in need of further exploration.

brother and sister" and that their communication has broken down since she disclosed her status to him. Whiteside & Lee (2006) also document similar trends in which women are more likely to be discriminated against and receive less social support as a consequence of disclosing their HIV status. The gender dynamics surrounding the issue of the mother's HIV infection have highlighted the existing gender inequalities in society. The structural inequality of men and women related to their control of productive assets and access to education and job opportunities has created an imbalance in power relations that has filtered into the dynamics of personal relationships as well. Addressing the HIV/AIDS epidemic therefore requires addressing gender inequality in society as well.

Further illustrating the gender-specific experience of the mother's lives is their acceptance of the burden of care within the household. Patriarchal gender norms are also apparent in the women's expectations of their partners. They believe that the children's fathers have a responsibility to contribute financially to the household, yet they do not expect them to assist in the day-to-day care of the children, showing that the division of gender roles has been internalised and accepted by the women in this study. Nonkululeko, alone, expresses frustration with her husband's inconsistent financial support while she stays at home to care for the children. Having lost their equal roles as "sisters" through the development of capitalism and the transformation of the family, the women have accepted sole responsibility for caring for the children as "wives," dependent on their husbands to provide for them (Sacks & Brodkin 1982). However, when their partners do not meet this expectation, the women and children are left without any income or connection to the means of production. Delphy (1977) would argue that the women in this study are actually contributing to the reproduction of their oppression and exploitation within a patriarchal system by accepting these norms. The societal expectation placed on the women has led to their acceptance of this role and hitherto contributes to the reproduction of the system.

As rates of unemployment rise and low wage labour continues to be the only form of employment, women are increasingly pressured to enter the workplace as well as taking care of the household. The compounding effects of patriarchy and capitalism result in enormous expectation placed on these mothers. Sacks and Brodkin describe the difficult situation of women in a capitalist and patriarchal society: "if she carries out her duties in the private service of her family, she remains excluded from public production and unable to earn; and if she wants to take part in public production and earn independently, she cannot carry out family duties" (1982: 98). As Nonkululeko described, she not only

expects herself to provide childcare and complete domestic tasks, but she expresses shame that she does not earn her own income. This example highlights how gender exploitation within the household as well as worker exploitation in the labour market has resulted in a super-exploited class of women (Delphy 1977: 16, 33; Sacks & Brodkin 1982: 12). The gendered roles related to the burdens of care within the household and women's reduced capacity to work as a result of childcare, illness, and marginalisation from job opportunities clearly portrays the difficulties women have navigating within their vulnerability context. Their vulnerability in the capitalist system "is further reinforced by systems of male dominion that, on one hand, deny or limit their access to economic resources and political participations, and on the other hand, impose sexual divisions of labour that allocate to them the most onerous, labour-intensive, poorly rewarded tasks inside and outside the home" (Sen & Grown 1988: 25). It is for this reason that it is critical to analyse the impact of patriarchy and capitalism alongside each other, as the two systems reinforce and sustain the oppression of women.

In light of the substantial challenges the women face, the government's social assistance program overlooks this group's vulnerabilities and instead selectively supports households with particular characteristics, such as extreme illness or young children. The intention of social assistance grants are to target specific vulnerabilities as a result of sickness or age, yet these goals are undermined when distributed without other comprehensive support, such as a basic income grant, free school fees, and job creation programs (Taylor 2007: 12-13). Naledi's story demonstrates that her entire household's material wellbeing depends solely on the Child Support grant, as it is currently their only source of income. In order to address the poverty of the entire household, Child Support grants must be accompanied by long-term livelihood support for the other members of the household (Ewing 2006: 92). Furthermore, the disability grant is offered on the assumption that the sick person will re-enter the labour market when they have recovered. This dramatically overlooks the marginalisation of the underclass to formal employment. Given Noluvuyo's marginalisation as a member of the underclass, it is unlikely that she will be able to replace her grant income when her CD4 count improves. This situation raises the concern that unemployed people have an incentive to stay ill, as this is their only viable form of income, and perhaps, survival (Nattrass 2006).

There are several areas of poverty that were not explicitly raised by the mothers in the interviews but emerged in the course of participant observation and conversations with Philani workers. Malnutrition is a serious threat to the

women and children in this study, evident in their enrolment in Philani's nutrition-based educational program, as well as their concerns over having adequate food in the house. Skills development and adult education is another issue that was not raised here, yet expressed indirectly through their frustrations over not being able to find work with their minimal levels of formal education. Similarly, depression and mental health were not specifically highlighted, but were alluded to by the women's intense anxieties over not being able to meet their children's basic needs and as a result of their state of unemployment. These are all examples of oversights of the current social assistance system, which focuses only on economic poverty. The literature highlighted this multi-faceted experience of poverty among members of the underclass, which were touched upon in the interviews through the mothers' discourse. For example, "Moller found that the unemployed not only had a far lower perceived quality of life than township dwellers as a whole but also experienced a range of psychological problems arising from unemployment. They were anxious, fearful, and depressed" (Seekings & Nattrass 2006: 295). Given that chronic unemployment and motherhood are entire class and gender-based experiences, interventions must also target the various forms of poverty discussed above (Taylor 2007: 12-13).

Conclusion – Creating an Enabling Environment for the Underclass

This paper has explored the multi-dimensional forms of poverty experienced by HIV-positive, unemployed mothers in Khayelitsha and established the impact of unemployment in a context of a structural dependence on wage-based income. Their stories have demonstrated the particularly difficult vulnerability context of living within oppressive capitalist and patriarchal structures, further exacerbated by personal burdens such as illness. The women's lives are illuminated by the theory of the underclass and the legacy of the discriminatory and oppressive South African policies of the past. Their stories speak to a lack of skills and education, fragmented family life, illness, and chronic unemployment. Through structural discrimination, the women received low-quality education as youths and have been marginalised from the labour market as adults. The poor infrastructure in their areas does not provide them with the health care, work opportunities, or education that is needed to better their lives. Personally, the effects of illness and the increased burden of care put additional strain on their lives and further limit their ability to engage in income-generating activities.

The women's stories illustrate the importance of expanding the definition of poverty to encompass many factors relating not only to material deprivation but also to anxiety, illness, and lack of safety. These many dimensions of poverty necessitate multi-lateral and creative responses. Though the women are able to attribute unemployment and a lack of income as the main source of their poverty, emotional and social needs were raised just as strongly in these testimonies as areas of severe deprivation and concern.

Despite the seemingly wide range of grants available, the welfare system is failing to significantly reduce the poverty experienced by the mothers. The grants are not comprehensive and do not meet the needs of the unemployed mothers interviewed here, they have stringent eligibility requirements, and may be difficult to access due to bureaucratic problems or personal illness. These factors begin to explain the discrepancies in household income among five unemployed women and the poverty that persists regardless of the assistance they receive.

The theory of the underclass offers insight into the chronic unemployment experienced by the mothers and demonstrates that the current welfare system is inadequate in addressing the needs of this population. The effectiveness of the current grants as supplementary support for especially vulnerable groups is therefore undermined without basic comprehensive protection for unemployed households. The limited social welfare net combined with their status as underclass households, is responsible for the strong connection between unemployment and experience of income poverty.

Gender emerged several times in this paper as an element that influenced the women's experience of poverty. All of the women in this study discussed the burden of childcare, with some expressing their inability to engage in other activities as a result. The system of patriarchy that dictates their responsibilities of caring for children compounds the system of capitalism that requires them to sell their labour power to survive, placing all of these women in challenging situations, often with little support from their partners.

In order to effectively address the women's burdens, a number of gender-based interventions are necessary that confront the systems of privilege operating in society: "structural interventions that empower women and girls by increasing their access to the social and economic resources that in the long term protect women, men, and their families in the HIV epidemic, thereby also altering the economic and social dynamic of gender roles and responsibilities" (Abdool

Karim 2005: 259). Establishing a new structural environment in which women will be enabled to care for their children, look after their health, and be economically active involves addressing the gender inequality that sits at the root of HIV infection. Structures that support and appreciate the care that women provide to children in their households can begin to change the current constraints placed on women by a patriarchal culture.

The mothers' stories have highlighted areas where structural change is needed to provide wider access to resources and reduced overall vulnerability. There are many ways that local and provincial government can intervene to raise a family's quality of life regardless of a family's employment status. The government must place high priority on addressing the levels of crime in poor neighbourhoods. Safe play areas should be provided for children. Adequate sanitation and water services must reach even the most informal areas of the townships. Basic housing must be provided in order to ensure personal safety and health. It is unacceptable that in South Africa these basic aspects of wellbeing are currently unavailable to poor families.

The concerns voiced by the women, and the poverty they experience can also be mitigated by certain supportive services, and priority must be placed on supporting the work of mothers and enabling them to care for their children. Free public transportation would allow the women to access the necessary health care facilities, as well as search for work opportunities in more developed areas. Free crèche facilities should be available to poor families, especially those headed by single mothers. These facilities would allow the mothers to engage in income-generating activities, attend school or skills training, or simply rest. This would dramatically relieve the mothers' burden of care and their entrenchment in their domestic roles. Additional services such as free laundry facilities and used clothes shops would further enable the mothers to meet their children's needs. Integrating mother and child health care services would contribute to far fewer missed doctor's appointments. The mothers' common concern over having enough food for their children could be avoided by community soup kitchens or food vouchers.

Furthermore, this paper has demonstrated the importance of taking the multi-dimensional experience of poverty into account when planning supportive services and interventions. Extending greater access to psychosocial health services, emotional counselling, and support groups can achieve positive results in a family's health and wellbeing. Increasing the numbers of social workers would assist families in accessing protection and counselling services. More

comprehensive and accessible home-based care services to address the needs of bed-ridden caregivers and their children are also a critical need defined by the mothers in this study.

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

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

Despite extensive improvements in access to health care, education, and social welfare, those on the fringes of capitalist society continue to be marginalised. The current welfare system is focused solely on alleviating the daily experience of material deprivation. While this is a crucial short-term strategy, long-term solutions rely on enhancing household resiliencies through addressing multiple sources of vulnerability. Providing the members of the historically marginalised underclass with improved infrastructure, high quality education and skills training, meaningful work opportunities, entrepreneurship, basic social and health services, and a comprehensive safety net for those who are unable to support themselves, can begin to change the state of inequality in South Africa.

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