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“I Pray You Enough”: Exploring Rural Early Childhood Development Through the Narratives of Caregivers.

Bethany G. Hart
SIT Study Abroad

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“I PRAY YOU ENOUGH”: EXPLORING RURAL EARLY CHILDHOOD DEVELOPMENT THROUGH THE NARRATIVES OF CAREGIVERS.

Bethany G. Hart

The University of Texas at Austin

Advisors: Dr Clive Bruzas, Dr. Stephen Knight

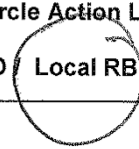
SIT Durban: Community Health and Public Policy, Fall 2014

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Title of ISP Proposed Research Childhood Development
Study Abroad Program SFH
Name of academic director John McGladdery
Names of LRB Members : Clive Bruzas (PhD), Frances O'Brien (PhD), John McGladdery

Identifying project number SFH FA 14.1 8

Research exempt from federal regulations. Action taken:

approved as submitted approved pending revisions
 requires expedited review requires full IRB review not approved

Research Expedited Review. Action taken:

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[Signature] 31/10/2014
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ABSTRACT

Childhood, including the antenatal period, is a time of invaluable physical and mental development – the effects of which last a lifetime. These experiences are shaped by a host of external factors (such as nutrition or mental stimulation) that are heavily affected by socioeconomic status. A study by the United Nations International Childrens Emergency Fund (UNICEF) found that South African children in rural areas are more physically and cognitively delayed than their less-rural peers (2007). Thus, the purpose of this study was to gain insight into the rearing and development of young children (5 years and under) in a rural South African setting through the lived experiences of primary caregivers, early childhood development teachers, and healthcare workers.

This qualitative case study involved gathering narratives (through interviews and observation) of several individuals in the rural town of Nzinga, Impendle, South Africa. I aimed to investigate themes of 1.) pregnancy behaviors (diet, antenatal care-seeking behavior, etc.), 2.) childbirth experiences, 3.) childhood health and nutrition 4.) early childhood education/cognitive stimulation, and 5.) perceived social support. In total, six primary caregivers, one community caregiver (CCG), one clinic worker, one daycare teacher, and one Grade R teacher were interviewed. Additionally, one day was spent shadowing the Grade R teacher.

Findings included both assets and needs within the Nzinga community. Assets included trained teachers and a well-implemented curriculums in both the crèche and the Grade R classroom, frequent health-seeking behaviors and adherence to emphasized health advice (including an impressive commitment to vaccination), high prevalence of hospital births, and general satisfaction with amount of psychosocial support (including government support) in caregivers. Weaknesses included late onset of antenatal care, insufficient and uneducated hygiene behaviors, lack of resources at education centers, and a prevalence of long-hidden pregnancies among teenagers and the unmarried.

COMMONLY USED ABBREVIATIONS

CCG: Community Care Giver; a health worker who performs home-visits within a community and reports back to a regional clinic or hospital.

ECD: Early childhood development; Early education programs (crèches, Grade R, etc.) are often referred to by literature and policy documents as “ECD Centers” or “ECD Facilities” but this is not meant to imply that they also provide child health services.

RHC: Road to Health Card; a booklet theoretically given to every South African child for the purpose of tracking key health events

INTRODUCTION

“I Pray You Enough”

During my freshman year in college, my mother sent me a letter in place of the care package she could not afford to send. In this letter, she transcribed a poem...

“I pray you enough sun to keep your attitude bright no matter how gray the day may appear.

I pray you enough rain to appreciate the sun.

I pray you enough happiness to keep your spirit alive and everlasting.

I pray you enough pain so that even the smallest joys in life may appear big

I pray you enough gain to satisfy your wanting.

I pray you enough loss to appreciate all that you possess.

I pray you enough hellos to get you through the final goodbye.” (Hart, 2011)

In my research, I often came back to this poem. Through this project, I have come to understand “enough” as a powerful concept. For most in this world, it is not an easy or expected thing for a child to be granted “enough”. “Enough” is a word fraught with emotion, painted with struggle and with hope. Yet, for those tasked with the monumental challenge of helping a brand new human grow into this world, the prayer for “enough” seems a unifying and beautiful idea. Again and again, those who shared with me their stories spoke of

“enough” – enough food to help them grow, enough education to help them succeed, enough sense to help them avoid trouble, enough resources to help them fully understand, enough love to fill them. It is my hope that this study helps illuminate a path forward in child development in South Africa, so that these caregivers may someday encounter a world more capable of granting “enough”.

An Introduction to Childhood Development

The National Development Agency defines early childhood development as, “the process by which children... grow and thrive physically, mentally, emotionally, morally, and socially” (NDA, 2012). Literature agrees that the first years of life, including prenatal months, make up “a period of rapid physical, mental, emotional, social, and moral growth and development” (UNICEF, 2007) during which “the foundations of brain architecture are laid down... through dynamic interactions of genetic, biological, and psychosocial influences, and child behavior” (Walker, 2011, pp. 1326).

As the brain matures during this time, it is subject to the sometimes-deleterious effects of the child’s external environment. Indeed, “over 200 million children under 5 from middle- or low-income countries were not attaining their developmental potential, primarily because of poverty, nutritional deficiencies, and inadequate learning opportunities” (Walker, 2011, pp. 1325). However, external factors that promote, instead of inhibit, development can attenuate the consequences of risk factors. As the National Development Agency explains,

“Providing appropriate cognitive stimulation, nutrition, care and health services during this critical development period results in: increased primary school enrollment, enhanced school performance, lower repetition and drop-out rates, reductions in juvenile crime rates, reduced remedial education costs and improved economic and social productivity in adulthood” (NDA, 2012)

The South Africa and Nzinga Context

The benefits of post-apartheid transformation in South Africa have not reached all children equally (Barbarin, 2003, pp. 248). South Africa houses 18.5 million children under 18 (or about 37% of the total population). Nearly 70% of children live in the poorest 40% of households and 66% of Black African children live under the poverty line (a monthly income under R604 per month) (Berry, pp. 86, 2013). Childhood hunger is highest among Black Africans, with 15% living in households that reported it as opposed to 1% of White children (Berry, pp 98, 2013). Unemployment and resultant poverty remain key factors in this inequity. South Africa's high unemployment rate of 25% ("Work and Labor Force", 2014) is a factor in South Africa's massive urban migration, which is combining with other population transitions to reshape family and community life. While 78% of children aged 0-9 have both parents alive, only 42.8% live in the same household as them (UNICEF, 2007). In KwaZulu Natal, 45.7% of children live in a household headed by a grandparent or great-grandparent. Labor migration has also created a wealth of single adult households headed by women (Barbarin, 2003, pp. 248). These trends can be observed in the municipality of Impendle – in which Nzinga is located.

Most of the Impendle municipality is made of "scattered settlements". With a population of 8,203, Impendle is 98% Black African. The local government hypothesizes that the long-distance employment of men due to stagnant job growth has led to the higher proportion of females than males (Impendle Municipality, 2014). Income is very low around the municipality. 40% of households have no regular monthly income and the remaining 49% have an income of just R1000-R1600 per month. (Impendle Municipality, 2014) Thus, Impendle – and by inclusion Nzinga – is no exception to the trends of unemployment and its resultant poverty and urban migration that so greatly affect the lives and development of young children.

Rural Inequalities

Given that poverty is thought to cause many of the risk factors that lead to developmental delay, “both local and international research suggests that children born into poverty may confront their greatest and most long-lasting disadvantage during gestation and the first few years of life” (Porteus, 2004, pp. 339). Thus it comes as no surprise that children from poor families have the highest rates of infant death, low birth weight, stunted growth, poor adjustment to school... and school dropout (NDA, 2012). Poverty is much more prevalent in rural areas than urban. These areas are among the worst affected both by stunting and malnutrition. Additionally, a lower proportion of children under 4 attend pre-school (EDC) institutions in rural areas than in urban (UNICEF, 2007). While there is clearly an issue in South Africa of rural-urban disparity in child development, both R. Conger and Lange, et. al. emphasize the need for further research into rural childhood development and family life that aims to find interventions for this problem (De Lange, 2012, pp. 86; Conger, 2013, pp. 135).

Child Health, Healthcare, and Nutrition

Some of the most obvious barriers to early childhood development in South Africa are child health issues like illness and nutrition. In 1995, the South African government created policy to prioritize children under five for food and micronutrient (vitamin) supplementation and in 1997, the government began providing free maternal and child healthcare (Republic of South Africa Department of Education, 2001). And though the infant mortality rate and the under-five mortality rate *have* decreased since 2003, children aged 0-4 years still make up 10.4 percent of annual deaths in South Africa and are at the greatest risk, among children, of dying. (UNICEF, 2007).

Of relatively popular consideration by literature is child nutrition. UNICEF reported that, in South Africa, 21.6% of children aged 1-6 years were stunted and/or chronically malnourished. Further, they found that 1 in 2 children were receiving less than half the recommended levels of key vitamins. Exclusive breastfeeding was only reported for 12% of infants under four months old and

caregivers were found to start weaning early by supplementing breastmilk with water or other liquids (2007). Issues of health that occur during these early years have been known to affect children long-term. Walker, et. al. reported that, “each episode of diarrhea in the first two years of life contributes to stunting” (2011, pp. 1328) and the NDA stated that “children who lack certain nutrients (such as iron and iodine) or those who suffer from general malnourishment ... do not have the same potential for learning as their healthy, adequately nourished counterparts” (2012). Lastly, UNICEF found that nutritional stunting¹ and Vitamin A deficiency were both more prevalent in rural areas than urban (2007). Despite the prevalence of childhood illness, many primary-care health facilities are seriously short-staffed. 47% of clinics report that doctor-visits are non-existent (Berry, et al., 2013, pp. 15). Though 47% of children live in rural areas in South Africa, only 12% of doctors work rurally, making this staff shortage especially prominent for rural clinics (Berry, et al., 2013, pp. 15). Thus health becomes one way, of many, in which social inequalities like poverty act to create disparities in childhood development.

Perhaps the key tool used to track children’s health in South Africa is the Road to Health Card (RHC). In theory, every child born in South Africa should receive an RHC – a multi-page packet that records a child’s important health events, including details of the mother’s pregnancy, details of childbirth, patient and family history, immunization record, growth and weight plotting, developmental milestone achievements, and illnesses. The card is intended for use by clinicians and community caregivers, and thus requires that a parent have the card on-hand at appointments (Tarwa, 2007, pp. 15). However, a study by Tarwa, et al. found that the records kept on the card were often incorrect or absent (2007, pp 17).

¹ A height-for-age lower than two standard deviations below the World Health Organization’s set standard caused by malnutrition

Early Childhood Education & Cognitive Stimulation

Just as the child's body requires appropriate nutrients, so its mind requires appropriate stimulation. Walker states that, "Lack of early learning opportunities and appropriate caregiver-child interactions contribute to the loss of developmental potential" (2011, pp. 1330). However, 84% of children aged 0-5 do not have access to a formal ECD facility and fewer than 1 in 6 children aged 0-7 were in one. Parental fees charged by these programs can be prohibitive (UNICEF, 2007). The National Development Agency (NDA) reported, "Some of the prominent challenges... facing ECD facilities include absence of learning materials and resources... minimal funding, lack of qualified teachers, inadequate security for children whilst at the ECD facility, as well as poor toilet amenities" (2012). Indeed, many operate without running water, electricity, or sanitation. (2012).

The lack of resources or infrastructure is a reflection of socioeconomic inequities. Facilities provided for predominantly Black African students had the highest number of "below average" ratings on resources (NDA, 2012). Additionally, ECD centers categorized as "emerging/survivalist" by the NDA – a label indicating minimal age-appropriate toys, no education-learning program, nutritionally insufficient meals, etc. – are correlated with a weak economic position of parents and community (2012). Thus, because the ECD programs influence childhood development and their quality is influenced by socioeconomics, early education becomes another source of disparity in development.

The South African government does provide support for ECD centers and Grade R classrooms, through funding and provision of food. White Paper 5 on Early Childhood Development first set a governmental goal of targeting support to high-poverty areas and asserted the Education Department's financial responsibility for Grade R provision. ECD facilities not including Grade R are mostly funded by the Department of Social Development, which offers a subsidy of R12 per day per child (0-4 years old) (NDA, 2012). This subsidy often proves insufficient however, and thus most ECD centers also charge caregivers tuition (Proudlock, 2014, pp. 47).

Perceived Psychosocial Support for Caretakers

At the intersection of poverty and parenting is a world of stressful scenarios to be dealt with on a daily basis. In their report on the perceived social support of caretakers in a rural South African setting, Johnson, et al. argue that social support can help cope with the stresses caused by a lack of resources (2002, pp. 18). Examples of social support include family and community support networks, as well as government assistance such as free health care and grants (2007, pp. 18). Statistically significant correlations were found between perceived social support and satisfaction with family support and between satisfaction with family support and parent/guardian level of depression (Johnson, 2002, pp. 20). Walker, et. al. found that, “Maternal depressive symptoms are negatively associated with early child development and quality of parenting across different cultures and socioeconomic groups.” (2011, pp. 1331). The results of the study reveal the importance of considering how caretakers feel about support available to them, as this is clearly an issue that affects childhood development.

As Johnson, et al. asserted in their study, a key component of this social support is perceptions of government policies and programs that relate to caregivers (2007, pp. 18). In recent years, the South African government has initiated several key changes in order to improve the status of children in South Africa. The South African Bill of Rights includes a specific section on children’s rights and asserts every citizen’s right to basic education, health care services, sufficient food and water, and to social assistance if they are unable to support themselves and their dependents (Republic of South Africa, 1993, pp. 558-559). The more recent Children’s Act 38 was written to “generally, promote the protection, development, and well-being of children” by giving effect to those constitutional rights of children, holding the Republic responsible for obligations to the well-being of children, and making provision for services to promote child well-being (2005). Perhaps one of the most successful government programs aimed at child well-being are the social grants given to caregivers.

The Child Support Grant (R300 per month per child) is widely recognized as one of South Africa's most successful poverty alleviation interventions (Proudlock, 2014, pp. 59). Each child a caregiver cares for is eligible to receive the grant. In 2011, over 11.3 million children received the grant, which studies show improves food security and quality, nutritional health, access to health services, and attendance at early childhood education (Proudlock, 2014, pp 60-61). Less popular because of higher burden of proof is the Foster Care Grant (R800 per month per child), which is intended for caregivers of court-recognized foster children (including orphans) (Proudlock, 2014, pp. 71). Both grants require both that the caregiver has an official ID and that the child recipient has a birth certificate and these requirements remain a key barrier to access (Proudlock, 2014, pp. 65). Birth certificates and official IDs must be applied for through the Department of Home Affairs (a process that also requires an official ID), whose service delivery and accessibility is particularly weak in rural, low-population areas (Proudlock, 2014, pp. 15). Thus, it is estimated that 2.35 million eligible children are excluded from accessing the Child Support Grant alone (Proudlock, 2014, pp. 19).

METHODOLOGY

Narrative Inquiry

Qualitative research, rather than speaking in objectively numerical data, "...[uses] forms of communication that are intended to do more than tell, but to show, that is, to convey a sense or feeling of person or place" (Eisner, 2001, pp. 43). To convey this sense, I find it most appropriate to communicate through narrative. R. Josselson describes narrative inquiry as, "obtaining and reflecting on people's lived experience" (Josselson, 2007, pp. 537). What research there is on early childhood development in rural areas often gives a statistical view ending in pragmatic needs-statements. It is the inherent "messiness" in parenting, and the lack of research accounting for this, that leads me to pursue a qualitative research model. A child's development is in large part shaped by the decisions of

its parent(s), who, being human, is swirled with the input of culture, emotion, instinct, and other complicating factors. Thus, I turn to narrative to describe this messy endeavor of raising a child, as

“... there would be nothing more truthful than a story that shows the complexities and ambiguities of emotional, bodily, moral and spiritual experience in scenes that use metaphor and imagery and show people talking about, thinking about, coping with, holding on to and changing their minds and interpretations in daily life” (Ellis, 1999, pp. 235).

Data Collection

In seeking caregivers to interview, I used purposive sampling – specifically criterion and maximum variation sampling. Criterion sampling involved recruiting caregivers based on specific characteristics I sought to understand (for example a teenage mother over 18, a very old mother, a mother who did not believe in taking kids to the clinic). This was combined with maximum variation sampling in which the criteria used were also as wide-ranging as possible (married caregivers, biological-mother caregivers, old caregivers, young caregivers, etc.) in order to gain the widest perspective possible of the experiences of different types of caregivers. Because I largely used my translator and guide for referrals, my sampling method could also be defined as Convenience Sampling. The sample consisted of six primary caregivers, a Grade R teacher, and two healthcare workers (one CCG, one clinic worker). Given the demographics of primary caretakers, teachers, and clinic workers in rural South African areas (see section 4.1), all participants were female, Black South Africans and most primary caregivers were older women (“gogos”). Only the stories of children currently under 10 were included, since parenting has changed dramatically in the past decade, due nationally to post-apartheid restructuring and locally to the introduction of electricity to Nzinga.

Such a small sample cannot possibly be said to represent the whole population. However, the purpose of this study is not to make statistically sound statements about Nzinga or South Africa.

Rather, I am aiming to provide a collection of stories that may illuminate paths of future research informed by the perspectives of those intimately involved in the question. Thus, the sample size chosen seeks to balance the provision of variety in perspectives with the feasibility of collecting in-depth, lengthy narratives.

The main method of data collection was interviews, conducted in caregiver's homes and professionals' work places. A smart phone was used to record all interviews. Interview questions were purposefully broad and were intended to draw the participant into "story-telling mode". Broad questions were supplemented with more specific questions asked only if more detail was needed. These focused on aims mentioned in the abstract. The list of pre-planned questions is available at the end of this report, however the natural flow of conversation introduced some unplanned questions and negated some planned ones in each narrative. Observational data was recorded using a field notes journal.

Data Analysis

The final step in constructing a narrative-based qualitative study is reporting these stories and analyzing them. To convey a complete, "whole" narrative, answers to questions were woven together into a stylistic story of each individual. Subsequent analysis of the narratives focused on exploring my main research theme and its five aims, as well as additional, unintended themes that arose in the conversations. While the presentation of multiple narratives in full runs the risk of seeming repetitive in some themes, this repetition is necessary for establishing commonality in analysis. Additionally, for the sake of brevity, not all interviews collected are presented here as full narratives. Key quotes and information gleaned from these un-included interviews were used, however, for analysis.

Ethical Considerations

SIT's Local Review Board has approved the ethics of this project. Given the sometimes-sensitive nature of experiences in parenthood, all participants were verbally informed before the start

of the interview that they could answer questions with as little or as much information as they wanted. They were also verbally informed that all questions were optional and that if at any time they wanted to end the interview, they were free to do so. Lastly, they were informed on both the consent form and verbally that, if at any time, they wanted to remove any or all of their interview from the written ISP, they would be able to contact me through my translator and I would remove it, no questions asked. I also verbally requested permission of every interviewee to record him or her. A consent form was given to each participant (written either in Zulu or English, to the participant's preference) explaining the study's purpose, policies on privacy, confidentiality, and anonymity, and contact information for SIT's Durban office.

To protect anonymity and privacy, all names were changed (except in the case of the Grade R teacher, from whom I received signed permission). No identifying information, such as detailed descriptions of people or houses, was used in the ISP. No participant was discussed with any other participant and the only other person who knows the identity of all interviewees is my translator, to whom I explained this study's policy on confidentiality and privacy. Every effort was made to fully conceal the identity of all subjects except those who provided written consent permitting otherwise.

Confidentiality of information learned from participants is also being protected. Audio data collected on my smartphone was password protected during the duration of the study and has now been deleted from the phone. The recordings, along with transcripts, are stored in a password-encrypted file on my computer. Audio file names include only the participant's pseudonym. No identifying information was recorded outside of the audio file and transcript (i.e. no names, etc. were written in my field notes).

Lastly, when analyzing and reporting narratives, it is important to remember that narrative inquiry is entirely subjective and, as such, cannot escape the voice (and its inherent biases) of the researcher. I am a white, female American with no children. I was raised in a middle-class home by married parents. I am currently researching early childhood development in an animal lab that studies

the link between prenatal environmental contaminant exposure and adolescent anxiety disorders. My background knowledge on childhood development comes from my own readings, my research experience, and my education as a Neuroscience major at The University of Texas. When writing these analyses, I strove to be constantly aware of my own biases and how they might be affecting my “narrative privilege” – that is, my position as the one who decides which stories are silenced, which are told, and *how* those stories are told. In the words of T. Adams, “...we must reflexively probe ourselves to consider how our expectations of and ethical stances toward a story may alter its crafting and reception” (2008, pp. 185) so that we can “discern who we might hurt or silence in telling stories as well as whose stories we do not (or may not ever) hear” (2008, pp. 181).

FINDINGS: PRESENTATION OF NARRATIVES

Note: All names in the following narratives have been changed to protect the privacy of the participant (unless written consent was obtained to use real names). Any resemblance to persons known is coincidental.

Fikile and Khulelaphi

We sat under the blistering sun with the sounds of sloshing laundry water as our only refreshment. It was a bright, clear Sunday and, arriving unannounced, my translator, Qaphelisile Mkhize, and I had come upon Fikile, my first participant, doing the family’s laundry. In the thin sliver of shade cast by a small rondavel², Fikile sat with her back to the outer wall determinedly scrubbing a pair of jeans over the brown water of a huge metal tub filled to the brim with soaking clothes. As Qaphelisile casually conversed in Zulu with Fikile, I stood feeling a little awkward and looked around the small property we’d just entered. A short, barbed wire fence that looked festive, draped as it was in colorful, drying clothing, surrounded the small dirt lot. A number of buildings – square,

² A rondavel is a small, one-room, round shelter usually made of dried mud, painted, and topped with a conical thatched roof.

two-room structures except for the rondavel – occupied the land, their doors open and many of their rooms seemingly empty. Hearing the conversation, a young woman stepped out of the rondavel to look at me curiously, a baby tied to her back with a thin blanket and a little boy, not much older, clinging to her leg. Somewhere in the conversation, Qaphelisile must have explained my presence because, as Fikile returned to her relentless scrubbing, Qaphelisile turned to me. “Okay Beth, you may ask your questions”...

At 54, Fikile is considered a “gogo” in Zulu culture – a grandmother. Yet, since they were born, Fikile has been the primary caregiver to her two grandchildren. Bhekisisa is the oldest, at three. “He’s very quiet,” Fikile laughed. “He’s always watching and not saying much. I like that about him.” (Fikile, 2014) Indeed, as the interview began, I had watched Bhekisisa quietly squeeze into the space between his grandmother’s back and the rondavel’s wall, where he now sat eyeing me suspiciously. Despite Fikile’s admiration of this attribute, her favorite thing about Nhlahla, two-years old, is the opposite. “She is always very talkative” (Fikile 2014). The woman, on whose back Nhlahla was lounging, looked up and laughed. This was Nhlahla’s biological mother, 22-year old Khulelaphi. She was visiting from Petermaritzburg, where she had moved, along with her sister (Bhekisisa’s mother), to find work (Fikile, 2014).

As I asked Fikile about the pregnancies, Khulelaphi excitedly chimed in, silencing her mother. The girls were young, 18 and 20, and unmarried when they got pregnant. Until their eighth month, both daughters hid their pregnancies – wearing large jackets and spending most of their time in their room (Khulelaphi, 2014). Though keeping the secret, Khulelaphi says she went to the clinic when she was supposed to.

“I went once a month for normal months, then every week in the ninth month. They gave us medication to make the baby healthy and at the sixth month, they took an ultrasound to check the baby’s heartbeat and other things. Every appointment, they measured my stomach and my blood pressure, checked my weight, and checked my sugar. I used to go to the clinic

after school and hide the medications in my school bag. At the clinic, there is a class every morning where they tell girls what to eat and what not to eat... just give them lessons. So there's nothing really to ask them, because they tell you everything.” (Khulelaphi, 2014)

Even though her pregnancy was free of physical complications, Khulelaphi was very worried during those nine months. Zulu culture, like many others, does not accept unwed mothers with much hospitality. Once her news was revealed, Khulelaphi encountered this. “When you get pregnant, [family] do not help because they are angry that you are pregnant and not married.” (Khulelaphi, 2014). However, her grandmother did give her advice.

“Gogo [grandmother] said I must not get angry when I'm pregnant. She said you must always work and exercise because there is a belief that if you are sleeping or resting, the baby won't come. So you do a lot of chores, like go get firewood or water and make some mud on the houses. I did Spring cleaning every day and no sleep!” (Khulelaphi, 2014)

When the time came to give birth, Khulelaphi went to a hospital. I asked what her childbirth was like. She let out a loud laugh. “I do not wish to go back, because it was so bad. It was so painful for the whole day. It's a bad thing.” She paused for a minute, her smile slowly fading into the silence, her eyes lowering to the tub of water. “It's just a bad thing,” she repeated quietly (Khulelaphi, 2014). As soon as Nhlala was born, nurses gave her a check-up and gave Khulelaphi some advice. “They checked the weight and the stomach... to make sure it's running the normal way. Then they told me I must give breastmilk so that my baby can be healthy. They showed us how.” And with that, Nhlala was brought home to Nzinga (Khulelaphi, 2014).

It was at this point in the story – the point after birth, the point where the raising of Nhlala starts – that Khulelaphi began to fall silent. As the conversation shifted to matters of day-to-day motherhood, Khulelaphi's focus returned to scraping the rainboots in her lap, which were caked with a week's worth of soggy earth. It was now Fikile's time to tell.

“When the children were born, it was just me alone here – no one to help. But I just accepted it, because these are my babies. There’s no way out, so you must just accept that there is no help. But I was happy” (Fikile, 2014) While Nhlahla was breastfed exclusively for a year, Bhekisisa liked formula so Fikile combined his breastmilk with formula and both were weaned using a mixture of soft porridge and milk. The kids both grew up without sickness their first year. Fikile was also watching their mental development. “It’s five months to sit, seven months crawl, and a year to walk. Talking... it depends. Like the boy, it is still sometimes hard to tell what he says. But the girl, she was very fast” (Fikile, 2014). Fikile says that the community caregivers (CCGs) check for development too – seemingly both mental and physical. “They check the mind... if the child is fast or slow. If something is wrong, they say if they need milk and porridge with Vitamin B12, which comes from the clinic. You bring the child to the clinic every month until they say that the baby is fine.” (Fikile, 2014)

Now days, the children are a little older and Fikile finds her help in the local crèche³. “I take them to the crèche every day from 9am-2pm. During this time, they get to spend time with other kids and I do the laundry and cooking. It costs R20 a month, but this is not expensive since they’re being taught how to count and sing. They play and they’re learning there” (Fikile, 2014). This daycare seems to inspire her belief that the government is sufficiently helping mothers like her. “The government is building more daycare centers and giving food to the centers and giving grant money” (Fikile, 2014). Though illiterate, Fikile believes it is as much her job as the crèche’s to teach her children. “The teacher and the parents should both teach. I like to teach them to draw... I draw Gogo and Mkhulu⁴ for them. When they were babies, I talked to them. It’s important to help them learn to talk and helps them talk faster.” However, Fikile believes that it’s most important for them to learn to count and to write before they start Grade R (Fikile, 2014).

³ A term for a daycare

⁴ Zulu for “grandfather”

Bhekisisa and Nhlahla eat some government-provided meals at their daycare and others at home. “They’re choosy,” Fikile laughs. “They hate cabbage. Mostly, they eat rice and potatoes, but also fruits and vegetables.” About every three months, a CCG will visit Fikile and her children.

“They don’t take any other measurements. They check for the child’s [RHC⁵] for immunization. They check the dates and tell the parents the dates the child must go in for immunization. And they give us advice on what to give the kids to eat. They say [the children] have to eat mealie porridge. It’s a must.” (Fikile, 2014)

I wondered if she ever asked the CCG any questions during these appointments and she paused, seeming confused. “No... she’s the one who comes and tells us what to do” (Fikile, 2014). Every three months, Fikile takes Bhekisisa, Nhlahla, and their RHCs to the clinic. While Fikile has always been strict about keeping the children’s RHCs up-to-date, she’s never been told the meaning of most checks on the card. “[The CCG] explained about the immunizations... but they don’t explain anything besides that” (Fikile, 2014) At the clinic, the children’s weight is taken and, every six months, they are given Vitamin B supplementation. The RHCs are appropriately filled out, ready for the next appointment (Fikile, 2014).

Overall, Bhekisisa and Nhlahla keep Fikile happy. “It’s nice to stay with them, because you’re not lonely. The kids are always talking, always asking for things,” she laughed. “They waste a lot of time outside, even if it’s raining. The girl likes her baby dolls and the boy likes his cars. But the boy also likes wearing high-heels and leggings like a girl. He’ll even take a bag and say ‘I’m going to town!’” (Fikile, 2014). Her happiest moments are when she sees that they are growing up. But, in growing up, they may also face her greatest worry. “The kids of today are drinking and using drugs. I worry most that they will do that when they grow older” (Fikile, 2014). Instead, Fikile’s greatest hope for them is education. “I hope that Bhekisisa becomes educated and comes back driving a car!

⁵ “Road to Health” Card: A booklet containing weight-to-height tracking tables, immunization records, neurodevelopment tests, and other appointment notes.

And I hope Nhlahla also gets educated and becomes a prosecutor or something like that.” (Fikile, 2014)

As our discussion drew to an end and Khulelaphi brought out a tray of juice and crackers, Mrs. Zulu and Fikile returned to their un-translated conversation. My attention drifted to Bhekisisa who, spotting a shiny copper ten-cent piece, was creeping slowly from his hiding spot. Bhekisisa picked up the coin, squeezed it between his tiny palms, and edged back into his cave. Opening his hands he investigated the coin – turning it this way and that to capture the light, brushing his finger against its impressions, digging shallow indents in the packed dirt at his bare feet. Finally, perhaps in one last act of exploration, Bhekisisa popped the coin into his mouth and sauntered off to play among the towels that blew like sails in the wind.

Grade R Teacher: Mrs. Funeka

I sat squeezed onto a tiny plastic chair, listening to Mrs. Funeka ‘s slow, hesitant, and kind voice as she recounted her favorite memories and hardest struggles as the Grade R teacher at Nzinga’s Holoma Primary School. I’d been observing her class all day and now, as we sat down to talk and the last little sweepers of the Pink Team grabbed their backpacks from their cubbies and ran out the door, the classroom seemed suddenly dark and quiet. Pale sunlight filtered through the rows of painted handprints lining the bottoms of the windows, casting pink and blue and green spots onto the cement floor. Dozens of posters adorned the yellow walls depicting numbers, seasons, birthday parties, and other features of the world outside. Above the chalkboard was a line of twenty-six big bubbly letters – each sitting beside its representative isiZulu example. The letter “x”, so hard to place in English, rested easy by a friendly frog – “ixoxo”.

When the children had arrived in the morning, they reminded me of frogs – hopping for no apparent reason, running everywhere, falling everywhere. At the sound of Mrs. Funeka’s call, the 23 students lined up in neat rows for the morning’s assembly, which included a prayer and some songs. After a restroom break, the students ran into the classroom to sit in a cluster on square of carpet

marked “Reading Corner”. Today’s theme was “holidays and birthdays” and the children’s day would start with a thirty-minute lesson on the subject. Though the lecture was conducted in isiZulu far beyond my comprehension, I sat focused on the musical rise and fall of Mrs. Funeka’s voice and the excited answers of students to her questions.

Mrs. Funeka has been a teacher for 18 years and a Grade R teacher for five of them. Though she’d planned to be a nurse, rejection from nursing school led her instead into education.

“I gain knowledge and information and I gained love of this work. That’s why I am [doing] it at the later stage because I’ve got to the decision that there is nothing wrong with this work. I started teaching Grade 4, and then I moved to Grade 3 for many years. Then from there I moved to Grade R. It’s not different teaching grade R from grade 3 except that these grade R’s are too young, so [teaching] needs to go with them according to their minds, according to their stage. But all young kids learn based on playing, to make them to enjoy the activity and to engage them because in your teaching, learners need to be fully engaged in your lesson.

Learners need to be part of the lesson so that they can understand the lesson (Funeka, 2014)

Though it was not her original plan, Mrs. Funeka loves teaching and has even earned a B.Ed Honors, along with an advanced certificate in teaching and primary education. “It’s nice, working with the kids. It removes any stress that you have. Sometimes I come here in the morning with the stress that I’ve got at home, but I end up feeling happy and laughing all the day with the kids. I like them. And I like this work” (Funeka, 2014).

Her favorite part is teaching lessons through play and integration. “Everything they do, they are doing in playing. The theme or the activity that we do is the integration of three learning areas. Grade R does isiZulu, Mathematics, and Life Skills, but we do it in combination. Pulling out a piece of paper, Mrs. Funeka explained further.

“Today, we talked about Christmas Day. If I write for them, ‘December 25 is a Christmas Day’ [in isiZulu] and maybe we draw a Christmas Tree... this [circling the “25”] is

mathematics, introduction to numbers. There are words – this is isiZulu. And there is a picture, this is Life Skills. Everything integrates... My activities always allow them to see and touch. As they are touching, they understand clearly” (Funeka, 2014).

As the lesson on holidays ends, the children race around the room to choose between four stations – Creative Area, Building Area, Fantasy Area, and the Reading Corner. Mrs. Funeka explained that whatever the students did had to be focused on the day’s theme. In the Creative Area – a small table with plastic drawers of crayons, clay, and paint – students shyly showed me what looked like clay disks with spikes. The children blew on their sculptures and I suddenly understood – birthday cakes. In the opposite corner, students sat at the Fantasy Area, digging through a box of ragged dolls, mismatched puzzle pieces, and a stylish pair of broken sunglasses. Others sang “Happy Birthday” to a group of dolls that sat around an overturned box, on top of which was a tin-foil square adorned with a birthday cake sticker. The clatter of wooden blocks came from the Building Area, though what these students were making they could not tell me. Meanwhile, children in the Reading Corner lay on their stomachs, flipping through tattered store catalogues, Christian brochures, and Zulu picture books.

After about twenty minutes, Mrs. Funeka called for the students to clean up their projects to move into “group-time”. The room filled with scurrying as the children brought out small plastic tables and squeezed around them, about six to a table. Mrs. Funeka does not have the resources for every student to do every activity, so while some groups use workbooks, she assigns the others non-workbook activities. The groups alternate every day (Funeka, 2014). Mrs. Funeka moved from table to table, helping some with worksheets while one group played with clay and another discussed holiday traditions. The workbooks include the kind of integration Mrs. Funeka loves, with that day’s worksheet including things like

shape- and color-identification, tracing, and numbers all in one page depicting a maze of holidays.

Seeing that her students are learning is what Mrs. Funeka is most proud of in her Grade R class as the fourth and final term of the school year winds to a close. “They recognize numbers when they see them. They are able to speak confidently. And they also know how to discuss the topics. Now they are confident in everything they know. And they show ‘there’s something that I’ve learned now’. Many are able to write their names” (Funeka, 2014).

However, Mrs. Funeka sees two major problems within the classroom that disrupt students’ education. The first is the knowledge disparity faced between students who attended crèches before entering Grade R and those who didn’t. “[Students who come from crèches] do better. They show that they have got some information. They have that confidence. Crèches do a lot of work” (Funeka, 2014). Between government-funded crèches and privately-funded crèches, there is also a difference.

“The big crèches are funded by the government. Even the teachers are employed by the government, unlike the smaller [private] crèches, where teachers are paid by parents. Sometimes parents pay, sometimes they do not pay. Teachers end up not working that hard... not looking at their work as the work they get money from. I think funding from the government would make a big difference” (Funeka, 2014).

The second problem is lack of resources. With such an emphasis on play, Mrs. Funeka asserted that the class desperately needs new toys and learning materials that students can touch, see, and experiment with.

“Sometimes I say things in theory, but they need to do it in practical. But sometimes we don’t have the resources. I tell them by mouth only and some say, ‘We don’t know that thing’. Sometimes I show them on pictures. We need more resources. Even outdoors. They are playing with dirt. We need to have a sand pit” (Funeka, 2014).

She said this lack of funding doesn't just affect Grade R. The school, as a whole, faces a shortage of supplies (Funeka, 2014).

As group time ends, the students put away their plastic tables in preparation for lunch. Meals are provided by the government, which also decides the menus. Two large metal bowls filled with putu-pap⁶ and beans and a plate of butternut squash, had been set outside the door to Grade R. Mrs. Funeka and I ladled a scoop of each, plus a piece of butternut, into each student's container (ranging from Tupperware dishes to old butter containers) and they each ran to the shade under the playscape to eat. After lunch came recess. Mrs. Funeka laughed and played, leading the students in chasing games and balance competitions. "[I am] doing the activities they do," she'd said. "It's very tiring." (Funeka, 2014). As the bell rang, students ran to the bathroom before racing back onto the Reading Corner carpet. "It's time for group movement and music," Mrs. Funeka explained. The students sang and chanted, performing coordinated dances to their songs and showing off their traditional Zulu dance skills. Sufficiently tired and sweaty, the students slowly quieted as Mrs. Funeka brought out an oversized book telling the story of bugs at a party. Though the reading, she said, would be tomorrow, they would talk about the pictures today. After an hour of story time, it was time for students to go home.

It's at home, however, that Mrs. Funeka says students encounter another barrier to learning. Without sufficient class time to do remedial work, Mrs. Funeka instead sends homework home with those students struggling in some concept. "Sometimes you see that, 'okay, now it's on the way. She's trying.' Sometimes, it's, 'she's still lost, I need to do more with this child'." (Funeka, 2014). However, some children rarely complete this homework. "Sometimes the children live with grandparents. Grandparents are illiterate, most of them. [The children] come in without homework and say, 'My grandmother, she did not know this

⁶ A dry, crumbly South African staple made from ground maize (mealie-meal)

thing,' and it ends there (Funeka, 2014). Mrs. Funeka also sees higher absenteeism among students with older caregivers. Sometimes, Mrs. Funeka will try to keep a child after school for individual help but, overall, she believes the solution is education for parents. "We need to work together as the school and the homes. Parents need to be educated so that they can also help their learners at home." (Funeka, 2014).

Talking about these problems, Mrs. Funeka seemed to grow tired. "This class needs a lot of love," Mrs. Funeka went on slowly. "Some are orphans, others are not orphans but they didn't know their parents. Others are adopted... When they are crying, they want to come cry on you. They need that love. They need the teacher to have that love... from the heart." (Funeka, 2014). As I walked out of the classroom, I noticed the incredible quiet lingering over the empty school, despite Nzinga's noisy nature of crowing roosters, bleating goats, and constant beating drums coming from one house or another. But at Holoma, the screams and laughs of the students had faded for the day, replaced with the silence of teachers steadily working on assessments and plans.

Lindiwe

The two sisters sat on a mat at our feet, giggling at some unspoken joke known only by them. "These two, they are like twins the way they're growing up," Lindiwe laughed (Lindiwe, 2014). At 43 years old, Lindiwe is no first-time mother. With seven children in total, her youngest are these seven-year old girls – one her biological daughter, and one her granddaughter (Mbali and Nosipho) (Lindiwe, 2014). Lindiwe, Qaphelisile, and I sat on a narrow bench watching the girls. My eyes wandered to the blue doorway of the nearby two-room house. Jazz poured out of the house and into the dusty air of the windswept dirt lot. I smiled, thinking back to a time of giggling in the backseat with my own sister, the car radio blaring my father's favorite blues and jazz tunes as we drove toward the bright city lights – a weekly tradition forever symbolizing the cool night's coming to grant our brief respite from the summer heat.

Mbali is technically Nosipho's aunt – sister to Nosipho's mother who passed away when Nosipho was three. Lindiwe couldn't, or perhaps wouldn't, tell me how her older daughter passed away – just that she became suddenly sick, went into a coma, and died. But one of her most prominent memories of Nosipho's early childhood was her questions about her mother. "She was always asking about her mother. We bury our family near where we grow the vegetables. So she would always ask, 'Does my mother grow as a vegetable?'" (Lindiwe, 2014). Nosipho began to laugh at this story in the same way that many do when hearing of that peculiar time of life when one lives but does not remember.

When Lindiwe found out she was pregnant with Mbali, she was excited. "I only had one girl and when I got pregnant, I thought maybe I'd get another one." Following her Zulu traditions, Lindiwe avoided sleep and worked very hard. "[The clinic] told me not to do hard work while I was pregnant, so I didn't do hard work in the ninth month. But all the months before that, I would still do work, like fetch water and get firewood." However, following the clinic's advice, Lindiwe's husband did help with some chores and she did change her diet. "Every day, I only ate black tea and vegetables." (Lindiwe, 2014).

During her pregnancy, Lindiwe visited the clinic every month (and every week in the ninth month). "They take blood and check blood pressure and weight." Because Lindiwe's blood pressure was very high, a doctor at the clinic suggested a Caesarian delivery. However, when Lindiwe arrived at the labor ward to give birth, she was rushed into a natural birth instead. Fortunately, no complications arose and Mbali was born healthy. After giving Mbali a check-up ("the eyes, the face, the weight"), health workers advised Lindiwe on proper health behaviors. "They told me about breastfeeding and how it is good. And about immunizations – how important it is to bring them for immunizations." (Lindiwe, 2014).

Back home with a brand new baby, Lindiwe said most of her help came from her husband. "He was very helpful, and I was very happy." As the baby grew, Lindiwe breastfed her for a year.

Given her experience, no family or friends gave Lindiwe advice about her baby, nor, she said, did CCGs. “I was thinking for myself. I just new, ‘this is the time’ and I would do things like put a thick blanket around to teach the child to sit... And you just think for yourself, ‘this [food] is good for my kid’, and you give it to them.” (Lindiwe, 2014).

When the CCGs do come, Lindiwe said, they mostly focus on immunizations. “They come and inform us when there’s a special immunization for the school and check the RHC. They don’t really do anything besides look at the RHC. The nurses [at the clinic] check for other things, but the caregivers never do that.” (Lindiwe, 2014).

Culturally, Lindiwe thinks it’s the community’s job to help raise Nzinga’s children by creating programs that help kids stay out of trouble. She feels there are some programs like this. “There’s a group of boys who dance and sing. I think that helps them avoid drugs and drinking.” In terms of the government’s role, Lindiwe thinks funding is helping. “If a kid is an orphan [like Nosipho], they give them a school uniform.” (Lindiwe, 2014).

Lindiwe’s greatest hope for her children is their education. Before the girls entered school, she, along with their daycare, taught them to write and to count. Now, she hears Holoma’s message of collaboration between home and school. “They are telling us that parents must help. If they have homework, you have to check and help them.” In the future, Lindiwe hopes that both of her daughters become nurses. “They’re very bright, so I think they can do it.” But she’s worried that teenage pregnancy will stand in their way. “I hope they grow up and get an education before they have kids.” (Lindiwe, 2014).

Healthcare Workers: Nompilo and Themba

I walked along a rocky path in silence, humbled by the thunder that came tumbling down the mountains in the wake of a suddenly turbulent sky. The path to the clinic is cut roughly into the hard-packed red dirt of Nzinga. Shaped by the foot traffic of thousands of citizens over the decades, the path winds through the crease between two cattle-filled hills to the dusty, white road that leads,

eventually, to the clinic. Arriving at the clinic, I stepped into the antenatal and child health building in the clinic complex and heard the sky give way like some waterpark bucket attraction that, once filled, releases with all suspense its water onto an appreciative and squealing crowd. Inside, the fluorescent lights buzzed softly to their reflections in the white linoleum floor. The red plastic waiting room chairs sat disordered from the long day and strewn with empty Styrofoam cups and crumpled brochures about child nutrition. The chairs all faced a bulletin board that took up most of one wall and held posters advertising average waiting time (65 minutes), signs of TB, and the stages of progression of AIDS.

Inside her office, Sister Nompilo sat, exhausted and frustrated at the end of her own long workday. She's been a nurse for 14 years. Much of her job, she said, is administrative work. Yet today she's not had time to get to it. The clinic's critical shortage of staff – caused, she says, by the prohibitively low wages paid to nurses – means that most of her time is spent treating patients, who she also finds herself increasingly frustrated by. “People are ignorant. They don't take treatment. They don't come in early for testing” (Nompilo, 2014). This behavior is indeed what Sister Nompilo would most like to see change. “Mothers who are pregnant should start the clinic early - most come in only after twenty weeks. They must take care of children so they're not exposed [to HIV]. They must know how important it is to immunize children” (Nompilo, 2014). When pregnant mothers do come in for antenatal care, they are given some education on the danger signs in pregnancy, signs of labor, breastfeeding, hygiene, the importance of cervical screening, immunizations, and HIV. After this, the nurses make a point of asking if the women have any questions. They rarely do. Unlike some other rural clinics, Nxamalala is set up to deliver babies, but only if the mother cannot wait the 3-4 hours it takes for an ambulance to arrive (Nompilo, 2014).

While many women seem not to keep their antenatal appointments, Sister Nompilo says most show up for their children's appointments. These appointments are every month until the eighteenth month and every six months for Vitamin A supplementation and de-worming until the fifth year.

Thereafter, children are only expected to come when sick or for immunizations at six and twelve years of age. Mostly, kids come in for diarrhea. Sister Nompilo wasn't sure why this problem is so common among Nzinga's young. "It's something about hygiene," she said. Advice about immunizations, breastfeeding, HIV, and malnutrition are typically given during appointments, but Sister Nompilo says it's clear that not all follow the advice. "Sometimes, granny is too old to come to the clinic. Sometimes the child is left at home without a Road to Health Card" (Nompilo, 2014). Sister Nompilo is proud, however, of Nzinga's Community Care Givers, who, she says, weigh children in the community and report this data back to the clinic for growth monitoring from afar (Nompilo, 2014).

As our conversation ended, I walked outside into a wet, muddy landscape and Sister Nompilo returned to the last few patients in the sterile waiting room. What lay ahead was an exhausting uphill climb on this trail from a clinic to its community.

At the top of this trail is the domain of the Community Care Givers (CCGs). To walk into the dim house of Themba – one of Nzinga's CCGs – is a decidedly different experience than the clean, quiet white halls of the clinic below. The house pulsed with the screams of young children, the quiet hum of a barely-audible television show, and the sizzling of frying chicken on the stove.

Themba became a CCG in 2002 because of her love of this community.

"I was worried to see the people who are ill and not able to help themselves. It was the Lord who called me to do this thing... It's hard when you get there and you see someone very sick. It touches you. But when someone is sick and I call the ambulance and they take them to the clinic or hospital, it makes me happy when I see that person well again." (Themba, 2014)

She works as a CCG for the Red Cross, which operates distinctly from the clinic-employed CCGs. Themba says that the role of CCGs is mostly to provide advice to those who are sick or in need of other assistance. "We know each other in the community. So, [CCGs] know what's happening next door. You know who is trying to get food on the table. We know the

person that needs help so we can go there and help – send them to get their certificate, to the social workers.” Themba and other CCGs must report to the clinic every month – reports she says only contain notes on what she told patients, not measurements taken of children she sees (Themba, 2014).

When CCGs visit a pregnant women, Themba says they come mostly in this advisory role. “We advise them about check-ups – like to go to the clinics, to check all the diseases before the child is born. We don’t take any measurements - just advice and send them to the clinic.” She says that the most common problem when it comes to Nzinga’s pregnant women is the delay in seeking care (Themba, 2014).

“There’s the problem that they don’t say early that they’re pregnant so they can be treated... especially teenagers, then it’s late – 6 months, 7 months. They hide it. Sometimes it’s the stress, because she doesn’t know the father – maybe she’s got three boyfriends now. Others are afraid of the parents - maybe they’re still in school. Others are drinking liquor during pregnancy.” (Themba, 2014)

After children are born, Themba says CCGs monitor their growth every two months by measuring the upper arm, give Vitamin A supplementation, and check that the RHC is up-to-date. They also offer advice “to follow the dates of immunization, and if the kid is sick, you must take the kid to the clinic, even if it’s a flu or running stomach. Hygiene, especially when the baby is bottle-fed. The baby must be washed and clean.” If kids are sick, it’s usually because of diarrhea and rash, which Themba attributes to the stream water that some still use. Themba says she recommends the clinic any time diarrhea has lasted for more than one day, even with glucose⁷. Though she’s a health worker, Themba’s greatest wish for change in the community is for more children to attend crèches before starting primary school. Themba sees the provision of crèches as a health issue as well as an early education issue because

⁷ A mixture used for household treatment of diarrhea consisting of 1 liter of boiling water, 9 teaspoons of sugar, and 1 teaspoon of salt

these centers provide kids with nutritious foods and a safe environment in which to play and learn (Themba, 2014).

Our conversation came to an end as Themba's young granddaughter edged up to her grandmother, tired and sniffing at the lateness of supper. I walked out into the quickly darkening evening, pulled my rain jacket tight around me against the growing drizzle, and headed toward my home, just a few houses away.

Nomsa and Siyanda

American women's wrestling was playing in the background. Bikini-clad women slammed together – elbows to jawbones – within the small brown frame of the 90s-era television set. On one side of the thick, pixilated screen were glitzy lights, shouting commentators, and a roaring crowd. On the other side was a quiet, dim Zulu kitchen⁸ - its walls lined with water buckets, straw mats, and a small table supplied with a camp stove and some packages of mielie meal and porridge. The only source of light was an open doorway, through which Nzinga's constant soundtrack (roosters and goats and playing children) filtered. Nomsa, Qaphelisile, and I sat on benches around the long-cold ashes of the morning's fire.

Nomsa is 72-years old. As she spoke, her hands shook and her voice quivered with the ever-present threat of another coughing fit, which frequently interrupted her story. In her lifetime, she has raised four children and nine grandchildren. Those still under ten – Lungile (6), Siphawe (6), Mpumelelo (4), and Thoko (4) – are all from different mothers (some daughters and some daughters-in-law). Thoko's mother, Siyanda, lives with Nomsa. Mpumelelo's mother is working in Johannesburg. Lungile and Siphawe's mothers died within months of each other. About four months after Lungile's birth, her mother went to visit Johannesburg. "In the morning, she said she had a headache and in the afternoon, we heard she'd passed away. It was very sudden." Siphawe's mother,

⁸ A multi-use, one-room rondavel and family gathering place housing a wood fire that may be used to heat water, cook breakfast, etc. It may also be used in traditional ceremonies to communicate with ancestors.

on the other hand, died during childbirth. “She fainted, so they took her to the hospital. It was not time for the baby – she was only at seven months. But because she was sick they delivered the baby [by C-section]... and then she passed away.” Siphiwe spent the next two months in an incubator (Nomsa, 2014).

Nomsa seemed most interested in discussing her two orphans, but as Siyanda sat near the stove listening, she began to include experiences of her own pregnancies. Siphwe’s mother had hidden her pregnancy for six months. An unmarried 21-year old, this would be her second pregnancy – her first being Siphwe’s older sister four years earlier. She’d gone to the clinic once, at five months, and never again. “Sometimes you could see she was worried, even before we knew she was pregnant” (Nomsa, 2014) Lungile, on the other hand, had had a smooth pregnancy. She was also unmarried, but had wanted to get pregnant. “The kids she grew up with already had kids. And her younger sister was already having her second baby. So maybe she worried she couldn’t have a baby and was happy when she got pregnant”. She’d gone to the clinic every month, starting at her third month (Nomsa, 2014). For Siyanda, Thoko was her second child and she spent most of this pregnancy sick and bedridden. “My womb was painful. I was always coughing. And I had no appetite. For my first child I started [to go to the clinic] at seven months, but for Thoko, I started at two months because I was so sick” (Siyanda, 2014). Along with regular measurements (heartbeat, weight, stomach), the nurses always asked Thoko if she was doing any hard work and if there was anything about the pregnancy she didn’t understand. “Sometimes the clinic sent me to the hospital for an [ultrasound] scan, and they’d say that the baby is fine.” (Siyanda, 2014). During pregnancy, Nomsa said it is mostly the mothers and grannies who give advice, such as not to work hard when you’re pregnant and to not carry mud [in buckets] on your head when you’re bringing it home (Nomsa, 2014). I asked Siyanda if this advice was more or less helpful than the advice from the clinic. “They both give good advice, but the advice is about different things” (Siyanda, 2014).

When the time came, all four kids were born at a hospital. Though Siyanda was there to help Nomsa with the Lungile and Siphwiwe, Nomsa sometimes wished they had more help.

“Both of them were very sick. And it was like having twins because they were the same age. I sometimes felt like, ‘What if someone was here to help us? Maybe that would be easier.’ But I had no choice because I didn’t have the money to hire someone... At the hospital [after Siphwiwe’s birth], they asked who was going to take care of the kid. The doctor said, ‘Its not good for you because you are old.’ I was sad about it, and scared because [Siphwiwe] was so tiny. But I just accepted it, because there was nothing I could do” (Nomsa, 2014).

During their first two years, Lungile and Siphwiwe indeed faced immense health problems. Chronic swelling in Siphwiwe’s face, eyes, and ears, despite treatment at the hospital and the optometrist in Pietermaritzburg, left her with lasting eyesight and hearing problems. Lungile had epilepsy until she was a year old (at which point, she grew out of it) and frequent bouts of diarrhea which necessitated constant trips to the clinic for treatment. Her leg was also badly burned by boiling water and she spent a year at the hospital recovering. Unlike the two eldest children, however, Mpumelelo and Thoko grew up without any health problems. Lungile was breastfed until her mother died, after which, from four months old, she was exclusively fed soft porridge. All four children began weaning with this soft porridge at two months (Nomsa, 2014).

As the kids grow, Nomsa’s help comes from Siyanda and, occasionally, her daughter who visits from Johannesburg. But Siyanda is thinking of looking for a job in Johannesburg as well. “That worries me, because if she goes, the chores will be harder.” (Nomsa, 2014). Help also comes from the government. Lungile and Siphwiwe’s, legally considered orphans, are given free school uniforms. Most of the help, however, comes from the Child Support Grant. “We depend on it. It’s not enough, but it’s helping a lot. All the children get the grant and I used it to buy mielie meal and meat” (Nomsa, 2014). The grant is the household’s only

income. *“I had a disability grant but the doctor stopped it because I’m well now. I’m still waiting for the Old Age Grant. There’s a mistake on my ID and it says I won’t be 65 until next year in December”* (Nomsa, 2014).

As for services to help her children’s health, Nomsa says the CCGs are lazy. *“They don’t come here. They’re not doing their job”* (Nomsa, 2014). They’ve never mentioned child nutrition or how her children’s brains grow or explained the RHC. *“You just think for yourself,”* she says. *“There’s one who notices if you don’t take the kid to the clinic for an immunization. She’ll come and tell you you need to go. But she only comes if you miss an appointment”* (Nomsa, 2014). Nomsa only takes the kids to the clinic if they need an immunization or if they’re sick. *“Sometimes, when they’re sick, I treat them at home. I treat them with a root called “ikambe” that we dig up outside. You mix it with water and put it in a syringe up the anus to clean the stomach”* (2014). Besides the occasional cold or flu, however, all four kids have been healthy, Nomsa says (2014).

Now that the eldest are starting school, Nomsa thinks it’s important to make them do their homework right away when they get home. Illiterate and never having attended school, she says she cannot help them so her 16-year old granddaughter helps instead. Nomsa enrolled the youngest two in a small crèche at R20/month. *“I think that if the kids will write first before going to school, it will help them. At home, you can see them writing in the dirt. The ones who never went to crèche [Lungiwe and Sipiwe] didn’t know how to do that. I think it’s helpful, because kids who start at crèche aren’t afraid of the other kids when they start school”* (Nomsa 2014).

Nomsa says that it’s very hard to raise a child who is young, but she’s happy when she sees them growing up. *“It was so exciting when they started walking. They take steps, and fall, take steps, and fall. God was next to me raising the kids, because I am so old now. They dance the Zulu dance and sing church songs. I like everything they do. But I worry that the*

girls will get pregnant... and that the boys will not build a house for themselves or will not look after Gogo when they grow up. I want them to be educated, so maybe one day I'll see them on TV as presenters. But mostly... I hope they find a good job" (Nomsa, 2014).

Crèche Teacher: Nobuntu

It was dark inside the crèche's rondavel and the sleepy eyes of the children who sat lining its walls peered at me in silent curiosity. Tiny backpacks rested on their laps. Outside, beyond the bare walls of the rondavel, a wooden playscape stood overlooking Nzinga – starkly white against the slowly brightening grey morning sky.

This crèche, with its current enrollment of 50 children, has been operating out of this small, one-room rondavel since Nobuntu founded it fifteen years ago with one other teacher (Nobuntu, 2014).

"We started because the kids were all over from around here... We were not getting any pay, we were just taking care of the kids. I love the kids... I'll always be there to clean them and stay with them... I'm proud because sometimes they don't want to go home because at crèche they are happy. They are doing some poems. When I'm teaching them, they do all the things that I'm teaching." (Nobuntu, 2014).

When kids arrive in the morning, Nobuntu said, they learn first about the weather.

"They all sit in the house and send one of the kids to go outside and check the weather. When he comes back, they'll ask, 'What do you see outside?' He'll say, 'I see the clouds.' They say, 'What's the meaning of the clouds?' And he'll say, 'The meaning of the clouds is that it's going to rain.'" (Nobuntu, 2014). After this, the kids spend their days learning about the months, counting, and colors in both English and isiZulu, as well as playing. Nobuntu didn't know the exact purpose of these learning activities, only that that is what the government has told them to teach in their four-week training. "The government is giving us someone to tell us what to do. We have to go to a place called Bulwur... They were teaching us about the

story telling and the poems. But the first thing they told us was that, ‘when you are angry from where you come from, take that [anger] aside. Don’t show the kids you are angry, because that’s abuse – to take your anger to the kid.’” (Nobuntu, 2014).

Indeed, beyond the introduction of teacher training at the crèche four years after its foundation, the government has become involved in the crèche in other ways. The government provides the crèche with meals for the students – budgeting R2/day for each child for food. Every day, each child is given soft porridge for breakfast and a lunch consisting usually of rice and either chicken or beans. While the parents do have to pay R20 per month to send their kids to the crèche, Nobuntu said that this money is taken to social workers to help pay for the food (Nobuntu, 2014).

The government is also building a new facility for the crèche, which will open in January and Nobuntu is very excited (Nobuntu, 2014). I’d remembered walking past this nearly-finished structure – a grey, cement building, about the size of Nzinga’s smallest houses, with a cherry red roof. Though small, the facility will enable children to be separated into classes by age (one class containing kids three years and up, the other two years and down), as South African law requires. The facility’s new nursery will also allow Nobuntu to accept infants – though she hasn’t heard if the government will provide another teacher for the new nursery or not. And because this building will have electricity, the crèche will be able to keep longer hours. “We’ll be starting at 7am and going until 4pm... The whole community will be happy because it was not early enough for them to go... It will be easier for the teenage girls that are going to school to drop the kid and go to school, then finish school and pick the kid up.” (Nobuntu, 2014).

But despite the government’s help, Nobuntu said the crèche could use more assistance. “If the government can get someone to help us, so we can get at least R1500 a month. We are getting less than R1000 per month now. We don’t have enough resources... At

the crèche, the challenge is that there are not toys. Others like to play with cars inside and bikes outside, but we don't have that.” (Nobuntu, 2014).

Despite these challenges, Nobuntu loves her job and loves her students. The crèche follows Holoma Primary School's schedule and when the fourth term of the year draws to a close, the crèche will close too. “When the schools are closed, I miss the kids very much,” Nobuntu laughed. “I'm a very shy person... but I'm missing them.” (Nobuntu, 2014).

Thando

It had been a sunny, hot day not an hour ago. But as I walked with Qaphelisile toward my last interview, the dull grey clouds had spilled, seemingly from nowhere, over the pure, blue sky. As we walked up to her house, Thando popped her head out of the doorway of a smoke-filled hut built of sticks and dense clumps of dark brown mud. She called for one of the children to bring the new arrivals some chairs. Barefoot children seemed to be everywhere – some sitting on the ground inside the smoky structure eating putu, some playing with a saw by the tall barbed wire fence, some playing chase in the patch of green grass on one edge of the lot, all with runny noses and deep coughs. Only one of these children, however, is Thando's – her two-year old daughter named Nthabi.

An orphan, Thando, along with many of her aunts and their children, lives with her grandmother. She became pregnant with Nthabi at 16, while she was attending high school in Pietermaritzburg. Dropping out of high school, Thando knew this pregnancy meant moving back home to Nzinga. “I was sad, because I knew that at home, there [was] going to be a problem if I'm pregnant... We were fighting a lot and sometimes [my aunt] didn't give me food. I would go to the relatives next to us to get food.” (Thando, 2014). At six months, Thando visited the clinic for the first time for antenatal care, but after that, she went every week. “They were advising me not to do the abortion, but to check the HIV so that I can take care of the babies before they are born. They were asking me to say if I have any questions, but I didn't.” Outside the clinic, Thando's relatives told her

she must not have a second child in the future. “[They said] I must go to the clinic and get the [birth control] injections after the baby is born.” (Thando, 2014).

Despite their tumultuous relationship, Thando said it was her relatives that helped her after she brought Nthabi home from the hospital. At 12 months old, Nthabi came down with persistent diarrhea. After trying glucose for three weeks to no effect, she was taken to the hospital and treated. The diarrhea still comes every few months and, while she is growing properly now, doctors have spent most of the last year treating Nthabi’s delay in growth. “They make the blood test and check the brain... like the veins of the brain are going the right way. After that, they give her medicine and she gets better.” (Thando, 2014).

With no income and a family that sometimes refuses her and her daughter food, Thando gets help from one of Nzinga’s Community Care Givers who knows her situation. “She’s giving me soap to do the laundry, food when I’m not given food.... even buying clothes for the baby.” CCGs also stop by to check on Nthabi. “They were telling us that the kids are not the same. At three months, that’s the time she must sit. At six months is the time to start crawling. At eight months is the time to start walking. [Nthabi] took a long time to talk... They were telling me that at first, when the baby is still an infant, from three to six months, we must not give them hard food except soft porridge.” When they come, Thando said they measure Nthabi’s arm, check for any sicknesses, and check her RHC. But they’ve also kept Thando in the loop on how they’re monitoring her daughter. (Thando, 2014),

“The thing [arm measurement tape] they are using, there’s a yellow line. They are telling me that the baby must not come close to this line. If the baby is close to that line, they have to take the baby to the hospital... There’s a line on the RHC that’s straight. If the baby is under this line, it’s not good. It’s not healthy. And the weight must not go zig-zag. It’s helpful because I’m taking care of the baby because I don’t want the RHC to go zig-zag. I make sure the baby is always on health condition.” (Thando, 2014).

Thando walks with Nthabi to the clinic for a check-up every month now to check her weight. “They ask if I have any questions... I asked them how to make the glucose if the baby’s sick and you’re at home.” (Thando, 2014).

Without money to take a minibus to Impendle, Thando can’t obtain a birth certificate for Nthabi at the Home Affairs Office, and thus cannot receive Nthabi’s Child Support Grant. Without the Grant, Thando has no income on which to support her child. “I wish that if, maybe sometimes, there would be those mobile trucks that bring services closer to the people who don’t have money to go to Impendle.” The Grant, Thando feels, would allow her to send Nthabi to a crèche. “For now, I’m not teaching her anything. I want to take her to the crèche in January but I have no clue how. But I wish for her to go to the crèche.” (Thando, 2014).

Beaming at her daughter, Thando said her hope is that Nthabi becomes a doctor one day but worries she’ll be like her – having a child as a teenager. For now though, Thando is happy raising Nthabi. Her favorite memories are playing with her daughter and the excitement of Nthabi finally beginning to speak. (Thando, 2014).

As Thando’s relatives returned – heads laden with firewood – Thando’s energetic eagerness transformed into a serious and withheld sort of silence. Sensing this conversation had best come to a close, Qaphelisile and I said our goodbyes and set off toward home. This was the last story of the last mother I would talk to in Nzinga. Three weeks of living in and listening to this community now completed. And just like those wispy, temperamental clouds that the mountains of Nzinga kept hidden until the last moment, the end of this journey appeared seemingly out of nowhere.

ANALYSIS AND CONCLUSIONS

Note: Two caregiver’s full narratives were excluded from the study – one because of page-limit and the other because of ethical concerns. In the following analysis, these caregivers will be referred to as “Joyce” and “Patricia”, respectively.

The narratives in this story cannot be said to definitively represent the whole of South Africa or even the whole of Nzinga. Yet, the experiences and thoughts of these caregivers hint at a wide range of assets, needs, and even new questions in the topic of rural childhood development. In analyzing these narratives, I have attempted to frame my discussion in the context of this project's five aims – pregnancy behaviors, childbirth experiences, childhood health and nutrition, early childhood education, and perceived social support. However, in listening, I soon found that even the simplest experiences related to one of these aims were also intricately wound into the fabric of the other aims. No feature of raising a child can be sorted into one just category or addressed by one just intervention.

Shifting Populations and Changing Family Dynamics

When I began planning this project, I had imagined visiting homes where one mother (and maybe a father) lived with all her children. But the stories above quickly complicated my western-paradigm definition of family structure and motherhood. Many of the households consisted of a mix of generations, with responsibility shared between adults who cared for the children of many different parents – some present, some absent. Perhaps the best example of the shift in defining motherhood was the story of Fikile and Khulelaphi. While Fikile was unable to say much about the pregnancies and childbirths of her two children, Khulelaphi's expertise ended at the day-to-day raising of her child. In other interviews, when I asked grandmothers where a child's mother was, my translator would quickly correct me, saying “[The grandmother] takes care of the child, so she is also the mother.” The actions of a caregiver in both of these stages have a huge influence on the child and thus both must be considered when defining motherhood. Pointing to *one* mother is not always so easily done and thus what it is to be a child's mother and caregiver is a complex idea characterized just as much by social factors as by practical or biological definitions.

The family structures in these narratives serve as an example of the results of recent population transitions due to urbanization and unemployment. Perhaps the most noticeable trend is that of “absent mothers” – a phenomenon that receives far less attention than South Africa’s “absent fathers”. All but one of the narratives collected involved an absent mother. The children in Fikile and Nomsa’s stories, as well the an un-included narrative of Joyce, had mothers who had left to seek employment in the city (usually Pietermaritzburg or Johannesburg). Lindiwe and Nomsa’s stories contained experiences with the death of mothers – some perinatal, some not. Over half of Black rural children under the age of 15 have absent fathers – defined, in part, as those who do not pay maintenance for their children (Eddy, 2013). I would argue that the significant lack of paternal financial support might be a factor driving mothers to seek employment in the city.

With parents absent, childcare seems often left to the grandmother, who may raise multiple generations of children in her lifetime. Many participants see the demographics of Nzinga’s caregivers (see Introduction) as the cause of problems. Mrs. Funeka noted both higher absenteeism and lower homework completion among students with older caregivers – owing, she said, to grandmothers’ illiteracy and lack of education. Parents who failed to follow health advice or keep appointments, Sister Nompilo said, are often older caregivers, who are too tired. Indeed the oldest caregiver interviewed – Nomsa – repeatedly referenced her own old age as a challenge when raising such young children. Thus, these narratives present the care of the young by the old as one barrier to the wellbeing of both children and caregivers.

Prenatal Health

Less than half of pregnant women in South Africa seek antenatal care before the 20th week of pregnancy – a behavior known to reduce the risk of maternal death (Amnesty International, 2014, pp 16). Of those asked, most participants indeed said they had first sought care between months five and seven. The reason for the delay was difficult to discern. Grandmothers often either didn’t know the

reason or blamed it on laziness, where as mothers usually said they didn't know they were pregnant or shrugged the question off. After beginning antenatal care, all but Siphiwe's mother (who, perhaps not coincidentally, passed away of complications) sought antenatal care monthly as prescribed by the clinic. To me, these responses speak to a gap in antenatal care knowledge. Though mothers seemed to understand the importance of regular antenatal care after beginning it, they seemed not to value (or perhaps understand) early antenatal care and thus were not particularly diligent about seeking it. Further research may be helpful in determining if more emphasis on the importance of early care (via clinic and CCGs) and perhaps education on the early symptoms of pregnancy may help alleviate this issue.

Another interesting trend discovered was a behavior change during pregnancy for the participants. The cultural belief that hard, physical labor during pregnancy is required is one that may be harming mothers and children. Though some of the women had been advised against the practice either by the clinic or by relatives, the fact that this practice threads through most of the narratives indicates that an intervention may be necessary

It is estimated that 90% of children are born in hospitals in South Africa (Berry, pp. 87, 2013). All children in the above narratives were born in a hospital and this trend seems to be inspired by both ideological and practical inputs. Khulelaphi stated she'd chosen a hospital birth because, "it's safer. There are more people to help you" and that many women go to stay near the hospital in Pietermaritzburg in the last weeks of their pregnancy (2014). Additionally, Sister Nompilo stated that mothers who seek antenatal care are informed of the early symptoms of labor, recognition of which may help them get to a hospital on time. However, the ambulance's 3-4 hour response time may work against these efforts to lower the risks in childbirth via hospital births.

Child Health

Looking at hygiene and its related illnesses (diarrhea, among others), one discovers a mix of strengths and weaknesses within these narratives. Most women in the study stated that CCGs and clinic workers had explained the concept of hygiene and stated that they believed it was important in keeping children healthy. However, when asked what they knew of hygienic behaviors, almost all mothers listed only bathing children and doing laundry. Only Thando mentioned, vaguely, the need to “keep food clean”. Meanwhile, most children I observed played barefoot on dirt often covered in livestock feces and ate food with visibly dirty hands. According to mothers I asked, most children use a bucket-toilet system instead of using the built pit latrines (which are considered dangerous for children). While some mothers said their children had had no episodes of diarrhea, many stories of a children’s earliest years included recurrent diarrhea – even possibly leading to growth stunting in Nthabi’s case. It seems a major asset, in my opinion, that these mothers have been introduced to hygiene and value it. However, based on these narratives, I believe this community would benefit from a more comprehensive education on hygiene – one that teaches more than a nightly bath and weekly laundry.

One of the greatest assets to child health described in these narratives is the pediatric health-seeking behavior of the caregivers. Almost all mothers⁸ interviewed claimed that they adhered strictly to the appointments written by clinic workers on their children’s RHCs and Sister Nompilo’s experience agreed with this. Immunizations were up-to-date in almost all cases⁹ and minor ailments (including diarrhea) were usually seen at the clinic within a few days. In talking with these caregivers, it quickly became apparent that the clinic was seen as an accessible, extremely important tool for managing a child’s health

⁹ The one case in which this was not true is a narrative that was excluded for ethical reasons (See “Ethical Considerations”)

Less clear was the status of nutrition in these narratives. Some trends were evident – such as those of breastfeeding. Just as UNICEF stated in their report (see Introduction), very few of the caregivers interviewed described exclusive breastfeeding for the recommended six months. Porridge was the main supplementation and it was first given as early as two months in Nomsa’s story. Porridge and mashed potatoes (the second most frequently listed weaning food) have been labeled as lacking in nutritional value and therefore leading to malnutrition in infants (Kruger, 2002, pp. 221). This is of definite concern, as Kruger et. al state that, “poor infant feeding and weaning practices can lead to stunted growth, delayed motor and mental development, immune incompetence, frequent attacks of diarrheal disease, macro- and micronutrient deficiencies and, most importantly, interference with the realization of full human potential” (Kruger, 2002, pp. 217). However, as to the nutrition of weaned children, I find it harder to make an argument about its role as either an asset or need. No mother described a shortage of food and that alone is a very positive outcome. Most children were generally said to eat meat on putu or rice and all mothers claimed their children frequently ate fruits and vegetables. It is worth noting that this same cuisine is what the government supplies to schools. However, given my lack of expertise on nutrition and the fact that I can find few resources that specifically discuss the nutritional standing of this traditional diet, I find it unwise to attempt to make an assessment and feel it more useful to leave the descriptions of nutrition as a possible resource to those who could more expertly interpret them.

In listening to the experiences of both caregivers and health workers, I found the perceived roles of the clinic and CCGs in children’s health to be a generally positive, if not well-communicated, asset to the community. Effective health communication, via both clinic workers and CCGs, seemed to be a huge asset in all narratives. Caregivers described being advised on such recommended health behaviors as breastfeeding, immunizing children, hygiene, maternal and child nutrition, and HIV testing. While some aspects of these behaviors are not being fully adhered to (see above), it is perhaps because of this education that all caregivers frequently exhibited their knowledge that

immunization and breastfeeding are important for child health and described this knowledge as their motivation for adhering to the behaviors. However, while perceived roles and performances of the clinic workers are constant throughout narratives, there exist large discrepancies between descriptions of the performance and perceived roll of CCGs and this could be cause for some concern. While both Sister Nompilo and CCG Themba listed regular growth monitoring via arm-band measuring as one of the CCGs' responsibilities only Thando said a CCG actually does this. Other caregivers stated that CCGs exclusively looked at the RHC for missing immunizations, without taking any other measurements, and only came when there was a new immunization requirement. In other words, according to the experiences of caregivers, CCGs are not monitoring growth. Nomsa and Patricia both stated that CCGs do not come *at all* – Nomsa even asserting that, “CCGs are lazy... They're not doing their job”. Some mothers, and indeed CCG Themba herself (“You know who needs help”), seemed to see the role of CCGs as an aid to those known to be sick. However, given that CCGs are considered Primary Healthcare workers (primary healthcare being ideally preventative in nature), this view does not seem entirely appropriate. Thus, further research may be needed into the actual performance of CCGs and their own interpretation of their role in healthcare, which I believe could be best done through a qualitative approach like the one used here – in which community members are given a voice to express what actually happens when a CCG comes to visit.

Early Childhood Education

Education seems one of the most unifying themes throughout the narratives. Every single caregiver stated that her ultimate hope for her child was an education. Mothers had high hopes for their children, from doctor to television presenter, to lawyer. Though some are unable to help their kids with homework and perhaps do not always send them to school, these hopes show, at the least, an understanding of the value of education.

It is also clear in these narratives that an understanding of the importance of an early introduction to education is not limited to the literature discussed above. Caregivers were confident in their assertions that teaching their child before Grade R (either themselves or through a crèche) would help their child in primary school. Every parent with a child in crèche (positively, most of those interviewed) saw specific evidence of the crèche educating their children in important concepts like numbers and letters. Mrs. Funeka affirmed these attitudes in her observation that children coming from crèches have more introductory knowledge and are more socially prepared for primary school. In Nobuntu's narrative, the importance of government-funded training becomes apparent. Though Nobuntu did not necessarily understand the reasons behind what she was teaching, this training equipped her with a curriculum that has led to the important knowledge-gain in children noticed by community members. Thus, in these narratives, Nzinga's crèches are shown to be an important asset to early childhood education.

The main need the narratives show is insufficient resources and funding from the government. Indeed, the South African government spends just 7% of its GDP on education (Proudlock, 2014, pp. 15) and, perhaps consequently, is thought to have the worst education system of middle-income countries (2014, pp. 15). Though children in Mrs. Funeka's classroom, through play and group activities, demonstrated engagement in the theme of the day, their ability to do so seemed limited by their supplies (broken, limited toys, shortage of workbooks, etc.). While it is true that the South African government has placed a funding-focus, in recent years, on early childhood education (NDA, 2012), the changes seem not to be sufficient as reflected in the experiences of the early childhood development professionals in these narratives. Mrs. Funeka's descriptions of how a lack of resources comes in the way of learning exhibit, I believe, the necessity for a greater financial investment in the early classroom by the South African government.

Psychosocial Support

As Johnston, et al. argue, the psychosocial support of a mother and caregiver greatly affects the environment in which a child is brought up. This support includes familial, societal, and governmental support that often affects the caregiver's emotional well-being (2002, pp. 18). Themes of psychosocial support were clear in these narratives – some seeming positive, some negative.

Perhaps the most prominent example in these stories was the lack of social support for teenage and unwed mothers, such that hiding one's pregnancy seems a common decision. Fikile and Nomsa's experiences both involved mothers who hid their pregnancies until very late in their terms. In each case, the caregivers or mothers who hid the pregnancy described their main emotion at the time as worried. These months of secret teenage pregnancy speak to months of worry with little to no psychosocial support and no advice – a high burden at such a young age. CCG Themba also described this practice – saying one reason could be because girls were scared of their families' reaction and indeed this was Khulelaphi's reason. Themba went on to blame this as one reason for delayed onset of antenatal care in the community. Statistics South Africa's 2012 household survey found that 4.9% of girls between 13 and 19 years old were reported as having been pregnant during 2011 (2012, pp. 18). Teenage and unmarried pregnancies are taboo in nearly all cultures and it is unrealistic to suggest the solution to this problem would be a grand societal acceptance and hospitality toward these women. Given the high prevalence of these pregnancies in South Africa, I believe it could be beneficial to provide confidential, judgement-free spaces in high schools or community centers where women not ready to reveal their pregnancies to family could talk to trained professionals, thus gaining access to at least some psychosocial support.

Also of some concern were the perspectives of Fikile, Nomsa, and Patricia – all older caregivers – after first being given the task of caring for their children. When asked how they felt emotionally, all described feeling as if they “had no choice” and said that they “just accept[ed] it”, despite feeling worried. The fact that every older caregiver interviewed (and no younger caregivers

interviewed) expressed this same perception of lack-of-control over a life-altering decision brings into view, again, the possible harms brought to older women who are expected to raise children regardless of their age, ability, and perhaps even their own desires.

A huge aspect of psychosocial support involves the help that a caregiver receives, both in the particularly challenging period of infancy and in later periods of childhood. Most women stated that most of their help during the child's infancy came from relatives. This reflects well on familial support of new caregivers – even those who were controversially not married upon giving birth. All women spoke of feeling happy after the baby was born, even if they had felt worried during the pregnancy. However, later in childhood, women typically received either no help or used government-provided services (discussed below). Some of the caregivers' stories do speak to a lack of social support, however. Thando, a very young mother, got help with her new infant from relatives at first but is now (and during pregnancy) frequently refused food from her family due to their rocky relationship following her teenage pregnancy. Additionally, all older caregivers, who arguably need more help than younger caregivers with day-to-day tasks, felt they receive no help now and both Fikile and Patricia had no help during infancy. Perception by a caregiver that they have no one to help when needed with the sometimes-difficult task of parenting may not lead to stress and negative emotional status and if this perception is indeed a reality, a child could be directly affected when something needed cannot be given.

However, one of the most surprising themes I discovered in these narratives is the extremely consistent worry about teenage pregnancy and alcoholism. Every single caregiver interviewed stated that their *greatest* worry for their children was that the girls may fall pregnant and that the men may choose alcohol or drugs over building a real life. As shown above, South Africa's rate of teenage pregnancy *is* high as is alcoholism among South African men. It is interesting, however, that, within these narratives, these two behaviors are not simply impersonal statistics or taboos used to judge others. These caregivers have a deeply personal, collective fear that their own children will be drawn

into these issues. The worry takes on the same sort of shape as if one were worried about a prevalent disease their child might catch. Indeed, worries of illness or hunger or death were what I had anticipated hearing. Instead, I was introduced to the deep-seated fear these women had of their children being affected by what, to me, had always seemed a ill-advised behavior done by others but not affecting my own life.

Lastly, these stories reveal a huge asset in the government's provision of services to caregivers. All caregivers but Thando perceived an adequate level of support by the government and felt the services had personally helped them. From the provision of school uniforms to orphans, to crèches, to the provision of food in schools – it was clear that the government's hard work does not go unappreciated. Sending her children to the crèche allows Fikile to get chores done during the day and she sees it helps them too. With no income, Nomsa's family supports themselves entirely with the Child Support Grant and indeed Mrs. Funeka said all but three of her students receive the grant. However, it is important to note that some barriers to access prevented some of the mothers from utilizing services. For example, Thando's inability to get to Impendle has prevented her from receiving her child's grant – money that would allow her to send Nthabi to crèche and pay for other essential needs. Overall, the narratives painted a positive picture of psychosocial support from the government in which services are utilized and appreciated but they also hint at a lingering need to reduce barriers to access for vulnerable populations.

Dependency vs. Empowerment in Healthcare

As discussed above, effective health communication seems to be a huge asset of Nzinga healthcare. However, I would also argue that these narratives show a relationship between clinic and community characterized more by healthcare dependency than health-empowerment. This culture seemed to be mostly created by the caregivers. While workers at the clinic were said to have made a point to ask if mothers had any questions, the idea of asking – of gathering information outside of what was prescribed necessary – seemed completely unfamiliar to most caregivers. Fikile seemed

especially taken aback by the idea, stating, “she’s the one... who tells us what to do.” Indeed, the RHC is to be adhered to, but is not necessarily understood (sometimes literally, as it is written in English). Healthcare workers thus distribute isolated facts unaccompanied by foundational education. I believe this could be partially what is leading to certain misunderstandings about recommended health behaviors among the caregivers such as the incomplete actions to achieve hygiene and non-exclusive breastfeeding. Indeed, Thando stated a nurse had told her that her baby should not eat “hard food” before six months, which is why she thought soft porridge would be fine before that time.

Whether parents’ self-management of their children’s health is yet a realistic goal for Nzinga is definitely a debatable idea. However, it is important to consider Thando’s experiences. Of all the caregivers, she is the only one to have had the RHC explained to her. The feedback of being able to really see her daughter’s growth chart and arm measurement and actually understand these indications seemed to give her motivation to follow recommended health behaviors. She was also the only caregiver to ask questions at the clinic, the only one to wait until six months to supplement breastfeeding, and the only one to mention food in her understanding of hygiene. Thus, I believe her story exhibits the value of creating a culture in which caregivers are more able to self-manage their children’s health – though obviously this cannot completely replace clinic and CCG care.

Final Conclusions

Overall, the experiences and stories conveyed by these caregivers reveal a world of complex and intertwining factors in childhood development. Some, like early childhood development centers and an accessible clinic, seem to me to be obvious assets. Others, like the lack of hygiene and non-exclusive breastfeeding, seem obvious issues needing further intervention. However, many features of these stories were not so clear-cut. Though older caregivers and the children they raise may be put at a disadvantage, these same caregivers described being happy raising these children and some stated that it made them feel less lonely. While there is a need for greater social support and acceptance of teenage mothers, teenage pregnancy *is* an issue of concern in South Africa – one that grips the fears

of caregivers – that is inarguably in need of a solution. Through all these narratives, I could not come to one consistent answer on what it is CCGs actually do or even what they are expected to do when it comes to children’s health. Thus, as with much other research, this exploration into rural childhood development has answered some of my original questions but has also introduced a host of questions in need of investigation.

None of those problems found come with easy, obvious solutions and thus it would be presumptuous to end this study with some grand fix to the issues found that may be holding rural children behind urban children. However, I believe that perhaps more important than the problems found are the assets. Like any community, Nzinga is a place with many weaknesses and many strengths. It is the many triumphs of Nzinga displayed in these narratives that, I think, provide a way forward to building equity in child’s health – physical, psychological, *and* social.

LIMITATIONS OF THE STUDY

The main limitation of this study was the language barrier between myself and many of the interviewees. In gathering a narrative, much information can be conveyed from subtleties in a participant’s speech, both from the words chosen, the order of these words, and the emotion in the voice. I felt that these valuable vectors of information were lost when filtered through a translator. Interviews conducted in English consistently yielded answers that were richer in detail and more story-like in nature than the summarized answers of my translator.

The second largest limitation was limited time and page-space. Three weeks is not nearly enough time to truly investigate a topic as huge and varied as early childhood development, even in so small a community as Nzinga. The number of narratives collected was largely limited by this time, but also by the short nature of this report. It was not possible to include all narratives collected. However, a larger and more in-depth project would likely be outside the scope of a three-week, undergraduate project.

RECOMMENDATIONS FOR FURTHER STUDY

South Africa's recent focus on early childhood education, and the resulting slew of reports on ECD issues is a positive and encouraging change. However, I believe that more qualitative research is needed into the lives of caregivers, teachers, healthcare workers, and children to further understand the needs and assets of rural communities raising children. The specific issues I especially feel would benefit from more investigation are discussed in detail the "Analysis & Conclusions" section, and include the role and performance of CCGs and the benefits of increased health communication on the importance of early care and pregnancy symptoms. Journalist Paul Brodeur once wrote that, "Statistics are people with the tears wiped off" (qtd. in Mukherjee, 2011, pp. 267). While statistical investigations of ECD issues are extremely important in assessing the current situation, these studies seem to me to require that we already know the right questions to ask and that we ask them in the right way. In contrast, narrative inquiry invites the participant to say what they feel is necessary to say and can thus provide answers to questions we did not even know to ask. I do not think any plan for future interventions will be complete without also considering the lived experiences and perspectives of those we are trying to help.

SUMMARY OF KEY LITERATURE

Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) (2013). *South African Child Gauge 2013*. Cape Town: Children's Institute, University of Cape Town.

Children's Institute's 2013 "South Africa Child Gauge" is a vital resource for anyone doing research on early childhood development in South Africa. The first and second parts of the report consist of a compilation of essays by child development experts around South Africa. Part A discusses recent law reforms that affect the status of childhood development and Part B's essays propose essential services needed for young children, including early education, child health, and social support for caregivers. Lastly, Part C is a comprehensive "child-centered" report of recent statistical information using

reliable sources such as the General Household Survey and governmental administrative databases. Thus this report presents policy information, early childhood development theory, and statistics of childhood all in one, well-organized package. This source was immensely helpful in building my own knowledge on government policies currently in place in South Africa, which proved essential in analysis of the government's role in the assets and needs revealed in the narratives. The "Child Gauge" also allowed me to update my original statistics and served as a confirmation that the specific aims I had decided to pursue based on older research were still relevant to child health today.

United Nations International Children's Emergency Fund. (2007). *Young Lives: statistical data on the status of children aged 0-4 in South Africa*. N.c: n.a.

UNICEF's report serves as a useful resource for information regarding very early childhood development – ages 0-4. Starting with a discussion on the importance of early childhood development, this document then goes on to provide important and interesting statistics. Perhaps most useful to me were the report's clear graphs and summary tables throughout. UNICEF's statistics cover a range of ECD topics, including child poverty, grant utilization, health and nutrition, and ECD education services. Much of my original planning for the project was based on UNICEF's report. The report first confirmed my own hypotheses on South African early childhood development and thus became the first source to set the heading for the project.

Walker, S. P., Rahman, A., Black, M. M., Grantham-McGregor, S., Wachs, T. D., Richter, L., et. al. (2011). *Inequality In Early Childhood: Risk And Protective Factors For Early Child Development*. *The Lancet*, n.v, 1325-1338.

Walker et al.'s paper consists of a massive literature review on the international risk and protective factors for early childhood developmental delay. This was a vital resource to me, as it helped place South Africa in the global context for ECD issues and thus made me truly aware (as opposed to

theoretically aware) of the widespread nature of socioeconomic inequalities among children. The study discusses the huge socioeconomic disparities found between children in high-, middle-, and low-income countries. The study also discusses recent examples of ECD problems within specific countries, how they were addressed, and how these solutions worked. This feature was immensely useful in writing my analysis, as it showed in data the idea I'd been encountering in the narratives – government interventions are tricky forces that, despite the best efforts, cannot be expected to always work according to plan. Overall, the study was also very useful for its summary tables of risks and protective factors that were easy to understand, yet acknowledged the complexity of these factors.

Connelly, F., & Clandinin, D. (1990). Stories of Experience and Narrative Inquiry. *Educational Researcher*, 19(5), 2-14.

Connelly and Clandinin's paper is a useful source of guidance for those pursuing narrative inquiry. The paper begins with a general discussion of the technique, moving from "beginning the story" to "continuing the process of narrative inquiry" to "writing the narrative". These sections discuss many topics important to narrative, including the construction of dialogical relationships when collecting narratives and the various forms of data collection in narrative (field notes, interviews, journal records, etc.). The paper ends with a discussion of the ethical risks of narratives. Having never heard of narrative-inquiry going into this ISP, Connelly & Clandinin's paper served as a constant guide in navigating the often-tricky waters of narratives - from helping me plan questions in ways that draw out story, to teaching me how to interact with participants in a way that encourages relationship instead of "data harvesting", to offering tips on writing stories, to building my own self-awareness of the responsibilities of the researcher to the researched.

Johnson, V., Clark, T., & Fleming, J. (2002). Parental Views of Development of Children in a Rural South African Community. *ABNF Journal*, 12(1), 18-22.

Johnson, Clark, & Fleming's study on the importance of social support to parents is, largely, what convinced me to investigate my own participant's perception of their social support as well as their own level of emotional satisfaction. Set in a rural South African setting, the study also has direct relevance with my own research. Using interviews with parents in a rural community in the Northwest Province, the authors' found that parental satisfaction is directly correlated to perceived social support and that the degree of satisfaction is directly related to level of depression. These results, as well as the discussion on the developmental detriments caused by parental depression and stress, introduced me to the idea that a child's environment is shaped not just by direct effects (like nutrition and education) but also by more subtle inputs like a parent's psychological health. Additionally, the authors' explanation of social support as including perceived access to government-provided services helped me understand what I had personally experienced talking women who felt inadequately aided by the government.

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APPENDIX A: LIST OF INTERVIEW QUESTIONS

Broad questions listed in bold, supplementary questions listed in italics (see "Methodology" section)

Caregiver Questions

Intro¹⁰

How many children do you care for? What are their names? Ages?

¹⁰ Intro questions are from the photo-narrative blog "Humans of New York", 2014 (see Works Cited).

Where is the children's mother? Father?

What is your favorite thing about the children?

What do you remember most from raising this/these child(ren)?

What is your happiest memory raising this/these child(ren)?

What do you hope the most for this/these child(ren)?

What's your greatest worry as a caregiver?

Pregnancy

What was/were your/the pregnancy(ies) like?

How did your/mother's daily activities change?

How did your/mother's diet change?

Did you/mother go to the clinic? What were these appointments like?

Did you/mother ask questions at the clinic? Or did you/mother mostly listen to their advice?

Were there any complications in the pregnancy? Do you mind talking about them?

Who gave you/mother advice or help during pregnancy?

What did they tell you? Or how did they help you?

Was this advice more helpful than what health workers or books told you?

Did you feel like you/mother had enough help when you were pregnant?

How did you feel about the pregnancy? Were you worried, excited, sad? Why?

How did the mother feel about the pregnancy?

Birth

Tell me about the birth(s)...

Where was the child born? Is this what you wanted? Why did you want this?

Clinic/Hospital Birth

What advice did the medical workers give you?

Did the baby get a check-up before going home? Do you know what the worker checked for?

At-Home

Who else was there to help you?

What happened after the baby was born? Did anyone check the baby for problems, etc.?

Were there any complications during delivery? Would you be willing to describe these?

Childcare (First Year)

Who helped you after the child was born? Did it feel like you had enough help?

How did you feel when the child was born? Did you feel tired, sad, scared, happy? Why?

Was the child breastfed? For how long? Was it exclusive breastfeeding?

When the child was weaned, what were the first solid foods they were given to eat?

Were there any health problems in your child's first year?

Any diarrhea?

How did you fix these?

How do you think a baby's behavior changes as it grows?

What have healthcare workers told you about a child's mental development?

Did you keep in mind what your baby should be acting like as it grew?

Did you ever notice that your baby wasn't acting like it should?

What was/is a day in the life of the baby like? What is/was its schedule?

How much time does/did your baby spend on your back?

How much time do/did you spend playing with your baby?

- Childcare (Years 2-5)

Who helps you now with the young child? Is it enough?

What role do you think the Nzinga community has in bringing up a child?

What does your culture say the community's role is?

What actually happens?

Do you feel like there are enough programs to help mothers like you?

For example, social security for expenses, daycares, etc

Do you use any of these services?

How do you feel now that the child is older? The same? Different?

Now, what does the child eat usually (if not breastfed)?

Does the school provide any meals?

Are any meals typically skipped?

What information have health workers given you about child nutrition?

Has anyone else given you advice about nutrition?

When a community caregiver comes, what do they do?

How often do they come?

Do they give you any advice or information about your child?

How helpful is this information?

Do you ask questions to the CCG? Are the answers helpful?

How many of your children have an RHC?

Was the child's Road to Health Card (RHC) kept up to date?

Did anyone explain this card to you?

How often do you take your children in to the clinic for a regular check-up?

When you go, do you ask questions or mostly just listen?

Have there been any health problems?

What were they?

How did you take care of it? (Clinic, home-treatment, traditional medicine)?

Did this solve it?

What does your child do to have fun?

Do they play outside? Watch TV? Color or read books?

What do you think your role should be in your child learning?

Is it important to talk to a baby?

To play with a child?

Why?

- **What do you think is the most important thing for your child to learn before it starts school?**

ECD Professional Questions

How long have you been a teacher of young children?

Why did you decide to work with small children?

What is the hardest part of your job?

What is your favorite part of your job?

What do you think is the biggest problem of this daycare/Grade R?

For the children you teach?

What do you think this daycare/Grade R class does the best?

Teach math? Feed children? Socialize children?

In terms of child education, what change do you most want to see in the community?

What activities do the children do?

What is the purpose of these activities?

Are meals provided? How many, and what do the children eat?

Are these planned based on nutrition or on what is available?

What is the training background of teachers?

Did they go to school to be teachers? For how long?

How many children are there per teacher?

How are classes separated?

What is the age range?

Does the government give any money or other help?

Does it cost to attend this daycare/class?

Clinic Worker/CCG Questions

How long have you been a health worker/CCG?

Why did you decide to do this?

What is the hardest part of your job?

What is your favorite part of your job?

What do you think the biggest challenge is for this clinic/CCGs?

What do you think the biggest challenge is to Nzinga children's health overall?

What do you think this clinic/CCGs does best in terms of children's health?

In terms of child health, what change do you most want to see in the community?

Clinic

How often do pregnant women come in for antenatal check-ups?

When a pregnant woman comes in for a check-up, what is done?

What measurements are taken? Why?

Is any information given?

Do the women ask any questions?

What is the most common pregnancy complication you treat?

Why do you think this is a common complication?

Do women give birth at the clinic?

How long do ambulances take to come for laboring mothers?

Explain what is done when a child comes in for a regular check-up

What measurements are taken? Why?

How often are children generally brought in for checkups?

Do you think this is enough?

What information do you give to caregivers when they come in?

Do you feel that caregivers follow your advice?

What are the most common illnesses that children come in for?

Why do you feel children get sick with this as often as they do?

Community Caregiver

Do you often go to see pregnant women?

When you do, explain to me what you do for these women?

Do you take any measurements?

Do you give them any advice or information?

Do you feel like they follow it?

Do they ask you any questions?

What are the most common complications you see in pregnant women?

Why do you think these are common?

Where do women most often give birth?

Do you ever help?

Explain what you do when you visit a house with a young child

What measurements do you take?

Do you use the Road to Health Card?

How often are these up-to-date?

What advice do you give caregivers information/advice when you visit?

Do you feel like they follow it?

Tell me about the most common illnesses you see in children here

Why do you feel these are common?

APPENDIX B: CONSENT FORM FOR PATICIPANTS IN ENGLISH (INTERVIEW ONLY)

CONSENT FORM

1. I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

2. Brief description of the purpose of this study
The purpose of this study is to study the experiences of primary caregivers who have raised children in a rural, South African setting from the perspective of early childhood developmental principles.

3. Rights Notice
In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.
 - a. *Privacy* - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.

 - b. *Anonymity* - all names in this study will be kept anonymous unless you choose otherwise.

 - c. *Confidentiality* - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive no gift or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982).

Participant's name printed

Your signature and date

Interviewer's name printed

Interviewer's signature and date

APPENDIX C: CONSENT FORM FOR PARTICIPANTS IN ZULU (INTERVIEW ONLY)

CONSENT FORM

1. Ukuchazwa kafushane kwalesisifundo

Inhloso yalesisifundo ukufunda ngalabo abanakekela izingane emaphandleni eSouth Africa nendlela abakhula ngayo

2. Amalungelo

Njengokomthetho wesikole iSIT lesisifundo sihloliwe sabhekwa abaphathi besikole. Uma uzwa sengathi usengozini yokuvezwa kwezinto ongathandi zaziwe ngawe unelungelo lokumisa ukubuzwa kwemibuzo. Uyacelwa ukuba uthathe isikhashane ufunde okungezansi:

a. Privacy - Zonke izimpendulo zizoqoshwa futhi zivikelwe ukuthi zingabonwa yiwo wonke umuntu

b. Anonymity - all names in this study will be kept anonymous unless you choose otherwise. Onke amagama abantu ayogcinwa eyimfihlo ngaphandle uma wena ungenankinga nokusetshenziswa kwegama lakho

c. Confidentiality - Ngaphezu kwalokho amagama asetshenziwe azovikelwa. Ngokusayina ezansi unikeza lowo obuza imibuzo ilungelo lokuvikela imininingwane . Obuza imibuzo naye uzosayina akunikeze elakho iphepha

I understand that I will receive no gift or direct benefit for participating in the study.

Ngiyaqonda ukuthi ngeke ngithole isipho noma umvuzo ngokusiza kulesisifundo

Ngiyaqiniseka ukuthi umfundi obuza imibuzo unginikezile ikheli lesikole esiseduze sakwaSIT uma ngifisa ukuya khona ukuthola imininingwane eminye uma ngiyidinga. (404 Cowey Park, Cowey Rd, Durban).

Ngiyazi ukuthi uma ngenemibuzo noma izikhalazo ngingathinta umphathi wesikole uZed McGladdery kulenamba 0846834982 ngaphandle kokuzidalula igama lami.

Igama lami

Ukusayina nosuku lwanamuhla

Igama lobuza imibuzo

Ukusayina nosuku lwanamuhla

APPENDIX D: CONSENT FORM FOR PARTICIPANTS IN ENGLISH (INTERVIEW & SHADOW)

CONSENT FORM

1. Brief description of the purpose of this study

The purpose of this study is to study the experiences of primary caregivers who have raised children in a rural, South African setting from the perspective of early childhood developmental principles.

2. Rights Notice

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview and/or shadowing period. Please take some time to carefully read the statements provided below.

a. Privacy - all information you present in the interview and shadowing period may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer/shadower know. No identifying patient information will be recorded without the patient's written consent.

b. Anonymity - all names in this study will be kept anonymous unless you choose otherwise.

c. Confidentiality - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive no gift or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982).

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

Participant's name printed

Your signature and date

Interviewer's name printed

Interviewer's signature and date