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**Testing the impact of health,
subjective life expectancy and
interaction with peers and parents on
educational expectations, using Cape
Area Panel Survey Data**

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Abstract

Theories of Human Social Capital Investment typically hypothesise that the AIDS pandemic will have a negative influence on people's real and subjective life expectancy, and that it will consequently also impact negatively on their willingness to invest in, for example, education. If such were the case, we would expect to see an influence of HIV-related factors on young adults' educational expectations. Unlike previous analyses on expectations, this study therefore analyses the significance of orphanhood, health, subjective life expectancy, and perceived risk of HIV infection. Data were collected by the Cape Area Panel Study (CAPS), covering an original sample of about 5000 young adults within the Cape Town Metropolitan Area. Findings illustrate that educational expectations are in fact very high among young adults, especially among those of the most heavily affected African population group. Analyses do show a remaining, significant and positive impact of health on expectations for all population groups. Subjective life expectancy, however, is insignificant in all groups. Perceived HIV risk is significantly negative only in the African sample, which might indicate some validity of the mentioned hypotheses. The study indicates, however, that measures of affectedness, health, perceived life expectancy, and even perceived infection risk are poorly understood. I argue therefore that much more in-depth work is needed to fully understand, for example, young adults' subjective life expectancy and expressions of health before they can be used as building blocks in the development of influential hypotheses.

Introduction

The persistence of unequal educational outcomes among the youth of different population groups in South Africa has generally been explained in terms of equally persistent economic inequalities and inequalities in the quality of schooling (Lam 1999; Lam, Seekings et al. 2006). Such inequalities are compounded by the HIV and AIDS pandemic, which is widely expected to have a profound and increasingly negative impact on the educational outcomes of young adults. Theories of Human Capital Investment hypothesise that, since the pandemic will influence negatively on young adults' real and subjective life expectancy through heightened confrontation with illness and death, it will consequently also impact negatively on their beliefs about the value and purpose of education (Barnett and Whiteside 2002; Bell et al. 2004; Mattes, 2003; Schonteich 1999; see also Fortson 2007).

As part of a broader study into young people's decisions around education, and the potential impact of HIV and AIDS thereon, this paper explores the impact of health and of subjective life expectancy on young people's educational expectations. Previously conducted parts of the study consisted of in-depth qualitative work with both affected and non-affected young adults (De Lannoy 2007a, 2007b), as well as an exploratory analysis of survey data on the influence of illness and life expectancy on how parents perceive the value of education (De Lannoy 2007c), and in-depth work with affected mothers (De Lannoy 2005). Existing research on educational expectations among youth in Cape Town has indicated that such expectations are very high in all population groups, but especially so among African youth – i.e. among those youth who are most heavily affected by the AIDS-pandemic (Beutel and Anderson 2005; Bray et al 2008; De Lannoy 2007 a and b). This study contributes to this literature by analysing survey data collected by the Cape Area Panel Study (CAPS) from a panel of young adults in the Cape Town Metropolitan Area.

The first part of the paper reviews what we know about young people's educational expectations in Cape Town, and provides an overview of possible determinants of such expectations. The paper then examines self-reported health and especially subjective life expectancy (SLE) among young people. These subjective variables do not seem to reflect objective realities among some population groups. Nor do educational expectations (as measured through the survey) reflect the much lower educational reality especially for African youth. Multivariate regression analyses indicate that health and SLE do have an impact on educational expectations, but these are weak effects. Also, it must be stressed that the regression analyses use measures that are far from ideal. A lot remains

unknown about how people estimate their SLE. Among African young people, especially, questions about educational ‘expectations’, for example, seem to reflect aspirations. Further research is required to better understand such measures.

Educational aspirations, expectations and the value of schooling

Trying to understand young adult’s educational expectations is important for a variety of reasons. Firstly, motivational studies generally assume that “high personal academic expectations predict subsequent performance, course enrolment, and occupational aspirations choice” (Eccless and Wigfield 2002). Hence, understanding what factors are of influence on such expectations can help in evaluating and formulating policy guidelines that attempt to diminish the educational inequalities among South African’s youth. Secondly, it can be assumed that “(educational) expectations indicate an individual’s orientation towards the future” (Beutel and Anderson 2005: 3). Thus, if HIV and AIDS would impact on young people’s subjective life expectancy and views on the future, one could expect to see a negative impact of that also on their educational expectations.

1. Possible determinants of educational expectations

Different theories present different sets of potential determining factors of educational expectations among youth. Earlier analysis by Beutel and Anderson (2005) of educational expectations gathered through CAPS took into account independent variables as emphasised in both the ‘Wisconsin model’ of Status Attainment and Social Capital Theory.

The Wisconsin Model of Status Attainment is concerned with, amongst other things, how aspirations and motivation determine educational attainment. It regards family background and school performance variables as factors that may provide support for such aspirations. Family background is thereby mostly captured through socio-economic status (i.e. parents’ level of education, household income, and occupation). A number of studies using the model have also included ethnicity, family structure, religion, and area of residence as independent variables (Jencks, 1979; Campbell 1983). Beutel and Anderson

(2005) point at the fact that studies in the US and other developed countries have provided support for the model. Studies in less developed countries have, however, only found insignificant relations between parental levels of education and academic performance and educational expectations. Even with regards to the applicability of the model in more developed countries, researchers have argued that it simplifies complicated processes of aspiration formation, overlooking for example the reciprocity in the influence of parents on young people's aspirations, and the fact that not only parents but certainly also peers can exert great influence in the formation of aspirations (Campbell 1983).

Social Capital Theory on the other hand, focuses specifically on the importance of "relations between actors and among actors". Such relations can be thought of as "social resources" that enable people to achieve certain goals and ends: "social capital is productive, making possible the achievements of certain ends that in its absence would not be possible" (Coleman 1988: 98). In family context, more specifically, social capital is found in "the relations between children and parents"; it is often captured in the time spent by parents with their children and the effort put into certain issues or topics. Hence, it is implied that when parents are physically absent, or are present but keep from spending time or building strong relationships with their children, social capital is missing in the children's environment (ibid).

Additional to Beutel and Anderson's theoretical framework, is the understanding of theories around Human Capital Investment that holds that people would make rational choices around the investment in their education¹ based on the expected return to that investment. However, in light of the HIV and AIDS pandemic, it is assumed that increased levels of morbidity and mortality in a society can lead people to assume that they will not live long enough to recoup their investment in their or their children's "human capital", i.e. in their schooling (Barnett and Whiteside 2002, Bell et al 2005).

2. Educational expectations among Cape Town youth: what do we know?

In-depth work with African young adults in the Cape Flats townships found that adolescents hold very high expectations and aspirations for their future lives, almost always including high educational expectations (De Lannoy 2007 a and

¹ Human Capital is assumed to be "embodied in the skills and knowledge acquired by an individual" (Coleman 1988: 100). It is again conceptualized as a form of resources that enables individuals to act in a certain way. Education is typically seen as such human capital.

b) – findings that were corroborated by extensive research in other parts of the Cape Peninsula (Bray et al 2008). Yet that same body of research painted a complex process of decision-making around schooling within which the high value attached to education, and expressed educational expectations did not necessarily correlate with the actions taken. Independently of their AIDS-affected status or not, positive educational decision-making was part of those young adults' lives who chose to regard their current situation of deprivation as temporal and to use education as a vehicle to future success. Often, however, their context of “fragility”, lack of clear guidance, wish to belong, and inability to resist peer pressure would force them out of the educational path they had chosen. On the other hand, some young adults who had dropped out of school, skipped schooldays, or did not put any effort into schooling, never openly rejected a positive value of education, but did seem to lose track of the concrete, long term “utility value” of education as a way to success. These young adults would define success in equally materialistic terms as their non-affected peers, but would be less clear about what route best to take towards that desired success, and would often chose more short-term oriented solutions. What did become clear is that the AIDS pandemic is but one factor in the complex and fragile world that determines this decision-making process (De Lannoy 2007 a and b).

With regards to expectations especially, we found that what some young adults express as “expectations” may in fact be closer to “aspirations”, based not so much on their observations of reality surrounding them, but on their hopes and dreams that are often, it seems, built on the post-apartheid dominant ideology of almost unlimited opportunities for the younger generations of “previously disadvantaged” South Africans (Bray et al 2008; De Lannoy 2007 a and b).

Beutel and Anderson (2005) used data collected by the first wave of the Cape Area Panel Study (CAPS). CAPS is a panel study of a representative sample of young adults growing up in the Cape Town Metropolitan Area (Lam and Seekings 2005). CAPS started in 2002 with a first round of interviews with 4752 young adults aged fourteen to twenty two, and just over 3300 households. Wave three data collected in 2005 consisted of interviews with 3536 young adults and 2341 households (Lam, Seekings and Sparks 2006). In African and White Census Enumeration Areas, households were oversampled in order to get an equal number of African, Coloured and White young adults in the sample. When weighting the data for this oversampling, as well as for non-response of household and young adults, results of CAPS can be considered representative for the Cape Town Metropolitan Area (for more technical details regarding the

survey design, see Lam, Seekings and Sparks 2006; see later sections of this paper for more information on attrition between the waves).

In both wave one and three, CAPS asked all its young adult respondents: *As it stands now, how much education do you think you will complete?* Reply options allowed for students to indicate the exact level of studies they expected to complete, ranging from less than matriculation, to for example “grade 9”, or a “university postgraduate degree”; the questionnaire also included a “don’t know” option. Parents were also asked how much education they expected their children to complete. Answers were coded in the same way.

The variables from the first wave of CAPS used by Beutel and Anderson, and their relevant findings, are set out in Table 1. Both South African parents and their children have high educational expectations independent of the population group they belong to, with just over 60% of young adults expecting to complete at least some form of post-secondary education. African young adults were found to have higher educational expectations than their White and Coloured peers.

Table 1: summary table of Beutel and Anderson's analysis of wave I CAPS data

Beutel and Anderson (2005) – wave I	Pooled sample	By pop group
Status Attainment Theory/ Family and school performance variables: <ul style="list-style-type: none"> - highest level of education of parents - household composition - young adults' academic performance 	Parental level of education was significantly and positively associated with young adults' educational expectations History of school failure was negatively significant	Younger children in the household were negatively significant for Coloured youth Number of adults was positively significant for African youth Parental level of education was significant for African and White respondents, marginally negative for African youth
Family Social Capital: <ul style="list-style-type: none"> - frequency of time spent with biological parent 	Frequency of discussing personal matters was negatively but only marginally significant	African young adults who had more frequent discussions with mothers had significantly lower expectations
Demographics: <ul style="list-style-type: none"> - Age - Gender - Population Group 	Age was significantly & negatively related to young adults' educational expectations Being African was positively significant;	African and Coloured young adults who were older had significantly lower expectations

Some evidence was found for the status attainment and family social capital theories in the models for the pooled racial sample. However, when looking specifically at the sample of African youth, the researchers found *negative* relationships between parents' levels of education and youth's educational expectations and between parent-child interaction and expectations. Both of these were contrary to the predictions of the theories discussed (Beutel and Anderson 2005). Many questions thus remained unanswered. Beutel and Anderson pointed to the need to look for additional measures of family social capital, rather than just including parental-child interaction, and to take into account other potential factors of influence.

CAPS 2005: testing the impact of health, subjective life expectancy and interaction with peers and parents on educational expectations

The theory on Human Capital Investment adds onto Status Attainment and Achievement Motivation models by hypothesising that changes in illness and mortality levels will lead to decreased real and subjective life expectancy, which would in turn lead to a lower “task value” among young adults and caregivers, and hence lowered motivations to invest time, money and energy into schooling.

Therefore, in the analyses presented in this paper, I take into account the potential impact of some of the variables also used in Beutel and Anderson’s model, but include independent variables expressing health status, household shocks, subjective life expectancy, “affectedness”, and perceived risk for HIV infection. Following out of my qualitative work with the young adults, I also decided to include measures for peer interaction and peer support around schooling. All independent variables are listed below. For descriptive and regression analyses, data were used of only those young adults that had complete individual and household level data in both wave I and III (n=3405).

Demographic variables: I included variables expressing the young adults’ *age*² (ranging from 16 to 25 in wave three), dummy variables for the youth’s *population group* (African and Coloured with White as reference group) and *gender* (coded 1 for female, 0 for male).

Family background variables: I included a categorical variable expressing *income bracket* of the young adults’ household in 2005. Similar to both the Beutel and Anderson analyses (and my earlier analysis of data on adults, from a different survey), I included variables expressing the *numbers of adults* (older than eighteen, including also the young adult) and *of children* (younger than eighteen, including the respondent) in the household.

² All regression models in the paper were run including age as a continuous variable and later rerun with dummy variables for different age groups. Results showed equal significances so for the ease of the overview of tables, the continuous age variable is included. Only 9 young adults in the sample were aged 26; these were treated as outliers and dropped so as not to skew the regression results.

Table 2: summary of independent variables used in the analyses on educational expectations

Beutel and Anderson (2005) – wave I	De Lannoy (2007) – wave III & change
Status Attainment Theory/ Family and school performance variables: <ul style="list-style-type: none"> - highest level of education of parents - household composition - young adults’ academic performance 	Status Attainment/ Family and school performance variables: <ul style="list-style-type: none"> - household monthly income - household composition - young adults’ academic performance
Family Social Capital: <ul style="list-style-type: none"> - frequency of time spent with biological parent 	Family Social Capital: <ul style="list-style-type: none"> - frequency of time spent with biological parent - amount of time parents spent on talking about educational matters with the ya (1 <i>never</i>– 4 <i>often</i>) Broader Social Capital/ peer influence: <ul style="list-style-type: none"> - Most friends continued to study (dummy, 1 for <i>agree</i> or <i>agree strongly</i>) - Encouragement of close friends to study (ibid) - Some or most of friends continued to study (ibid)
Demographics: <ul style="list-style-type: none"> - Age - Gender - Population Group 	Demographics: <ul style="list-style-type: none"> - Age - Gender - Population Group
	Health <ul style="list-style-type: none"> - self rated health (1 for <i>poor</i>, 5 for <i>excellent</i>) - improved, deteriorated or equal health status (dummies, change wave I to wave III)
	Experience with death in household and family
	Subjective life expectancy
	“Affectedness”
	Perceived risk for HIV infection
	Orphanhood

Additionally, I included dummy variables expressing young adults’ “*orphan status*”, coded 1 in the case of *double orphans* (i.e. those young adults who have lost both their biological parents), *maternal orphans* (those who lost their mother), and *paternal orphans* (who lost only their father). Young people whose parents were both still alive were omitted as reference category³.

³ As a matter of comparison, analyses were run also omitting maternal orphans and including non-orphaned youth. Results of both regressions were equal.

Social capital was broken down more specifically to family social capital and peer group social capital:

- Family social capital was captured through both the more general variable expressed in the *amount of time the young adults' biological parents or guardian spent with just them* in the past twelve months, as well as the more specific *amount of time that the parents or guardian spent on talking about educational matters* with the young adult. In all cases, response categories ranged from 1 “never” to 4 “often”⁴.
- Peer social capital was included with dummy variables coded 1 for those who *agreed or agreed strongly* with the statements “*Most of my friends continued to study*” and “*My close friends encouraged me to study*”, and those who replied that *some or most* of their friends intended to study at some tertiary educational level.

School performance variable: as Beutel and Anderson, I used the variable expressing the proportion of years enrolled in school that the young adult had failed by the age of thirteen.

Health variables:

- I included a variable capturing the young adults' self-rated *health*, coded 1 for *poor* through to 5 for *excellent*. More information on this variable is available in the following section.
- It could be assumed that a change in health between waves I and III might impact on both subjective life expectancy and educational expectations. Hence, *dummy change variables* expressing whether the respondents' self-rated health has either *improved*, *deteriorated* or remained *equal* between waves one and three were also included, omitting *equal* as a reference category.

⁴ I decided to not construct a compound variable for those, but to look at the potentially different impact between involvement with different parents on the one hand, and of “just” spending time with a parent or caregiver, and more specifically talking about schooling on the other. As will become clear from later regression results, “just” spending time with one's biological parents shows no significant effects. It may have been too vague a measure to really capture what would be social capital. Hence the variable was not included in other but baseline regression models. In any more elaborate models, the variables specifically expressing spending time “on education” with one's parents was included.

- I furthermore created a variable *affected* coded 1 whenever a respondent replied he or she knew someone among their close relatives or had a spouse/partner who was HIV positive or who had died of AIDS⁵.
- Finally, I included a variable expressing the respondent's *perceived risk for HIV infection*. Dummy variables were created, coded 1 when someone expressed they thought they had a low risk for infection, equally so for all variations through to high risk⁶.

Furthermore, an ordinal variable with several categories ranging from *less than 30* to *80* expressing the young adults' *subjective life expectancy* was included in the model. More details on this variable are available in later sections.

Finally, a variable capturing a *household death* that occurred between 2002 and 2005 was included as a *dummy variable* coded 1 in case of a death⁷.

⁵ For a brief discussion on what exactly is understood as “affected” by the AIDS pandemic, see e.g. De Lannoy 2007c: 2-3. The CAPS survey included questions on whether or not respondents knew someone who was either HIV positive or who had died of AIDS, and asked how that person was related to the respondent. I decided to take into account those who identified such relationships as either a close relative or a spouse/partner, so as to be more sure of the “concreteness” of affectedness. Within the African CAPS sample, 28.2% were identified as “affected”, compared to close to 4% in the Coloured and 2% in the White sample (but the White sample size is very small with only 312 respondents).

⁶ Within the African subsample, close to 10% assumed a high risk for infection, compared to 6% within the Coloured and 2% among White young adults.

⁷ It was my original intention to include a more specific variable expressing the experience of either a maternal or paternal death, and even whether that death was premature (i.e. happened before the parent reached the age of 60) but sample sizes became too small for that. Hence only the *household death* variable was included in the regression models to follow.

Table 3: experiences of death within the household in Caps wave III sample

Young adults' experiences with death in family and household 2002-2005		
	Observations	%
Household death between 2002-2005	419	13.4
African ya	270	21
Coloured ya	138	9.3
White ya	11	3.5
Maternal death between 2002-2005	101	3.3
Premature maternal death	55	55.6
Paternal death between 2002-2005	210	8.2
Premature paternal death	45	17.2

Given the fact that both the health measures and the life expectancy variable are new elements in the analysis and the life expectancy variable is an experimental construct, the following sections of the paper will provide a short summary of the health data, followed by a more elaborate section on subjective life expectancy. After that, a complete analysis on educational expectations will be presented.

Apart from the descriptive cross tabulations, multivariate regression analyses were run using STATA 9.2. Weights and the “svy” command were used to adjust Stata outcomes according to the complex survey design of CAPS and attrition between the waves, and present representative findings for youth in the whole of the Cape Town Metropolitan Area.

Table 4: summary statistics of the CAPS sample

Summary statistics

	Observations	%
African	1,364	43
Coloured	1,539	48
White	325	10
Female	1,753	54
Often discussing education with mother	1419	48
Often discussing education with father	878	36
Friends continue to study	1643	59
Friends encourage study	1657	58
Friends intend to study tertiary	1920	61
Affected	459	14
Household death	417	13
Maternal orphan	156	5
Paternal orphan	592	19
Double orphan	104	3
No perceived HIV risk	1523	47
High perceived HIV risk	236	7
Poor health	36	1
Excellent health	1370	43
Deterioration of health	964	30
Subjective Life Expectancy (SLE) ≥ 70	1835	61
	Mean	St Deviation
Age	20.5	2.46
Years of education	10.53	2.18
Per capita income	1451.28	2531
Number adults in house	3.43	1.61
Number children in house	1.61	1.42

1) Health among Cape Town youth

As with many other (national) surveys, CAPS waves I through III did not include medical examination of its respondents in order to try and establish health status. In line with surveys as the Demographic and Health Survey (DHS), the General Household Survey (GHS), the Population Census and broader oriented studies as the World Value Survey (WVS), health data were collected rather through self-report questions that on the one hand asked

respondents to rate their health on a scale ranging from poor to excellent, and that, on the other hand, listed a number of diseases and symptoms asking the respondent whether he or she suffered from any of these.

Self-rated health, clinical conditions & disclosure of HIV status in CAPS

The majority of youth rate their health *very good* or *excellent*: with a total of 78% among White, 60% among Coloured and 61% among African young adults. Interestingly, the population group that is hardest hit by the HIV pandemic has the highest proportion of respondents rating their health as *excellent* (more than 46% of the African youth). It should of course be kept in mind that the AIDS pandemic is not in the same advanced stages in Cape Town as it is in the rest of the country: it is estimated that about 4% of youth between the ages of fifteen and twenty four in the Western Cape are HIV positive, with approximately half of those in the asymptomatic stage one of the disease, and only 2.4% in stage four (data from the full ASSA 2003 model). It is possible that the 7% of African youth rating their health as poor or fair include those who are HIV positive, but there is no certain way of knowing this: self-disclosed HIV-status is extremely low in the sample, with less than 0.2%. The CAPS 2005 survey did not include a list of symptoms that would have allowed us to at least try to identify infected or affected young people. Hence no measurement of HIV-status was included in any of the following regressions.

In total, only 6 to 7% of Cape Town's youth rate their health as only *fair* or *poor*. This is a considerably lower proportion than found in adult samples of for example the World Value Survey or the South African Social Attitudes Survey, or the Cape Area Study (CAS) 2005 that contained a very comparable health scale⁸, but in line with findings that an increase in age also sees a significant increase in the reporting of "ill health" (see De Lannoy 2007: 59-60). Table 5 presents an overview of self-rated health in the CAPS waves I and III, broken down by population group.

Appendix 1 provides an overview of the descriptive statistics on this self-rated health variable. In the descriptive analysis, very similar results were found as those in analysis of the CAS data and in descriptives on poverty and well being in South Africa (See De Lannoy 2007a; Bhorat and Kanbur 2005): population

⁸ In CAS 2005, for example, 13% of respondents rated their health as fair, 5% as poor. In SASAS 2003, 12% of respondents rated their health as poor, 4% as very poor

group correlates significantly with health, as does socio-economic status as measured through household income, and level of education.

Table 5: self-rated health among youth in the Cape Town Metropolitan Area

	Poor	Fair	Good	Very Good	Excellent
African					
Wave I	1	6.2	32.1	14.2	46.5
Wave III	2.3	5.1	31.6	14.7	46.3
Coloured					
Wave I	0.9	6.6	31.8	23.9	36.9
Wave III	0.5	5.5	34.2	20	39.8
White					
Wave I	0.6	4.8	29.5	34.5	30.7
Wave III	1.1	4.4	15.8	33.3	45.5

Multivariate regression models⁹ were run on health status to identify the determining factors (or correlates). In the final model, being Coloured, being female, and having lower levels of education are significantly and negatively associated with self-rated health. An overview of the determinants included in the final model is presented in table 5. It is not clear why race remains significant for the Coloured young people in the sample, after controlling for both income¹⁰ and level of education, but not for African youth, controlling for income. In general, a higher level of “negative reporting” is noticeable in the

⁹ I ran ordered probit regressions. Ordered probit regressions are used when trying to model the determinants of a categorical variable that takes on more than two values, e.g. in our case, the health variable, but later also the SLE and educational expectations one. The various values of the categorical variable have a certain order, meaning: “excellent” is higher in value than “very good”, or “good”, but we cannot assume that the intervals between these adjacent categories are equal. It is because of that uncertainty that some argue that the use of OLS is not justifiable with ordinal outcomes (see e.g. Long 1997: 114-115; see also Natrass, 2005: 36). Coefficients in these regressions are not as easily interpretable as in OLS, but significance and direction thereof give a first indication of what factors influence health. In later additions to the paper, the odds ratios for the models will be calculated for further clarification.

¹⁰ The independent variable *income* was included first as dummy variables expressing income brackets as captured in CAPS wave I, then as a continuous variable with several categories; Significances and directions thereof remained the same; in this table only the results of the continuous variable are included.

Coloured young people, with for example also lower levels of educational expectations and life expectancy (see later sections). In those cases, equally, the models applied to explain differences do not seem to capture the complex background to the higher degrees of what could perhaps be called pessimism. Further research and modelling will be necessary to unravel exactly what factors are at play within the Coloured communities in Cape Town to determine their views on life, etc.

Table 6: ordered probit regressions on self-rated health

	Regression 1		Regression 2		Regression 3	
	Coefficient	P	Coefficient	P	Coefficient	P
Age	0.005 [0.010]	0.609	-0.009 [0.010]	0.366	-0.007 [0.010]	0.474
African	-0.202 [0.081]	0.013	-0.118 [0.102]	0.250	-0.074 [0.102]	0.468
Coloured	-0.271 [0.079]	0.001	-0.177 [0.090]	0.051	-0.175 [0.093]	0.060
Female	-0.256 [0.049]	0.000	-0.307 [0.053]	0.000	-0.302 [0.054]	0.000
Household monthly income in 2005			-0.001 [0.029]	0.973	0.001 [0.030]	0.986
Level of education young adult			0.054 [0.012]	0.000	0.053 [0.012]	0.000
Affected			0.151 [0.076]	0.047		
Household death			-0.091 [0.070]	0.198		
Double orphan					-0.071 [0.133]	0.594
Maternal orphan					0.023 [0.131]	0.860
Paternal orphan					0.036 [0.063]	0.569
N	2702		2702		2638	
F	10.81		8.62		6.92	
P	0.000		0.000		0.000	

Apart from the more general self-rated health question, surveys often include a list of clinical conditions to establish respondents' health status. No such measurement of health is entirely trustworthy, however: it is generally accepted that self-report on chronic or other illness is an under representation of one's real health status (Department of Health 1998, full report: 168). Indeed, in the CAPS sample, very low levels of clinical conditions were reported, with only 6 % of youth in wave III reporting that they suffered from any of the listed

problems¹¹. The small number of positive replies makes a potential *clinical conditions* variable not very robust and was therefore not taken into consideration as an independent variable in the regression models in later sections of the paper.

2) Subjective life expectancy

The theory on Human Capital Investment assumes an impact of HIV and AIDS on young people's educational decision-making through a decreased life expectancy. But what do we know about subjective life expectancy (SLE)? What factors influence SLE, and what evidence do we have that SLE does impact on decisions about education?

Psychology researchers Mirowsky and Ross (2000) have looked into subjective life expectancy in the United States and its determinants over a prolonged period of time. They found significant and positive influences of achieved socio-economic status, current health, self-confidence about the future, feelings of control in life, and anticipation of future risks to health and survival. In later studies, they found that those who exercise expect to live longer lives, as do those whose parents are still alive, and those who report high levels of emotional support and of informal health care (Ross and Mirowsky 2002). Subjective life expectancy has, in turn, been found to influence "older adults' economic decisions and morale" (Ross and Mirowsky, 2000: 133).

Another study in the USA, Caldwell et al. (2006) found that "future certainty" – which consists of, among other things, expected longevity of life – was a stronger predictor of both "delinquent behaviour and school adjustment among African American Adolescents" than neighbourhood disorganisation and family socio-economic status. SLE has also been found to influence decision-making around savings and spending behaviour, especially among older cohorts (see e.g. Thornton and Lam 2007).

CAPS wave three included questions that asked young adults whether they expected to still be alive at the age of 30, 40, and so on, up to 80. Thornton and

¹¹ CAPS wave III asked respondents whether they had any of the following: tuberculosis, other respiratory problems, physical handicap, problems with sight, hearing or speech, mental problem, HIV/AIDS, other sexually transmitted diseases, diabetes, heart disease, cancer, epilepsy or fits. Diseases were ticked off in case of a positive reply (n=235), other cases are missing, but it cannot automatically be assumed that all missing values would have been negative replies. Hence I decided not to create a dummy variable for this and exclude clinical conditions from the regression models.

Lam (2007) used these data for preliminary analyses on determinants of SLE. Table 8 shows the variables they used in their regression analyses and their matching results. Self-reported health had a significant and negative effect on subjective life expectancy. Being male had a significant and positive effect. Being coloured had a significant and negative effect. Years of education completed were positively significant in the White subsample only, as was employment in the Coloured subsample.

In line with the work already done on these variables by Thornton and Lam (2007) – and by myself when analysing data on adults (De Lannoy 2007a), I combined the answers to the separate questions about life expectancy into a single variable. When a respondent expected to be alive at the age of 30 but not at 40, the value of “30” was entered, etc. Whenever a respondent was sure to still be alive at the age of 30, but answered “don’t know” to the age of 40, this too was captured as subjective life expectancy of 30¹².

¹² This is slightly different from the approach to the CAS data, where I kept the uncertain variables separate, and where I eventually used a variable “low life expectancy” as the dependent variable in regression models. However, given the unclear results of those analyses, and in order to be complimentary to the work of Thornton and Lam, I here decided to follow a similar variable creation system to theirs and to “count those who are unsure about living up to a specific age the same as those who are certain they will not live up to a certain age” (Thornton and Lam 2007: 8).

Table 7: summary of results of Thornton & Lam (2005) and De Lannoy (2007)

Thornton and Lam (2007) prelim analysis		De Lannoy (2007) prelim analysis	
Age	-	Age	Negatively sign in African sample
Gender (Male)	Positively significant	Gender (female)	Negatively sign in African sample
Population Group	Coloured negatively sign	Population group	Coloured negatively sign
Years of education	Pos significant in White sample only	Level of education ya W III	Negatively sign in Coloured
Numeracy score	-	Income	Pos sign in pooled sample, Black & White pop group
Employment	Pos significant in Coloured sample only		
Perceived HIV risk	Marginally sign in pooled sample, not in African population	Perceived HIV risk	Negatively significant in African sample
		AIDS “affected”	Insignificant also in base models
Self reported health	Poor health negatively significant in all pop groups	Self reported health	Better health positively significant in pooled sample and Black and Coloured pop group
		Household death	Negatively significant in African sample
		Orphanhood	Paternal orphanhood negatively significant in pooled sample

a) Perceived life expectancy for self

Table 10 shows that a large number of young adults are very optimistic about their life chances, with more than half of them (60%) expecting to live until at least the age of 70. Almost half (48%) expected to be alive at the age of 80.

Table 8: Subjective life expectancy of CAPS 2005 respondents

<i>Life_expectancy</i>	<i>Distribution (n=3018) %</i>
Below 30	0.20
30	4.4
40	5.5
50	12.3
60	16.9
70	12.5
80	48.3

Thus, at first sight, belief in longevity of life seems high among these young people, especially compared to the projections on life expectancy for a country as heavily affected by HIV and AIDS as South Africa. It has been estimated that life expectancy at birth in South Africa decreased from approximately 50.9 years in 2001 to 47.7 over the period 2000 to 2005 (UNDP, 2003). The South African Actuarial Society's ASSA 2003 model furthermore predicted a life expectancy at birth of 50.7 in 2006, and of 56.2 at the age of 20. Thornton and Lam compared the subjective life expectancy of South African youth in the CAPS survey to life tables constructed by the World Health Organization and equally found much higher percentages of respondents believing to be alive at higher ages than would be predicted on the basis of these life tables (Thornton and Lam, 2007: 7). The researchers assumed that the difference was perhaps due to the fact that life tables are calculated for the South African country as a whole and that young people from within Cape Town live in a better off area. However, ASSA 2003 calculated for the Western Cape specifically, a life expectancy at birth of an estimated 61.5 years and 64.9 years at the age of 20 (ASSA 2003 full model), still far below the expected 80 years of life among a large proportion of the Cape Town youth. Even in the Western Cape declines in LE over the last few years are noticeable with a loss of one year in a period of just three years time (LE of 66 at the age of 20, as estimated in 2002; 65 as calculated in 2005; Life expectancies calculated for ages 20-25 are largely at the same level of 65 years: ASSA 2003, calculations by Leigh Johnston 2007).

Interestingly, however, a not undeniable, cumulative proportion of 22% of the young CAPS respondents believe their life expectancy to be 50 years or less, hence displaying a more negative belief in life longevity than the one predicted by ASSA. It is possible that life expectancy captured in the way the variable has here been constructed, oversees a fairly large proportion of young people who

simply “do not know” whether they will still be alive above the age of, for example, 50. Allowing for this uncertainty in the variable breakdown shows that, rather than the firm belief not to be alive at the age of for 50, it is indeed the uncertainty of not knowing whether one will, for example, live to be older than 50 that has been captured.

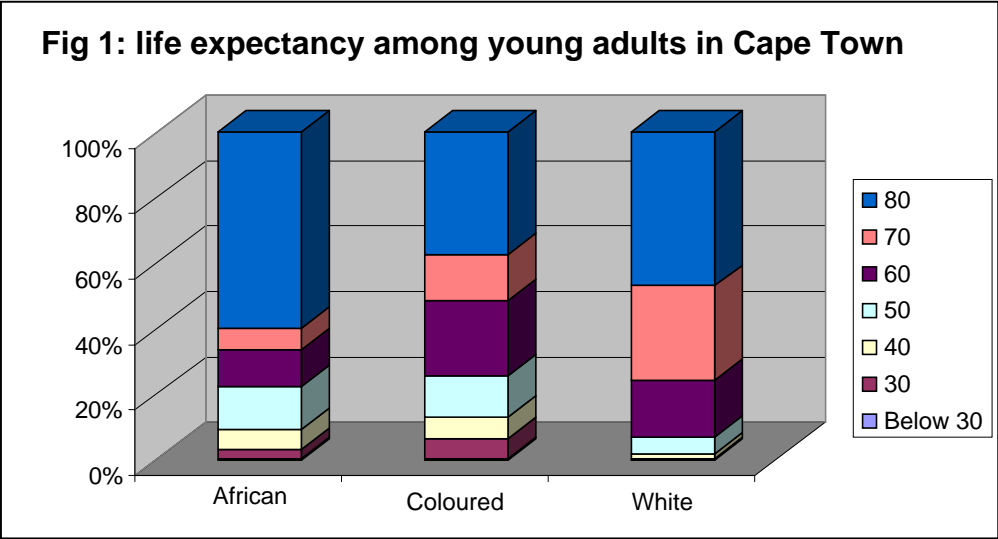
Table 9: subjective life expectancy of CAPS 2005 respondents

Life Expectancy	Distribution (n=3018)
Below 30	0.2
30	0.2
Uncertain above 30	4.2
40	0.7
Uncertain above 40	4.9
50	1.4
Uncertain above 50	11
60	3.1
Uncertain above 60	13.8
70	2.4
Uncertain above 70	10.1
80	48.3
Total	100

Lam and Thornton (2007) find that level of uncertainty increases with age – a similar finding to those of the Cape Area Study Analyses (De Lannoy 2007a), yet also point at the very high levels of uncertainty in this sample of youth. It is subject of further investigation to understand the cause and role of “uncertainty” in subjective life expectancy questions: Lam and Thornton point at the necessity to understand a potential correlation between numeracy levels and replies. However, it is important to note here the recurring reference of young adults in the author’s own qualitative research with African young people living in resource poor townships to the high levels of crime and violent deaths in their neighbourhoods, and the consequent uncertainty about how long they might live. One young adult would assert that “we all die” due to gangsterism and violent crimes, another one would express not knowing whether he “would make it to 2010” as he had himself become involved in gangsterism and was scared other gang members might take revenge on him. Others would simply not have given any thought to how long they would possibly live (De Lannoy 2007b and c). In other instances, including when piloting CAPS, people would claim they could not possibly know how long they would live, as only God would be the One

who knows about that. In further work on life expectancy among young people and the impact of illness and death on their outlooks on life, greater attention has been paid to the way in which youth interpret “life expectancy” (De Lannoy 2008b). However, for the sake of this analysis, I will maintain the life expectancy variable without levels of uncertainty as described earlier. A breakdown of descriptive statistics on subjective life expectancy is found in appendix 2.

Striking differences are noticeable in the disaggregation by population group. It is especially important to note here the optimism among African youth, with a higher proportion than any of the other population groups assuming they would at least live until the age of 70 – a finding that goes directly against evidence on real life expectancy in the midst of the AIDS pandemic. Pessimism, on the other hand, is found among Coloured youth. More than 6% believe that they will only live until the age of 30, compared to 3% among African and less than 0.5% among the White respondents. As Thornton and Lam (2007) point out in their analysis, this lower SLE is noticeable across the range of responses. Only 37.5% of Coloured youth expect to be alive at the age of 80, compared to almost 60% of African youth and 47% of White.



Household monthly income also correlates significantly with life expectancy. Over 5% of young adults living in households that have an income within the lower brackets (i.e. less than R500 up to R3000 to R8000 per month) expect to only live until the age of 30, compared to less than 1.5% in the highest income bracket (i.e. above R20 000 per month). Yet at the same time, high levels of optimism are noted with close to 50% of those in the lower income brackets

expressing a subjective life expectancy of 80, compared to 47% of those in the highest income bracket.

Level of education is significantly related to life expectancy. For example, 25% of young adults who in 2005 had only completed between 5 and 10 years of education expected that they will live until the age of 50 or less, compared to 13% of those who had completed matric or more. However, at the other end of the scale, an almost equal proportion of approximately 62 to 64% of young adults express the belief to still be alive at the age of 70 or more, irrespective of years of education.

There is thus constantly a divide between what seem unrealistic high expectations irrespective of socio-economic factors and a degree of pessimism influenced by a disadvantaged socio-economic background, which can for example also be found in the results on self-rated health and educational expectations (see later).

Self-rated health has a statistically significant effect on life expectancy, as was also illustrated also in Thornton and Lam's analyses (2007). A lower proportion of people with poor health reported a life expectancy of 70 or more years (54%) than those with excellent health (68%). Affectedness, on the other hand, has no significant correlations with the life expectancy variable.

There are, however, considerable and significant differences in findings on orphanhood¹³, with more than 26% of double and paternal orphans believing they will only live until the age of 50 or less, 22% of maternal orphans expressing that same belief compared to just over 20% of non-orphaned young adults. On the other hand, there is again still a very noticeable optimism among youth, with close to 48% of double orphaned young people believing they will still be alive at the age of 80, compared to 44% of non-orphaned youth.

Perceived risk for HIV infection has a marginally significant impact on subjective life expectancy, with close to 28% of those who perceived themselves under greater risk for infection expressing the belief to live only until 50 or less,

¹³ It has been estimated that approximately 1.2 million of children below the age of eighteen have lost one or both parents to the AIDS pandemic and it is generally assumed that also among young adults, orphan rates are increasing as a consequence of the pandemic (Subbarao and Coury 2004; ASSA 2003 full model). It is not my intention to treat all orphaned young adults as those who have lost parents due to HIV and AIDS but merely to understand the potential influence of having lost a parent, on one's own life expectancy, and subsequently on educational expectations.

compared to 20% among those who expressed lower levels of risk. However, still 56% of those believing to be at high risk, believe they will live until the age of 70 or above. Having experienced a household death within the last two years also correlates significantly with SLE: close to 25% of those who experienced a household death express a SLE of 50 or less, compared to 21% of those who did not encounter a loss in the household. Again, however, still 56% of those who experienced a death believe they will live until at least the age of 70.

Multivariate regression analysis allows us to identify more precisely the factors that influence young people's SLE.¹⁴ The models do not include direct measures of young people's HIV status or level of affectedness by the disease but other variables are used to approximate these: self-rated health, "affectedness", perceived HIV-risk, death within a household, and orphanhood. Variables expressing current SES were originally included in the proxies *level of education reached by respondent, household income, and employment of the respondent*.

Table 10 presents the results of the various regression models¹⁵. Self-rated health is significantly and positively related to SLE. Being Coloured remains negatively significant. Socio-economic status variables, such as current employment and household income, are positively correlated to SLE, but years of education completed by the respondent remains insignificant¹⁶. Being

¹⁴ Life expectancy was treated as a continuous variable with equal intervals between the different ages: 30, 40, 50, etc. Therefore, only OLS regressions were run.

¹⁵ The sample of White respondents with complete data becomes small (n=266) and the explanatory power of the model low (R squared 0.013) with only monthly income showing up as positively significant. Therefore, for the sake of ease of overview, the findings for the White sample are not reported in this table.

¹⁶ The Model presented in table 12 is the final, full model. It should be noted that variables were added step by step. The first model run was a very base one including only demographic variable and showing only a negative significance of population group for Coloured youth. In a second step, years of education completed, as well as current work status and health were added, showing a strong positive significance of health on SLE. Changes in health were added consequently, without changes in significance. The same was true for affectedness. The presented findings include only controls for level of education and household income out of concerns for over specification of the model: someone currently working would add onto the household income, so variables might be mutually influential, therefore only monthly income is included.

The models were also run separately including dummy variables of income brackets, age groups and categories of health. Significance and directions were the same and to keep the many tables in the paper as simple as possible, only results of the continuous variables are displayed.

affected by HIV and AIDS has no significant impact on SLE for the pooled sample when controlling for all other factors¹⁷.

These results are indicative of the fact that health, as experienced at one given point in time, as well as economic resources have an impact on subjective life expectancy. Findings are corroborated by those of Thornton and Lam (2007), and they also resemble the findings from the USA by Mirowsky and Ross (2000; 2002). Being a paternal orphan relative to non-orphaned young adults is significantly and negatively correlated with life expectancy, controlling for all other factors¹⁸.

Finally, counterintuitive results are found when controlling for perceived HIV risk, with those who rate their risk for HIV infection as low or medium expressing higher levels of SLE than those who claim to have no risk for infection¹⁹.

¹⁷ A separate basic model was run, controlling only for “affectedness” and demographic variables, but being affected remained insignificant.

¹⁸ A smaller model, controlling only for orphan status and base demographic and health variable had no impact on the results: of the different “types” of orphans, only paternal orphanhood remained negatively significant.

¹⁹ The models were run also without the confusing HIV risk variable, with no changes in above mentioned significant variables.

Table 10: OLS regressions on subjective life expectancy

	Regression 1		Regression 2		African		Coloured	
	Coefficient	P	Coefficient	P	Coefficient	P	Coefficient	P
Age	-0.018	0.226	-0.018	0.227	-0.040	0.045	-0.015	0.518
	[0.015]		[0.015]		[0.020]		[0.023]	
Female	-0.038	0.574	-0.049	0.475	-0.210	0.025	0.050	0.680
	[0.068]		[0.068]		[0.093]		[0.111]	
African	0.114	0.358	0.132	0.302				
	[0.124]		[0.218]					
Coloured	-0.500	0.000	-0.487	0.000				
	[0.114]		[0.115]					
Health wave 3	0.267	0.000	0.269	0.000	0.225	0.000	0.331	0.000
	[0.036]		[0.036]		[0.044]		[0.057]	
Affected	-0.022	0.825	0.015	0.880	0.088	0.397	-0.138	0.541
	[0.098]		[0.098]		[0.104]		[0.226]	
Low HIV risk	0.165	0.042	0.172	0.033	0.127	0.205	0.225	0.081
	[0.081]		[0.080]		[0.100]		[0.128]	
Medium HIV risk	0.186	0.091	0.211	0.058	-0.119	0.540	0.407	0.011
	[0.110]		[0.111]		[0.194]		[0.158]	
High HIV risk	-0.144	0.320	-0.142	0.326	-0.295	0.096	0.126	0.556
	[0.144]		[0.144]		[0.176]		[0.213]	
Household death	-0.148	0.100	-0.110	0.236	-0.336	0.008	0.042	0.759
	[0.090]		[0.093]		[0.124]		[0.136]	
Level of education young adult	-0.011	0.527	-0.017	0.321	0.008	0.763	-0.038	0.104
	[0.017]		[0.017]		[0.028]		[0.023]	
Income in 2005	0.085	0.025	0.077	0.044	0.096	0.077	0.091	0.123
	[0.038]		[0.038]		[0.054]		[0.058]	
Double orphan			-0.249	0.272				
			[0.227]					
Maternal orphan			-0.020	0.893				
			[0.150]					
Paternal orphan			-0.183	0.068				
			[0.100]					
Constant	4.987		5.095		5.670		4.327	
N	2526		2466		1090		1170	
<i>R squared</i>	0.087		0.089		0.059		0.059	

Within the African population group, self-rated health and income are both significantly and positively associated with life expectancy. A high perceived risk for HIV infection as well as the experience of a death in the household between waves one and three are negatively significant. Age is negatively related, as is being female. Within the Coloured population group, self-rated health is significantly correlated. Counter intuitively, level of education is negatively significant, which may point at the fact that people with higher levels of education have perhaps a more realistic look upon life. In general, however, the higher degrees of pessimism in the Coloured sample seem poorly

understood. Perceived low and medium risks of HIV infection are positively significant, which is equally surprising as in the pooled sample.²⁰

Wanting to understand how much of the population group effect was, in fact, an effect of neighbourhood, the same regressions were run not by population group but by area. Very similar, significant results were found, except for the fact that household income loses its significant for young adults residing either in an African area or in a Coloured area²¹.

It is important to bear in mind that in all analyses run, self-rated health measured at one point in time remains significantly and positively related to life expectancy. Being affected by HIV and/or AIDS does not show any significant relationship with life expectancy, but perceived HIV risk is negatively significant in the African sample, as is the death of a household member. Findings in the whole of this section are especially important with regards to the hypotheses around the impact of HIV and AIDS on subjective life expectancy. The model picks up on some influence of the pandemic, through its perceived risk for affection in the African sample - even though perceived HIV risk does not rule out the effects of income, gender and age and thus only explains a certain part of what shapes people's SLE – and through the importance of health – although health as rated at one point in time is not necessarily HIV related. It is important to keep in mind that, although theoretically the model seems to have some explanatory power, we remain with very little knowledge on how exactly people even in heavily affected societies perceive longevity of life: African young adults in the Cape Town Metropolitan Area reside in areas that are generally believed to have equally high HIV prevalence rates as some of the most affected provinces in the country, yet express very high life expectancies.

²⁰ The sample of White young adults for this regression model went down to 261 people, showing no other significant relationships than a positive correlation between household income and SLE. Findings are not presented in the table for the sake of simplicity.

²¹ Census data include a variable expressing the predominant population group within a certain sampling area (cluster). In the majority of cases, the population group as captured for CAPS respondents corresponded to the predominant population group in their area of residence. Only 1.4 % of African youth were found to live in White enumeration areas, 0.5% in Coloured areas; 4% Of Coloured youth lived in a predominantly White area, 1% in an African neighbourhood; 1% of White respondents lived in areas with a predominantly Coloured population. It goes to show that even in post-apartheid South Africa, spacial segregation by population group is unfortunately still very much a fact. Results of the analyses per neighbourhood are not included in the tables, but age, gender, health, a household death and a perceived high risk for HIV infection all remained significant in the same directions for the African youth and health and perceived HIV risk remained significant among Coloured youth.

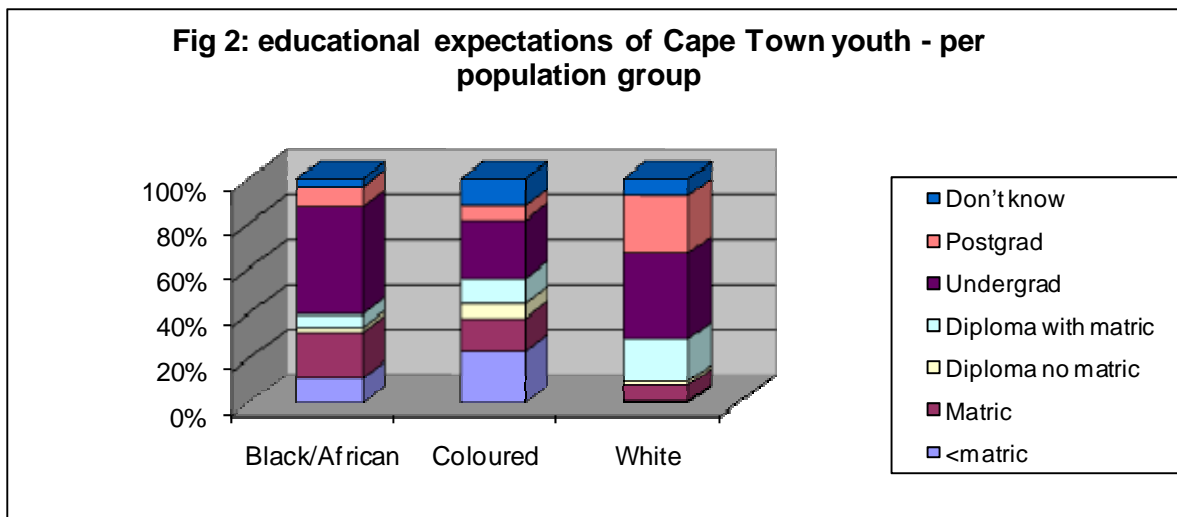
Secondly, for those who are potentially HIV-positive²², the clinical state of being positive itself, may be less important than how healthy one actually *feels* at any point in time. Similar indications are found in Thornton and Lam's analysis of data collected in Malawi that showed that someone's HIV-positive status did not relate to their SLE (ibid: 2007) and in studies on SLE among young patients suffering from heart diseases (Reid et al 2006).

Educational Expectations in CAPS wave three

This penultimate section of the paper looks into the determinants of educational expectations of youth in Cape Town, also taking into account the earlier described independent variables on health and subjective life expectancy.

We find, using 2005 data, as did Beutel and Anderson (2005) using 2002 data, that young people in general express high educational expectations, with close to 50% expressing the expectation to complete under or postgraduate education. However, a higher percentage of African young people express the expectation to complete an undergraduate degree education (47.5%) than either their Coloured (25.7%) or even White (37.8%) peers. However, as much as 26% of White young adults expect to get a postgraduate degree, compared to a much lower 8.9% of African and 6.4% of Coloured youth. In many ways thus, the findings resemble those of Beutel and Anderson (2005) and reflect the gap between expectations and realities especially for African youth in Cape Town. Coloured young people perhaps express more on reality tested expectations, whereas some of the African young people express their aspirations rather than their expectations.

²² Within the Western Cape, HIV prevalence among youth aged fifteen to twenty-four is an estimated 4%, with more than half of them in the asymptomatic stage 1 of the disease. Only 2.5% are estimated to be in the fourth, AIDS-sick stage, and 2.3% of all infected youth is considered to be on antiretroviral treatment (ASSA 2003 full model), which means that only a small proportion of CAPS respondents would in fact have fallen ill with the disease and rate their health and subsequently their life expectancy on lower levels.



Strikingly, of those young people who have lost either both their parents or their mother, close to 44% expect to receive less than matric or just matric level education, compared to less than 30% of non-orphaned children in the sample. The proportion of maternal orphans who expect to complete their schooling to a postgraduate level is less than half of the non-orphans (almost 5% compared to close to 11% respectively). Paternal orphans' expectations seem slightly less affected by the death of their parent than maternal or double orphans, with still 8% believing they will reach a post graduate degree, and 39% who expect to reach less than or only just matric. Case and Ardington (2004), using longitudinal data from Kwazulu Natal found that maternal orphans were less likely to be enrolled in school, (The significant role played by mothers in their children's education becomes clearer also in analyses below).

Apart from orphanhood, paternal residence has a significant effect on educational expectations, with 39% of those young adults who do live in the same household as either of their parents expecting to complete less than or just matric level education, compared to 25% of youth in the same household as both parents. Not only the presence of mothers thus, but the possibility of perhaps finding support with one or both one's biological parents influences young people's educational expectations.

The majority of young people who dropped out of school – i.e. left school before taking their matric exams – express the belief that they will maximally reach matric level, compared to a vast majority of those who were still in school in 2005 expressing the belief that they will reach either undergraduate or postgraduate levels of schooling. This confirms findings from earlier qualitative work that for those who drop out of school, finding the path back to school and completing matric is not easy.

Finally, household monthly income has a significant impact on young people's educational expectations, with close to 43-44% of young people in households that earn less than R3 000 per month expecting to complete matric only, compared to 16% of youth in the income bracket R8 000 to R20 000 per month, and 7% of those who live in households with an income above R20 000. However, an almost equal proportion of 39 to 43% of youth in the poorest households expect to complete tertiary education to an undergraduate or postgraduate degree. This again seems to reflect the dichotomy between those who express their expectations based on realities of their every day life, and those who maintain high expectations – or perhaps rather aspirations – despite the hardships around them.

I also ran multivariate ordered probit regressions using the educational expectations variable without the “don't know” option. Various models were run, testing the impact of health and life expectancy in all, but controlling for other independent variables consequently. Table 12 presents the findings for these analyses for the full sample of young adults who had complete data for both wave I and wave III. Table 13 illustrates the findings of the same analyses but for a sample of youth restricted until the age of 20.

Model one was constructed to resemble Beutel and Anderson's analysis (2005) of wave I data. Indeed, for the pooled racial sample - both with and without age restrictions - very similar results were found. Age, being Coloured, a history of school failure, and the number of children in the house had significant and negative effects on expectations. Income and being African are positively significant: controlling for all other factors, African youth are more likely to have higher educational expectations than their White and Coloured peers. The variable originally used by Beutel and Anderson to capture social capital, i.e. *time spent with one's biological parents*, had no significant effect. Again similar to Beutel and Anderson (2005), a history of school failure is negatively significant, while household income is positively related to educational expectations in the non-age restricted pooled sample. The same factors were significant in the age restricted sample.

These first regression models were run also by population group, with very similar results except for the fact that the number of children in the household does not remain significant in the African sample. In the African sample restricted by age, school failure loses its significance as well, but income and time spent with ones biological mother are positively significant. Interestingly, within the age restricted Coloured sample, spending time with ones biological father becomes positively significant.

Table 12 shows the results of a full model. This includes measures of social capital and factors potentially simulating an effect of HIV and AIDS: *self-rated health*, *subjective life-expectancy*, *the experience of a household death*, *affectedness by the AIDS pandemic*, and *perceived HIV risk*.

Social capital clearly proves an important correlate of educational expectations, with a positive significance of time spent *talking about education* with one's mother significant in all models run. Peer influence is significant in one or other form in the pooled sample and for both Coloured and African youth, with or without restricting the age until twenty²³. Perhaps a small nuance is noticeable in the African sample, with no significance for the concrete experience of having friends who actually continue to study. This might again be one indication for the fact that African youth base their educational expectations not so much on concrete examples and knowledge, but rather on more abstract intentions and encouragements.

Health is significantly and positively related to educational expectations in almost all models (except the age restricted sample of Coloured youth). Subjective life-expectancy, the experience of a household death and having identified as being affected by HIV and AIDS, show no significance in these models, for any of the population groups. It is important to note that, when running the models controlling only for demographic, health and HIV-related variables, subjective life-expectancy does have a significant and positive relationship to educational expectations. As soon as social capital variables are controlled for, however, SLE loses its significance, indicating that, as long as support structures are in place, SLE has no significant impact on young adults' educational expectations. Perceived HIV-risk within the pooled and non-African models shows some counter-intuitive results with either no or a positive significance. Importantly, however, within both the complete and age-restricted African sample, perceived HIV risk shows a significantly negative relation to educational expectations.

All of the above findings point at the importance of a network of support for young adults to maintain their educational expectations: especially, it seems maternal support on education, and/or the support and motivation of peers surrounding the youth. It also becomes clear, however, that factors influencing

²³ Models were run by including the peer variables one by one as well – each one always showed up significantly. Results presented here include all to illustrate the remaining significance of all of the peer variables and small nuances between the different population groups.

and explaining educational expectations differ between the population groups²⁴. Coloured youths' expectations are influenced by some concrete resource constraints (income and number of children in the house), but no such clear concrete factor was found among African youth (except for the proportion of years failed by the age of 13). Importantly, however, perceived HIV risk does have a significantly negative impact on educational expectations among African youth.

Finally, in the light of the impact of the AIDS pandemic, I wanted to test whether having lost one or both parents would be significantly related to potentially lower educational expectations. The original intention was to run the full regression models for each "type of orphan": young adults who had either lost neither of their parents, or had lost their mother, father or both parents. Sample sizes became too small, however, to draw any significant conclusions. Hence orphan status was included in the above described model, excluding however, interaction with biological parents.

When looking at the impact of orphanhood on educational expectations, again, we find more parallels with Case and Ardington's (2004) findings, in that, even when controlling for demographic, household and interaction factors, having lost either one's mother or both parents has significantly negative influences on educational expectations. Having lost one's father, however, has no significant impact, a confirmation perhaps of the researchers' idea of mothers as "gate keepers" and definitely external motivators, for children's education. In an age restricted sample of those younger than 21, only having lost both parents is negatively significant for educational expectations. Table 14 presents findings when controlling for orphanhood.

Finally, it is important to also note the significance of a high feeling of control and belief in future opportunities for educational expectations in all models run. It resonates with theories on the locus of control that hold that one "should expect to succeed to the extent that one feels in control of one's success and failures" (Eccless and Wigfield:111). Feeling in control of things makes young people believe they can achieve more educationally. Table 11 presents a summary of the findings.

²⁴ Regression models were again also run by area rather than population group with similar significant results.

Table 11: summary of regression analyses with educational expectations as dependent variable

De Lannoy (2007) – wave III	Pooled sample	By pop group
<p>Status Attainment/ Family and school performance variables:</p> <ul style="list-style-type: none"> - household monthly income - household composition - young adults’ academic performance 	<ul style="list-style-type: none"> - History of failure is significantly and negatively related to expectations - Household income is positively significant - Number of children is negatively significant 	<p>African & Coloured ya: proportion of years failed in the past is negatively significant</p> <p>Coloured ya: household composition and income are significant</p>
<p>Family Social Capital:</p> <ul style="list-style-type: none"> - frequency of time spent with biological parent - amount of time parents spent on talking about educational matters with the ya (1 <i>never</i>– 4 <i>often</i>) <p>Broader Social Capital/ peer influence:</p> <ul style="list-style-type: none"> - Most friends continued to study (dummy, 1 for <i>agree</i> or <i>agree strongly</i>) - Encouragement of close friends to study (ibid) - Some or most of friends continued to study (ibid) 	<ul style="list-style-type: none"> - Frequency talking with one’s biological mother on educational matters is positively significant - Peer support is positively significant for young adults’ educational expectations 	<p>All ya: frequency of discussing educational matters with mother AND some form of peer support are positively significant</p>
<p>Demographics:</p> <ul style="list-style-type: none"> - Age - Gender - Population Group 	<ul style="list-style-type: none"> - Being Coloured remains significantly and negatively related to educational expectations 	<p>White ya: being is older is positively significant</p>
<p>Health</p> <ul style="list-style-type: none"> - self rated health (1 for <i>poor</i>, 5 for <i>excellent</i>) - improved, deteriorated or equal health status (dummies, change wave I to wave III) - self reported parental health <p>Experience with death in household and family</p> <p>Subjective life expectancy</p> <p>Affectedness</p> <p>Perceived risk for HIV infection</p>	<ul style="list-style-type: none"> - Self rated health is significantly and positively related to young adults’ educational expectations - SLE loses its significance as soon as social capital factors are controlled for 	<p>African and Coloured ya: health is positively significant</p> <p>African youth: Perceived risk for HIV infection is negatively significant</p> <p>Experience of death in the household and “affectedness” are not significant for any population group</p>

Table 12: ordered probit regression analyses on educational expectations

	Base model pooled		Full model pooled		Full model African		Full Model Coloured	
	Coef	P	Coef	P	Coef	P	Coef	P
Age	-0.024 [0.012]	0.049	0.031 [0.015]	0.035	0.011 [0.021]	0.610	0.005 [0.020]	0.809
Female	-0.083 [0.062]	0.183	-0.029 [0.076]	0.708	0.194 [0.120]	0.110	-0.082 [0.114]	0.471
African	0.237 [0.133]	0.076	0.034 [0.151]	0.822				
Coloured	-0.484 [0.118]	0.000	-0.381 [0.123]	0.002				
Proportion of years failed by 13	-3.164 [0.425]	0.000	-2.710 [0.545]	0.000	-1.708 [0.542]	0.002	-3.293 [0.927]	0.001
Income 2005	0.266 [0.039]	0.000	0.255 [0.042]	0.000	0.107 [0.066]	0.110	0.333 [0.057]	0.000
Number of adults in house	-0.018 [0.020]	0.374	-0.013 [0.021]	0.538	0.010 [0.035]	0.780	-0.038 [0.031]	0.229
Number of children in house	-0.099 [0.023]	0.000	-0.078 [0.237]	0.001	0.016 [0.037]	0.668	-0.106 [0.030]	0.001
Time spent with biological mother	0.036 [0.034]	0.289						
Time spent with biological father	0.012 [0.028]	0.678						
Time spent with bio mother talking about edu			0.240 [0.038]	0.000	0.261 [0.051]	0.000	0.206 [0.052]	0.000
Time spent with bio father talking about edu			0.023 [0.032]	0.460	-0.016 [0.045]	0.728	0.066 [0.043]	0.131
Proportion friends continue study			0.113 [0.085]	0.183	0.066 [0.130]	0.612	0.218 [0.097]	0.026
Frequency friends encourage study			0.483 [0.092]	0.000	0.304 [0.189]	0.110	0.431 [0.099]	0.000
Proportion friends intend to study further			0.219 [0.065]	0.001	0.276 [0.101]	0.008	0.183 [0.087]	0.039
Health in wave III			0.084 [0.035]	0.018	0.091 [0.048]	0.061	0.121 [0.049]	0.015
SLE			0.0375 [0.024]	0.113	-0.012 [0.032]	0.715	0.030 [0.031]	0.335
Household death			0.079 [0.131]	0.544	0.155 [0.167]	0.358	-0.013 [0.229]	0.954
Affected by HIV/AIDS			-0.090 [0.126]	0.698	0.079 [0.129]	0.540	-0.081 [0.249]	0.746
Low HIV risk			0.0388 [0.072]	0.590	-0.313 [0.105]	0.004	0.197 [0.098]	0.046
Medium HIV risk			0.173 [0.111]	0.121	-0.005 [0.202]	0.979	0.230 [0.137]	0.094
High HIV risk			0.050 [0.157]	0.748	-0.391 [0.175]	0.028	0.394 [0.272]	0.150
N	1801		1382		515		679	
F/ pseudo Rs	22.14		15.62		4.09		11.90	
P	0.000		0.000		0.000		0.000	

Table 13: ordinal probit regression analyses on educational expectations, restricted to younger than 21 year old youth

	Base pooled		Full pooled		African		Coloured	
	Coef	P	Coef	P	Coef	P	Coef	P
Age	-0.075	0.032	-0.058	0.174	-0.085	0.208	-0.087	0.118
	[0.035]		[0.042]		[0.067]		[0.055]	
Female	-0.110	0.212	-0.170	0.104	0.087	0.556	-0.173	0.156
	[0.088]		[0.104]		[0.148]		[0.122]	
African	0.377	0.020	0.180	0.312				
	[0.161]		[0.177]					
Coloured	-0.367	0.008	-0.265	0.082				
	[0.138]		[0.152]					
Proportion of years failed by 13	-3.615	0.000	-3.167	0.000	-0.367	0.661	-4.004	0.000
	[0.533]		[0.646]		[0.837]		[0.889]	
Income 2005	0.289	0.000	0.231	0.000	0.094	0.296	0.316	0.000
	[0.044]		[0.050]		[0.090]		[0.075]	
Number of adults in house	-0.035	0.190	-0.004	0.883	0.082	0.100	-0.050	0.206
	[0.027]		[0.031]		[0.050]		[0.040]	
Number of children in house	-0.078	0.009	-0.079	0.014	-0.016	0.765	-0.097	0.027
	[0.030]		[0.032]		[0.053]		[0.044]	
Time spent with biological mother	0.021	0.643						
	[0.044]							
Time spent with biological father	0.021	0.565						
	[0.037]							
Time spent with bio mother talking about edu			0.240	0.000	0.360	0.000	0.112	0.105
			[0.056]		[0.083]		[0.069]	
Time spent with bio father talking about edu			0.044	0.271	0.018	0.753	0.180	0.002
			[0.040]		[0.057]		[0.057]	
Proportion friends continue study			-0.137	0.239	-0.009	0.974	-0.001	0.995
			[0.116]		[0.262]		[0.146]	
Frequency friends encourage study			0.687	0.000	0.534	0.109	0.535	0.000
			[0.121]		[0.334]		[0.147]	
Proportion friends intend to study further			0.182	0.038	0.213	0.137	0.188	0.113
			[0.087]		[0.143]		[0.118]	
Health in wave III			0.084	0.068	0.162	0.013	0.087	0.143
			[0.046]		[0.162]		[0.060]	
SLE			0.037	0.210	-0.027	0.599	0.041	0.312
			[0.030]		[0.051]		[0.040]	
Household death			0.153	0.387	0.175	0.367	0.063	0.850
			[0.176]		[0.194]		[0.335]	
Affected by HIV/AIDS			-0.121	0.452	-0.112	0.462	0.073	0.806
			[0.161]		[0.152]		[0.298]	
Low HIV risk			0.011	0.906	-0.358	0.022	0.231	0.074
			[0.093]		[0.156]		[0.129]	
Medium HIV risk			0.075	0.635	-0.319	0.217	0.192	0.339
			[0.159]		[0.258]		[0.201]	
High HIV risk			-0.033	0.867	-0.580	0.014	0.336	0.202
			[0.197]		[0.237]		[0.264]	
N	967		769		275		375	
F / Pseudo R Squared	16.34		12.05		0.085		0.139	
P	0.000		0.000		0.000		0.000	

Table 14: ordered probit regressions on educational expectations, controlling also for orphanhood

	Regression 1		Regression 2	
	Coef	P	Coef	P
Age	-0.028	0.010	0.011	0.382
	[0.011]		[0.0125]	
Female	-0.063	0.252	-0.059	0.361
	[0.055]		[0.065]	
African	0.195	0.115	-0.018	0.893
	[0.123]		[0.134]	
Coloured	-0.544	0.000	-0.487	0.000
	[0.116]		[0.119]	
Income 2005	0.261	0.000	0.250	0.000
	[0.035]		[0.036]	
Maternal orphan	-0.244	0.037	-0.204	0.084
	[0.117]		[0.118]	
Paternal orphan	-0.056	0.405	-0.006	0.935
	[0.068]		[0.074]	
Double orphan	-0.350	0.020	-0.294	0.055
	[0.149]		[0.153]	
Health			0.095	0.001
			[0.030]	
SLE			0.017	0.388
			[0.020]	
Affected			-0.040	0.683
			[0.095]	
Proportion of years failed			-2.86	0.000
			[0.392]	
Friends continue to study			0.160	0.034
			[0.075]	
Friends encourage to study			0.589	0.000
			[0.082]	
Friends intend to study further			0.286	0.000
			[0.057]	
N	2269		1853	
F	27.96		24.28	
P	0.000		0.000	

Changes in educational expectations between CAPS wave one and three

In this final section, I investigate the possible influences of AIDS-related factors on potential changes in educational expectations. In light of the hypotheses around the negative impact of HIV and AIDS, it could be expected that a decrease in self-reported health, the experience of a death in the household, high perceived risk for HIV, or low subjective life expectancy²⁵ would decrease educational expectations.

Changes in educational expectations were looked at only for those young adults with both complete young adult data and household data for both waves I and III. Changes in expectations between waves I and III are considerable, with close to 40% of the young adults expressing lower levels of expectations in wave III than in wave I. Decreases among especially African and Coloured youth are found especially on any post-secondary levels of education, as illustrated by figure 4 below. This is in line with the significant negative impact of age on educational expectations found in the earlier regression analyses.

In order to better understand factors of influence, also taking into account the potential AIDS-related factors, probit regressions were run with the dummy variable *decreased educational expectations* as the dependent variable. Results for the pooled sample show significant and negative impact of household income, interaction with one's mother on educational matters, and encouragement of friends on the changes of decreased educational expectations. Marginally and positively significant is the impact of a household death on decreased expectations. Within the African sample, being female and spending time with one's biological mother on education, decreases the odds to lowered expectations; among Coloured youth, a higher life expectancy, spending time with one's mother on educational matters, a higher household income and encouragement of friends are all significantly and negatively related to lowered educational expectations. Being female and living in a household with more adults increases the odds of having lowered expectations. Perceived HIV risk as measured in wave III has a marginally significant impact in the African sample. Results are presented in table 15. Areas in the table that have been left blank, are for those variables that were included in the model but did not prove significant.

²⁵ Preferably, we would be able to study the impact of changes in subjective life expectancy and of perceived risk for infection, but the questions thereon were only included in wave III and not before.

Figure 4: educational expectations over time, by population group

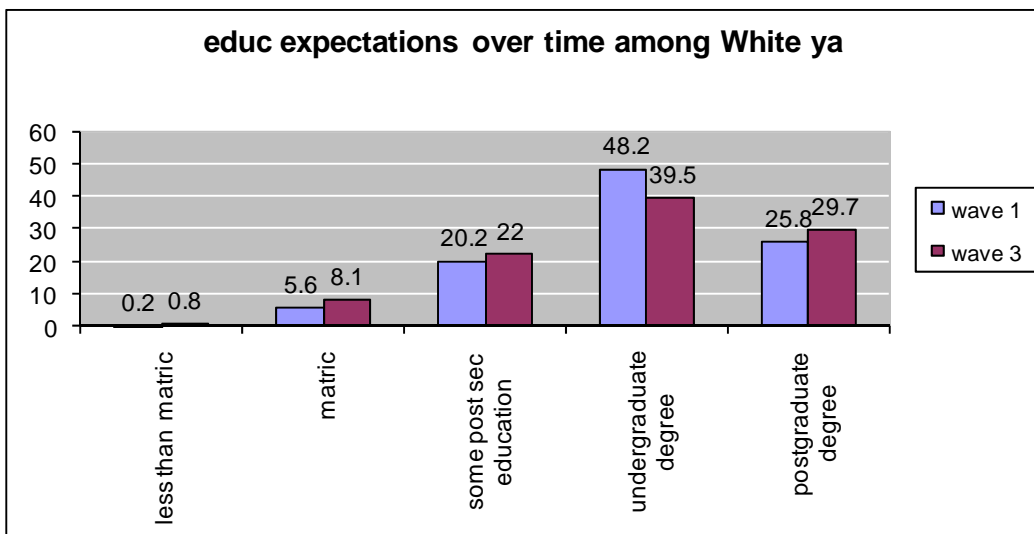
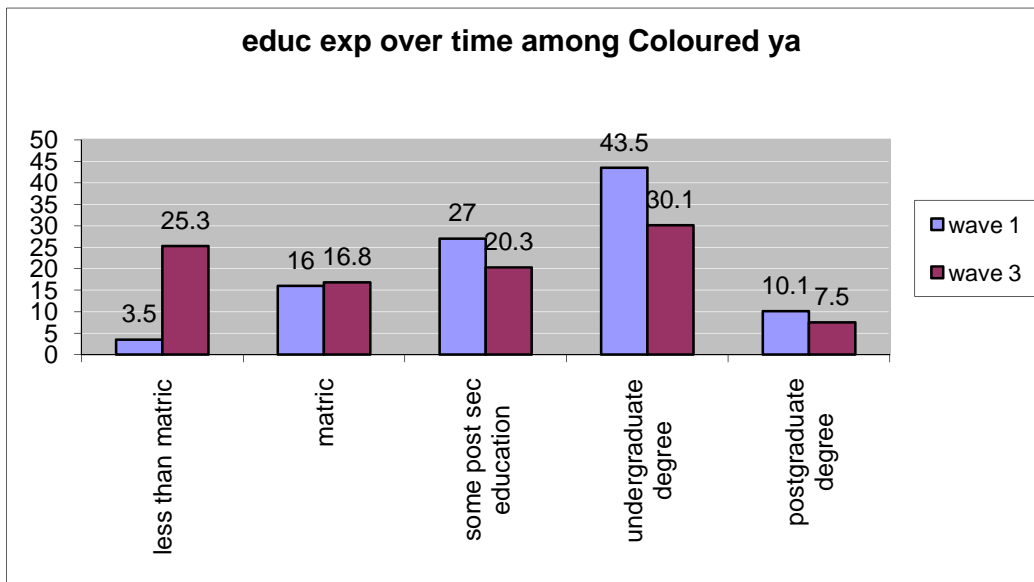
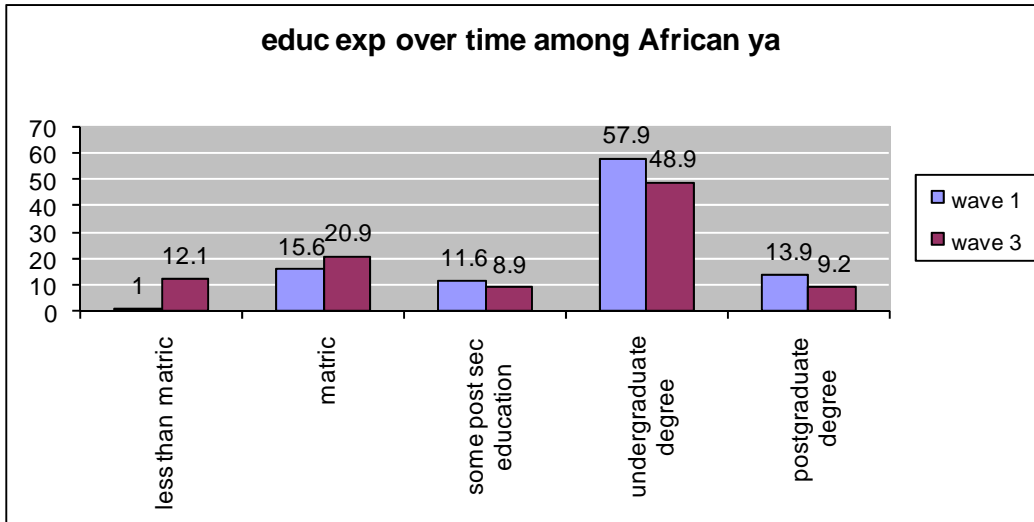


Table 15: probit regressions on decreased educational expectations between waves I and III²⁶

	African		Coloured	
	Coef	P	Coef	P
Deterioration of health				
Improvement of health				
Subjective life expectancy wave 3			-0.091 [0.043]	0.037
Household death wave1-wave3				
Age of young adult in wave 3				
Female	-0.252 [0.124]	0.045	0.267 [0.140]	0.059
Dropout between 2002-2005				
Monthly household income wave 3			-0.222 [0.074]	0.003
Number of adults in the household			0.086 [0.044]	0.056
Number of children in the household				
Frequency spent time with biological mother	-0.213 [0.062]	0.001	-0.110 [0.066]	0.097
Frequency spent time with biological father				
Frequency talked about education with biological mother				
Frequency talked about education with biological father				
Number of friends continued to study				
Frequency friends encouraged to study			-0.322 [0.154]	0.038
Number of friends expecting to study at tertiary level				
Low HIV risk	0.261 [0.144]	0.074		
Medium HIV risk				
High HIV risk				
N	470		532	
P	0.005		0.003	
F	2.31		2.36	

²⁶ Only those young adults with data for complete young adult and household questionnaires for both waves were kept in the sample for this analysis. Additionally, only those who had observations for expectations in both waves I and III were taken into account, hence the much smaller number of observations in these analyses.

However, when looking at changes over time, it is necessary also to take into consideration the impact of attrition in the sample on the results. McGuigan et al. (1995) state that “if attrition is systematically related to outcomes of interest and if non-response adjustments are not made, bias may result” (ibid: 402; see also Winship and Mare 1992).

By wave III, of the original 4752 young adults, 3536 were still part of the sample. The biggest reason for attrition between the waves was found to be migration, either of mostly White youth going overseas, or of mostly African youth moving within South Africa (especially to the Eastern Cape). Attrition was highest among White young adults. For some of the young adults who were re-interviewed in wave III, household-level data is missing (typically because of “interviewee fatigue” - Lam et al. 2007: 46). The total number of young adults with complete individual and household interviews in wave III was 3413. Probit regressions on attrition showed that non-respondents in wave III were “more likely to be older, not in school or working in 2002, not born in Cape Town, and non-Coloured” (ibid: 56).

Various weights have been calculated for CAPS. The original weights for wave I data controlled oversampling in selected areas and for uneven non-response, at the levels of both the household and the young adult²⁷, so as to be able to “provide results that are reasonably representative of the young population of Cape Town” (Lam et al. 2007: 23). A new weight was constructed for wave III, to adjust for attrition also. This weight has been used in all analyses and regressions run and presented in this paper.

Conclusion

This paper looked at the influence of various factors on educational expectations. I tested the influence of demographic and household socio-economic factors. Unlike previously conducted analyses, however, I also examined the significance of peer interaction, orphanhood, health, subjective life expectancy and perceived risk for HIV infection – the last four of which were

²⁷ In doing so, it is assumed that “the households that responded to the interview do not differ systematically from the households in the same sampling area that did not respond. While this assumption is unlikely to be strictly true, it is true that most enumeration areas are relatively homogeneous neighbourhoods. Since we have no information on households that did not respond to the interview, there is no way to explicitly examine the extent to which they differ from responding households.” (Lam, Seekings et al. 2006)

considered important in light of the HIV and AIDS pandemic and its potential impact on young people's expectations and decisions around education. Findings contribute to the understanding of differences in expectations between the various population groups, and to the potential consequences of HIV and AIDS.

Within the pooled racial sample, I find some support for the Status Attainment Theory in that prior performance in school, household income and the number of children in the household are significant correlates of expectations. Similarly, some support is found for the Family Social Capital Theory: expectations are higher among young people who discuss schooling with their mothers. The death of one's mother or of both parents has a significant and negative influence. Further, different types of interaction with peers around educational matters are significantly and strongly correlated with educational expectations. However, the picture changes when disaggregating by population group.

Among African youth, there is little support for the Status Attainment Theory, but interaction with mother or peers correlates significantly with expectations (especially among people younger than 21 years). This seems to indicate that African youth do not so much take into account possible practical factors that may hinder their educational path, but attach more importance to encouragements and support in their close environment. It points at the necessity for support in one's direct environment and again mirrors narratives of young adults in resource poor settings who maintain very high expectations and values, making very conscious choices around friendships and support networks.

Coloured young adults, on the other hand, have much lower expectations, with resource constraint factors seemingly playing an important part in that. Perhaps this is where the distinction between aspirations and expectations can be captured in the different population groups: Coloured youth may express more concrete expectations compared to the more abstract aspirations of their African peers. Coloured youth, in fact, express lower levels of optimism in all variables under analysis: they reported worse levels of health and lower levels of life expectancy as well, yet the models were not sufficient in explaining these observations.

Among White young adults, it seems that high educational expectations are a given, with no resource constraint factors at play, nor the necessity for parental interaction.

With regards to the potential impact of HIV and AIDS, firstly, I find very high levels of subjective life expectancy, especially among African youth – the group of youth that is most vulnerable in light of the AIDS pandemic. Clearly then, we do not fully understand how young adults express such SLE and what factors they take into account. Perhaps the measure used to capture subjective life expectancy is not the best one to be used, and future research will indicate whether there are other, better ways of measuring it. However, bearing in mind findings also of qualitative work with affected caregivers and youth, life expectancy as such did not seem influenced by the AIDS pandemic, nor did it have an impact on youth’s educational aspirations and values.

Further, I did find an impact of self-rated health status (either measured at one point or changing over time) on educational expectations, yet not of clinical conditions, nor of life expectancy or of “affectedness”. This raises some questions on the theories around Human Capital Investment and their negativist view on the impact of the pandemic on young people’s views and attitudes towards education. The only factor showing significance was the perceived risk for HIV infection among African youth. Again, this measure is poorly understood, but in light of its significance requires further in-depth research.

Appendix 1: Descriptive Statistics on young adults' self-rated health

Self-rated health (% replies)					
Indicator	Poor	Fair	Good	Very Good	Excellent
Population group*					
African	2.26	5.09	31.64	14.71	46.3
Coloured	0.53	5.47	34.17	19.99	39.84
White	1.05	4.43	15.78	33.28	45.46
Gender*					
Male	0.87	4.36	26.95	19.09	48.72
Female	1.24	6.01	34.54	21.81	36.4
Agegroup					
16-18	0.62	5.69	30.75	19.5	43.44
19-20	0.7	4.62	31.05	22	41.63
20-22	1.06	5.2	26.96	21.93	44.85
23-26	1.39	4.93	32.85	19.37	41.45
Orphanhood*					
Both parents alive	0.98	5.33	29.82	21.88	41.98
Double orphan	1.03	5.28	30.66	20.51	42.52
Maternal orphan	1.82	5.44	31.94	15.48	45.32
Paternal orphan	1.11	5	33.34	15.98	44.56
Parental residence					
Both parents resident	1.14	5.21	29.54	21.22	42.89
One parent resident	0.79	5.76	31.71	19.28	42.46
No parents resident	1.37	5	31.98	20.86	40.8
Respondent's highest level of education*					
5 years	1.6	12.76	36.68	23.14	25.82
5-10 years	1.79	5.5	34.95	17.57	40.18
10-12 years	0.53	4.69	30.22	20.6	43.95
Matric and more	0.37	4.85	22.51	26.66	45.61
Household Monthly Income					
Less than 500	1.75	5.81	36.08	12.34	44.03
500-1000	1.76	4.75	31.31	18.7	43.49
1000-3000	2.45	6.02	32.39	15.19	43.95
3000-8000	0.49	5.67	34.19	19.4	40.25
8000-20 000	0.49	4.97	27.81	23.46	43.27
More than 20 000	0.71	1.99	14.18	40.93	42.2

Appendix 2: descriptive analysis of perceived life expectancy for oneself.

Perceived life expectancy (% replies)							
Indicator	Below 30	30	40	50	60	70	80
Population group*							
African	0.26	3.06	5.98	13	11.18	6.57	59.95
Coloured	0.18	6.21	6.4	12.79	22.97	13.99	37.46
White	0	0.34	1.19	5.31	17.19	29.02	46.94
Gender							
Male	0.24	3.45	5.72	11.54	18.58	15.31	45.17
Female	0.12	5.41	5.3	11.9	19.09	13.14	45.04
Agegroup							
16-18	0	3.3	6.06	9.09	18.25	16.94	46.36
19-20	0.34	4.34	5.18	13.25	19.96	14.61	42.32
20-22	0.18	5.02	4.03	11.95	18.79	13.62	46.41
23-26	0.18	5.39	6.14	11.69	18.91	12.35	45.34
Orphanhood*							
Both parents alive	0.2	4.25	4.76	11.3	19.81	15.62	44.06
Double orphan	0	6.26	9.77	10.88	13.39	11.74	47.95
Maternal orphan	0.57	3.07	7.77	10.52	19.87	12.66	45.54
Paternal orphan	0	5.91	7.71	14.1	16.17	8.85	47.27
Parental residence							
Both parents resident	0.15	5.17	4.34	10.72	19.54	17.73	42.35
One parent resident	0.22	4.03	6.28	11.95	19	11.92	46.6
No parents resident	0	4.18	6.35	10.84	18.2	12.25	48.12
Respondent's highest level of education*							
5 years	0	1.73	7.96	14.28	13.73	12.21	50.09
5-10 years	0.15	4.91	6.78	13.31	16.61	10.86	47.39
10-12 years	0.13	4.92	5.21	11.12	20.06	15.27	43.29
Matric and more	0.15	1.86	2.63	8.97	22.58	20.17	43.64
Household monthly income*							
Less than 500R	0	2.75	9.09	12.27	22.02	3.26	50.6
500-1000	0	5.44	5.61	12.85	14.51	12.13	49.46
1000-3000	0.51	5.4	7.74	14.03	14.23	8.54	49.55
3000-8000	0	5.66	5.83	12.39	20.41	11.52	44.13
8000-20 000	0	2.32	3.1	8.98	23.98	21.39	40.23
Above 20 000	0	1.46	1.91	2.94	13.67	33.01	47.01
Self-rated health*							
Poor	2.02	6.87	6.26	24.16	6.8	24.32	29.57
Fair	1.3	4.91	7.79	13.17	21	15.99	35.85
Good	0.15	8.27	8.16	12.67	20.51	11.64	38.59
Very Good	0	3.71	5.16	12.04	22.86	15.62	40.61
Excellent	0	1.96	3.57	10.47	15.95	14.87	53.09

Appendix 3: descriptive statistics on young adults' educational expectations

“educational expectations (% replies)								
Indicator	No educ	<matric	Matric	Diploma no matric	Diploma with matric	Undergrad	Postgrad	Don't know
Population group								
African	0	11.6	20.3	2.2	5.9	47.51	8.93	3.53
Coloured	0	23.3	14.8	6.52	11.3	25.7	6.4	11.9
White	0	0.8	7.6	1.8	19	37.8	25.8	7.2
Gender								
Male	0	16.4	14.6	5.9	10.6	33.6	9.3	9.6
Female	0	17.7	15.8	3.6	11.4	32.8	10.3	8.5
Agegroup								
16-18	0	15.3	10.7	4.9	10.1	39.3	9.47	10.3
19-20	0	17	15.2	4.6	11.1	31.8	10.7	9.6
20-22	0	15.9	15.7	4	14.2	31.4	10.9	7.9
23-26	0	19.8	19.3	5.2	9.2	29.9	8.5	8.2
Orphanhood								
Both parents alive	0	15.6	13.8	5	11.8	33.7	10.7	9.4
Double orphan	0	25.6	18.5	2.3	5.7	30.8	7.1	10
Maternal orphan	0	25.7	20.2	1.5	9.9	29.2	4.8	8.8
Paternal orphan	0	19.6	18.5	4.7	8.5	33.7	7.9	7.1
Parental residence								
Both parents resident	0	12.4	13	5	13.5	33.3	12.2	10.5
No parents resident	0	21.8	17.4	4.6	7.6	32.2	9.1	7.2

“educational expectations (% replies)								
Indicator	No educ	<matric	Matric	Diploma no matric	Diploma with matric	Undergrad	Postgrad	Don’t know
Study vs. work								
Study only	0	3.8	9.5	2.6	12.1	51.2	15.6	10.6
Work only	0	0	22.6	3	21.8	32.3	9.8	10.6
Combined study & work	0	1.5	1.8	5.3	17.4	43.5	25.8	4.8
Not studying, not working	0	2.4	25.1	3.1	13.6	36.8	8.5	10.5
Dropped out, now working	0	42.5	15.3	9.5	3.5	17.3	1.9	10
Dropped out, not working	0	41.3	18.8	5.5	2.4	16.1	2.4	13.5
Respondent’s highest level of education								
5 years	1.6	44.9	19.7	0	1.1	0	1.2	31.4
5-10 years	0	34.9	14.5	5.4	4.1	25.6	4.5	11
10-12 years	0	4	21.4	5.2	14.4	37.7	9.4	7.9
Matric and more	0	0	2.6	1.2	19.9	44	26.8	5.4
Household monthly income*								
Less than 500R	0	25.3	18.6	1.8	7.9	34.5	9.2	2.6
500-1000	0	23	22.1	4.97	2.81	35	4.7	7.5
1000-3000	0	24.3	19.4	2.2	6.9	32.6	6	8.6
3000-8000	0	20.8	15.3	6.5	11.7	26.8	7.4	11.6
8000-20 000	0	4.7	11.4	4.8	15.6	42	13.7	8
Above 20 000	0	2.1	5.1	3.4	15	39	31	4.2

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