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POLITICAL AND SOCIAL ECONOMY OF CARE: SOUTH AFRICAN PROPOSAL

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Background on social policy development in South Africa[1]

The foundations of apartheid were laid well before the Nationalist Party came to power in 1948. The Dutch were the first colonial settlers, and were followed by the British. Both colonial powers dealt with the indigenous and 'non-white' immigrant people as inferior races. Already by the close of the nineteenth century, labour policies had been developed which sowed the seeds for the formal policy of apartheid which was to follow. In particular, gold mines, white-owned farms and the new cities needed workers, and the migrant labour policy drew African men away from rural areas while strictly regulating their presence in urban areas. African women and children, as well as men too old to work for the 'white man', were largely restricted to the impoverished rural areas.

Under apartheid all citizens were classified into one of four so-called 'population groups' or 'races': African, coloured, Indian and white. (African, coloured and Indian were collectively referred to as 'black' during the struggle, and where 'black is used in this proposal, it has this collective meaning.) The allocation of resources and opportunities was fundamentally determined by official racial classification, and some of the resulting patterns are still in evidence today, twelve years after the formal end of apartheid.

Industrial social legislation developed early in the twentieth century in South Africa. Compensation for industrial disease and accidents was regulated in 1914, and an unemployment insurance fund established in 1937. Benefit levels were racially differentiated, and lower-paid workers and women were disadvantaged. Some African people – primarily men – got access to social benefits as workers, but not as citizens. From the 1930s onwards there were increasing signs of the recognition of the importance of collective provision of social services, including public works programmes and state-run nutrition schemes in schools. These two programmes were restricted to white people, and other programmes were heavily skewed in favour of whites.

When the Nationalist Party government came to power in 1948, aspects of citizenship-based welfare state thinking survived – but for whites only. Welfare policy was based on a model of family life which encompassed a two-generational nuclear family with a father in formal employment and a mother doing the unpaid care work at home. Black people, whether or not they fit into this model, were meanwhile largely expected to take care of themselves.

During the 1950s and 1960s government created the 'bantustans' in the form of largely undeveloped rural areas inhabited by Africans and into which millions of additional Africans were 'exported'. These areas were given a token form of 'self-government'. Across all fields of social policy, patterns of provision emerged which were skewed towards the protection of white interests. The social security system was initially set up to cover white elderly people and people with disabilities; other grants and policy measures provided for the protection of white family life. Children were included in the system of

[1] This first section is extracted primarily from Lund, F. 2001. 'South Africa: Transition under Pressure', in Alcock, P. and Craig, G. (eds.) *International Social Policy*. Basingstoke: Palgrave. In the course of the research, this schematic background will be further elaborated from a gender and care perspective.

‘family allowances’ introduced towards the middle of the last century. Gradually basic state assistance was expanded to cover the black groups. African people in the Bantustans were, however, largely excluded and never became eligible for some benefits. Even where expansion to ‘non-whites’ happened, it was done on a highly unequal basis. In the 1970s, for example, the ratio of grant benefits was 10:5:1 for white: Indian and coloured: African.

Alongside the social security system, social services developed as a partnership between government and a network of voluntary organisations. The state used a combination of its own subsidies and legislation controlling fund-raising to force all welfare organisations to apply racial discrimination in services. Virtually no attention was paid to the development of the voluntary welfare sector in the bantustans.

A series of strikes led by black workers in 1973 marked the beginnings of the breakdown of the old regime. The strikes were followed by the 1976 student uprisings and the threat of ungovernability coincided with a downturn in the economy. By the early 1980s the government embarked on what has been described as the twin strategies of reform and repression. By the end of the 1980s, policy work for ‘after the struggle’ was firmly on the agenda, and in 1991, with the unbanning of the leading struggle organisations, the end of apartheid was clearly in sight. By the time of the democratic elections in 1994, significant policy work had been done, and people from opposite sides of the political fence had started learning how to work together.

After 1994 there was an intense period of policy making across virtually every sector. During this period the overall sectoral approaches were thoroughly interrogated, with a tendency to want to change everything, and as soon as possible. In addition to the overall approaches, attention was paid to some more specific areas, including a range of social policies. Within a few years, the difficulties of ‘transformation’ became fully apparent and the challenge of implementation had to be faced. Nevertheless, policy making has continued at a pace that is probably unusual when compared with other countries.

The policies which have been developed include many which are directly relevant to the topic of care. They include, for example, the introduction and subsequent expansion of the child support grant, an extremely long and participatory process of developing a comprehensive child care bill/act, and recent finalisation of a policy and legislation in respect of the elderly. In terms of HIV/AIDS, the policy and practice relating to anti-retroviral therapy has received most media attention, but there have also been significant developments in home-based care and other elements of the more care-focused aspects of the pandemic. In practical terms, there have also been policy experiments, including a ‘flagship’ income-generation programme for unemployed women with young children, and several (largely unsuccessful) attempts to roll out early childhood development (ECD) in all provinces.

Twelve years after the end of formal apartheid, the legacy of ‘separate development is still clear. In terms of income distribution, the gini coefficient remains more or less where it was (depending on who is doing the analysis!). At the top end of the socio-economic

scale there are now significant numbers of black people. At the bottom end of the scale, it is still overwhelmingly African. Unemployment stands at very high levels, with the highest levels for African people, women and youth.

But there have also been many changes – some positive, and some less so – which make South Africa in 2006 very different to South Africa of 1994. For the purposes of this project, one of the most important remaining legacies is the fractured social and 'family' setup, which contradicts many of the assumptions and norms which underlie policy making in other countries and, in some cases, still implicitly or explicitly, underlie policy making in South Africa. The fractures within this setup have been vastly exacerbated by the HIV/AIDS pandemic. The pandemic itself has particular ramifications for the provision of care which lies at the centre of the UNRISD project.

The South African study will focus on the post-1994 period. This date is chosen as a cut-off as it was so clearly a watershed in the country's history. More pragmatically, reliable quantitative data for the pre-1994 period are not easily available. For the most part official data were collected only on 'white' South Africa. Where data were collected on other areas, they were often of poor quality and used different methods.

A snapshot of South Africa a decade after democracy

Selected indicators

Population	47,8 million (51% female)
Urbanisation rate	Approximately 50%
GDP per capita (Among 50 wealthiest countries in world)	US$ 9401
Unemployment rate	25,6% (30,3% for women)
HIV prevalence (total population)	11,2% (12,3% female)
Number full-blown AIDS	600 000
Life expectancy	50,7 years (62,4 in 1985)
HDI country rank, 2004	119 of 177 (93 of 175 in 1993)
Population under US$2 per day, 2000	18m of 44m
% of 7-13 year olds in school	97,1% boys; 97,9% girls
Female % of tertiary education enrolments, 2001	53%
Female % of national parliamentarians	33%
Women ministers	12 of total of 26

The indicators above present a mixed picture. While the country is relatively wealthy overall, it has one of the highest rates of inequality in the world. A contributing factor is the extremely high rate of unemployment, which is significantly higher for African and coloured people than whites, and for women than men. While educational enrolment rates are relatively high and more females than males are enrolled, the quality of education is poor. While the country has performed well in respect of representation of women and has introduced a range of gender-sensitive laws since 1994, levels of all forms of gender-based violence are extremely high. This contributes, among others, to the high HIV/AIDS prevalence levels. There is also a high rate of teenage pregnancy. In 2001, close to one in

every 14 African girls aged 15-19 would have given birth each year, even after excluding miscarriages and stillbirths. This early childbearing by young women is combined, as discussed further below, with very low levels of participation of men of all ages as fathers.

On the macroeconomic front, in 1996 the post-apartheid government introduced the neo-liberal Growth Employment and Redistribution (GEAR policy), with its primary goal being reduction of the budget deficit. Subsequent years have, however, seen social spending increase at beyond inflation to the extent that it accounted for an increasing share of the overall budget. This was facilitated by significant improvements in revenue collection. The question of health care spending has, however, been particularly fraught as a result of the ambivalent stance of the government in respect of HIV/AIDS and its failure to acknowledge the seriousness of the pandemic.

Organising theme

As its organising theme in terms of focus, the research will build on the feminist work done challenging assumptions embedded in various policies about 'breadwinners' in households by asking: 'What happens in terms of caring when assumptions about 'normal' patterns are not true for significant numbers of people in a society? How, if at all, do policies address the needs and interests of people living in 'atypical ' situations?'

The research will, in particular, focus on the fact that the following assumptions are not true for many South Africans:

- ♀ that the majority of children live with their mother and father: In South Africa, while 36% of children live with their mothers and fathers, and 40% with the mother only, less than half of all children live with their father, and about a fifth do not live with either mother or father. What does the untruth of this assumption mean in terms of caring for children?
- ♀ that most fathers who are resident with children can adequately fulfil the breadwinning role: South Africa has a very high rate of unemployment. In March 2006, the official rate of male unemployment, which excludes 'discouraged' workseekers, stood at 21,6%. The rate for African males was 25,6%. (Rates for women were even higher, at 30,3% and 36,2% respectively.) Of those who are employed, many earn too little to support themselves and their families adequately. Even where there is more than one earner in a family, income might not be adequate.
- ♀ that most children are born within marriage: In South Africa, this is untrue as a result of low rates of marriage, high rates of divorce, and large numbers of children born outside of formally contracted relationships (although the marriage might be formalised later). In this situation, what happens to the assumption of a shared burden of financial, physical and emotional care for children?
- ♀ that younger and middle-aged adults are providers of financial, physical and emotional care (particularly for the young and aged), rather than recipients of care: The HIV/AIDS pandemic has been a major factor in making this assumption untrue, in that it is this age group that is most likely to be infected,

ill and/or die. In this situation, who takes on the roles of caring? And who cares for people in this age group who need care?

♀ that men will assist in bearing the care burden associated with a crisis such as that caused by the AIDS pandemic: South Africa appears to have a higher than usual preponderance of men who do not engage in care work in the way that other southern African countries report happens when AIDS reaches a particularly advanced stage.

The research will explore what happens to people living in situations which fall outside the 'norm', and assess the extent to which public policy 'sees' them and meets their needs. We are not using the word 'norm' in a way that implies a value judgement; social policies, however, generally articulate normative assumptions about family life, and it is these that we will be interrogating.

While the South African experience might be different from that of other countries in some respects, and the characteristics described above are particularly stark in their breaking of assumptions, we hope that the research will be useful for other countries that experience 'assumption-breaking' caused by similar or other characteristics.

The research will investigate these issues by comparing the situation of people in different circumstances and with different demographic and socio-economic characteristics in their roles as recipients and providers of care. In this way, we expect to illustrate that South Africa has a multiplicity of 'care diamonds' or, perhaps more accurately, the South African diamond is multi-layered and complex.

The research will span care for children, care for the ill and disabled insofar HIV/AIDS is concerned (including children ill and disabled from HIV), and care for the elderly (insofar as the assumed carers will often be absent and the elderly might now, in the absence or illness of their own children, themselves be taking on a large care burden). The different types and recipients of care will, however, not be examined separately. Instead, we will focus on the interactions between the different types and recipients and providers of care within different household/ family/ kinship settings.

The main focus will be on care for persons. In looking at unpaid care work limited attention will be paid to housework and related activities. These activities will, however, obviously not be ignored as they are necessary activities that provide the conditions for personal care giving.

The 'points' of the 'care diamond'

At the November/December 2006 workshop in Geneva, it was generally agreed that there are not strict boundaries between the various 'points' that constitute the 'care diamond' metaphor used to frame the research proposal. The categories are nevertheless useful in highlighting particular characteristics that are common at or near the different 'points'. The following paragraphs are presented to illustrate the ways in which the South African research will encompass all 'points'. We do not, however, envisage that the research report will be organised primarily in terms of these 'points'.

State

Public policy in respect of the following (among others) will be considered: HIV/AIDS policy, expanded public works programme, child support grant, foster care grant, home and community based care, and old age grant and direct service provision for children and the elderly. In all of these areas, the state plays significant role as provider. In many it plays additional roles, for example as regulator or funder, and our examination of public policy will therefore also provide information on other 'points' of the care diamond.

For each of the policy areas covered we will attempt to obtain information both on policy and on actual implementation. This information is available, among others, in annual and other reports of government agencies, but will need to be supplemented from other documentary sources and sometimes through interviews. Examination of policy will include examination of budgets to see how much is being allocated for grants, as well as for service provision by government and through subsidisation of non-government providers of services such as early childhood development, children's home and homes for the elderly. An important source in terms of care of children will be the detailed costing that was developed in respect of the Child Care Bill/Act. This source will provide us with information both on current provision and on levels of (unmet) need.

Within our qualitative case studies, we will include a focus on nurses (see below). Nurses are employed in both private and public institutions in South Africa. Our main focus will be on nurses in public institutions, as it is these which are meant to provide services for poorer people, who are the main focus of our research. We will, however, also need to look at nurses in private employment as competition for the scarce human resources available between the public and private sectors is one of the factors currently placing pressure on public provision of care.

The market

We will describe the size and shape of the 'market' in respect of both the health and welfare sectors. The market in respect of 'care' in welfare is extremely small in South Africa, and more attention will thus be spent on describing the situation in health. We will describe the interaction between spending in the public and private health sectors, and, within private, between allopathic and traditional. In these descriptions we will pay particular attention to the profile of beneficiaries and users of the different services and, in particular, patterns of usage by poor (predominantly black) people. As noted above, we will also look at the distribution of health care staff (and nurses, in particular) between public and private. Our work in this area will involve secondary research, as a great deal of research already exists in this area by institutions such as Health Systems Trust.

We also plan to analyse data from the labour force survey and earlier household surveys to investigate possible trends in paid care work over our relatively short period. For example, we plan to identify the occupations that one can classify as involving care work, and determine the profile of workers involved (population group, sex, 'class') as well as the value of the work as measured by their earnings. These trend calculations will, however, not give an unambiguous measure of care delivered through the market, as

there will be paid workers in non-market situations, such as state institutions and non-profit organisations. For the later years, we should be able to distinguish paid workers by type of institution for which they work, and thus get a clearer picture of 'market' care. For the earlier years, however, before the labour force survey was introduced, this information will probably not be available. We should therefore be able to provide a snapshot of the market through this approach, but not a trend.

As discussed below, we have chosen paid domestic workers as one of our in-depth case studies. These workers lie at the more informal end of the market, although – as will be described – South Africa has taken important steps in extending labour legislation and protection to these workers since 1994. Also at the more informal end, we will examine early childhood development (ECD) provision (crèches). This is one example of an area where the boundaries between the 'points' of the diamond are again fuzzy. In particular, 'private' community-based provision is sometimes subsidised by government, ECD is sometimes part of the expanded public works programme (although the focus seems to be mainly on training), and many women provide these services on such an under-paid basis that it is difficult to categorise this as the market.

The 'community'

The time use survey will provide some indication of the time household members spend providing unpaid care to people outside their households. This is the more informal end of community care.

Our focus on home- and community-based care constitutes an example of 'community' provided care. As before, the boundaries are not clear as there are sometimes government subsidies for this work, and some of it is done under the auspices of the expanded public works programme. A larger proportion is, however, done under the auspices of non-profit organisations and community-based groupings which range from the more formal to the very informal. There is an existing literature that we can draw on to inform this part of the research. There are several pieces of ongoing research by students, described below, which will help with this focus. We hope that these pieces will help us illustrate the complexity of, and wide range of practices covered by, this third 'point' of the diamond.

The family

A core source for covering this 'point' will be the time use data. Our initial plans for analysis of these data are described below.

Some macro measures

At a macro level, we will examine labour force and other data to describe the overall patterns of paid care work in the economy. In addition, we will attempt a series of valuation exercises to give a sense of the relative sizes of the paid and unpaid (care) economies. Our ideas in this respect are as follows:

- ♀ Calculating the value of total paid work in the economy vs value of total unpaid work, including the sex breakdown for the total paid and unpaid, with broad sub-categories within both paid and unpaid.

- ♀ Calculating the value of unpaid care work compared with different types of tax revenue, differentiating between care narrowly defined and broader notions of care.
- ♀ Calculating the value of unpaid care work compared with different types of government expenditure on salaries, such as in schools and hospitals.
- ♀ Calculating a measure of care produced by care workers falling within the SNA production boundary. This is described above.
- ♀ Calculating the value of unpaid care as a percentage of gross domestic product.

In addition, the introduction to our research report will include background information in respect of demographic, economic and social trends over the period since 1994. South Africa's data for this period are relatively good and we foresee no problem in presenting the basic trends required.

Case studies of non-family provision of care

We will include three 'case study' foci in respect of non-family provision of care. For each of these significant categories of worker we will explore both how they give care and how they receive care/organise care of self:

- ♀ Domestic workers: South Africa has approximately a million domestic workers, the overwhelming majority of whom are black women. Over recent years, legislative provisions for these workers have been improved to the extent that there is now a minimum wage and coverage in respect of unemployment insurance. This group nevertheless constitutes a poorly paid and vulnerable (exploited) workforce, and not all workers enjoy the rights and protection to which they are entitled. There will be an emphasis on domestic workers as carers (for example, to what extent are they required to provide personal care beyond 'housekeeping' tasks, and whether or not these are formally contracted for), as well as assistance from employers in receiving care (to the extent that, being situated in a home from a 'higher' class, domestic workers might have access to services and support of different kinds that they would not ordinarily access);
- ♀ Nurses: South Africa, like many other countries, has a nursing crisis. This has been exacerbated by the HIV/AIDS pandemic, which has led to incapacity, death and emigration of nurses, but the pandemic is by no means the sole cause of the problem. The focus will again be on nurses both as carers of patients at work, and of ill family members at home, and as people needing care in that they are not immune from being infected and affected by the pandemic.
- ♀ Home and community based care: This is seen by the South African government, like many other governments in developing countries, as a key strategy for addressing care needs and reducing the burden on the health care system. Conceptually this area is interesting because of the widespread activities of 'volunteers' across the spectrum of groupings undertaking this work (ranging from formal welfare organisations to small women's and church groups), with some of the 'volunteers' paid (poorly) and some of them unpaid. As with the two other groups, in addition to investigating the care

provided by these workers, we will attempt to explore how their own care needs are satisfied.

There is some general literature and research available on both domestic workers (for example, related to the introduction of a minimum wage and conditions) and home and community based care (much of this commissioned by government and donors) that could be useful for the purposes of this study. This will, however, need to be supplemented by further research that focuses on the core questions of this project. There is less literature of which we are aware that is likely to be useful on nurses in South Africa, but some work has been done even on this topic in the past, for example by the Women's Health Project. The time use survey may allow some investigation of patterns of paid and unpaid care done and (unlikely?) purchased by domestic workers, but the sample sizes for the other two groups would definitely not be large enough to allow this analysis. Even for domestic workers, it may not be possible to use this source. The interfaces between these different types of work and methods of obtaining care will thus need to rely primarily on new, mainly qualitative, methods.

Quantitative sources

In terms of quantitative research, the main data source will be the time use survey of 2000. Strengths of the time use survey are that it is diary-based, that it includes basic information on income of the household and individuals for whom diaries were collected (and thus allows some poverty-related analysis), that it includes labour-related information (allowing for analysis of interaction between paid and unpaid work), relationship information and other basic demographic information (allowing comparison of activities of different 'types' of people in different living/relationship situations) on the diary informants. It thus has the ability to provide information on many of the questions that need to be answered for the purposes of this research. This will avoid the complications of trying to match data and observations from different surveys.

One limitation of the time use survey is that it was a one-off survey, which disallows tracing of patterns over time, which is unfortunate as the HIV/AIDS pandemic changes quite rapidly over time. Other characteristics of society tend to change less slowly, and the lack of time series data or more recent information should therefore not be so serious. The classification system also does not distinguish between care for different types of adults (e.g. elderly or ill).

Another limitation is that the time use can tell us very little about use of paid forms of care. For each household there is an indicator of employment of a paid domestic worker, but there is little beyond this to investigate purchase of paid care.

The final nature of the analysis of the time use analysis will need to be shaped by what the data tell us. Initial steps in exploring the data will include:

♀ Tabulations in respect of the distribution of people's time between paid work and unpaid care work. For this analysis, categories of people will be defined in terms of sex, population group, age, marital status, 'childed' status, employment status, settlement type (two categories of urban and two of rural),

personal income level, household income level, and the composition (in terms of three age-defined groups) of the households of which they are a member. These tabulations will be performed in respect of unpaid care work as a whole (e.g. including general housework) as well as unpaid care work more narrowly defined (i.e. the work that is done more directly with and for people).

♀ Tabulations in respect of the different sub-categories of unpaid care work. At a broad level, the classification system distinguishes between (a) household maintenance, management and shopping for own household; (b) care for children, the sick, elderly and disabled for own household, and (c) community services and help to other household. This set of tabulations will focus, in particular, on category (b) and on the sub-categories of (c) that relate directly to care of persons. The classification will also allow us to distinguish between care for children and care for adults in the household, as well as between more passive and more active forms of care for children.

The findings from the above tabulations will inform further analysis. Where, for example, clear patterns are found between particular groups, these will be further investigated through methods such as further disaggregation or simple statistical analysis. The extent to which these more in-depth investigations can be done will be limited by the sample size for particular sub-groups. For example, for the most part we will probably not be able to provide measures for all four population groups as the Indian group, in particular, is very small. Similarly, for household income we will need to use only two or three groups to get reliable results.

The analysis will deal explicitly with simultaneous activities by including analysis using the 'full' minute (not adjusted to fit the 24-hour day) and the 24-hour minute. For determining how long different categories of people spend on particular types of care, the 'full' minute will usually be the most meaningful, while distribution of time between paid work and unpaid care work is more usually presented in terms of 24-hour minutes.

Other quantitative surveys that might be useful are:

♀ Actuarial Society of South Africa model, that provides time series projections of a range of variables, including the number of people at various stages of HIV infection (and thus needing different levels of care), by province, population group, sex, age. The model allows for changing of assumptions about government interventions.

♀ The General Household Survey (GHS) that has been conducted annually by Statistics South Africa since 2002. The 2005 data include information on whether children's parents are alive and, if so, whether they are living with them; similar information about spouses, reasons for children not being in school (one option being 'family commitments (including child minding)', and questions on health care seeking behaviour.

♀ The six-monthly Labour Force Survey (LFS) of Statistics South Africa in its March 2006 round included a module on child labour addressed to all children in the household aged 10-17 years inclusive. (All the standard labour force questions were also asked of all people 10 years and above.) The child labour

module includes a question asking how much time the child spent in the last seven days 'caring for other children, or for disabled, ill or old people or for others', as well as how long spent on other forms of household work. When asking about reasons for absence from school, options include the need to help with household chores because adults in the household are sick or disabled, own illness/disability, and falling pregnant/having children. The March 2006 LFS also included a question asked of all people aged 10 years above as to whether they did 'uncompensated work for the benefit of a community, neighbourhood or interest group' over the last twelve months. The first two options in respect of such work relate to helping sick or 'handicapped' people in their everyday life activities, and providing medical care, or counselling, to sick or 'handicapped' people. More generally, the LFS can be used to give the overall patterns of SNA labour in the economy, including patterns of care-related SNA work.

♀ Regularly produced quantitative reports from the Department of Social Development summarising the demographic characteristics (sex, relationship to child, etc) of primary care givers for the child support grant.

Qualitative sources and approach

The team will draw on two categories of younger researchers for two different types of investigations:

♀ Masters students at the University of KwaZulu-Natal who choose to focus on particular aspects/questions for thesis purposes and who will be supervised by Francie Lund will explore more complicated conceptual/theoretical issues (through empirical research).

♀ Other younger researchers will be commissioned to collect information on issues that pose fewer conceptual/theoretical issues, but where we need 'facts and figures'. This would, for example, include information on government budgets, or on particular government policies and programmes. The interviews of these younger researchers will be supplemented by interviews conducted by the two lead researchers where the status of the interviewee or complexity of the topic requires this.

In respect of the first category, there is a range of planned or ongoing research that is relevant for our purposes. As seen from the short descriptions below, these research pieces go beyond simple questions of who provides care to more textured questions, including quality of care. The planning or ongoing research includes:

♀ **Anna Wallwork** (expected completion date: August 2007)

Field of study – An assessment, using a gendered lens, of the ability of different models of home-based care (HBC) provided by non-kin to provide an adequate and sustainable level of care to people living with AIDS in KwaZulu-Natal

Method – Interviews with personnel in four different types of HBC in KwaZulu-Natal – with and without government funding, using and not using volunteers, faith-based and not faith-based.

The main importance of this small study for the UNRISD project will be its

exploration of two points of the care diamond – the difference that is made by state provision; and the third and vague 'point', the 'community' and how this is gender blind. Anna looks at the gender-blindness of present community and home based health care policies; investigates the use of volunteers, the majority of whom are women; and looks at how non-kin carers get pulled into hands-on care, though they are meant to be 'training' household members. She shows the inadequacy of much of the 'training'; the enormous stress level of the carers; and mechanisms they use to cope with the stress.

♀ **Christa Johannsmeier** (expected completion date: August 2007)

Title - The social and economic effects of the disability grant for people with disabilities and their households – a qualitative study in KwaZulu-Natal province

Method – Literature review on social and economic impact of other state grants; seven or eight carefully composed focus groups, spread to include rural, peri-urban and urban areas with between six and nine African people with different types of disability, each group lasting some three hours

Aim – To establish which of the findings of research on the state old age pension can be generalised to those receiving state disability grants. Some key questions are: Is it a mechanism of social and economic inclusion? How does it affect the status of the disabled person within the household? Is the grant income pooled? Who controls its use? How is it used, and especially is it used to buy care, or to seek employment?

The study speaks directly to the state pillar of the care diamond, in terms of assisting people to provide for care for themselves, and it speaks to the interaction between state provision, private care, purchase of private insurance, and the labour market. The main focus is not on care; nevertheless much can be drawn out about care, in this fairly rare study of the impact of the disability grant. This grant is relevant in terms of the topic in that over recent years increasing numbers of HIV infected people have gained access to it.

♀ **Leigh Berg** (expected completion date: August 2007)

Title – A comparative analysis of models to expand early childhood development services

Method – In-depth interviews with key informants in KwaZulu-Natal in the ECD NGO sector, Education Department, the ECD field, and ECD site managers, and especially those who have been involved in or affected by the inclusion of ECD training in the expanded public works programme.

Pertinence to UNRISD Care Project - The study compares home-based, community-based, and school-based models of provision and assesses their costs and benefits both in terms of employment creation for women, and quality of care for young children. It speaks to the state and the 'community' points of the care diamond, as well as to what happens to children's ECD needs when neither of these is present, and when the market does not provide. The government has tried to set up an ambitious programme, but we suspect with little idea at all of what is needed for adequate provision; also, it poses itself as a programme 'for women', but is completely gender-blind or gender-neutral.

This project should supplement both Budlender and Parenzee below, and Wallwork above.

♀ **Bradley Burger** [not yet confirmed, but likely to happen]
This student is doing voluntary work at an AIDS support organisation which relies greatly on the voluntary work of women. He is interested in developing network mapping technique, which looks at how women are drawn in as volunteer carers, their relationship to each other as well as to the leader of the organisation. This would in some ways be similar to the approach proposed in Geneva for network mapping.

There are also a number of studies that have already been completed:

♀ **Sabrina Lee** on how municipal policies on AIDS and on street vendors (most of whom are women) affects street vendors' vulnerability to AIDS, as well as how their caring responsibilities conflict with or can be reconciled with their need to vend. It will be useful as an example of local level of state provision; we too often get fixated on the nation state level, whereas it is local level policies that may impact mostly on women and care work.

♀ **Nina Hunter's** completed and ongoing research on perceptions of family caregivers who are caring for those very ill with HIV/ AIDS, using data from the qualitative component of the KwaZulu-Natal Income Dynamics Study (KIDS), a panel study with three waves so far (1993, 1998, 2003). One paper is an assessment of the government's home-based care policy on real carers, and on the quality of care received by those who are ill. It includes extracts from time-use diaries of a small sample of people caring for those in advanced stages of HIV/ AIDS. The other paper (in progress) is on the perceptions of carers as to their caring role; mostly it is older women caring for younger children or relatives. She is now doing her PhD work on measuring and valuing the costs of caring, drawing from the same research study.

♀ **Sibongile Khosa's** completed study of women participants in the KwaZulu-Natal public works road maintenance programme does not have findings directly related to care work. It is rather an example of a state programme that was designed to a) take the reality of AIDS into account, by offering rotating placements to households; b) directly targets women; c) is designed to allow women to undertake other work at the same time if they wish to.

Beyond the University of KwaZulu-Natal, there are a further three studies on which we plan to draw:

♀ **Debbie Budlender and Penny Parenzee** (expected completion mid-2007)
This exploratory research, funded by the New York-based Social Sciences Research Council, aims to document progress in implementing the Expanded Public Works Programme (EPWP) in the area of home and community based care. (The research will touch to a smaller extent on the EPWP in respect of early childhood development, which is what the Leigh Berg masters research covers.) Methods include documentary review (government budgets, annual reports, and other research) as well as interviews with government officials in two provinces.

- ♀ Completed research by the **Children's Institute and Centre for Actuarial Research** on the foster care grant as a way of providing for AIDS orphans, in which Debbie Budlender was a co-researcher. The research argues that the foster care grant is theoretically intended to provide for children with special care needs, such as those that have been abused, but is also being used as a poverty-alleviating grant for children orphaned by AIDS.
- ♀ Ongoing research by Andries du Toit of the University of Western Cape in Khayelitsha and in the Eastern Cape on kinship links and how these come into play in respect of care.

Debbie Budlender & Francie Lund
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