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The Gendered Character of Social Care in the Non-Profit Sector in South Africa

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ACRONYMS

AIDS   Acquired Immune Deficiency Syndrome

CBO   Community Based Organizations

ECD   Early Childhood Development

EPWP   Extended Public Works Programme

FBO   Faith Based Organizations

HCBC   Home and Community Based Care

HIV   Human Immunodeficiency Virus

NPO   Non Profit Organizations

PSC   Public Service Contractors

ACKNOWLEDGEMENTS

INTRODUCTION

Since non-profit organisations (NPOs) are the major providers of care services for particular target groups in South Africa, especially in poor communities, they are conceived of by government as their main partners in the delivery of services. Over the past decade, various public policies have been adopted and implemented, and this has resulted in increasing numbers of paid and unpaid care workers – many of whom are volunteers – performing care work in a wide range of programmes funded by both government and private donors. This trend has been accelerated by the need to respond to the enormous HIV and AIDS crisis in the country. High poverty levels and rising unemployment have increased the burden of care of poor families, households and communities, with women carrying the greatest responsibility in domestic life. This situation is exacerbated by inadequate and ineffective public services that contribute to the burden of care and gender exclusion.

The gender dynamics of care in the South African NPO sector has not been systematically analysed although there is an emerging awareness among some NPOs of the gendered nature of care (Palitza 2009).

This paper forms a small part of a larger global cross-national study of gender and care commissioned by the United Nations Research Institute for Social Development. The larger study has as its aim to develop a better conceptual understanding of the gendered character of care in all sectors of society. The focus of this thematic paper is on the non-profit sector in South Africa with particular reference to care services delivered at the community level. NPOs constitute one component – alongside the state, the market and families/households – of the overall institutional arrangement providing care; this arrangement is referred to as the "care diamond" (Razavi 2007). This thematic paper works from the assumption that the South African NPO sector consists of a diverse cluster of care providers that are often loosely referred to as the 'community' or 'voluntary' or 'non-market' sector (Razavi 2007). Limited knowledge and understanding exists of what the differences are between the various types of NPOs, specifically with regards to their relations with government and donors. More specifically the objectives of this thematic paper are as follows:

- to explore existing policies and legislation that provide the mandate for the implementation of social care programmes by the non-profit sector;
- to understand the working relationships between, on the one hand, government and the non-profit sector, and on the other between donors and the non-profit sector and how this sector's care work is influenced by government and donors; and
- to examine the gender dynamics of care in NPOs in relation to the nature and scope of the care programmes being implemented by voluntary organisations: the gender profile of carers and beneficiaries, remuneration, incentives, recruitment and perceptions of care providers.

Defining NPOs and the focus of the paper

For the purposes of this study, adapted criteria defined by Swilling and Russell (2002:7) were adopted to describe the NPO sector as:

- **Organised:** including both formally and informally organised NPOs with a relative persistence of goals, structures and activities and excluding *ad hoc* or temporary groups.
- **Private:** excluding government structures but able to receive funds from government or be contracted by government to deliver services/development activities.
- **Self-governing:** (relatively) autonomous, in control of its own activities and able to develop its own rules or protocols of operation.
- **Non-profit distributing:** generated profits are reinvested in the organisation to achieve the mission of being a public benefit organisation.
- **Voluntary:** no compulsion to participate in activities.

While registration as an NPO in terms of the NPO Act of 1998 is a requirement to receive public funds from most government departments, both registered and unregistered organisations were considered in this review. The focus of the paper is, however, on NPOs delivering welfare services in the community, specifically to children and the elderly.

There are three reasons for this choice of focus:
- Firstly, the voluntary welfare sector has an established tradition of service delivery.
- Secondly, these organisations provide the largest infrastructure of care services nationally through different types of non-governmental organisations (or NPOs) that have different institutional relations with the state, foreign and local donors and with civil society organisations.
- Thirdly, the vast historical backlogs in the delivery of health and welfare services coupled with pressures to respond to the care needs arising from the HIV and AIDS pandemic resulted to some extent in the adoption and implementation of community-based care strategies by voluntary organisations including community-based organisations (CBOs).
- Fourthly, the passage of new legislation in the post-apartheid era, including an ambitious Children's Act, requires a broader range of services to be provided, and will require an even greater contribution than before by NPOs.

The majority of professionals, paraprofessionals and informal community carers and volunteers in this sector are women engaged in either paid or unpaid work. This study aims to provide a rich overview of the character of care services and the gender dynamics of care in the sector. NPOs operating in the welfare sector are diverse and have varying contractual relations with the state and donor agencies; these NPOs include public service contractors (PSCs), donor-funded NPOs, faith-based organisations (FBOs) and CBOs. Some organisations fall into more than one of these categories. Many, for example, receive contracts from government as well as receive donor funds. Moreover, most FBOs will be reliant to some extent on donors.

NPOs gender and care

I take the view that NPOs constitute a distinct category of civil society and form an integral part of the pluralist institutional arrangements in South Africa. NPOs are authorised in terms of various policies and legislation to deliver particular types of care services in the community. However, the fluidity or intersection between the domestic (family) and the public (state and civil society) spheres is acknowledged as care roles are often carried over from the private to the public spheres (Phillips 2002).

A gendered analysis of care is informed by the following key ideas. Gender is socially constructed and is based on socially acquired notions of what are appropriate expectations and responsibilities for men and women in a society in relation to, among others, the provision of care of families, children, older persons, people with physical and mental disabilities and chronic illnesses.

Since mainly women provide care in the private domain (family/household), NPOs, FBOs and participants in informal community-based organisations by and large consider it acceptable and appropriate for women to provide care services in their communities.

Subsequently, gender divisions are reinforced within NPOs, with the burden of care increasingly falling on women especially because of the HIV and AIDS epidemic (Patel et al 2007). The gendered nature of care work in the welfare NPO sector has remained largely unacknowledged possibly because it mimics and does not distinguish itself from the trend of unequal gender relations and power inequalities between men and women in the society at large.

However, NPOs *do* provide an important space for women in communities to participate in development activities, which may lead to the further empowerment of women. Phillips (2002) argues that civil society organisations may be more attractive than the state or market to feminists because they are diverse, are loosely structured and provide room for unheard voices and counter discourses that may be transformative in nature. Therefore, it can be asked whether feminism is more likely to flourish in NPOs engaged in care work and where women are able to use these spaces to advocate for improved care services for beneficiaries and for greater material and non-material benefits for themselves.

South Africa's welfare regime

Briefly summarised, South Africa's developmental welfare regime is characterised by a pluralist model consisting of state dominance in the financing of welfare services with NPOs or third sector dominance in the delivery of services.

Two ideas under-gird the welfare regime:
- Firstly, it is informed by communitarian thinking and a community development approach to service delivery described as the "process by which communities collaborate with government and voluntary organisations to enhance their well-being" (Hall and Midlgey 2004). The community is viewed as the context and locus

of social service delivery (including care services) for people with intensive care needs. The community is seen as the local sphere "where the day-to-day lives of people are lived, and where there is a direct interface between the personal, household, family [and] neighbourhood and where social, economic and political processes take place" (Patel 2005:159).

- The second idea shaping the welfare policy regime is the notion that service provision should be family-centred. 'Family' is defined in the *White Paper for Social Welfare* as "individuals who either by contract or [informal] agreement choose to live together intimately and function as a unit in a social and economic system". Various family forms and structures are recognised including cultural and religious diversity (Department of Welfare and Population Development, 1997:93). This formulation leaves the definition open (Hassim 2006) and explicitly recognises that households are made up of different family forms that constitute the basic unit of society. The policy takes perhaps too functionalist a view of family roles and responsibilities with limited attention paid to the gender division of labour and the burden of care that this might place on women. Sevenhuijsen et al (2003:299) argue that national welfare policy "should be positioned in notions of citizenship rather than family or community" and that "care should be deprivatized and made a common concern" that is "centrally placed in human life".

Limited research on the gender perspective of voluntary welfare organisations has been conducted in South Africa. It is these issues that are addressed in this thematic paper with a view to developing insights that could promote greater gender equity and social development.

Research design

The research was of an exploratory descriptive nature and involved desktop research, focus groups, key informant interviews and or feedback via emails. The literature search involved the collection of relevant policies and legislation including published and unpublished literature such as organisational reports and documents. Two focus group discussions were conducted, one in the urban Gauteng province, which is the country's economic heartland, and one in the rural Limpopo province, one of the country's three poorest.

These provinces were selected in order to be inclusive of the wide social disparities that exist between urban and rural services and contexts. The participants in the focus groups were either (i) community caregivers, staff and/or volunteers of NPOs delivering community-based care services or (ii) actively involved in the provision of care to orphaned and vulnerable children, services to the elderly, people with disabilities and people affected by HIV and AIDS.

The invitation to participate in the focus group in Gauteng was widely distributed to welfare NPOs. Five organisations were represented, the majority of which worked with children. One of the respondents also came from a government department engaged in funding welfare services.

The Limpopo focus group consisted of 21 participants who were actively involved in the community care programmes of Aged-in-Action, a national umbrella organisation delivering services, such as residential and community care services, to the elderly. The work of Aged-in-Action in this province is, however, more community-based than their programmes in urban areas, with many of the respondents engaged in clubs for the aged, home and community-based care and the delivery of services to older persons and children in their care.

While it can be argued that the fact that the focus groups' participants were representative of organisations working largely with older persons (Limpopo) and children (Gauteng) that may have skewed the data, the main target groups served by welfare NPOs (Patel et al 2008) were nevertheless covered.

The focus groups were facilitated by the principal researcher, and discussions were initiated according to a specific set of questions (see Appendix A). The focus groups were transcribed and analysed according to the research aim and objectives. Key staff members/consultants who participated in the focus groups provided additional information on the different types of NPOs engaged in care programmes, and informants from government as well as researchers were also consulted. For a full list of focus group participants and key informants, please refer to Appendix B.

The triangulated data collected via the literature study, focus groups and from key informants are presented in an integrated fashion according to the study's aims and objectives.

Structure

The paper is structured as follows: Part 1 provides an overview of social welfare in South Africa and traces the development of state-voluntary service relations in social welfare and social policy in a post apartheid context. Part 2 captures the gender and social development context and challenges; it also highlights the care needs of children and the elderly, with particular reference to the demands arising from the HIV and AIDS pandemic. This section also provides an overview of NPOs in South Africa. Policy, legislation and key national strategies pertinent to the provision of care-related services are outlined in Part 3. The focus here is on policy and legislation for children and the elderly, including national government strategies for early childhood development (ECD) and home and community-based care (HCBC) supported by the Expanded Public Works Programme (EPWP). Part 4 includes a discussion of the institutional characteristics of NPOs in social care with reference to the different types of NPOs. The gender characteristics and dynamics of care are discussed in Part 5 followed by the conclusions in Part 6.

PART 1   SOCIAL WELFARE IN SOUTH AFRICA

Colonialism and apartheid

Pre-colonial South Africa relied on women, mutual aid, kinship, communalism and community support systems to meet human needs (McKendrick 1990). Male dominance marked patriarchal and patrilineal kinship group relations and authority over land, headship of households and the well-being of children. Women occupied a junior position in patriarchal society accompanied by the sex-based division of labour, which preceded colonialism, apartheid, and a class-based system. Women remained responsible for social reproduction and for the care of the family within the kinship system (see Walker 1982).

Dutch and British colonialism changed the socio-economic organisation of the South African society, resulting in the erosion of the subsistence economy and traditional African family systems of support. Gold and diamond mining was the main driver of industrialisation; it was made possible by cheap migrant labour and influx control that relied on women in the reserves and a familial and communal system of care. Women in the reserves became the *de facto* heads of households; they also carried the main burden of care of the young and old and the sick and disabled. The migrant labour system gave rise to a sexual imbalance between town and country in the early 20th century, and this undermined the stability and the organisation of traditional African family structures (see Bozzoli 1991 and Walker 1982).

Social welfare provision for Africans was non-existent. Rudimentary provision emerged in British colonies through the Colonial Development and Welfare acts giving rise to the establishment of public welfare administrations in South Africa in the early parts of the 20th century; the administration was fashioned on a poor relief philosophy of caring for the 'worthy poor'. Services were also provided by missionaries and charities established by the settlers or educated local elites. Formed as early as 1904, women's charitable associations, such as the Afrikaanse Christelike Vrouevereniging, played a leading role in responding to the needs of poor white families and orphans. This was followed by the formation of the first child welfare society in Cape Town in 1908 and in Johannesburg in 1909 (Potgieter 1998). These societies marked the establishment of the first formal voluntary welfare organisations in the country, many of which continue to deliver welfare services in present day South Africa.

The early to middle parts of the 20th century also brought about significant changes to the position of the African woman because of the decline of the reserve subsistence economies. Women began to escape from the oppressive conditions in the reserves and entered wage labour, mainly domestic labour in the urban areas that was "merely an extension of their domestic work into the public wage sphere", where they were employed in the least skilled jobs with the lowest pay (Walker 1982:14). Gradually African and white women became engaged in other sectors of the economy, including traditionally female professions such as teaching, nursing and later social work; these professions were seen as extensions of women's maternal and care roles in the domestic sphere. Nevertheless, these experiences

thrust women into wider social engagement in a range of women's, religious, voluntary, welfare and political organisations and trade unions that were organised along racial lines.

By the 1920s, urban poverty and associated social problems among whites began to receive increasing attention. The new government formed after the Union in 1910 searched for ways to build a stable white society and to mitigate the competition and conflict between white and black workers for employment. The Carnegie Commission of Enquiry into the 'poor white' problem culminated in the adoption and implementation of far-reaching proposals that laid the basis for public social welfare provision, extensive social investment programmes and employment in the public service. The basis was laid for the creation of a racially differentiated and inequitable welfare system that favoured whites after the Nationalist Party came to power in 1948 in a class alliance of Afrikaners with a strong support base among white workers. Public welfare policies for whites became more expansive and redistributive whereas policy for blacks was residual or non-existent (Patel 1992, 2005).

Apartheid social welfare provision was characterised by a partnership between the state and the voluntary sector, philanthropy and religious organisations (McKendrick 1990) in which Afrikaner women's and religious organisations played a key role. Services were delivered on an unequal and racial basis. Voluntary organisations were the preferred delivery agencies of the apartheid government. These voluntary organisations gained valuable experience and built up an infrastructure and capacity to deliver public social welfare services on behalf of government over many years. Financing policies mandated the financing of welfare services based on financial norms and standards for racially differentiated services in a range of fields such as child and family welfare, mental health, crime and rehabilitation of offenders, substance abuse and services for various types of chronic illnesses, among others.

Today, these organisations continue to play a key role in the delivery of welfare services in the post-apartheid era. A parallel voluntary sector took root in the 1980s through grassroots women's, youth and civic and community-based development organisations aligned with opposition movements. Many of these organisations were localised, informal CBOs and larger NPOs funded by foreign donors. By and large, these organisations were a response to state failure to meet the needs of the people. Alternative models of service delivery emerged from these initiatives and informed post apartheid developmental welfare policy (Patel 1992). A major challenge for post-apartheid policy makers was to create an integrated voluntary sector of NPOs made up of these two types of NPOs with different political traditions.

Post apartheid social welfare policy

The Mandela government's policy approach was based on a liberal constitution that upheld individual rights and promoted social transformation through the Bill of Rights, which included the right to equality with strong provisions promoting gender equity and social and economic rights. Following the first democratic elections in 1994, the Reconstruction and Development Programme was adopted and provided the policy framework for the new government. Briefly, the policy was based on a combination of development approaches: the basic needs approach, the alternative development approach with its focus on pro-poor policies and people-centred development, and economic growth with redistribution. All this was central to the national project of nation building and reconciling past imbalances in order to 'heal the wounds of the past'. The settlement also involved a compromise of different classes, political parties, trade unions and interest groups. In view of South Africa's long tradition of civil society engagement, a participatory approach to social and economic development was widely endorsed.

These ideas and principles informed the *White Paper for Social Welfare* with its developmental approach to social welfare policy. The Paper was adopted by parliament in 1997.

There is general consensus among South African researchers that South Africa's welfare system does not fit neatly into Esping-Anderson's (1990) conservative, liberal and social democratic welfare state regimes (Patel 2005; Seekings 2005). The country has a diversity of development strategies that combine some features of corporatism (Swilling and Russell 2002), market-based strategies and social investment emphasising productivist elements, which include redistributive strategies.

The focus of welfare policy is, however, directed at realising benefits for the most disadvantaged. A leading role for the state in promoting social and economic development was envisaged by the Reconstruction and Development Programme, and the *White Paper for Social Welfare* proposed a partnership between the state, NPOs, families/households and communities and the private market (welfare pluralism or a mixed economy of social welfare). The precise balance between these components in the welfare architecture was not clearly spelled out.

Early in the term of office of the Mandela government, the growth, employment and redistribution strategy called GEAR was adopted. GEAR can be described as a voluntary structural adjustment programme of some sort designed to promote economic growth, the management of debt and the budget deficit, and introduced inflation targets. GEAR also advocated privatisation and the liberalisation of the economy. Clearly South Africa was not unaffected by the global diffusion of neo-liberal ideas.

The GEAR policy was a market-oriented policy criticised for sacrificing the government's social goals at the expense of its economic goals. While this was true to a large extent, the picture was a contradictory one as there was no large-scale contraction of overall social

spending on health, education and welfare. In addition, some new social protection programmes, such as the Child Support Grant, were rolled out. Low economic growth rates also played a role in limiting fiscal spending. Growth rates were sluggish at about 1.7 per cent in the early years of the Mandela administration although they improved to a high of 5 per cent by 2006. After 2000, government social spending increased in line with improved growth levels although spending levels were kept within limits to manage debt. Current growth projections have been set at under 2 per cent in 2009 in light of the impact of the global economic crisis.

South Africa's social policy package is well documented and critiqued (see for instance Budlender and Lund 2007) and will not be covered here in detail. Briefly, the social package is made up theoretically, but not in practice, of universal access to primary health care and basic compulsory education up to 15 years. Although this does not amount to universal free education, 60 per cent of schools in poor areas are designated 'non fee paying' schools, and it is government policy that no child should be excluded from education because of an inability to pay. Social security and welfare services are intended to provide social protection for children, youth and families, the elderly, people with disabilities and people with chronic illnesses, among others. The person responsible for a person with a physical or mental condition requiring care is eligible for a grant in aid subject to a means test. In addition to a large publicly funded social assistance programme with demonstrated redistributive impacts, selective targeted housing policies and public works programmes also exist. Many of the care-related programmes are provided through the small social welfare services budget and HCBC programmes delivered by the departments of Health and Social Development with some measures, such as primary school nutrition, being provided by the Department of Education. ECD programmes are provided by the Department of Social Development up to four years of age, and a compulsory reception year was introduced and is still being rolled out for five-year-olds as part of a school readiness preparation programme that is administered by the Department of Education.

In all these areas, significant achievements have been noted in deracialising public policy and delivery and in the introduction of legislation. Increasing access to basic education has been highly successful with more than 90 per cent of children of school-going age in school. Social assistance has been significantly expanded from reaching 3 million beneficiaries in 1995 to 12 million in 2008. There are many policy gaps, and significant delivery failures exist due to a range of inter-locking factors of an institutional, fiscal, human resource, public management and delivery nature, the scope of which are beyond this paper. Although gender equity features prominently across the board with women identified in some of the key programmes – including public works, health and social welfare – as the targeted beneficiaries, a gendered analysis of social care did not under-gird social welfare policies. The *White Paper for Social Welfare* (Department of Welfare and Population Development 1997) was more focused on meeting women's needs rather than the social relations constraining women and the gendered nature of social reproduction in the private domain. Community-based development is widely advocated, but no real account was taken at the time of the unpaid labour of women in the provision of care in communities (see Hassim 2006). The policy has also been criticised for containing a range of gendered assumptions that inserts care into a familialist and communitarian approach

without questioning the implications of these approaches for the achievement of gender equity (see Sevenhuijsen et al 2003 for a fuller discussion of the critique). The nature of NPO care strategies and their dynamics are examined further in the discussion on the gendered character of care.

PART 2 GENDER AND SOCIAL DEVELOPMENT CHALLENGES

South Africa is described as an emerging market economy and a new democracy with a population in 2005 of 47.9 million people. The gender distribution of the population is more or less equal. Post-apartheid South Africa has had low rates of economic growth after 1994 followed by significant improvements since 2004 of up to 5 per cent. However, as noted above, the international economic crisis has resulted in much lower rates predicted for the coming year.

Despite the country's classification as a lower middle-income country, South Africa's human development performance has declined significantly as a result of the HIV and AIDS pandemic reaching levels equivalent to that attained in 1980 (UNDP 2007/2008). South Africa has a medium range Human Development Index ranking of 0.674 and was placed 121 out of 177 countries in 2005. The declining human development situation is also accompanied by increasing levels of income inequality in the society (Seekings 2007) and unacceptably high poverty rates. Income poverty increased from 34.2 per cent of the population in 1993 to 36 per cent in 2000 (world development indicators cited in Budlender and Lund 2007).

With regard to gender disparities, South Africa does not fare well when its gender-related development index is compared with its Human Development Index values. This is the case for all countries in the world, but South Africa does appear to have high levels of gender disparities. The gender-related development index measures the same dimensions as the Human Development Index but captures inequalities in achievement between women and men. Out of 156 countries of which figures are known for both indices, 85 countries had a better ratio than South Africa.

However, since 1994 higher levels of gender empowerment have been recorded with increasing political participation of women and growing female economic activity. According to the UNDP, 46 per cent of females aged 15 years and older are engaged in economic activity, compared to 54 per cent of males (UNDP 2007/2008)[1]. Women are, however, over represented in the services sector of the economy (79 per cent) relative to men (54 per cent) with women engaged largely in low paid and unskilled work (UNDP 2007/2008). The estimated earned income for women was $6 927 (PPP US$ in 2005) in comparison with men, whose earned income was estimated to be $15 446 (PPP US$).

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[1] The data sources are drawn primarily from the UNDP's Human Development Report 2007/2008 – Country Fact Sheets on South Africa http://hdrstats.undp./org/countries/country_fact_sheets/cty_fs_ZAF.html. Data are also drawn from Budlender and Lund 2007.

Unemployment rates are also higher for women, coming in at around 30.7 per cent in 2006 with African women being worse off compared to white women. Overall literacy rates have improved since 1994 but women's literacy rates in 2005 were still slightly lower than that of men (80.9 per cent for women and 84.1 for men). There are, however, no major differences between men and women in relation to combined primary, secondary and tertiary enrolment rates. Fertility rates in South Africa have also declined to 2.8 in 2005 (UNDP 2007/2008), a fact that has implications for private care burdens. These figures do, however, mask racial and class disparities between women of different race groups with white and Indian women faring better then African and coloured women on most of the indicators. Due to labour migration to urban areas, geographic disparities are also significant as poverty levels remain higher in the rural provinces made up disproportionately of women and children, older persons and people with disabilities.

The composition of households is changing with only a third of households (34.5 per cent) conforming to the nuclear family norm. The remaining 25.7 per cent are made up of a middle generation with no children; 20 per cent are three-generational households with children, middle and older persons; 8.8 per cent consist of older persons only, and 6.8 per cent are made up of middle and older people. Child-headed households make up 0.5 per cent of the total number of 12.7 million households in South Africa with households consisting of children and older person households making up 3.1 per cent of the total (Budlender and Lund 2007). The Bureau for Market Research's population and households projections 2001-2021 (BMR 2007) also show that households are being reconfigured and include more relatives than previously, possibly as a way of pooling resources and to share care responsibilities. The report indicates that nuclear households have decreased from 24,2 per cent in 1996 to 17,7 per cent in 2006 (the figures are lower than those cited by Budlender and Lund which is based on 2006 data only). A similar trend is also being observed for single-parent households that have decreased by 2.6 per cent over the same period. However, households made up of couples, children and other relatives increased by 2.4 per cent; single parents with other relatives increased by 5.8 per cent and heads and other relatives by 4.5 per cent. This provides important insight into the changing patterns in household composition, particularly in relation to the types of households in which children and the elderly find themselves.

This cursory overview of the key gender and social development indicators highlight the main challenges facing South Africa in relation to achieving both social development and gender equity. An in-depth discussion of the social, economic and political context including the socio-demographic trends and their implications for social policy and social care is well documented in Budlender and Lund (2007). Since the focus of this paper is on NPOs engaged in meeting the care needs of children and the elderly especially in light of the HIV and AIDS pandemic, some of the key social care trends are briefly summarised below.

The challenge of care

The HIV prevalence rate in 2008 was 21.5 per cent (IndexMundi 2008), which has far-reaching implications for the care of adults who are ill and the care of children and the

elderly in need of care. In the 20 to 46 age bracket, which constitutes the primary reproductive and productive years, more women (21.6 per cent) are infected with HIV and AIDS than men (15.4 per cent). Budlender and Lund (2007) estimated the number of people who were AIDS-sick and not on anti-retroviral drugs to be around 500,000 in 2005. As more people receive treatment, the numbers in need of intensive care will decline. Effective treatment coupled with a significant slow down of new infection rates could reduce the burden of care. About 40,000 babies are infected perinatally as a result of mother-to-child-transmission of HIV with a further 25,000 being infected due to breast feeding (ASSA model cited in Budlender and Lund 2007:16). In addition, the care needs of children have increased significantly with approximately 3.8 million children being 'orphaned' largely due to the HIV and AIDS pandemic (Meintjes et al 2008). This figure includes maternal, paternal and double orphans with the number of orphaned children increasing by 4 per cent between 2002 and 2006. The number of double orphans are, however, smaller in comparison with other types of orphans. This scenario demonstrates the extent of the care burden of the HIV and AIDS pandemic, which is being borne largely by women who may be either the mothers of the children, relatives or grandmothers.

The HIV and AIDS pandemic, coupled with high poverty levels in households with children under 18 years, increases the economic and personal pressures on already poor households that are struggling to survive. Just over half of children live in ultra poor households with a monthly income of less than R800 while two-thirds of children are living below the poverty line of R1 200 per month (Leatt 2006). Of particular significance are the care needs of young children because of the feminisation of the labour market, the growing numbers of women working in informal employment and the large numbers of female-headed households with young children.

Limited formal ECD programmes exist for low-income groups. Only 5 per cent of children under three and 15 per cent of children aged three and four are being catered for in organised ECD care out of a cohort of 5,1 million (Biersteker 2007) (see ECD section under Part 3).

Despite declining fertility and life expectancy levels, South Africa's overall population as well as its ageing population is growing. In 2000, persons older than 60 years made up 2.8 million (7 per cent) of the overall population. This number is expected to increase to 4.6 million (11 per cent) by 2025 (Department of Social Development cited in Patel 2005). The white population is significantly older than the rest of the population but the majority of the elderly are African; white older persons make up 23 per cent of the population over 60. There are also more women than men among the elderly with 43 per cent of women aged 65 or more being widowed compared with about 12 per cent of older men (Noumbissi and Zuberi 2003). Inadequate retirement provision, poverty, lack of access to basic services, health care, food insecurity and a lack of affordable accommodation are some of the challenges facing older persons. The growing HIV and AIDS pandemic has resulted in the loss of the middle generation, leaving the elderly more vulnerable to a lack of care.

In conclusion, this review demonstrates the enormous social development challenges facing a post-apartheid society 15 years after the creation of a democracy. While some progress

has been made in achieving gender equity in terms of certain indicators, significant challenges remain. To a large extent, the HIV and AIDS pandemic has resulted in the reversal of some of the country's human development trends and has increased the pressure on government and the society at large to meet the growing demand for care and to reverse the progression of the epidemic.

The non-profit sector in South Africa

NPOs in post apartheid South Africa face many challenges as some foreign donor funding was redirected to government after 1994. NPOs also lost staff to government in this period and continue to lose staff as government salaries are increased, while subsidies for NPOs are not. A more constrained fiscal and donor funding environment in the latter part of the 1990s resulted in the closure of many NGOs operating in sectors such as social services and development. Some also probably lost their *raison d'être* after the demise of apartheid and found it difficult to adapt to the changed conditions although this occurred to a lesser extent among welfare NPOs than among others, as they are older and more established.

The Non-profit Organisations Act 71 of 1997 created enabling legislation and taxation policies to support the sector. The legislation provides for voluntary registration of NPOs and incentives to register in order to realise tax benefits and to win the confidence of prospective donors. This benefit has been realised mainly by larger, more established NPOs as opposed to informal CBOs (Umhlaba Development Services 2006).

The size of the NPO sector has grown significantly since the first study of the size and scope of the sector was conducted in the early 1990s (Dangor 1997; Honey and Bonbright 1993). The most recent research on the size and scope of the sector (Swilling and Russell 2002) estimated the number of NPOs to be 98 920 organisations with NPOs contributing 1.2 per cent to gross domestic product in 1998. NPOs employ an equivalent of 645 316 full-time employees, which is greater than the number of employees in many major sectors of the economy. The NPOs surveyed were involved mainly in the social services (23 per cent), culture and recreation (20.8 per cent) and development and housing sectors (20.6 per cent). Smaller numbers were involved in religious organisations (11 per cent), advocacy and politics (6.9 per cent) and health (6.6 per cent). The race and gender profile in welfare NPOs is discussed in Part 4.

Swilling and Russell (2002) estimated the number of volunteers in 1999 to be 1.5 million; this figure represented 316,991 full-time jobs and accounted for 49 per cent of the non-profit workforce, which is well above the international average. Volunteer labour was estimated to be worth R5.1 billion in 1999. Much of this volunteer work was executed in sectors such as culture, recreation and the social services, including religious social services and social care. Everatt and Solanki (2005) also found high levels of giving by South Africans based on a national survey in which 17 per cent of the respondents indicated that they volunteered time to a charity or other social cause with no payment in the month preceding the interviews in October/November 2003; if this figure is extrapolated to the whole population, it amounts to 4.6 million people volunteering their time. The figure is significantly higher than the Swilling and Russell estimate, but the authors indicated that it was derived in a different way.

While more women volunteered than men, Everatt and Solanki (2005) did not find a significant gender gap between the volunteers, although women tended to give more time to volunteering than men. The average number of hours volunteered was 2.2 hours per month for women in comparison with 1.7 hours per month for men. Poor respondents (23 per cent) were found to volunteer more than non-poor people with rural-dwellers volunteering the most (23 per cent) followed by people living in informal dwellings in small towns (16 per cent). The majority of volunteers were also black (70 per cent) which includes Africans, coloureds and Indians with 30 per cent being white which is high relative to the national population (9.5 per cent). Poor respondents are more likely to volunteer than the non poor according to Everatt and Solanki (2008). This is contrary to previous assumptions that volunteers were mainly white and came from more priviledged socio-economic backgrounds (Patel et al 2007; Everatt and Solanki 2005, 2008). In Gauteng, where the focus groups were conducted, volunteering was estimated to be between 11 and 13 per cent of the population (Everatt and Solanki 2008; de Wet et al 2008), and in Limpopo it was estimated to be 26 per cent (Everatt and Solanki, 2008). Causes for which respondents volunteered were among others: religious causes (60 per cent), the 'poor' (31 per cent), HIV/AIDS (23 per cent), children (18 per cent), the elderly (19 per cent), the homeless (15 per cent), people with disabilities (13 per cent) and victims of violence (5 per cent).

Individual giving is also highly valued by South Africans with 54 per cent of individuals making largely financial contributions and some contributions in kind to charitable NPOs or other social causes (Everatt and Solanki 2008). South Africans mobilise almost R930 million in an average month, which amounts to 2.2 per cent of the total monthly income of the overall working age population in 2001 (Everatt and Solanki 2008). Two-thirds are reportedly motivated by feelings of human solidarity, want to address poverty or are involved for religious reasons. A further third of respondents also cared for the children of relatives in their homes (Everatt and Solanki, 2008).

NPOs are some of the main beneficiaries of corporate philanthropy or corporate social investment. Approximately R3 billion was invested for development action in 2007 (Habib and Maharaj 2008).

PART 3   CARE RELATED LEGISLATION, POLICIES AND STRATEGIES

Relevant care related policy, legislation and key national strategies are discussed in this section. The focus is legislation and policies for children and the elderly including national strategies on ECD and HCBC supported by the EPWP. These are key policy frameworks and strategies within which NPOs deliver care related services.

Children: policy and legislation

The Children's Act 38 of 2005, the Children's Amendment Act of 2007 and the draft regulations to the Acts give effect to the rights of children contained in the Constitution.

The legislation is comprehensive, and only a few aspects pertinent to gender and care are explicitly identified. The Act takes a broad definition of 'care' (see Section 1(a)-(i)) and defines it as the promotion of the social, emotional, physical and intellectual development of children including the material maintenance and care responsibilities of parents in the raising of children.

Parental rights and responsibilities are defined in terms of meeting children's care needs and protecting them from harm. The legislation attempts to respond to the realities of the HIV and AIDS pandemic, the changing composition of households and the diversity of family forms prevailing in South Africa today. In this respect it recognises not only parental rights in broad terms, but also the rights of biological mothers, whether married or unmarried, and the rights and responsibilities of married and unmarried fathers.

The term 'caregiver' is considered to describe a person other than the parent or guardian who actually cares for a child. This may include foster parents, persons who care for children with the consent of the parents or who care for children in shelters, centres/facilities. It includes child and youth care workers and children who are heads of child-headed households. There is also recognition of the role of family members in the care of children, including persons who are unrelated but are significant in the lives of children. In this way, the legislation shifts away from the dominance of the nuclear family form and recognises relatives and significant others in the lives of children.

Despite these progressive and proactive provisions in the new legislation, it continues to mirror some of the features of the Anglo American child protection model that is well established in South Africa's child welfare system (Schmid 2008). Briefly, the legislation provides for extensive court procedures to protect children at risk that require social workers to process court applications for alternative care arrangements such as foster and institutional care. This system of child protection is considered to be both remedial and residual. It also places the responsibility on parents, which in practice refers to the responsibility of mothers. The child protection system is implemented through complex statutory procedures that are adversarial and investigative in nature (see Schmid 2008 for comparative systems of child protection). The legislation makes extensive provision for child protection, which constitutes a large proportion of the services delivered by child welfare agencies (Patel et al 2008; Child Welfare South Africa 2007).

Prevention of social problems and addressing the systemic conditions that lead to the need for child protection received limited attention in the new legislation leading to what Giese (2008) describes as a vicious cycle undermining services for children. A lack of funding for community-oriented services and a lack of human resources with the appropriate skills to deliver the full spectrum of services provided for in the legislation are other barriers.

The model informing the legislation is a very costly one estimated to have amounted to between R6 billion (low cost scenario) and R42 697 billion (high cost scenario) in year one of implementation (Barberton 2006). Spending levels in 2007/2008 for welfare services show an increase of 32 per cent over the 2002/03 budget. There are also considerable provincial variations with provinces with the largest child poverty rates spending the least. Expenditures vary between 8.0 per cent in the North West Province (rural) and 31.3 per

cent in Gauteng (urban). The main cost driver in the implementation of the legislation is personnel costs, which account for the growth in the welfare services budget of about 22 per cent per annum between 2005/06 and 2008/09 (Republic of South Africa National Treasury 2006).

Social workers are the main implementers of the legislation. In 2006 there were 12 252 registered social workers in South Africa, and only about 5 000 of them were employed by government and NPOs to deliver services to children (Lofell et al 2008). The low cost scenario identified the need for an additional 16 504 social workers and in the high-end scenario, a need for 66 329 social workers was identified. NPOs are also losing staff to government in view of higher salaries paid in the public sector. Successful international recruitment of social workers has also resulted in a loss of human resource capacity with a fair number being recruited to practise in the United Kingdom, particularly in social care jobs.

Furthermore, foster care placements have increased by 700 per cent between 2002 and 2007 due to the impact of the HIV and AIDS pandemic. Foster care has, in fact, become a poverty reduction strategy and not a child protection measure. A recent study of welfare NPOs also confirmed the trend that social workers are spending more time on implementing statutory child protection services that are labour intensive and costly to implement. The placement of children in institutional care has also increased (Patel et al 2008). When statutory intervention is a front line response rather than a procedure resorted to in exceptional cases, as is the case in South Africa, it raises serious questions about the viability of the child protection model under-girding the legislation.

National policy provides for the expansion of capacity through increasing the use of other categories of social service personnel to lower levels of workers such as paraprofessionals, child and youth care workers, community development workers and social auxiliary workers. However, progress in this direction has been slow.

Early childhood development (ECD)

The Children's Act and related legislation provide for the delivery of ECD services, which are referred to as partial care (day care) for children up to 4 years. ECD services are defined in the legislation as including those services offered by someone other than the child's parent or caregiver. Key objectives of the Act are firstly to support and strengthen families and households caring for young children and secondly, to strengthen and develop community structures that could assist in the provision of care and in the protection of children. Promotion of child well-being and early intervention and prevention are other objectives of the legislation although Biersteker (2007) points out that the emphasis is rather on protection from harm than on the social investment potential of ECD and on the gender and development outcomes that could be realised through ECD provision.

Registered, centre-based ECD programmes dominate and are delivered largely by NPOs of which a small proportion receive a state subsidy per child amounting to R9 per child per day (Biersteker 2007) with some provincial variations. Provision of this subsidy is based on a means test and conditional on the child attending for each day for which the subsidy is

provided. These services only cover a small proportion of children in this cohort (see Biersteker 2008). The majority of ECD practitioners in centre-based programmes are women (Biersteker 2007). ECD programmes receive state funding but also raise funds from fees and fundraising initiatives. Corporate donors do not make a significant contribution to NPOs for ECD programmes and, the numbers of volunteers in ECD initiatives are low, as the programmes are often perceived to be commercially driven (Biersteker 2007). Where foreign donors fund ECD, they tend to fund the establishment costs of programmes as these are perceived to be more tangible investments.

NPOs engaged in home, community-based ECD programmes and childminding in support of poor and vulnerable babies and young children play a key role in meeting the demand for services. State funding for non-centre-based programmes of this kind is low (Carter et al 2008), and current national and provincial budgets do not provide a breakdown for expenditure on ECD. Only registered NPOs qualify for a state subsidy, which means that large numbers of informal community-based NPOs that find it difficult to navigate their way through the complex procedures and stringent health standards set by provincial and local governments are excluded. Three spheres of government are involved with different requirements, norms and standards and financial awards; this bureaucracy makes it difficult for home and community-based programmes to obtain the certification and funding. Non-centre-based programmes are not included in the ECD guidelines of the legislation and regulations to the Acts and no government funding norms and standards exist to support these programmes. Data on the numbers of children in home and community care are not available. While it is known that large numbers of children are cared for by child minders who care for up to six children in a home or a back yard shack on their property, it is unclear how many children are cared for in such circumstances. These services are common in urban areas where some of these home care arrangements grow and become home-based crèches that fall outside the regulatory framework. Childminders are organised by a national association with the majority of carers being women.

The lack of research on children in this cohort, high poverty levels and HIV and AIDS prevalence point to a desperate need to increase access to both centre-based services and home and community-based care (Carter et al 2008). The demand for affordable day care for poor children is growing from working women, primary caregivers of children and from women engaged in subsistence activities in the informal sector. Here again, the HIV and AIDS pandemic has resulted in particular needs for care such as caregivers who are not well enough to take care of the children themselves or grandmothers who are caring for young children who may need respite care. There is also an additional demand for care of children who are HIV infected; this demand is estimated to represent 3.7 per cent of the 5.6 million children in the 0 to 4 year cohort (Biersteker 2007).

In view of this scenario, the National Integrated Plan for Early Childhood Development in South Africa was adopted in 2005. This plan commits government to the "massification" of ECD provision and to the strengthening of home and community-based interventions for young children. The plan is an inter-sectoral programme that promotes the development of young children through multiple strategies such as direct services to meet the varied needs of children, training of caregivers, education of parents and primary caregivers of children who are not their parents, promoting community development and participation and public

awareness programmes around ECD issues. The target groups include children younger than 4 and children in poor communities who are vulnerable, such as orphaned children, children with special needs, children affected by HIV and AIDS and children from dysfunctional families. A new personnel category – a community development worker - was created in the public service to facilitate these programmes at provincial level. NPOs were identified as key partners to deliver the bulk of the ECD services, especially in poor areas. Increased government support would be provided through subsidies. Funding was provided through the EPWP discussed below, but far from sufficient to meet the ambitious goals of the Plan.

The *White Paper on Early Childhood Education* (2001) expanded access to basic education for 5-year-olds through the provision of universal access to a reception year (Grade R). By incorporating this age group, large numbers have been absorbed into the educational system through a publicly subsidised programme.

EPWP (ECD and Home and Community Based Care (HCBC)

Launched in 2004, the EPWP created one million jobs by 2008, a year earlier than envisaged with the potential for expansion in the future. Women are specifically targeted and make up the largest beneficiary group (60 per cent) followed by youth (30 per cent) and people with disabilities (2 per cent) among others. The first phase of the programme aimed at alleviating poverty and unemployment. Based on the success of the first phase and lessons learnt, the EPWP is being scaled up over the next five years. The EPWP's next goal is to create two million full time equivalent jobs for poor and unemployed people and to contribute to halving unemployment by 2014 through the delivery of public and community services.

The first phase of the EPWP created employment in home and community-based care and in ECD. In the HCBC component of the programme, the plan was to create 122 240 work opportunities of which 14 per cent was to be learnerships to be established in collaboration with the departments of Health and Social Development and the Health and Welfare Sector Education Authority. The ECD programme planned to skill 19 800 practitioners with the view to increasing their capacity to generate income and improve the quality of care and learning of children. This training was to be provided by the Department of Education in partnership with the training authority responsible for education. It was envisaged that 2.9 million people would have access through HCBC services and 400,000 children would be serviced by various ECD sites and trained practitioners.

As far as the roles between government and its NPOs partners are concerned, national government sets the regulatory framework for the EPWP and allocates funds for the programme. Provinces are responsible for the implementation and monitoring of the programme. Provinces in turn fund NPOs to deliver the bulk of the services via grants and subsidies. The NPO partners are responsible for the signing of an employment contract with the EPWP participants, adhering to the programme norms and standards, managing and administering the programme and meeting reporting requirements. The NPO partners' key responsibilities are training and learnership programme facilitation and exit counselling. These responsibilities involve the recruitment of unemployed people and volunteers

providing them with on the job experience, paying stipends and training them for relevant qualifications and possible long-term income opportunities[2].

Older persons: policy and legislation

The Older Persons Act 13 of 2006 seeks to address the plight of the elderly by establishing a legal framework aimed at their empowerment, protection and the promotion and maintenance of their status, rights, well-being, safety and security. The Act regulates the delivery of community-based services, the management of residential facilities providing 24 hour care for the elderly, respite care and their protection from harm and abuse. The protection of the elderly involves statutory processes that may be initiated by social workers or health professionals. These bear some similarity to the provisions pertaining to child protection, although the scope is more limited. Regulations to the Act set minimum standards for the delivery of all the services including home and community-based care services.

Chapter 3 of the Act deals with community-based care and support services. The aim of this provision is to ensure that older persons reside at home as long as possible (s10(a)), pursue opportunities for full development (s10(b)) and benefit from family and community care and protection in accordance with society's cultural values (10(c)). The main shift in the legislation is from residential care (old age homes) that was the preferred option under the Aged Persons Act of 1967 towards incorporating community and home-based care. In 1995, residential facilities were the main mode of service provision for senior white citizens; those who resided in old age homes amounted to
87 per cent of the total welfare services budget (Department of Welfare and Population Development 1997).
Section 8 of the Act mandates government to fund NPOs to deliver services and to enter into contracts with service providers and prescribes the conditions for NPOs to receive funds and to meet accounting standards. A range of programmes are contemplated; these include meeting their social, recreational, spiritual and physical needs through to supporting productive activities/livelihoods, promoting intergenerational support from family members, rehabilitation and frail care. Provision is made for the registration of community-based care and support services and home-based care. Home carers have to be trained and social and health workers need to be registered practitioners. Care worker complements at residential facilities (retirement homes) should ideally include professionals (social workers and health professionals) and volunteer care workers. Data on the number of staff engaged in service delivery and volunteer care could not be obtained.

Currently, just over 2 million elderly people receive non-contributory old age pensions; these constitute 19 per cent of the total number of social grant beneficiaries. The programme is selectively targeted based on a means test and is estimated to reach more than 80 per cent of elderly citizens in South Africa, most of whom are African. The grants are well targeted, gender-sensitive and reach deep rural areas providing much needed support to extended families as a result of the pooling of household resources (see Lund

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[2] See www.epwp.gov.za, accessed on 18 May 2009.

2006). Previously, women accessed the grant at an earlier age than men, but these provisions have now been changed with both sexes qualifying at 60 years although the programme is being phased progressively. Old age pensions support the care of older persons in the family/household and the community. In addition to social security, spending on care and services for older persons is estimated to amount to 14 per cent of the total welfare services budget in 2008/09. It is the second highest expenditure with childcare and protection services and services to families (34 per cent) having a first call on public revenue (Republic of South Africa National Treasury 2006).

PART 4   INSTITUTIONAL CHARACTERISTICS OF NPOS IN SOCIAL CARE

Four types of NPOs that operate in the social services field can be identified:
- PSCs, or NPOs that deliver services on behalf of government,
- donor funded NPOs that are not reliant on government for their main source of funding,
- FBOs, which tend to be a hybrid of the first two types and
- CBOs, most of which are not funded by government or donors directly but are partners with intermediary NPOs in the delivery of services.

The funding sources or sponsors distinguish between the different types of NPOs although there are large overlaps between categories. CBOs distinguish themselves from the other types of NPOs by the nature of their partner relations with PSCs and donor funded NPOs. The different types are outlined below in order to develop a better understanding of the working relationships between NPOs, government and donors and how their work is influenced by their sponsors.

Public service contractors (PSCs)

It is estimated that between 2 089 and 4 000 NPOs (based on audit of data by Patel et al 2008 and figures supplied by National Council of Social Services) deliver services on behalf of government via provincial governments. A recent study by Patel et al (2008) provides insight into the nature and profile of these organisations. This study is briefly summarised below.

PSCs are largely formally organised, registered NPOs, and 80 per cent of them have been in existence for between 21 and 80 years. The main types of services delivered are services to children and families, care of the elderly and care and support of families. Other beneficiaries of PSCs include individuals who are vulnerable due to substance abuse, crime prevention programmes and rehabilitation and support programmes aimed at people with physical and mental disabilities.

Regarding collaboration with other NPOs in the delivery of services, 69 per cent of PSCs indicated they collaborate with other NPOs in their area of operation, 59 per cent work with community or self-help groups and 35 per cent with CBOs. They also liaise with local authorities (59 per cent) around infrastructure needs and provincial governments (80 per cent) mainly in relation to the funding of services. Only 6.4 per cent collaborated with international NGOs.

Key changes have occurred in the profile of these organisations over the past decade: beneficiaries are now mostly black and come from poor communities, governing boards are more diverse in terms of race and gender, and staff is more representative of the communities being served. However, services continue to be largely urban-based (83 per cent) and located mainly in Gauteng and the Western Cape, while slightly over half are operating in rural areas. Service users continue to be largely women, although more men (24 per cent) are beginning to use the services. The nature of services delivered continues to reflect past patterns with remedial, statutory and institutional services dominating, especially in the delivery of child protection services.

In relation to the elderly, the focus is on institutional provision mainly in urban areas. However, in a rural province such as Limpopo, NPOs such as Age-in-Action are beginning to make the shift to community-based services. Box 1 below describes the workings of a community-based care programme, who the carers are and how this type of NPO works with local community organisations in a rural setting.

Box 1: NPOs delivering services to older persons in Limpopo

Limpopo is a rural province and one of the poorest provinces in the country with large numbers of children living in households that have incomes of less than R1 200 per month. It also has the largest number of children living in child-headed households (Meintjes, John-Langba and Berry 2008:64). Services for the elderly are underdeveloped with the lowest per capita spending nationally on services for the elderly.

Age-in-Action is a national NPO that is contracted mainly by provincial governments to deliver services. The organisation has established more than 10 000 community clubs for the elderly on a national basis. In Limpopo, Age-in-Action affiliates deliver a range of services such as education and awareness programmes to mitigate elder abuse, intergenerational projects that encourage young people in the community to support and value older persons, sport and recreation and home and community-based care. The Limpopo Age-in-Action delivers services via its affiliates and the Limpopo Older Persons Forum; these associates have large numbers of clubs, community groups, religious and self-help groups affiliated to them. Through these community organisations, they recruit volunteers and carers and provide training for care workers. The majority of the carers are unpaid volunteers. Some of the volunteers are older persons while many are unemployed women who are eager to volunteer in order to gain work experience and training as a stepping-stone to gaining access to employment. Most of the training is not accredited. Where funds are available from government for HCBC, the organisation pays stipends to carers. No information was available on the numbers of carers and volunteers

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and how many were paid stipends.

The community carers visit those in their care three to four days per week, which amounts to between 16 and 24 hours per week. They assist with bathing, food preparation, medication and referral to government agencies where there are problems with grants and other services. Since the carers live in the community, they have easy access to households in need, but it also places them under pressure to be available at all times.

Sources: Limpopo focus group; interview with Thomson Sithole, director of Age- in-Action, Limpopo

Funding and contracting

Many welfare NPOs are highly dependent on government for their core funding. They do, however, raise a small percentage of their budgets themselves for specific programmes. A breakdown of the sources of funds are provincial governments (67 per cent), corporate donors (44 per cent), and to a lesser extent international donors (5 per cent) (Patel et al 2008). Local government contributes in the form of infrastructure development support. A small number of welfare organisations charge middle-income groups user fees for specialised services, for example therapeutic family services. Subsidised NPOs delivering ECD services also charge user fees. Government does not set funding criteria or levels for charging user fees for NPOs.

The Department of Social Development is by far the largest contractor of NPOs. Almost 60 per cent of the provincial social development budgets are transferred to NPOs (Republic of South Africa National Treasury 2006). This figure decreased to 53 per cent in 2009/2010 and is projected to increase to 57 per cent in 2011/2012 (Budlender and Proudlock 2009). However, significant variations exist between the provinces with some transferring as little as 30 per cent, largely due to the uneven rural/urban distribution of PSCs. In the rural provinces with limited NPO capacity, provincial governments deliver services directly through regional and district level structures. An extra 15.5 per cent has been budgeted for welfare services over the next three years.

NPOs are responsible for 90 per cent of the operation and management of facilities such as residential facilities for children, older persons (including frail care), people with disabilities and youth in conflict with the law. They also deliver services to more than 60 per cent of the total number of clients served by government and NPOs. Most of the services are of a statutory nature. Subsidised crèches amount to 5 692; a further 3 432 crèches have been identified that are not subsidised. Allocations within social development budgets provide an indication of per capita spending on specific target groups. Per capita spending for child welfare services is R54 excluding social grants while per capita spending on older persons is R147 excluding social grants. Here again there are major differences between the urban and rural provinces; for instance, per capita spending (excluding grants) on older persons in Limpopo is a low R26 while per capita spending in the Western Cape is a high R290 as the latter province has a large number of retirement homes. HIV and AIDS care made up 7.5 per cent of total welfare services spending in 2008/09; increases are

however small (1.7 per cent since 2002/03) relative to the scale of need (Republic of South Africa National Treasury 2006).

Challenges in contracting out of services to NPOs

A major obstacle for PSCs is the lack of funding and resources for care services. Contracted services are not funded at the full cost of services. Subsidies for salaries are low resulting in low remuneration levels for professional PSC staff, mainly social workers, compared to the public sector. This has had negative consequences for recruitment and retention of staff and the quality of service delivery.

Funding norms have not been aligned with the new policy direction, and developmental and preventative services remain under-funded. Other problems relating to government funding are inefficiencies in the management and administration of funding, resulting in NPOs not being able to meet their commitments. Unplanned cutbacks in welfare spending by provincial governments and changing priorities have also impacted negatively on the sustainability of NPOs delivering services on behalf of government.

Different norms across government departments and provinces for the payment of stipends for volunteers and community carers are a major problem for NPOs. This is not only a problem with government funding but also in the funding levels set by donors. An NPO may receive funding from diverse donors that have different policies and funding levels for programmes and the payment of stipends, and reconciling these sometimes conflicting demands has proved a significant challenge.

A lack of co-ordination between government departments and between different spheres of government also present significant challenges for NPO providers. Respondents in the focus groups commented as follows about the challenges:

> "NGOs often have to submit funding proposals to different government departments as they fund different aspects of a programme that we provide. They have different systems, funding levels and reporting requirements, which make our work very cumbersome."

> "The government has thrown responsibility to the third sector (i.e. NPOs) but then insists on a management template that is bureaucratic … leading to the dissipation of the energies of civil society."

Focus group participants highlighted the need for sustainable and dependable public funding for NPOs engaged in the delivery of care services.

Staffing, volunteering and incentives

The race and gender profile of the staff has changed significantly with more black people and women being employed, especially in management positions. Close to 80 per cent of managers in the PSCs surveyed were women, up from 66 per cent a decade ago. There

appears to be greater opportunities for career advancement for women in these types of NPOs although remuneration in this sector is lower than for similar levels in the public and commercial sectors.

National Council of Social Services affiliates appoint far more social workers (76 per cent) than any other kind of employee. Less than a third of the NPOs employed community development workers, 23 per cent employed home-based care workers, 16 per cent employed ECD workers, and child and youth care workers were employed by 15 per cent of the organisations. While social workers remain the dominant professional group, other categories of personnel are emerging in the organisations.

Almost 60 per cent of organisations indicated that they used fewer than 25 volunteers, and 13 per cent used over 100 volunteers. Sixty-seven per cent of the organisations indicated that the volunteers were mainly women, and in a smaller number of organisations there was an equal split between male and female volunteers. This finding may suggest that welfare NPOs delivering services on behalf of government may have a different volunteer profile to the national profile (see Swilling and Russell 2002) because the services are mainly professional services and child protection oriented. Also, historically, middle class women and men served on the boards of organisations and contributed specialist expertise in financial management and service delivery. Almost 40 per cent of the organisations indicated that their volunteers were middle class women.

Stipends for volunteers involved in home- and community-based programmes were received from the departments of Health and Social Development. The Department of Health funded stipends at between R1 000 and R1 250 per month. The Department of Social Development funded stipends at a lower level, between R500 and R750 per month in both Limpopo and Gauteng provinces. The focus group respondents found the differences in stipend levels between the two government departments to be a vexing issue. One of the carers thought that a fair wage was R2 000 per month. One of the respondents was angry about the lack of payment of salaries for carers and the low stipends paid. She said, "There are no incentives, and that is why this work is so difficult."

Most of the carers in Limpopo do not have other forms of paid work; they relied on the stipends for volunteer work as a sole source of income. Some of the volunteers cited lack of work opportunities and boredom as reasons for their engagement in care work. Some respondents in the Limpopo focus group pointed out that a lack of work opportunities can be attributed to the fact that farming activity had dropped severely as a consequence of the drought.

Some said that they try to supplement their income through income-generating activities such as arts and crafts, which they try to sell in their communities and to tourists. Vegetable gardens are also popular and small farming projects are supported by the Department of Agriculture. Some of the volunteers also said that they did not have the time to participate in other work or income generating activities as they worked between eight and ten hours per day, five days per week, which is contrary to the provisions of the Basic Conditions of Employment Act. Their proximity to members of the community who needed their

assistance also made it difficult for them not to be available when needed. Some respondents also used their own meagre resources to pay for transport and food to support beneficiaries in the programmes. The Limpopo projects reported a high volunteer turnover due to the said difficulties.

Other than stipends paid to volunteers, the NPOs also provided training and skills development.

Advocacy and lobbying

NPOs receiving government funding for services are represented by the National Council of Social Services. Through this forum, they engage with government directly around mutual issues of concern. Some NPOs are also part of other national structures such as the Welfare Forum, the National NGO Coalition and the Alliance for Children's Entitlement to Social Security (Acess) that advocate and lobby government around a range of issues. Some of the national agencies also engage with government directly around issues that affect them specifically. In addition to adopting adversarial stances in relation to government, NPOs also participate in consultations in the development and review of policy and legislation. These organisations do walk a tight rope with government as their main funder, and many refrain from publicly challenging government departments, senior officials and politicians out of concern that this may affect their funding negatively or result in poor relations with public officials. In view of the restrictive nature of the mandates within which they operate, there is not much room to engage in innovation or in the flexible application of procedures in their respective programmes. Close to half (47 per cent) of the respondents in the national welfare NPO survey (Patel et al 2008) referred to above agreed that government subsidies directly influence what services they offer. Forty-one per cent agreed that government subsidies directly influence whom they deliver services to.

A participant in this study's Gauteng focus group said that NPOs tend to change their vision, focus and service activities in order to meet government's funding specifications. About 20 per cent in the earlier survey mentioned above indicated that government funding allowed them to expand their services. While some respondents were of the view that their organisations follow the priorities of donors, the majority (95 per cent) felt that they set their own priorities.

Donor funded NPOs

It is unknown how many welfare NPOs that receive limited government funding or none at all, there are; further research on this group is needed. It appears, however, that there are fewer NPOs in this category. Swilling and Russell (2002) estimated that only 11 per cent of social service NPOs were funded by private donors in comparison with 56.5 per cent that were government funded. Overall, the health, environment, development and housing sectors fared better than social service NPOs in securing funding from private donors. This estimation was based on a much smaller sample in Swilling and Russell's study and should be treated cautiously. Private donors include local concerns such as large companies (by way of their corporate social investment programmes), funding agencies

established by government to support NPOs (such as the National Development Agency and the National Lottery) and foreign concerns. These types of NPOs also rely on investment income (4.7 per cent); user fees, sales and dues (2.7 per cent); fundraising and contract work such as training; and, to a lesser extent, research contracts (see Swilling and Russell 2002). Where NPOs do not receive government funding, donor funds constitute the bulk of their income; supplementary income is provided by other sources of funding, which may be very small. Box 1 illustrates what the funding sources are of a donor funded social service programme, Isibindi, and of the relations between the NPO and the donors.

Box 2: Donor funding and donor relations: the Isibindi model
Funded by donors, Isibindi is an innovative community-based programme caring for orphans and vulnerable children. Successful long-term funding partnerships with foreign and local donors have been entered into with committed donors including the United States Pepfar Fund; the Royal Netherlands Embassy and the local Kimberly-based De Beers Fund. The Pepfar-funded Isibindi projects are required by the donor to focus only on children affected by HIV and AIDS, while the De Beers Fund projects are able to focus more broadly on all vulnerable children. According to Zeni Thumbadoo, the director of Isibindi, some donors are willing to make changes to their funding programmes if proposals are well motivated.

The success of the Isibindi model has also attracted funding from provincial government departments in KwaZulu-Natal and the Northern Cape. Funds have been committed from provincial budgets to cover implementation costs of the projects, and in these two provinces, governments departments are actively engaged in rolling out Isibindi projects to under-served communities. Isibindi also received contributions from the public, external donors, religious communities and private corporations. Examples cited were Absa bank, Vodacom and Telkom. These donors tend to fund things that the larger donors do not fund including food parcels and transport costs.
Source: Wilson 2009

The above example also shows how innovation and successful outcomes help NPOs attract funding and influence government to become involved in picking up some of the core funding that many donors are not keen to support. Wilson (2009) stresses the problem of a lack of sustainability of these programmes and the need for government to fund NPOs that are delivering services that fall squarely in its mandate and especially in supporting new areas of service delivery that it has not previously funded. Since donors provide funding for specific focus areas only, NPOs often tend to reconfigure their programmes to fit these foci. The Isibindi case suggests some openness on the part of the donors to new ideas. In this regard, Acess director Patricia Martin states the following:

> "Donors influence our work in as much as we influence their focus and where they put their funding. We enter into partnerships where Acess and donors have common ground around which we can build and advance a comprehensive package [for children]. The direction we take from donors is that we may prioritise the immediacy of a particular element within our mandate in line with funding streams – but we never move outside of our mandate to attract donor funds."

Although donor-funded NPOs represent a much smaller sub-set of welfare NPOs, they are nevertheless influential because they enjoy greater autonomy from government and are able to set their own agendas even though donor agendas are constantly shifting. With the exception of statutory services, these types of NPOs deliver a similar range of services to PSCs, and they also work with PSCs, government and local community organisations. A key difference between the two types of NPOs is that donor-funded NPOs tend to be innovative and are more responsive to local needs, especially where there are gaps in government service delivery.

For instance, paid child and youth care workers at Isibindi supervise and mentor child-headed households, households with AIDS-ill parents and households caring for orphaned children where caregivers are either siblings in their early 20s or grandmothers. The majority (87 per cent) of these child and youth care workers are women between the ages of 31 and 40 who have a grade 12 education. Compared to statutory child protection services, the Isibindi model is more cost efficient, has a wider reach, provides care in the home and community and is more accessible. In addition, it is less reliant on a social worker with a four-year degree to deliver services. Through fairly successful task-shifting to less skilled but well-trained child and youth care workers, positive outcomes have been achieved (see Wilson 2009). Based on this experience, the organisation lobbied successfully for the inclusion of home and community-based supervision of child-headed households in the new children's legislation.

NPOs also influence government policy through forming civil society organisation alliances that advocate for policy change, monitoring government performance and facilitating service delivery partners to address gaps or barriers in realising children's rights. The aforementioned Acess is an NPO that is playing a key role in this area. Comprising an alliance of 1 300 membership organisations committed to making children's rights to comprehensive social security a lived reality, Acess' diverse membership base in both urban and rural areas has positioned it as an important voice for children's rights.

Faith based Organisations (FBOs)

The number of NPOs that could be classified as religious organisations ranged between 16 105 (Swilling and Russell 2002) and 29 000 (Cuthbert cited in Swilling and Russell 2002). The study, however, does not provide an indication of the number of FBOs engaged respectively in social services, health, education and housing and development. Religious philanthropy is widely believed to be extensive; 80 per cent of financial giving from citizens is directed through religious institutions (Maharaj et al 2008:81). The different forms of giving of the various religious communities in South Africa and their contribution to poverty alleviation and development initiatives are well documented in Maharaj et al (2008).

FBOs consist of a hybrid of NPOs that are both PSCs and multi-religious NPOs that have their own structures and ways of organising development activities. FBOs that are PSCs are probably not very different to welfare NPOs in the nature, structure and organisation of

social services. Faith-based NPOs that are relatively independent of government are supported almost entirely by congregation members' donations. South Africa is a multi-religious society with 84 per cent being Christian, 1,5 per cent Muslims and Hindu and 0,2 per cent Jewish. Christian philanthropy is also provided by national ecumenical bodies, such as the South African Council of Churches, responsible for inter-church cooperation and action. With the support of global religious partners, these bodies play a role in social welfare and development, human rights and advocacy for various social justice causes.

Since PSCs were discussed in depth in the previous section, a vignette of the social care initiatives of the Siyababha Trust is presented to deepen our understanding of the workings of an FBO (that is not a PSC) engaged in social care and community development.

Box 3: Siyababha Trust: a vignette of FBO care and community development services

Siyabhabha Trust is the social welfare and development arm of the South African Catholic Bishops Committee (SACBC). It is known as Caritas South Africa and is part of the Caritas International network. All its funding is received through the SACBC and Caritas International. Since 2003, the SACBC has been funding various civil society organisations and projects engaged in social services and development. Two types of structures that engage community-based workers (CBWs) – sodalities (discussed below) and civil society organisations – are responsible for programme implementation. These two programmes are briefly described below. The services delivered by both CBWs and sodalities include care of sick people, orphans and vulnerable children, the elderly and people with disabilities; ECD, home-based care; counselling and education; community health; education and awareness programmes; food provision; food gardens; income generation and poverty relief.

Sodalities
Communities of care that consist of church-based organisations, sodalities deploy largely women (9 out of 10 are women) who are unpaid volunteers. There are 19 national sodalities with a total membership of 65 650. The sodalities are largely urban based with fewer serving communities in the poorer rural provinces.

The sodality member profile is different to that of the CBW. Sodalities are less formally organised, and their members are older. Fewer sodality members receive stipends, and they work fewer hours. They are less likely to be unemployed and are more educated than the average CBW. Members of sodalities are motivated to serve in their communities by strong religious beliefs.

CBWs
Community development activities are spearheaded by 297 NPOs that engage 7 994 CBWs. These organisations have a high level of autonomy in setting local priorities and in mobilising their members to address needs and community concerns.

About 20 per cent of these NPOs are church structures while the rest are NGOs (65 per

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cent), CBOs (9 per cent) and income-generating projects (6 per cent). The CBWs live in the communities in which they serve, have good links with community structures and leaders, are selected because of their commitment and enhance the capacity of employed staff. CBWs are volunteers with half of the workers receiving stipends amounting on average to R500 per month. CBWs were estimated to contribute R36 million in free time to community work for which they are not paid, which makes up 60 per cent of the cost of the total CBW programme. The CBWs are mostly women (only one in ten were men) aged between 20 and 30. They are mostly unemployed single or married women with a large proportion having some high school education. About 35 per cent work fewer than 25 hours per month, while 20 per cent work practically full time. Training is provided through the NPOs, and a few of them have formal volunteer contracts.

Religious character of FBOs
The religious character of FBOs influences the content of programmes. Sister Aine Hughes pointed out that their programmes are value based and are respectful of all other religions and those who do not subscribe to religious beliefs. This ethos shapes their commitment to their work, the manner in which they work with people and in their commitment to the poor. In relation to Siyababha's stance on condom use she reiterated the Pastrol perspective of the church on condom use in the context of the HIV and AIDS pandemic as follows:

"People have a moral obligation to promote and protect life and to take the necessary precautions to preserve themselves from imminent danger. The church accepts that people....may be in danger of contracting HIV/AIDS have a responsibility to protect themselves and use a condom..... The church respects the right of peoples to freedom of choice and does not discriminate against people on the grounds of their particular choice or orientation" (Personal Communication with Sr Aine Hughe, 14 July 2009).

Sources: Siyababha Trust and Mutengo Consulting 2008; Sister Hughes of Siyabhaba,personal correspondence with author, 14 July and 10 April 2009; Gauteng focus group October 2008

CBOs

Studies of the size and scope of the NPO sector indicate that there were between 30 000 and 53 929 CBOs in South Africa in 2002 (Swilling and Russell 2002). This means that just over half of the total number of NPOs falls in this subset of NPOs. This type of NPO is generally unregistered, not as formally organised and operates at a local community level. CBOs are small, locally-based organisations that have limited access to skills or funding. They generally do not employ staff and tend to use volunteers. They are located largely in poor rural and urban townships and informal settlements. The exact size of this sub-set of NPOs is not known, but it is widely accepted that they constitute a substantial proportion of NPOs in South Africa.

Dangor (1997) says that the distinction between NGOs in South Africa is partly historical, reflecting the power differentials between those who had access to funds and those who did not and between those who were localised and had direct relations with communities at grassroots levels and intermediary NPOs. Swilling and Russell (2002) also identify another category of CBOs – survivalist NPOs, found in areas where most people are very poor and barely survive.

Some preliminary insights can be gleaned from the description of the various types of NPOs engaged in social services and care outlined above. PSCs, donor-funded NPOs and FBOs all cited CBOs as their collaborating partners in the delivery of social services, HCBC programmes, ECD and community development efforts. Through their relations with PSCs, donor-funded NPOs and FBOs, the CBOs are able to access resources for their programmes. While the other three types of NPOs employed professional and non-professional staff, the CBOs appear to engage largely volunteers who are community-based carers or care workers with the nomenclature changing depending on the programme. They do have a fairly high level of autonomy to pursue their own priorities, although once they become partners with other intermediary organisations, this may change as they have to work within the mandates and parameters of these programmes.

The care services that the CBOs deliver are fairly standardised across the programmes and include HCBC; care of orphans and vulnerable children, people who are chronically ill and the elderly; HIV and AIDS education and prevention; ECD; food relief; and livelihoods interventions. The numbers of carers and community-based workers varied across the programmes. Carers in CBOs appear to be deeply rooted in communities, have strong face-to-face relations at the local level, are well connected and recruit their volunteers from the communities where they live. They enjoy a high level of trust in the communities that they serve. CBO activities do make a substantial contribution to local social development. Compensation in the form of stipends seems to be paid to roughly half of the participants in the programmes with the remainder receiving no financial compensation for the care work that they perform.

Summary: types of social service NPOs

Four types of NPOs were identified and can be distinguished from one another by the nature of their primary source of funding, which in turn shapes the nature of their relations with the state.

Type 1 NPOs are formal PSCs, which provide services on behalf of government. Large numbers of FBOs (Type 3) are also PSCs, and their profile is not very different to that of other PSCs. PSCs are formally organised, registered NPOs and deliver a wide range of services and facilities including professional services for specific target groups. These organisations are distinguished from the other types of NPOs in that they are highly reliant on the state for funding and operate within strict public sector mandates, bureaucratic procedures and accountability systems. Of the different types of NPOs, they also have the least autonomy to set their own priorities and have limited flexibility in programme

development and implementation because these are based on predetermined national norms and standards.

While donor-funded NPOs (Type 2) and some FBOs funded by religious bodies (Type 3) are also registered and formally organised, they enjoy greater autonomy and flexibility to set their own agendas in terms of what they deliver, where they deliver services and what methods and practices are employed in the delivery of care services. Donor-funded NPOs may be constrained by the priorities and focus of donors leading to the realignment of their programmes with those of donors. However, there appears to be scope for bargaining and mutual influence about programme priorities and direction with donors. In the case of FBOs (Type 3), a religious ethos shapes the character of the FBO and its approach to service delivery.

CBOs (Type 4) are different in many respects to the other types in that they are informally organised and structured, are unlikely to be registered and engage mainly unpaid volunteers to realise their goals. CBOs are deeply rooted in local communities and may also be closely associated with religious and traditional structures. CBOs are perceived as delivery or implementing agencies for government, PSCs, donor funded NPOs and FBOs. In general, they receive their funds for the care work that they perform from the former types of structures, and this may reconfigure CBOs significantly along the lines of the primary funding organisations. This reflects the power differentials between CBOs and other intermediary NPOs who are reliant on CBOs because of their direct access to grassroots communities. How to harness the rich development potential of CBOs while maintaining their comparative advantage remains a key challenge for policy makers and donors. On the one hand, policy and legislation could protect CBOs and care workers from exploitation and lead to increased recognition and the strengthening of CBOs. On the other hand, this may require a level of institutionalisation and formalisation of CBOs that could compromise their authenticity.

PART 5   GENDER CHARACTERISTICS AND DYNAMICS OF CARE IN NPOs

This section is a synthesis of the data gathered through the literature review, focus group discussions and from key informants who are knowledgeable of selected community-based care programmes. It also summarises the data and key themes that emerged from the discussion of the institutional characteristics in the previous section.

Gender profile of carers in NPOs

Across all types of NPOs engaged in direct social welfare service delivery and development programmes, women are the main providers of services and care. Both professional and paraprofessionals across all types of NPOs are largely women with more women than men holding managerial positions. With regard to race and gender, it is also apparent that NPOs employ large numbers of women, the majority them being black, with white women

playing a more prominent role in the management of welfare and health NPOs. Men feature less prominently both in professional and non-professional categories and among volunteers and community care workers. For instance, in the focus groups only three of the community-based programmes had male participants, one programme only had two men out of a total of 28 volunteer carers and another had 16 out of 248.

An HIV and AIDS education programme initiated by the Department of Health had a comparatively high male participation rate. As part of the Men as Partners Programme, men were involved in health education and prevention through a deliberately created men's forum. Although Isibindi actively recruits both men and women for their programmes, only 13 per cent of Isibindi child and youth care workers are men. None of the other programmes represented in the focus groups actively recruited men. While men were active across all types of programme activities, they were involved more in decision-making, committee work, financial matters and programmes that were considered to be 'men's work'.

Information on the gender profile of beneficiaries in the social services programmes was not readily available. Both men and women are the target groups of various social welfare programmes with some programmes, such as the EPWP, specifically targeting women. It is, however, apparent that women beneficiaries constitute a large part of the PSC beneficiary groups (see Patel et al. 2008) and NPOs delivering care services in the home and the community such as in HCBC. This is not unexpected as the main focus of welfare services is on children and families, the elderly and people with chronic illnesses and disabilities where the responsibility for care in the family or at a household level falls squarely on the shoulders of women. Women in need of support with care-related issues might be more inclined to reach out to NPOs, and especially CBOs where they may know the carers, although the converse may also be true because of the privatisation of the issues being addressed. This demonstrates the intersection between the private and the public spheres.

Gender attitudes to social care

Feminists argue that gender attitudes nurtured in the domestic sphere influence the attitudes of both men and women about social care. The levels of male participation in volunteering and in social and community care initiatives are closely related to the nature and type of programme and reflect attitudes about the gender division of care. For instance, home-based care and childcare programmes attract more women while the programmes attracting men are directly targeted at them – for instance HIV and AIDS education and prevention. The gender division in care was probed at length in the Limpopo focus group to gain greater insight into gendered attitudes about care. This is what some of the respondents said:

> "Men are labelled as breadwinners … They feel pressured to bring money home. Some are ashamed to work for nothing … as the head of the family; they must bring something home,"

"Caring is seen as a woman's job, and men do not want to be involved with it."

"Men do not want to mix with women. Handwork is not their job."

Culture and tradition were cited as other reasons why men do not share family duties with women. The main barrier to men's participation in child and youth care projects was the view that it is 'women's work' (Wilson 2009).

The Ntshuxeko Health Development programme actively recruits men. The programme consists of a range of development projects such as life skills, poverty and livelihoods, vegetable production and voluntary counselling and testing. "We are trying to get men to stand up and break the silence about HIV," said one of the focus group participants.

In rural areas where there are limited employment opportunities, male participation appears to be higher than in urban areas where a larger number of men (and women) can find employment.

Motivations for participation in care work

All the participants were in agreement that they were motivated by a desire to help others, to respond to community needs, to access training, learn skills and gain experience with the hope of obtaining employment. These benefits of participation were valued irrespective of gender. Many indicated that they helped others because when *they* are in need, they are able to turn to these organisations for help. Reciprocity was considered very important in participant motivations to help.

One of the other participants said, "I do it out of the goodness of my heart", suggesting an altruistic motive and a willingness to sacrifice payment or stipends as a result. Responding to a question about care work being exploitative, the following responses emerged:

"I do not think care work is exploitative because it makes us happy and we see how the beneficiaries are happy and healthy."

"No, because we willingly do it."

Thus, the intrinsic caring motives of care workers allow NPO employers to easily take advantage of them by paying them less, which resonates with the 'prisoner of love' conceptualisation of care work (England 2005) in relation to paid and unpaid care discussed below.

Community and family support for care workers

Family and community perceptions of care work were also probed in the focus groups. While carers were highly motivated and received acknowledgement from communities being served, participants were of the opinion that the community did not always view care work positively. "They stigmatise volunteers because they are working with people who are

HIV positive," said one of the participants while another said that her "family could not understand why she did not just sit at home and relax and enjoy herself".

Negative community attitudes seem to be influenced by a lack of knowledge about what the carers and volunteers are involved with, and in this respect, the respondents thought that they have an important educational role. A participant from the men's forum said that their work is important because "We are assisting in changing the perception of care work."

In relation to family support for carers, both positive and negative experiences were identified; some partners were critical of their (mostly female partners') involvement and of their alleged neglect of their own households and families. Women also did not think that care work was exploitative and that it was unfair that they should provide care. This might suggest the acceptance of women's caring roles and the normalisation of care work as being 'women's work'.

Recruitment for volunteer community care work took place by word of mouth, through local community structures, churches, clinics and some organisations distributed flyers as part of local recruitment drives. All participants came from local communities. The more formally organised PSCs, donor-funded NPOs and FBOs followed standard recruitment practises for professional positions such as social workers. Attempts were made to recruit more men to do care work, but this proved difficult because of the gendered attitudes about care referred to above.

Paid and unpaid work

Formal welfare NPOs employ various categories of staff such as management, professionals, paraprofessionals, administrative and support staff; these are mainly full-time staff. Volunteers make up a large component with many employed in paraprofessional categories. Budlender's (2008) research on remuneration in welfare organisations found that professional staff members receive the highest pay while paraprofessionals and administrative staff respectively receive around one-sixth and one-third of what professionals earn. Salaries for support staff was way below the minimum salary set for domestic workers. A common occurrence amongst FBOs, the Siyababha Trust being one example, is that their volunteers are not paid as your chosen religion is expected to be the motivation for involvement with care work.

Most of the welfare organisations are in favour of the setting of minimum wage rates for personnel in the welfare sector. The Department of Labour's Employment Conditions Commission is considering developing a sectoral determination for the welfare sector (Budlender 2008).

A pay penalty for social service work in the NPO sector does exist for professional staff, especially for social workers who earn less than their counterparts in government and the private sector (Earle 2008). While information was not readily available for other categories of staff, this nevertheless indicates a bias against care work and the devaluation of care work

Estimates of the number of volunteers deployed by welfare NPOs range between 44 per cent (Budlender 2008) and 60 per cent (Patel et al. 2008), of which half are paraprofessionals (Budlender 2008). Remuneration of volunteers comes in the form of stipends, transport, food and allowances. Stipends are the most common form of payment, but no accurate information exists of the number of volunteer care workers not receiving stipends. No estimate has been made of the cost of unpaid care work among HCBC organisations. The departments of Social Development and Health, donors and FBOs fund stipends; however, different amounts were paid across government departments and NPOs. Stipends vary between R500 and R1 250 per month in a government-funded programme while volunteers caring for orphans and vulnerable children funded by a private foundation receive R850 per month (Gauteng focus group feedback). The hours of work also vary with some working fewer than 25 hours per week. Seventy-nine percent work full time (Budlender 2008). There is a lack of clarity between volunteer work that is unpaid and stipended care work and how one should distinguish between the two. Policy guidelines are being developed to bring HCBC work in line with the Basic Conditions of Employment Act.

All the participants are of the view that they should be paid a stipend as they are 'doing government's work'. They all seem to agree that stipends should be fair and standardised as differentials cause a great deal of conflict in communities. They are of the opinion that the reason that they are not considered to be employed as carers is because volunteering is not recognised as employment in South African labour law. Nevertheless, for some, volunteering in social care is a livelihood strategy; the stipend is small but it provides them with a means of survival.

The participants feel that not only should care work be recognised and subsidised but families should also be supported for the costs incurred from caring for sick people. The Grant-in-Aid programme provides for a small grant to be paid to the caregiver (usually a woman) of a person with a physical or mental disability. The number of beneficiaries of this programme is small relative to other social assistance programmes.

There is a high turnover rate of participants because of low or no remuneration; when participants get paid jobs, they leave. The turnover specifically of women volunteers is considered to be due to the fact that it is expected of them to care for their own families as well as contribute to community care.

Professionalisation, training, accreditation and career paths for care work

The Social Service Professions Act of 1998 provides for the recognition of the profession of social work and a paraprofessional category, social auxiliary workers. Professional boards are being established for community development and child and youth care workers. The National Association of Child and Youth Care Workers has played a key role in promoting the professionalisation of child and youth care workers and improving the standards of care and treatment in family, community and residential settings for troubled

children and youth at risk. The child and youth care workers employed in the Isibindi programme provide training of paraprofessional community care workers. Training for community development workers is also accredited at a paraprofessional level; the standards have not been developed for the professional community development category.

Community carers deployed as part of the EPWP in ECD and HCBC are required to be trained, and this training should be accredited. A learnership programme is provided for, but the numbers of people actually accessing these learnerships are small. While it appears as if training is being provided by NPOs, some of which is funded by government through various programmes, NPOs also fund their own training. It is critical that the training, accreditation and career path opportunities for care work be implemented and accelerated. Policies are in place to facilitate this, but resource constraints and administrative and management problems continue to be barriers to implementation.

Participation and empowerment of women in NPOs

Since the majority of paid and unpaid staff in NPOs are women, these organisations believe that they provide important opportunities for women to participate in setting the agendas, leading and implementing programmes. In this regard, the director of Acess says that they have "created spaces for more women [to participate] and for women's interests to be expressed and fed into policy and service delivery practices". Since Acess is an alliance of NPOs advocating children's rights, which is also a gender issue, they are supporting women in accessing resources and opportunities that will make a difference to the quality of their lives. Acess also facilitates capacity building of NPOs and CBOs and networking between NPOs and between NPOs and government with a view to developing knowledge and expertise to advance their concerns through these networks. Through these structures, women involved in these NPOs will then be able to take forward their concerns, build social networks, advance their own standing in the community as well as contribute to wider community development. Some of the women received awards for community leadership. Not only do these organisations provide spaces for women's voices to be heard in social service and care work, but they are also able to contribute to practices of local democracy in civil society structures (see Phillips 2002).

Gender advocacy in NPOs

All types of NPOs are engaged in one form of advocacy or another and have created their own structures to shape governmental agendas pertinent to the services that they deliver. Although PSCs are less inclined to engage in radical action campaigns, they have organised themselves into forums to represent and articulate their interests. The types of issues being addressed are, among others, policy advocacy, service delivery improvements, rights-based issues, funding and contracting, and salaries and working conditions. The majority do not take up gender issues directly and do not frame these in terms of women's entitlements as part of citizenship rights (Hassim 2006). This issue was explored with Patricia Martin, director of Acess, to gain insight into how Acess takes up gender issues in their advocacy for children's rights.

Martin argues that their "core gender issue is that the well-being of children is essentially a gender concern" in South Africa because women caregivers are responsible for providing for many of South Africa's children. "[They] often lack the means to provide the material support," she explains. She points out that "Support for children goes through women, and our aim is to ensure that women are able to access the support necessary to provide for their children." Women bear the greatest responsibility for the care of children in view of gender-based patterns of care and the breakdown of family life due to historical factors. Acess' advocacy campaign to extend the qualifying age of the Child Support Grant to 18 years has taken on a more explicit gender focus. "Gender prejudice and sexism underlie much of the arguments against the extension of the grant," she says, with opponents of social grants arguing that women abuse the grants and that they provide perverse incentives.

In this regard Budlender (Personal Communication 7 May 2009) noted that the reality is that women bear the burden of caring for children which is more pronounced in South Africa than in other countries. Helping to lessen the burden of care on women should be viewed positively and is not the same as stating that "things are good for women because they are good for children".

While the new anti-poverty programmes in some Latin American countries have incorporated gender equity as a result of feminist advocacy through NPOs, Molyneux (2006) cautions against positioning motherhood as the key to the successful outcome of these programmes. The issue of how women and mothers are positioned in social policies and social development programmes as a means or a conduit to achieving the objectives of social programmes remains contested.

PART 6   CONCLUSION

South Africa's welfare regime is characterised by a pluralist model made up of four sectors that deliver and finance care services. These sectors are the commercial, informal, state and voluntary sectors. The commercial sector caters for those who can afford to pay for care through private savings and private insurance arrangements. The informal sector is largely made up of families and households, relatives, friendship and other networks; this sector remains the main form of support for the majority of people in the country. NPOs contribute significantly to social welfare and development, but the gendered character of NPOs is not widely acknowledged or understood. The welfare NPO sector consists mainly of women carers and beneficiaries, and the implications of this scenario for the delivery of gender sensitive social services has not been seriously considered.

Although the state is conceived of as a funder and direct provider of social welfare services, its contribution to direct service delivery is limited. Social welfare NPOs make up a significant component of the 'care diamond' or welfare mix. These non-governmental organisations have a large infrastructure to deliver services either on behalf of the state or independently and are institutionally authorised by policy and legislation to provide care services to specific target groups with various care needs. Care services range from formal

provision in residential and non-residential facilities to professional social services and informal family, household and community-based services delivered by different types of NPOs that have multifaceted and interlocking relations with the state and donor agencies and among the different types of NPOs. There is, however, a close interconnection between family and household systems of care and services provided by the state and voluntary organisations particularly in HCBC.

Although the four sectors are interconnected and should in theory provide universal coverage, the system is structurally inefficient and ineffective with many people falling through the cracks, especially those with intensive care needs who are poor and live in rural areas. Since PSCs are largely based in urban provinces, an over-reliance on this type of NPO – a delivery vehicle without financial incentives to expand services – will perpetuate unequal access to care services between urban and rural provinces. Unregistered, informal NPOs are at a disadvantage in accessing funds from both government and donors. They have a comparative advantage in being locally based and rooted in communities. However, CBOs rely on volunteers who are largely women and who do much of the care work without payment. The introduction of stipends as part of a strategy to absorb unemployed women engaged in care work may be viewed both positively and negatively. Care work has been and remains largely undervalued. However, 'stipends for care work' may open the door to promoting the recognition of care work, especially in ECD and in HCBC programmes, to support women, grandmothers and female relatives who are the main providers of care. The stipend is low, not standardised, and there is no clear definition of who is eligible for them and how to distinguish between 'real … and ambiguous volunteers' as Lund describes them (Lund 2008:25).

Volunteer care workers in some of the programmes work long hours and perform care work on a full-time basis. There is an urgent need to develop an occupation-specific dispensation to recognise the status of care workers and their rights. Training and career path planning for entry level care work could be a positive development if it is effectively implemented. However, improving the working conditions of unpaid community care workers will by itself not alter the existing gender divisions that exist amongst them. The numbers of men involved in care professions such as social work, auxiliary social work, child and youth care, ECD and home and community-based care is still small. As efforts are made to recruit more men to work in home and community-based care, much can be learnt from the programmes that have been successful in attracting men to join their volunteer corps, particularly those in rural and very traditional communities. Generally, social work services do not involve men directly in intervention programmes. Curricula in the care professions and training programmes for community care workers need to be more gender sensitive.

Remuneration levels in the welfare NPO sector are lower than in the public and commercial sectors. There are two main reasons. Firstly, care work is considered a female occupation, often called 'women's work'. Both men and women in care-related professions therefore pay a penalty for performing care work (England 2005). Secondly, public funding levels for NPOs involved with care work are inadequate. Care work in the public sector is more lucrative, which results in difficulties with staff retention and capacity to deliver quality services in the NPO sector being compromised.

This paper's analysis of wide-ranging programmes shows that women loom large in civil society organisations in the social services. Not only are they leaders and managers, they are the providers of services in large and small NPOs and in many different social and community contexts. Through various forums in civil society, women have shaped policies and legislation and influenced decisions to improve the quality of life for themselves and their communities. Through grassroots participation in community activities women are empowered to contribute to local democracy and development. Whether women use the power gained through these experiences to challenge gender inequality and the division of labour in the home and family is not known.

While advocacy initiatives might not specifically target women, gender issues are addressed in the bigger process of caring for children and other target groups in communities. In this sense, welfare NPOs do provide opportunities for feminism to flourish but for it to be a real force, the gendered nature of social welfare provision will need to be addressed more explicitly by social service NPOs and more broadly supported by women's and social movements.

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LIST OF FOCUS GROUP PARTICIPANTS

GAUTENG FOCUS GROUP	
Name	**Organisation**
Sister Aine Hughes	Siyabhabha Trust /Caritas South Africa
Sophie Okeke	Women of Vision, Department of Social Development
Karuna Singh	Central Gauteng Mental Health Society
Bafana Kunene	National Association of Child Care Workers: Isibindi Project
Thuso Nemugumoni	Multi-Sectoral AIDS Unit
Glenda Conskol	WASG
Jackie Loffell	Johannesburg Child Welfare Society, Gauteng Welfare Social Service and Devel Forum

LIMPOPO FOCUS GROUP	
Name	**Organisation**
Amukelati Florah Chauke	Xikukwani Development Organisation
Tebogo Mapomya	Age-in-Action
Mulaudzi Edzisami	Phiphidi Society for the Care of the Aged
Martha Sikhwari	Makwarela Social for the Aged
M. G. Ralufhe	Tshimo for the Aged
S. N. Magongoa	Mbathitu HBC for Older Persons
Mbedzi Mapul	Tshiudzini Society for the Aged
Anikie Mokoma	Mbathitu
Kelly Modisha	Mbathitu
Anikie Mokoma	Mbathitu
R. G. Baloyi	AIA
Jace Mashitisho	Mmabosemahla
Nancy Letsoalo	Batlaphela Bakone Old Aged Home
Moses Shiviti	Ntshuzeko Health Development
Refilwe Themba	Refilwe Drop in Centre
Rahab Mohlapamfsu	Mmatswele Old Age Day Care
Sellina Phosa	Tsherane Multi-Purpose Centre
Rosina Mazhete	Tsherane Multi-Purpose Centre
N. P. Mphelo	Tsherane Multi-Purpose Centre
Althea Ngele	Ratanang Service for the Aged
Siphiwe Vilikazi	Pholoso Home Based Care

LIST OF KEY INFORMANT INTERVIEWS/EMAIL RESPONSES

Sister Hughes, Siyabhaba Trust, Pretoria   Follow up interview
                                                            31-03-2009

Thomson Sithole, Director of Age-in-Action Limpopo   Follow up interview
                                                            09-04-2009

Patricia Martin, Director of Acess
Alliance for Children's Entitlement to Social Security,
Cape Town   Email response,
                                                            17-03-2009

FOCUS GROUP DISCUSSION SCHEDULE

Title: Understanding the gendered character of social care in the **not-for-profit** sectors in South Africa.

Aim: The aim of the research is understand the gendered character of social care in the non-profit sector in South Africa.

Researcher/faciliator: Leila Patel

Background: NPO sector is diverse and consist of PSCs, donor-funded NPOs, CBOs, and FBOs. With regard to gender, we recognise that the majority of caregivers and providers of social support in communities are women. The study aims to understand the gender dynamics of care better.

Participants of focus groups: Community caregivers and staff of community-based NPOs that have a membership base and that are actively involved in the provision of HIV and Aids care as well as those who provide care for orphaned and vulnerable children, the elderly and/or the disabled have been invited to participate.

The research questions to be addressed are outlined below:

Introduction: Please introduce yourself, your name and the organisation that you come from.

1. **Policy and legislation**
   - Are there specific policies and legislation that you implement in your organisation? e.g. child care legislation; HIV/AIDS, elder care etc.
   - Are these policies facilitative of your work, or do they hinder what you actually do?
   - If yes, explain.
   - Do you think that these policies should be changed? And in which way?

2. Identifying information/profile of the participants and organisation

3. Structure of NPOs delivering community-based services
   - How would you describe your organisation? e.g. are you an NGO, CBO, FBO, community group/club, indigenous structure or something unique to the area in which you work?
   - Do you have a governing body of some sort?
   - Is your organisation loosely organised? Describe how your organisation is organised.
   - Do you employ paid staff? If yes, how many? Are they professionals or non-professionals?
   - How do you organise the actual service delivery? Here we are interested in the structures e.g. committees, volunteers, monitoring of work, management and co-ordination of the tasks.
   - What are the facilitating factors that promote the participation of both men and women in the project?
   - What are the barriers to their participation?
   - We think that fewer men participate in caring. Why is this so?
   - Are there any advantages in using certain structures as compared to others?

4. Relations with government, donors, the private sector and other NPOs

- Who is your main funder?
- Why is this your main funder?
- Do you prefer to work with government or particular donors?
- Do you collaborate with other agencies?
- What working relationships exist between government and your organisation?
- What other contributions do the public, external donors, religious communities and private corporations provide?
- How do these various forms of giving interface with government policy and its agenda?
- Is there any role for international donors? And how does this influence the design of social care programmes?
- Which organisations are able to access external donor funding? What is the impact of this on your programmes/priorities?

5. Gender profile and dynamics of care

- What is the gender profile of the carers in your programme?
- What is the age, educational profile of the carers and their socio-economic status?
- Are they paid for the care work that they do? e.g. is it a salary or a stipend?
- Do they do other forms of paid work?
- What other forms of unpaid care work do they do? E.g. family, neighbours and the community, work in a family business, collect water, shopping, meal preparation etc.
- What other incentives does the organisation provide?
- Do you encounter difficulties with payment of carers? e.g. amount paid; payment of carers *vis a vis* other members of the community, cost to the organisation.
- How did you recruit the participants?
- Why do you think they are doing this type of work? (probing their motivations for doing the work)
- Would they leave if they obtained a formal job?
- What difficulties do you have in managing the carers? E.g. personal caring vs caring for others?
- Are the participants involved in care work in the wider community? If yes, describe this please.
- How do their families and male partners perceive the care work that they do?
- What factors – incentives, training, recognition and socio-cultural factors – motivate carers to work voluntarily?

6. General and conclusions

Do you think care work is exploitative of women? Motivate your answer.
What are the major barriers/enablers for the non-profit sector in the provision of care?
What are the major recommendations to improve social care by the non-profit sector?