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Paid Care Providers in South Africa:

Nurses, Domestic Workers, and Home-Based Care Workers

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ACRONYMS

AIDS	acquired immuno deficiency syndrome
ARV	anti retroviral
APN	associate professional nurse
ASSA	Actuarial Society of South Africa
BCEA	Basic Conditions of Employment Act
CBO	community-based organisation
CCMA	Commission for Conciliation, Mediation and Arbitration
COIDA	Compensation for Occupational Injuries and Diseases Act
COSATU	Congress of South African Trade Unions
DENOSA	Democratic Nursing Organisation of South Africa
DoH	Department of Health
DoSD	Department of Social Development
ECD	Early Childhood Development
EPWP	Expanded Public Works Programme
GDP	Gross Domestic Product
HBC	home-based care worker
HIV	human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
ILO	International Labour Organisation
ITUC	International Trade Union Confederation
LRA	Labour Relations Act
LFS	Labour Force Survey
NEHAWU	National Education, Health and Allied Workers Union???
NGO	non-governmental organization
NPO	non-profit organisation
NQF	National Qualifications Framework
OVC	orphans and other vulnerable children
OAP	old age pension
OSD	Occupation-Specific Dispensation
PN	professional nurse
RVE	Risk, Vulnerability and Employment study
SADSAWU	South African Domestic Service and Allied Workers Union
SANC	South African Nursing Council
TUS	Time Use Survey
UIF	Unemployment Insurance Fund

CONTENTS

1 INTRODUCTION

This is the fourth report on the South Africa research for the care project, and it covers three groups of carers: nurses, domestic workers, and paid and unpaid home-based care workers. The first report, RR1 (Budlender and Lund 2007), gave a country overview; characteristics of poverty and inequality; policy changes over the time of transition to democracy and subsequently; and socio-demographic trends, in particular, characteristics of household composition, fertility and mortality. In the second research report, RR2, Debbie Budlender used the 2000 Time Use Survey to estimate the value in time and money of unpaid care work, and to estimate the involvement of different social groups (using for example sex, age, race, income and employment status) in paid and unpaid care work. She used the valuation estimates for comparisons with the value of paid care work, all paid work, GDP, and taxation (Budlender 2007). The third report, RR3, (Lund 2007) focused on non-household institutions providing care – the state, private sector, and the organized social sector, and to lesser extent informal providers. It attempted to assess the nature and dynamics of 'the care diamond', looking particularly at provision of care for three generations – children, adults of working age, and older people.

This fourth paper considers people working in three occupations where the work is centrally about care: nurses, home-based care workers, and domestic workers. These were selected for a number of reasons. Women are concentrated in these types of work, which provide employment or opportunities for voluntary work for hundreds of thousands of South African women. The work is found in both the public sector and the private formal health sector, as well as in the subsidized not-for-profit welfare sector. Domestic workers work in the private homes of their employers. The selection enables the identification of movement horizontally across and within private and public sectors, for example nurses moving between government and private sector employment. It also enables analysis of vertical movement within a sector, for example when nurses' tasks, formerly restricted to certain professional grades, are shifted downwards towards lowly paid or unpaid women 'volunteers' (so-called 'task shifting'). The three occupations also contain a range of types of employment and work, from very formal and relatively well paid, to thoroughly informal, and low paid and altogether unpaid. They are active on a continuum from the secure, formal employment of professional and assistant professional nurses, to the informal home-based care workers, some of whom are truly volunteers, while others are in an ambiguous and precarious employment position. Domestic workers occupy a position in-between: domestic work in South Africa was regulated fairly recently and there is access to some social security coverage.

The purpose of RR3 was to capture the dynamics that took place between different non-household pillars of provision of care work – the state, the private sector, and community-based organized care. In this paper the focus is on the work that different groups of paid (and some unpaid volunteer) carers do, and the boundaries, some fixed and some changing, within and between these occupational groups. The groups cross all points of the 'care diamond'.

The sources and reliability of the data for each of the selected occupations needs to be noted. Nurses and domestic workers are both captured relatively clearly in the national labour force surveys, and there are supplementary surveys of both these groups as well. There has been no national survey of home-based carers, but this paper has drawn on the growing body of quantitative and qualitative surveys from different parts of the country. Survey sources have been supplemented with interviews with selected informants on all three groups of carers. Thus the main tables and figure have data pertaining to the nurses and domestic workers. While domestic workers are enumerated in the labour force surveys, the surveys probably do

not capture a category of kin members who do domestic work in exchange for 'board and lodging', and nor will they usually capture domestic workers from neighbouring countries who are in the country illegally as it is in the interests both of their employers and themselves not to be 'counted'.

For data analysis, nurses are a relatively straightforward category to deal with. Two main categories – the professional nurses (PNs) and associate professional nurses (APNs) - can be identified in the LFS. A small group of midwives were omitted from the numerical analysis as their numbers are so small. We tried to include a broader range of less skilled health workers, but the numbers for groups such as orderlies were too small.

This paper uses the term home-based care worker (HBC) to mean a non-family member who visits people who need care, mostly in their own homes, but sometimes in community-based facilities, and who is sometimes attached to a health facility such as a clinic. This is clearly distinguishable from the household caregiver, the resident family member who cares for a sick person in that household. The number of HBCs is impossible to estimate accurately. As described by Parenzee and Budlender (2007) in a study of the Home/Community Based Care Programme (HCBC) component of the Expanded Public Works Programme (EPWP), they are found in a number of programmes and departments; their employment position is often ambiguous; there is confusion between 'learnerships' and 'work opportunities'; there is provincial variation in what they are called and how they are categorized; and the line between 'employment' and 'voluntary work' is very fuzzy. This is one of the themes of this paper.

The study takes place in the context of the crisis of the HIV/ AIDS epidemic, and the stresses this has placed on the society as a whole, and on caring work. As reported in RR1, the AIDS and Demographic Model of the Actuarial Society of South Africa (ASSA) estimated that in 2007 there would be 5.5 million people infected with HIV/ AIDS, giving a prevalence rate of 11.4 percent (ASSA model accessed www.assa.org.za 31 March 2005). Prevalence rates are higher among women than men – 21.6 percent of women and 15.4 percent of men in the age group 15 to 49. The epidemic affects poor and rich people, but poorer people are more likely to be infected and less likely to have access to health services, or take up such provision even when it is there. Large numbers of people die each year, and many die in their own private homes or formal and informal hospices as the hospitals and clinics are full. The need for care-giving and for care-receiving is acute. The increased need for care is accompanied by a shortage of trained health personnel: 36 percent of posts for health professionals in the public sector were vacant in 2008, with variation between provinces - 48 percent in the poor rural province of Eastern Cape, compared to 28 percent in urban Gauteng (Health Systems Trust website). Greater use is being made of volunteers and low paid care 'workers', the great majority of whom are women, while at the same there is an exceptionally high unemployment rate among both men and women.

2 CARE WORK IN THE SOUTH AFRICAN LABOUR MARKET

As noted in the first research report in this series (Budlender and Lund 2007), in 2006 about two thirds of men and half of women aged 15 to 64 years old were recorded as being economically active, with about 13.5 million people being in paid employment. There are exceptionally high rates of unemployment in South Africa: again in 2006, 30.7 percent of women and 21.2 percent of men were unemployed, using the strict definition of unemployment. This unemployment happens alongside low rates of self-employment. The

informal economy in South Africa is still relatively small (Devey et al 2007), though a more recent estimate puts it at over 30 percent (Heintz and Posel 2008).

Budlender (2007) assessed the extent of paid care work within total employment in South Africa. Twenty four occupational categories were chosen and used to compare the imputed value of unpaid care work with the remuneration of paid care workers in the economy as a whole. There were some 2.8 million paid care workers in the total of about 13.5 million people in paid employment. Thus paid care workers accounted for a fifth (21 percent) of all employed people, nearly two out of five (38 percent) of employed females, and less than one in ten (9 percent) of employed males.

Domestic workers accounted for over a third (37 percent) of all the care workers, and two fifths of female care workers. The professional nurses and associate professional nurses accounted for 1 percent and five percent respectively. Between them, nurses and domestic workers account for 19 percent of all employment, with female domestic workers constituting 16 percent of all women in employment. There do not appear to have been consistent increases or decreases in the numbers of people working in these occupations between 2000 and 2007.

3 DESCRIPTION OF THE THREE GROUPS OF CARE WORKERS

This section describes some characteristics of the selected groups – how important each group is as a source of employment or work activity for women and for men, and whether they involve work in the public or private sector. It describes who the workers involved are, in terms of sex, age, race, education and marital status.

Numbers in employment
The first point to be made is that large numbers of people, most of whom are women, are employed in these occupational categories. Domestic workers form by far the largest group of the three, with over one million captured in the September 2007 Labour Force Survey. According to the 2000 Income and Expenditure survey, 11 percent of households report spending on domestic workers (falling to 9.5 percent when restricted to households with at least one child 0 – 12).

Table 1 about here

Among all health professionals, nurses are by far the most numerous. Table 1 shows that some 32 PNs and 128 000 APNs were enumerated in the 2007 LFS (after weighting), compared to the next most numerous group, the medical practitioners, where the 45 000 counted in the same LFS were about equally divided between men and women. With regard to social workers, some 11 000 were registered with the South African Council for Social Service Practitioners (the council governing the social and associated workers) in September 2005, of whom 89 percent were women, and half African, and just over a third white (Earle 2007). Not all of these would necessarily be practising. The umbrella council for the health professions, the Health Services Professional Council of South Africa (HSPCA) had 5 300 psychologists and 6500 physiotherapists in their register in 2008 (Health Systems Trust website).

Public and private sector
Domestic workers, by definition, work for private individuals, though some may be employed through employment agencies. The two categories of nurses we deal with work in both public

and private sectors, though the majority are in the public sector: 66 percent of PNs and 71 percent of APNs. Most of these are employed by provincial government (the level known as state government in countries such as India and the USA - that is, not local government, and not national government) - 57 percent of PNs and 58 percent of APNs. A quarter of both PNs (24 percent) and APNs (25 percent) work for the category called 'private business or private household' – it is not possible here to distinguish between those employed in a private hospital, and those employed in someone's private home.

The HBCs are employed in various ways. Most are attached to NGOs, and some of these are subsidized by government via the NGOs contracted by government to employ them (sometimes through the avenue of the EPWP); others are attached to small and informal CBOs and religious groups. Their precarious employment status will appear as a central theme in the discussion.

Sex

As shown in Table 1, nearly all of the nurses and domestic workers are women, and the vast majority is African. Likewise HBCs are largely African women. This is demonstrated in three studies: the systematic sample of a small group of urban and rural carers across KwaZulu-Natal (Hunter 2005); the larger survey done by Community Agency for Social Enquiry (CASE) which included 135 caregivers from 45 sites nationally (Mwite et al 2005); and Wallwork's sample of four types of organisations in Durban area using paid and unpaid volunteers (Wallwork 2007).

Age

Table 1 shows the ages of the nurses and domestic workers. Two thirds of the PNs and 62 percent of the APNs are in their thirties and forties, while the domestic workers are more evenly spread over the thirties, forties and fifties. The CASE study (Mwite et al 2005) of home- and community-based care recorded the ages of 130 HBC caregivers, 91 percent of whom were female. Over a third of them (36 percent) were in their twenties, compared to the lower proportions of nurses and domestic workers in that younger age group – 10, 13 and 17 percent for PNs, APNs and domestic workers respectively (Table 1). Far fewer were in their forties and fifties - about thirty percent, compared to the situation where about half of all the PNs, APNs and domestic workers (52, 51 and 49 percent respectively) were in these age groups.

Race

The racial distribution in the occupational groups reflects the continuing apartheid legacy. While the majority of nurses are African, substantial numbers of white and coloured women, and a few Indian women, also do nursing. While more than half (54 percent) of the PNs, who are the most skilled and educated occupational group are African, this is way below the more than 80 percent of the general population constituted by Africans; whites, however, who constitute just less than 10 percent of the general population, constitute 23 percent of all PNs. Domestic workers are overwhelmingly African (91 percent) with most of the remainder being classified 'coloured'. Though there is no national database on HBCs, they are largely African, with some coloured women as well.

Education

With regard to education, Table 1 reflects, as expected, the higher levels of education of PNs compared to APNs, with 74 percent compared to 59 percent having some tertiary education.

Seventeen percent of the PNs had a first university degree or higher, whereas only three percent of the APNs had this qualification, and none a higher one than this.

The education figures for domestic workers are clearly different to those for the nurses. More than one in ten (11 percent) have no schooling at all (none for the nurses); and the rest are distributed between some primary schooling (35 percent) and some secondary schooling (53 percent).

Education levels for the HBCs are not known in any detail. Their younger ages suggest they may have higher levels of education than domestic workers. It is known that in the Early Childhood Education (ECD) component of the EPWP, applicants must have achieved the first level of the National Qualifications Framework, NQF 1, with a move underway to have this increased to NQF 4 (the equivalent of completed secondary school), as entry level to the programme (Berg, 2007). There appears to be no such requirement for HBCs.

Marital status

Table 1 shows that over half of the nurses, but only 28 percent of the domestic workers, are married, with a further 8 percent of APNs and 14 percent of domestic workers recording that they are living together with a partner. Two fifths of the APNs and the domestic workers (40 percent and 41 percent respectively) have never been married. RR1 (Budlender and Lund 2007) noted that not being married does not mean that women do not have children; unfortunately it is not possible to get the childed status of the nurses and domestic workers from the LFS. The study of over a thousand domestic workers in Johannesburg likewise does not report on whether those surveyed had children or not (Peberdy and Dinat 2005).

4 NATURE OF THE WORK

Nursing

Internationally, nursing is one of the oldest professions for women and has been an important path for security and upward mobility for women. It embraces a range of levels of skills and occupational status, from less trained nursing assistants through to nursing managers with specialized post graduate degrees. There are specialized fields of care, such as midwifery, orthopaedic, psychiatric and geriatric nursing, with specializations demanding further specialized training and accreditation. Though nursing is meant to comprise attending to the total physical, mental and emotional well-being of the patient, and is meant to include preventive, promotive and curative work, in reality the focus of work for the average nurse is attending to the curative needs of ill people, including very basic care tasks (such as feeding people, and cleaning bedpans). It is widely recognized that the higher in the professional hierarchy a nurse is, the less likely she is to be involved in bodily care of a patient.

Four factors are impacting on changes in nursing. First, the current focus on task-shifting is part of an international movement being coordinated through the World Health Organisation, and in South Africa driven by the AIDS crisis (Stevens et al 2008). Second, there is a movement of nurses from the public to the private sector, with an accompanying increase in the number of employment agencies. Third, many South African nurses emigrate to more developed countries; the country also receives nurses from other lower income countries who move here because of better conditions of work, and opportunities in general, than in their home countries. Finally, the last three years have seen a rapid roll-out of ARV therapy (in 2007, about 400 000 people with HIV/ AIDS were receiving ARV therapy, with about the

same number who needed it not yet having access to treatment). This is changing in significant ways the work that many nurses and HBCs have to do (Gentile 2008).

Domestic work

Domestic work takes place in private homes, with a core set of menial tasks of household maintenance. It sometimes also involves aspects of care of children, and may include elements of a nursing role, for example where care of elderly household members is concerned. Thus there is overlap between 'maid', 'cook', 'nanny' and 'nursing assistant'. It may be that there is overlap between tasks done by domestic workers and by HBCs.

Traditionally in South Africa, domestic workers have been employed by rich and poorer white families, and by richer Indian and coloured families. Increasingly, domestic workers are employed by families from all races. There appears to be a possibly large yet undocumented group of African women who work in the households of kin members. They are not formally recognised as domestic workers, but work for the family in exchange for board and lodging. Some move from rural to urban areas in this way; others come from neighbouring countries, where clan names are shared and the idea of 'family' is broad and loosely bounded.

Home-based care work

There has been a proliferation of care workers of different types in the last decade or so. Different terms are used in different ways by different programmes. The terms Community Health Worker (CHW) and Community Based Health Worker (CBHW) are associated more closely with the health sector. CHWs were used in the 1980s in some progressive primary health care schemes especially in rural areas. CHWs were jettisoned by the new government in 1994, and are now re-appearing as a category of worker (Friedman 2002), and we will discuss them in connection with task-shifting. Community Based Worker (CBW) and Home/ Community Based Worker (HCBW) are terms used by the Department of Social Development (DoSD), the government department responsible for leading the two main social programme components of the Expanded Public Works Programmes (EPWPs) – the Early Childhood Development (ECD) programme, and the Home/ Community Based Care (HCBC) programme. A number of non-governmental organizations (NGOs) run HBC programmes, some subsidized by government to do so, and they may use variations of these terms.

The tasks of the HBCs vary from programme to programme, but can cover counselling and spiritual support, training household members in simple nursing tasks, hands-on treatment such as bed sores, surveillance of medication, and provision of resources such as nutrition. In practice, these workers also sometimes do ordinary household chores such as cleaning and cooking as well. They are there to supervise patients in the later stages of AIDS, and to follow up patients who have been discharged. The DoSD's interest in HCBC was originally, and perhaps still is, primarily in respect of support for 'orphans and other vulnerable children' (OVCs) in these households. This represents a difference of focus between the DoSD and the Department of Health (DoH), with the latter health department focusing more on the care for the sick. In all likelihood, the carers being funded concern themselves with both the OVCs and the ill adults, but it is one of the many areas of confusion in this work. HBCs are typically allocated a certain number of households or patients for whom to do care work. One of the important tasks that HBCs workers perform is to help households get access to the pensions and grants that featured in the third research report (Lund 2008): inter alia the pensions for elderly people, and people with disabilities, and children in poor households. One hears anecdotally that this aspect of their work is important to the HBCs, as it is a very practical way in which they can make a difference to those in their care.

5 CONDITIONS OF WORK

The general regulatory regime

Nurses are far and away the most formally regulated of the three occupational groups in this study. They are covered by the national labour relations legislation. In addition, the Nursing Act of 2005 sets out rules for standards, tasks and conduct. The South African Nursing Council (SANC) regulates the nursing profession, based on the Nursing Act and other legislation. The umbrella Health Professions Council of South Africa (HPCSA) regulates all of the health professions.

Table 2 about here

Table 2 shows that in the September 2007 Labour Force Survey, 94 percent of PNs and 93 percent of APNs had a written contract. There are clear rules for dispute settlement; and they are a highly unionised group, with 77 percent of PNs and 74 percent of APNs being members of unions.

Domestic work has moved from being totally unregulated in the past, to being incrementally included in basic conditions of employment legislation in 1994, and in a sectoral determination in 2002, which included the determination of a minimum wage (Budlender 2005). In November 2007 this was R5.24 an hour, which calculates to about R838 for a four-week month of 40 hours per week. It was less than that for contract cleaners at R7.40 for hour, and less than the rate for agricultural workers, R989.90 per month. Basic social security coverage, in the form of unemployment insurance, was also extended to domestic workers at about the same time that the sectoral determination was put in place.

Table 2 shows that in the 2007 LFS, 36 percent of domestic workers said they had a written contract: a half of all the men, and a third of the women. This was a sharp increase on the figure for 2004, which was 25 percent: 19 percent of the men and 27 percent of the women domestic workers (Budlender 2005: 8). This increase almost certainly reflects the impact of the sectoral determination.

Box 1 draws from a focus group discussion with domestic workers held as part of the Risk and Vulnerability in Employment (RVE) Study in the Mtubatuba area of KwaZulu-Natal province in 2003. It was held soon after the sectoral determination for domestic workers and their inclusion in the unemployment insurance, and the research area was a very conservative small town in KwaZulu-Natal, which one would not have expected the legislation to have reached. Four out of the five workers were already covered by unemployment insurance.

Box 1: New legislation and the working conditions of five domestic workers in Mtubatuba, KwaZulu-Natal, October 2003

Hours of work, and the minimum wage

- One said that her employer now does not want to see her in the house after 5pm. She tells her to leave work at 5pm, to follow the new legislation. They signed a contract, which sets out exactly what tasks she has to do in a normal day, and the hours of work, and they follow that. She stated that her employer got these contract forms and other related documents … and sat down with her to sign the contract. She now gets her money in an envelope.
- One stated that there is no change in her wage, it is below the minimum wage and she is still working from Monday to Saturday as she did before the new legislation.* She also said that one day her employer asked her to work on a holiday. She then asked the employer if she was going to pay her for that service and the employer agreed. She then worked and she paid her R10.
- One stated that she does not work on weekends anymore.
- One of them stated that she feels so bad that everyone in this discussion had changes in their working condition. She stated that there have been NO positive changes at all in her work.
- They all stated that they do not want to work on Saturdays and the government has to stop this. They want to go home, as mothers, to spend time with their children and other family members.

Taking leave to attend family funerals

- Four workers said that their employers allow them to take leave when they have to go home for funerals.
- One of them in particular stated that her employer does not have a problem in this regard at all. Her employer would ask her how many days she would need for the funeral, and then she would gladly let her go home.
- One of them said that she had a death in her family and requested her employer to let her go home but she refused. She said that she then decided to go without (the employer's) permission. The employer then said, 'If you go, you make sure that you do not come back here again.' The employee burst into tears. Seeing that, the employer said, 'Continue crying, I do not care. You do not cry blood, you only cry water and salt.' She said that her employer is so insensitive.

*Note: Working six days a week is not illegal.
Source: RVE Project, project documents, held at School of Development Studies, UKZN

Box 1 shows how varied their situations were with regard to the sectoral determination on the minimum wage, and with regard to how employers responded to requests to take leave to attend family funerals; extracts also show that the legislation had had a noticeable effect on their work. Some in the group were learning about their new work rights at evening classes offered by the local offices of the department of labour.

The employment regime of HBCs is very varied. The most informal are unpaid carers, who are not 'employed' although they are working. Examples are volunteers in a religious group, where women provide spiritual counselling to ill people, in their homes, perhaps once or twice a week. At the other end of the continuum are community health workers, with some training, paid by the DoH, and attached to a health team at a clinic. They have a roster of people to be visited each week, guidelines for the work, and their work is monitored and supervised. They receive a 'stipend' or 'honorarium', and are clearly 'employed', though they receive few if any work-related benefits such as pension or health plans.

The number of people doing HBC work has increased, and the employment status of many is ambiguous. In South Africa, workers doing the same work can have widely different rights, depending on who the employer is (Samson 2008). With regard to HBCs, those working

within the same national programme such as the EPWP may have different statuses in different provinces (Parenzee and Budlender 2007). Some provinces follow the Ministerial Determination for Special Public Works Programmes of 2002, which was issued in terms of the Basic Conditions of Employment Act (BCEA) and approved by the National Economic Development and Labour Council, and the associated Code of Good Practice for Employment and Conditions of Work for Special Public Works Programmes. Other provinces do not follow these, and officials at the highest levels in the EPWP were ignorant of both the Determination and the Code (Samson 2008).

Income

In this section we describe the incomes of the selected groups. We then find comparators in non-care occupations with which to compare carers' incomes, in an attempt to explore whether there is a 'care penalty' in South Africa. Do those working in care-related occupations face a relative wage penalty, receiving lower hourly pay than they would be predicted to have, based on the characteristics of their jobs, the demands on their skills, and their qualifications?

It is important to note that household size, and whether an earner is the sole earner in the household, affects greatly how far an income has to stretch. Of all employed people in South Africa, 35 percent of women and 44 percent of men are the sole earners in their households. In our selected groups, a large number of the nurses and domestic workers are the sole earners: 48 percent of the PNs, 40 percent of the APNs, and 43 percent of the domestic workers. The mean household size of domestic workers is larger than that of the nurses – 4.8 for the domestic workers, 4.1 for the APNs, and 3.9 for the PNs (LFS 2005). (Unlike surveys in some other countries, 'live-in' domestic workers are not considered as part of the household for whom they work. They are enumerated as belonging to a separate household.) Nevertheless a substantial number of these workers live in households with more than six members – nine percent of the APNs, 13 percent of the PNs, and 26 percent, or more than a quarter, of the domestic workers.

As noted, nurses work in both the public and private health sectors, with the conditions in the private sector having received better salaries than those working for government. Public sector nurses recently received a much-improved remuneration policy in an Occupation-Specific Dispensation (OSD) as a result of the 2007 public sector strike, and also in recognition of the critical shortage of nurses in the public sector. The entry level salary for those in the public sector, after a four year qualification and one year of community service, increased from R86 000 to R106 000 a year; a better career path with more finely grained steps for advancement was introduced, and prior working experience in the private nursing sector was recognized for the first time in determining salary levels. The OSD only relates to those working in government service. However, Netcare, one of the largest private health care companies, has increased its salaries for nurses in line with the OSD. The impact of the OSD on wages, and on reducing the vacant posts in the civil service, will only be known in 2010, two years after the March 2008 implementation (Budlender 2009a).

Labour force survey data show that, as expected, the professional nurses earn more than the associate professional nurses. Fifteen percent of PNs, but only five percent of APNs, are in the income band of R11 001 to R16 000 per month. Both these groups of nurses earn far higher than domestic workers. No domestic workers earn over R3 500 per month; only 18 percent of PNs and 14 percent of APNs earn less that R3 500 per month (and some of these will be part-time workers).

We noted previously that a minimum wage for domestic workers was set in 2002, which was set at R5.24 an hour in November 2007, or R838 per month for a four week month of 40 hours a week (for those who worked a full week for four weeks a month – which many do not). Many domestic workers receive lower than the minimum wage that would be payable for full-time work, with the LFS data being supported in this respect by both Hertz (2005) for national level data, and the study in Johannesburg (Peberdy and Dinat 2005). The earnings of domestic workers are very similar to, though slightly lower than, average earnings of informal sector workers.

Little systematic information could be found about the income of HBCs. There are variations between programmes, and in the same programme but in different provinces. Budlender (2009b) summarises findings from a study (Mitchell 2007) of wages and stipends paid to people engaged in the EPWPs. Caution about reliability of the data is expressed, as some additional benefits may be given to workers (for example in the form of meals or transport); nevertheless, the figures are shocking. Across all programmes rates vary between R9 and R176 a day. People in the social sector programmes (HBCs and ECD workers) get much lower rates - ranging from R9 to R80 – than those in infrastructure programmes (R30 to R120) and environment and culture (R31 to R176). The social sector was the lowest paying, but the periods employed were of longer duration than those on other programmes.

Melanie Samson reports that incomes typically ranged between R500 and R1500 a month (Samson 2008). Volunteers at the hospice in Durban were getting R420 a month for ten days on, ten days off. Thus it is likely that incomes for HBCs are pretty similar to those of domestic workers. In KwaZulu-Natal province, the health department pays Home Based Carers R500 a month and Community Health Workers R1000 a month (Cathy van der Ruit, pers.comm.)

Is there a 'care penalty' in South Africa? We explore this by comparing the starting salaries of the two categories of nurses (who work with people) with those of two categories of engineers and architects (who work with 'things'). We compare professional nurses (91 percent female) with professional engineers/ architects (92 percent male); we compare the associate professional nurses (89 percent female) with the natural and engineering science technicians (68 percent male). The comparisons are appropriate because the occupational coding system is meant to reflect the level of skill; engineers and professional nurses both fall within the 'professional' category; the technicians and associate professional nurses both fall within the 'associated professionals' category. The percentage of workers in each group that has matriculation or more, and at least one degree, confirms that those in the nursing categories have a similar profile to those in the engineering-related categories. If anything the engineering-related workers have lower formal educational qualifications than the nurses.

Table 3 about here

Despite these similarities in educational profiles, Table 3 shows that the engineers tend to earn more than the nurses. While 56 percent of the professional nurses are recorded as earning R6000 or more a month, this is the case for at least 65 percent of the engineers. Comparing the associate professionals, 34 percent of the APNs earn R6000 or more a month, compared to 50 percent of the engineering-related associates. More than a third (36 percent) of the engineering professionals, and 8 percent of the associate engineers earn R16000 or more a month, while only 1 percent of the professional and associate professional nurses do so. These patterns suggest there is a care penalty in South Africa.

Working hours, rest and privacy

The long hours worked by both domestic workers and nurses are well known. Nurses do shift work, and many work at nights, and over weekends. Domestic workers on the other hand typically work in the day only, though this may start before dawn and extend into early evenings, and one day of a weekend. In a study of domestic workers in Gauteng province, respondents worked on average 5.4 days per week; one quarter (26 percent) worked a six day-week and a further fifth (19 percent) a seven-day week (Peberdy and Dinat 2005: 19). Whereas nurses' hours are fixed, those of domestic workers may be varied by the employer, with requests to work later on a particular day, or come in on a weekend day to help with entertainment. This is likely to affect live-in domestic workers particularly, as they are regarded as 'on hand and on call'.

Ironically, though, at the social level, they may have too much privacy. Domestic workers who live in are very isolated. In the Gauteng study, 86 percent of the domestic workers lived away from home, either in their employers' homes, or in accommodation away from their own family homes. Many who lived in were not allowed to receive visitors (Peberdy and Dinat 2005). Daily observation of the suburbs of South African cities shows the importance of religious life to many domestic workers, with groups meeting in parks, and going to churches.

The hours worked by HBCs are likely to be extremely varied. 'Voluntary' work carries the advantage of flexibility. However some studies record that too many households are allocated to each HBC, such that they cannot cover the households allocated to them. Wallwork's study, on the contrary, described how the volunteers themselves tended to want/ feel they needed to work long hours, risking burnout, and it was the supervisors who had to ask them to truncate their hours (Wallwork 2007).

For all of these categories, the work is physically demanding. This is perhaps least so for some of the HBCs however, because of their more variable hours and their more constrained set of tasks, though some also fetch water, turn patients, and do other nursing-type activities. It is likely that it is the lower ranks of nurses who have to do the most physically demanding work.

Additional stress for nurses and HBCs in the context of AIDS has come from having to devote so much time to younger people who have no hope of recovering – as nurses say, 'I did this training in order to heal people, not to help everyone to die'. HBCs report that denial by patients and their families of HIV/ AIDS is a real cause of stress – as they are then unable to talk openly and plan a course of action (Hunter 2005).

Unemployment insurance and medical aid

South Africa has an Unemployment Insurance Fund which covers formal workers. Employers and employees each make a monthly contribution of one percent of wage or salary. Government employees are specifically excluded from this fund (as their employment is secured by other means). As many of the nurses are in the public sector, the 52 percent and 56 percent respectively of PNs and APNs, shown in Table 2, who are covered by UIF is not a good indication of the extent of security. Not shown in the table, of the nurses who are not employed by national or provincial government, 71 percent of the PNs and 84 percent of the APNs report that their employer makes UIF deductions from their pay.

Domestic workers were included in the UIF in 2002, and surprisingly many were registered early on – by April 2003, some 579 000 employers had registered with the fund. Table 2 shows that according to the 2007 LFS, about a third (32 percent) of domestic workers had employers who contributed to the UIF. Furthermore, there are likely to be numbers of domestic workers who themselves choose (illegally, and in collaboration with employers) not to have part of their wage deducted for UIF; present income may be perceived to be more reliable than income from a scheme that is new for them. The extension of the UIF to domestic workers has happened simultaneously with other effects such as written contracts, and greater awareness of employer responsibility to raise the wage annually. Unemployment insurance obviously does not extend to domestic workers from other countries who are illegally in South Africa, or who are not permitted to work in South Africa.

The HBCs will generally not be covered by UIF, because they are not employed or are in informal or ambiguous employment and the code of good practice and ministerial determination specifically state that they will not fall under UIF. However, in her study of different types of HBC schemes, Melanie Samson found one programme where HBCs were registered with the UIF. In this case, an NGO in the health sector was contracted by DoH to employ CBWs, and the state paid the NGO the UIF in addition to the wage for the CBWs. Yet the government still insisted that the care workers were not 'employed' (Samson 2008).

Savings for elderly years

A high proportion of nurses – just less than 90 percent for both PNs and APNs (Table 2) – have employers who contribute to a pension fund. Some may in addition have coverage by their spouses, and some widows may in addition be receiving a widow's pension in case of accidental death or disease related to the late spouses' work.

Table 2 also shows that very few domestic workers – 12 percent – had employer contributions to a pension fund. It is doubtful whether any HBCs have such coverage except perhaps through other family members such as husbands. However most of the domestic workers and the HBCs will know that they can expect to be eligible for the state pension for elderly people, at the age of 60 for women and 65 for men (though the age is in the process of being equalized for both sexes). The present amount of the pension is R1200 per month. About half of all domestic workers earn well below this amount, as, one imagines, will almost all of the HBCs. This pension is a vital source of support for older women and for their households, is relatively reliable, and can be planned for (Lund 2002). It secures them their place in the household, and moreover enables them to continue to care for others (Schatz and Ogunmefun 2007).

Burial societies, both formal and informal, play a large role in the perception of security of South Africans. Many belong to more than one, and they offer a range of services, from simple coverage of mortuary, coffin and burial fees, to coverage of catering for the event, and educational insurance for children. In a very real sense, this is a form of savings. Very poor people are not able to afford membership of either burial schemes or rotating credit associations (Lund and Ardington 2006: 45). We do not know the extent to which nurses and domestic workers belong to these societies.

Relationship to employers

In both the private and public sectors, the nursing profession is precisely and hierarchically controlled, with clear procedures and lines of authority. It is stiff and formal, but has the virtue of being transparent. At the other end of the formal/ informal continuum, many HBCs have no recognisable employer, though all will be accountable in some degree to the programme in which they are active. Others, receiving a stipend, honorarium, or wage are in a more clear relationship to the person supervising them, though the conditions of work may not be clear, nor their access to dispute resolution mechanisms.

Domestic workers work in the private domain of households, in a clearly subordinate position, in terms of class and power relationships, with a threat to employment if they raise problems, and this in an environment of very high unemployment. At the same time, however, the person most directly involved with the domestic worker is likely to be a woman, and for some domestics and their employers, relationships of affection, psychosocial support and reciprocal obligation develop over time, in what may become a mutually caring relationship.

Especially in this time of HIV/ AIDS, where so many domestic workers and their families are affected and infected, the resource flows from employers to domestic workers may be significantly under-estimated in surveys. If the domestic worker relationship is only ever looked at as extractive and exploitative, then one is not able to understand the complexity of care work, of how women themselves can transform these relationships in supportive ways, and of what lies beneath the surface of 'the care diamond'. At the same time, some of the comments in Box 1 show the extreme lack of care and concern that prevails, and this is more likely to be 'typical' in the employer-employee relationship.

Safety

There are different aspects to the safety of paid (and unpaid) care workers, including getting to and from the place of work, safety as they go about their work, and safety issues arising from the work tasks. With regard to *getting to and from the place of work*, apartheid forced a great distance between the place of work and the place of residence of the majority of South Africans, and this distance still exist today. Black South Africans were forced in to townships in the periphery of urban areas, and to the rural Bantustan areas. Public transport is inadequate, unreliable, hazardous and expensive. Some nurses may live in nurses' residences, especially those working in rural hospitals, and will not have such transport problems. Domestic workers who live-in at their place of work, in their employers' homes, likewise do not have safety problems getting to work on a daily basis. Domestic workers in Mtubatuba, however, report that when their employers' homes are broken into by thieves during the day, they, the domestic workers, are also threatened (RVE study, FGD with domestic workers, project files).

With regard to safety *as they go about their work*, some nurses and the great majority of HBCs move about in the communities they serve, with HBCs often having to walk between households and community facilities. South Africa has a high crime rate, and a high incidence of violence against women. HBCs express concern for their own safety, though they may to some extent be protected by being 'from the community'.

With regard to *safety issues associated with the work tasks required*, the care work that is done by all three groups of workers in this study presents safety hazards associated with the

physical nature of the work – turning patients, bending to make beds and to clean, dealing with others' incontinence and ablutions, fetching and carrying equipment.

AIDS as an additional source of stress

In the South African context, HIV/ AIDS has now introduced a new and weighty set of safety issues. The pandemic has bought a new source of stress – more death, and young death - into the lives of the vast majority of South Africans, and most certainly to the nature of work of the nurses and HBCs. Nurses themselves are dying before retiring age, and many emigrate overseas. AIDS has turned things upside down: sexual activity becomes a threat for those wanting to have children; children are dying before their parents; adults are burying their children; women's (and men's) 'community time' on weekends is filled with funerals.

As Zellnik and O'Donnell note, nurses in South Africa face 'risk of occupational exposure to HIV/ AIDS, working conditions that are severely impacted by the epidemic, and the professional burden of caring for the sick and dying' (Zellnik and O'Donnell 2005: 165). The threat to nurses and HBCs of being infected by HIV/ AIDS through needlestick injuries or cuts and sores receives a lot of publicity. In reality, though, the far greater threat to their health comes from their constant exposure to disease, especially to tuberculosis and viral infections, and from the constant emotional stress of caring for the very ill.

The staff shortage increases the burden of care at work. Box 2 presents a picture of the interaction between patient and nurses, where a very sick person, with few resources to access the health services, comes face to face with nurses who are demoralized, despairing, and having to implement a policy of rationed ARVs that they must know will have fatal effects in some instances.

Box 2: Patient-nurse interaction in accessing ARV treatment in the public sector

Themba suspected he was HIV positive , and approached a public health facility. To qualify for ARV therapy a person has to be extremely sick, with a CD4 blood count of less than 200, meaning the person's mobility is heavily compromised.

The nurses explained that he would have to present three times at the clinic, so that he could go through the voluntary counselling and testing (VCT) procedures, and so that he would show them that he was serious about getting and maintaining the treatment – in the words of the health professions, that he would 'be compliant'.

He went twice, and each time they took a blood sample, without his being clear why this was needed. He was told his blood count was less than 20. Each of these visits took time and money, and he was getting steadily sicker. On the third visit, the nurses, with queues of patients still waiting go be seen, explained inadequately to him what he needed to do to stay on the programme. He said that he felt he was 'running out of blood', and refused to let them take another blood sample until they gave him a reason he could understand.

The nurses, impatient and exhausted, tore up his clinic card and records and threw them in the waste-paper basket. This meant he would have to start from scratch if he were to again try accessing ARV treatment.

He died at a bus stop a few days later, on his way to another health facility.

Source: Personal communication with Themba's employer.

With the rapid provision of ARVs over the last four years, the impact on nursing care has changed and will continue to change. Gentile (2008) cites nurses in hospitals and clinics saying how they now work with hope again; a house mother in a small hospice said the same thing.

The denialism around and stigma attached to HIV/ AIDS affects all groups of workers. A study of prevalence among all health care professionals showed similar patterns to those in the general population (about 20 percent in the adult population); yet nurses are reluctant to report on their own work-related exposure to infection, and to take post-exposure ARVs to prevent infection (Zellnik and O'Donnell 2005). Over a third of the domestic workers in the Johannesburg study knew someone who had died of AIDS; a third had someone in their family who was HIV positive; a fifth had cared for or supported someone with AIDS. They had good access to health services; they knew where to get condoms for free. Yet few used condoms, and they reported little knowledge about how to have safe sex despite the extensive media campaigns on this issue (Peberdy and Dinat 2005: 42).

5 PROVISION FOR CARERS' OWN CARE NEEDS

How do people in these three occupational groups see to their own care needs? Workers have differential access to a number of means of support – from state services, to state assistance through pensions and grants, to support by organizations, and support from extended families – though many have responsibility for care for sick family members as well.

All three groups, as South African citizens, have access to free health care throughout their lives, though the quality of the health services is wanting. If citizens are poor enough, they receive the state pension for elderly people when they reach the eligible age (60 for women, and 65 for men). Large numbers of the nurses, who would not qualify for the means-tested elderly pension, belong to pension schemes. A body of research (summarized in Lund 2002, and research done subsequently) has demonstrated that the pension for elderly people buys care for the elderly themselves and enables their care for others. While conservative economics worries that the state spending 'crowds out' private savings, it has been argued that on the contrary, it 'crowds in' a great deal of care (Lund 2002).

The nurses are well covered by medical aid: two thirds of the PNs and more than three quarters (78 percent) of the APNs belonged to contributory schemes (Table 2). They were either covered directly, or through being a partner/ household member of someone who belonged. In contrast, no domestic workers at all were covered by medical aids.

The end of working years may, for some women who do care work, signal a shift in where they live. Nurses in public employment receive a housing subsidy, and may well be home owners near where they work, but may also have rural homes to retire to. The domestic workers in the Gauteng study all had families elsewhere, and would likely rejoin their families when they stop work. It is not possible to speculate about where HBCs live when they get older – except to say that in South Africa, high numbers of poorer older people live in extended families.

A study of four different kinds of HBC organizations in the Durban area found that the organisations supported their HBCs in a variety of ways. The relatively well-resourced large hospice brought in a psychologist monthly, especially to attend to the concerns of the HBCs, who also met with the project manager weekly about the nature of the work. A church organization offering voluntary services gave volunteers a half day out of the field each week, to do paper work, and to talk to each other: 'We just laugh and talk and pretend that the world is okay', said the project manager (cited in Wallwork 2007). A third HBC organization had set up a support group, run by outsiders, who met regularly with the volunteers, and a church organization offered spiritual support, a dinner and a food parcel to the volunteers once a week (Wallwork 2007).

One of the organisations studied by Wallwork was organizing 150 volunteers, nine of whom were men, and employed 2 nurses and 20 paid staff. Between them the volunteers covered 600 households, in many of which there were three or four people in need of care. The volunteers are each given only five households to visit, in order specifically to prevent them burning out. However they felt duty bound to take on more households when they came across illness, and it was the supervisors who tried to cut down the HBCs' hours of work.

The same study found that volunteers left the organisation through finding employment because of the HBC training they had received, rather than leaving through stress or burnout (Wallwork 2007). This is in contrast to the situation where nurses said they felt that the stress of dealing with AIDS contributed to colleagues leaving and going overseas (Zellnik and O'Donnell 2005).

6 'VOICE' AT WORK: THE RIGHT TO ORGANISE, AND ACCESS TO DISPUTE RESOLUTION

The occupational groups are vastly different in terms of their ability to improve their own conditions of work through collective action. Greater regulation, such as that experienced in the nursing profession, usually means greater ability to organize to express demands. Ambiguity of working status, such as experienced by HBCs, and working in private homes, such as domestic workers, inherently carries vulnerability that comes with insecure work status.

South Africa has a relatively high density of unionization of the work force. Most nurses work in formal places where they can meet and organise. Table 2 shows that about three quarters of both PNs and APNs are union members. Nurses' organizations and unions to which nurses belonged were racially fragmented in the past, and the white unions were politically conservative. In the 1980s a number of new organizations of health professionals emerged, such as the National Medical and Dental Association, and the Democratic Nursing Organization of South Africa (DENOSA), set up in opposition and as an alternative to the predominantly white professional associations. In 1987 the National Education Health and Allied Workers Union (NEHAWU) was established, organizing health workers in a more radical way than previously.

Nurses in the public sector do their collective bargaining through the Public Sector Bargaining Council (PSBC). NEHAWU, DENOSA and other unions to which nurses can belong (such as Health and Other Services Personnel Trade Union of South Africa – HOSPERSA) participated in the 2007 public sector strikes. The strike resulted in the introduction of an Occupation Specific Dispensation for three care work sectors in which

women predominate – nurses, teachers and social workers. The nurses, through their unions, were the first to reach agreement with government, and implementation started in 2008.

Regulating the professional standards of nurses are the regulatory councils governing the nursing profession, the SANC and the HPCSA. These are bodies where the nursing profession can lay complaints against members of their own profession, and patients can lay complaints about the actions of nurses. Settlements of disputes can also take place through the Commission for Conciliation, Mediation and Arbitration (CCMA), an independent dispute resolution body set up through the 1995 Labour Relations Act. In the final analysis, nurses also have access to the law courts.

Domestic workers by contrast are invisible to most organisers of workers. Domestic workers are in the private homes of their employers, in subordinate positions, and are hard for union organisers to reach.

Domestic worker organisations have never been large or strong in South Africa. But after its founding in the late 1980s, COSATU attempted to support organisation in this sector, and SADWU became an affiliate of the federation. Support for better conditions and treatment also came from other, liberal sectors, including the churches whose members included employers. Interest in extending protection for domestic workers continued after 1994, and was strengthened by the fact that a number of ex-trade unionists entered the bureaucracy, particularly the Department of Labour, as well as other decision-making positions. Indeed, the Minister of Labour at the time the sectoral determination was promulgated was the son of a domestic worker, as was one of the first director-generals of the Department of Labour. While this would be an unlikely situation in other countries, it is not all that surprising in South Africa given, firstly, the huge number of domestic workers, and secondly, the fact that the post-apartheid era has seen many leaders emerge who were previously solidly working class.

The new South African Domestic, Service and Allied Workers Union (SADSAWU) has recently emerged. It has links with the new International Trade Union Congress ITUC, which has shown itself to be more open to assisting less formal categories of workers to organise. ITUC has recently positively supported the initiative the Self Employed Women's Association of India (SEWA), a trade union of informally working women, to b accepted as a ITUC union, with full membership.

Domestic work is again on the agenda of the ILO, with a General Discussion planned for June 2010. This *might* present a new opportunity for using international union partners to support international domestic workers organizations such as in South Africa. For this to happen effectively, however, the internal level of organization and coherence needs to be more effective than it is at present.

In terms of dispute resolution, domestic workers, alongside other workers, have access to the CCMA, and to the Small Claims Court. The CCMA has been an important institution for domestic workers, partly because of the low levels of organization and the fact they usually work alone with an employer. The AIDS Law Project reports cases where individual domestic workers sought out the CCMA to bring cases against employers who had forced them to be tested for HIV/ AIDS and declare their status. However, given the high unemployment rates, and the typically subordinate position of domestic workers who depend not only for their wage, and, for some, also for their accommodation on employers, it is likely that access to justice is more notional than real for the vast majority of domestic workers.

The third group of workers covered in this study, the HBCs, are in a very different position to both the domestic workers and the nurses. Given that they are in the main not recognised as employees, or their employment status is ambiguous, their power to organise or be organised is highly constrained. Many are doing the work precisely in order to increase their chance of getting a 'proper job' such as a nursing assistant, and as such they are hardly likely to embark on assertive action.

There is one interesting initiative, however, where a major union has stated its intention to organize HBCs (Samson 2008, and Samson, interview). NEHAWU is trying to take up the new challenges of organizing thrown up by global changes in the labour market, and to focus on organising new types of workers. In 2001 the union passed a resolution to organize HBCs (whom they call home care workers). In a study commissioned by a union-aligned research institute, it was found that HBCs 'were passionate about wanting to organise'. There were limits within NEHAWU on organizing in general, and the campaign would require leadership, organizing skills and resources which to date have not been forthcoming (Melanie Samson, interview) Melanie Samson also made the point that although it may be difficult to bargain for higher wages, given that these depend on allocations to NGOs from government, there were many actions that could be taken to improve the situation of HBCs immediately, such as establishing timely payment of stipends, ensuring that all such workers receive stipends, providing better safety equipment, ensuring that NGOs comply with labour law, and building the capacity of NGOs to comply with labour law. It was suggested that once their status as employees is firmly established, the scope and the coverage of the apposite bargaining council should be extended to include the many HBCs who are engaged by NGOs, and who work in the EPWPs and other care programmes.

FORMAL AND INFORMAL CARE WORK AND CARE SERVICES

The HIV/ AIDS epidemic has introduced new needs for care, and more strains on the already burdened health services. More formal hospital beds are allocated to people with HIV/ AIDS, and there has been an increase in the number of informal health facilities responding to this need for care, as well as a growth in the numbers of volunteers doing care work.

Box 3 describes different types of care workers in a small community-based hospice in a Durban township, run and funded through the Catholic church, and illustrates the way the service responds to urgent calls from the public health sector.

Box 3: An informal community-based hospice in Durban

In response to the need for care facilities, a local businessperson donated a small house to the Catholic Church. The church converted it into an eight bed hospice for those in the terminal stages of AIDS, and two nuns were allocated to run the service. In 2006, Nompu, in her forties, started volunteering there as a care worker when her step-daughter was admitted as she was dying of AIDS. Nompu earned R350 a month as a volunteer. When the two nuns left, she took over as 'house mother'. She lives on the premises with her three children. She works very long hours, and the church pays her R2000 a month. She is on a three-month renewable contract. While working at the hospice, Nompu has completed her secondary schooling, and is now enrolled at a distance-education university, doing courses in care and counseling. She plans to improve her career prospects through this.

There are ten women HBCs, who are called volunteers, who work six hour shifts, ten days on and ten days ten days off, and earn R450 a month for this. All the volunteers are also looking

for better and 'proper' jobs, based on their recorded volunteer experience. Some have signed up with an employment agency. They work a night shift when called, earning R200 a night for this.

During the day, a retired nurse who lives nearby comes to help in an emergency, or when her professional skills such as giving injections are needed. At night there is a volunteer and a qualified nurse on the 11-hour shift, and the nurse gets R1100 a month.

A few years ago, it was a true hospice, with all those who were admitted being expected to die in the short term. Now anti-retrovirals (ARVs) have arrived. They are easy to get, but expensive, through the private health sector; they are cheap but hard to get through public hospitals, because of the lengthy procedure involved, including tests for compliance, and mandatory counseling.

Nompu is able to access free ARV treatment through a church-run clinic. A person working at a public hospital at Scottburgh, a hundred kilometers away, knows Nompu personally. When a patient is very near death, yet still cannot get access to ARVs, the nurse phones Nompu and sends the patient to the hospice. Nompu takes the patient to the church-run clinic, where it is possible to go through the voluntary counseling and treatment (VCT) procedures in three days, compared to the weeks it can take in the public health services.

Source: Field visit and interview, community hospice, Durban, August 2008

A number of important points regarding care work emerge from this example. First, it is not registered nationally as a health facility, though it does appear in a directory, compiled by a health NGO, of provincial health facilities providing support to people with HIV/ AIDS families (Nina Hunter, pers.comm.). The high standard of care being offered was easily evident – it was 'caring care' – yet it is probably borderline in terms of its legality, and certainly in not having a registered nurse present all the time.

Second, it shows how one person, Nompu, started as a volunteer and gradually improved her position to become the manager, but in a low paid and probably precarious position in terms of longer term financial security. As a non-registered facility, the hospice receives no subsidy, and relies on church donations: in her words, though, there is 'AIDS-fatigue' in the church congregation: "AIDS is not so fashionable any more". The other volunteers are also dependent on church funds for their small stipend, but like Nompu, are using this opportunity to build up a track record of care work, and find additional and better paid temporary work. They had received their training through the Red Cross, went to the hospice for their practical placement, stayed there because they liked the environment, and signed up with employment agencies for occasional night work, for which they got paid R200 for one night, compared to the R420 per month for shift work as a volunteer.

Third, the example illustrates the informal but well-organised 'cross-over' between public and private health services, organized by networks of formal and informal women carers, in the interest of saving people's lives. And finally, it is important to note that the widespread rollout of ARV has changed the function of this facility from being a true hospice for the about-to-die, to being a place for the longer term management of HIV/ AIDS as a chronic disease.

Wallwork (2007) studies different types of health and welfare organisations providing ADIS-related care in the Durban area. A manager of one such organization, managing 150 volunteers, said that the availability of funds for care programmes had led some HBCs to

leave the organizations in which they were working, to start their own HBC programmes, sometimes with no hope of sustainability:

> "Because there is funding for care, you are getting a lot of ex-volunteers setting up their own HBC programmes and getting funded with no background on how to do it and they just basically go round providing…who knows what. … I see them all the time, they get funded for a year, funding doesn't come the next year, they collapse and that's the end of that, patients just get left, and nothing happens." (Sinosizo Project Manager, 2003, cited in Wallwork 2007)

Care work offers opportunities to some women to get entry into the labour market. This volunteer work creates (some) opportunities for better employment in the private health sector. Wallwork (2007) reported also the exit of volunteers from NGOs because they found more secure employment. Nevertheless, the care burden in South Africa will continue to grow for some time. The HIV/ AIDS epidemic is shifting how people work, and how people need care, and who provides the care. There are some new employment opportunities for women, but the prognosis on the whole will be of more unskilled women doing even more care work.

TASK-SHIFTING WITHIN THE HEALTH SECTOR

Task shifting is the process in which tasks that have been defined as able to be done by those with a particular level of skill or qualification are delegated to those of a different level of skill or qualification – sometimes upwards, but most commonly downwards, allowing less formally skilled people to do a broader variety of activities. Within the health profession, well known examples are nurses being allowed to prescribe certain medicines and give injections, formerly the prerogative only of doctors; in many African countries, health assistants with a short training taking on aspects of health promotion and local health surveillance.

Task-shifting in the health sector is not new in South Africa. In the 1970s community health workers operated in rural hospitals, way ahead of their time and ahead of the Alma Ata commitment to primary health. During the 1980s there was an active campaign for the introduction of community-based rehabilitation workers, working in the fields of physiotherapy, occupational therapy and speech therapy. Also in the 1980s, social work started introducing social work auxiliaries. In the restructuring since 1994, pharmacists have taken over roles formerly allowed only to nurses and doctors. More recently, the idea has been mooted of integrating mental health services in the district primary health care package. The idea would be to supplement the work of the scarce psychologists and psychiatrists, who have between seven and ten years of training, with mental health counselors (four years training) and mental health community based workers (two years training) (Petersen 2008).

Marion Stevens, a key actor in the NGO sector in the 1990s campaign for the introduction of legal abortion said that this campaign gave rise to an example of international best practice in task-shifting. It had previously been exceptionally difficult to get a legal abortion in South Africa, and it could only be undertaken by medical doctors. Stevens holds that for the new legislation to work successfully, hundreds of nurses had to be trained to do the procedure. Substantial time and resources went into this, in a concerted and well-designed training initiative that has been (largely) successful.

South African nurses and other health professionals are now actively engaged in promoting task-shifting within the nursing profession, at part of a global initiative (Stevens et al 2008; Marion Stevens, interview). The obvious driver is the shortage of nurses associated with the

HIV/ AIDS epidemic and the strains this puts on care. Also, however, within the ideology of primary health care is the idea that health promotion and prevention is best done by people from 'the community'. So the current international campaign for task-shifting has presented an opportunity within South Africa to re-open the possibility of getting community health workers recognised as part of the comprehensive health approach, and part of the district health team. This idea had been there in the 1980s, and was lost in the political transition.

All international evidence says that, for task-shifting to be successful in the health sector, it has to be well-resourced and proper trained provided (Stevens et al 2008; Petersen 2008), as was the case with abortion noted above. However it is often resorted to in situations of stress and scarcity, to *solve* a resource problem, as is happening in the face of the HIV/ AIDS crisis at present. The current initiative seems to be focused on including new categories of health workers in the health team, without systematic strategic thinking about the gendered implications and impacts. With the stress already being felt within nursing, it is hard to see how it could be well-resourced and well-trained. There is evidence of the stress felt by household members, and HBCs, when they care for people without being sufficiently trained and resourced (Hunter 2005).

The danger exists of task-shifting displacing care responsibilities downward and outward onto unresourced 'communities' (that is, local women), 'volunteers' (that is, women) who are really workers, and unpaid workers (that is, women) in households.

10 CONCLUSION

In this concluding section we draw attention to the major themes that have emerged in the South African study through this focus on selected groups of carers. First, it has made clearly visible the intersection of gender, race and class, in a way that is all too familiar in South Africa. Apartheid ensured that white people had most education and employment opportunities, and Africans the least, with coloured and Indian people in between. In the groups selected here, HBCs and domestic workers are almost exclusively African women, with very low wages. The professional nurses had higher incomes and education relative to the associate nurses; white and Indian women were disproportionately represented in the nursing professions, with none being employed as domestic workers.

Second, the picture of care work is almost entirely female. The occupational groups in this study – nurses, domestic workers, and HBCs – have, as do virtually all care work occupations, a predominance of women in them. The way AIDS is spreading in southern Africa means that more women are being affected. HBCs care for greater numbers of women than men – partly because men with AIDS are cared for by women members of their own households. In addition, demographically there are a greater number of elderly people who need care, and more of these are women. The HIV/ AIDS epidemic has led to a focus on the role of grannies and older ants as carers of younger people. Their own care needs are not in the public eye. Also as the white population has aged, it is likely that numbers of African domestic workers take on a greater number of care tasks.

Third, the different groups of workers have very different means of occupational entry and exit, and very different levels of autonomy and choice about what they do and where they do it. Qualified nurses for example, are relatively skilled members of the female labour force, and in South Africa, are in short supply. Nurses enter the profession through a formalized system of training, accreditation, and recruitment. To a substantial degree they have choice over whether to work in the private or public sector, and they may move between these, for

short term gain, and/or as part of a career plan for upward mobility. This may include, at some point, a plan to work outside of the country, for a short time or in permanent emigration. Netcare, one of the biggest private health providers, and which operates internationally, now recruits South African health professionals to take up short-term contracts abroad, and recruits as far afield as India for nurses to fill vacant posts in South Africa.

The situation of domestic workers is very different. It is likely that most domestic workers find employment through networks and word-of-mouth, rather than through advertising. Given their low education levels, this is the only type of work that many are able to find. Some may have to leave work to provide care for others, though it has been noted that domestic workers are members of large households, and it is likely there are other household members to help with caring work. Some lose their work because employers change cities, or emigrate.

Third, there is a strong spatial dimension in the gendered analysis of care work. Many domestic workers come from rural to urban areas to seek work, yet retain membership of a rural household. The growth in numbers of HBCs as a response to care needs associated with HIV/ AIDS means that there are expanding 'work' or voluntary work opportunities for poorer women in rural as well as urban areas. With the growth in numbers of the care work component of the EPWP, an analysis is needed of how many of the placement opportunities are provided in rural compared to urban areas. Another feature of the spatial dimension of care is its increasingly global nature: nurses emigrate from South Africa to other developed countries, whether on a temporary or permanent basis. Skilled white South African women with no training in health or care work go overseas to do care work. Simultaneously, South Africa starts to draw nurses from other countries, from nearby countries such as Zimbabwe and Malawi, and from far-away India and further east, recruited by South African private health firms.

Fourth, the paper gave evidence of interesting dynamics between the different pillars of care. There is evidence of substantial movement between the public and private sectors, and between public and private domains. Nurses move from the public sector to the private sector in search of better conditions of work. Yet still, government spends far more on health insurance per capita for government employees than it does per capita on the public 'free' health service (Lund and Budlender 2008). At the same time, social workers in South Africa are moving in significant numbers from the private sector to the civil service. In their case, salaries and other conditions of work in the civil service are far higher than those in the NPOs, as government subsidies of welfare organisations do not provide for salaries equivalent to those prevailing in the public sector. Yet these under-resourced NPOs are then sub-contracted by government to recruit and manage the HBCs, most of whom are radically underpaid, and are not recognised as workers.

There is a move from the public to the private sector in terms of formal health care, and from the private health and welfare sectors to the 'community' or domestic domain in which volunteers and HBCs work. This is a fuzzy domain in which the status of work is at best ambiguous, and in which even the legislated basic conditions of employment are not monitored. Furthermore, through task shifting downwards, some tasks that were done by nurses are now undertaken by HBCs.

It may be that, because of both demographic trends and the decrease of state subsidization of institutional care for the elderly, domestic workers in private homes may be task-shifting upwards, doing more nursing-type care of elderly employees, though with no accreditation or extra reward. The advantages of greater regulation of domestic work – including the

minimum income, and some social security coverage – may be offset by greater hidden exploitation in terms of the tasks they are required to do. In other words, the tasks may require more skill, but there will be no recognition of this reflected in remuneration. At the same time, the paper has argued that there are likely to be substantial resource flows, from employers to domestic workers that are not captured in surveys.

Government is extending its tendency to contractualise, as seen specifically here in government contracts to NGOs to 'employ' HBCs to do care work. The task-shifting within nursing has already de facto been taking place, and the types of tasks that will cascade down and out to HBCs, and the extent to which this will happen is an unfolding process. It is likely that the work of Community Health Workers involved in this task shifting will be more clearly defined, and possibly better regulated and supervised, than with other categories of HBCs, for example those attached to the social development department, and those active in informal HBC programmes.

Fifth, ARV therapy will have an impact on care work. The recent and rapidly expanding availability of this treatment is already changing the nature of care work, for those in the public and private formal sectors, and for those in 'the community' and doing home-based care. ARV therapy gives hope not only to those infected, but also to those who care for them. AIDS needs no longer be a terminal illness – it should be managed as a chronic illness. However the criminal ineptitude of the general political leadership, and specifically of the health ministry, and the denialism around AIDS, means that thousands of South Africans cannot yet get access to ARV therapy and will die. Many will die in their own homes, needing an intensive level of full time care (Hunter 2005).

Finally, in selecting nurses, domestic workers and HBCs for special focus, it was hoped to gain a more comprehensive insight into shifting boundaries between paid and unpaid care. The HBCs were chosen precisely because they straddle the boundary between paid and unpaid workers, between real volunteers and ambiguous 'volunteers'. There needs to be a systematic engendering of the analysis of home-based and community-based care, its implications for women, and thereafter an equitable policy which recognises the worker rights and status of HBCs. As Samson pointed out, if HBCs are a central plank in the government strategy to combat HIV/ AIDS, then it is incumbent on government to think through and develop a clear policy on the status of HBCs. They are implementing government policy, and government should not be able to evade ensuring the implementation of labour law by outsourcing to NGOs. Explicitly acknowledging the position of the HBCs in the labour market could also fit government's agenda of motivating NGOs and CBOs to be better able to assist informal workers to find pathways into more secure and more formal work.

In the absence of this, there will continue to be a massive displacement of the burden of care onto ambiguously employed female HBCs, unpaid female volunteer workers, and females in poor households. Ungendered notions of 'community' and 'volunteerism' have dangerous implications for the care work of all women, and especially poorer women. The introduction of ungendered 'task-shifting', by nurses themselves, into the dynamics of care, will add to the growing burden of women's care work in this time of AIDS.

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KEY INFORMANTS

Sandy Lund, a senior social work manager in a large welfare NPO, on the use of volunteers and auxiliaries by social work agencies, 14th August 2008, personal interview
Jeanne Prinsloo, gender studies and journalism academic specialist, on employer-employee reciprocal relationships in domestic work, 6th August 2008, phone interview
Melanie Samson, political scientist, and union activist, on challenges faced by unions in organizing HBCs, 13th August 2008, phone interview
Marion Stevens, key women's health activist and academic, on task-shifting within nursing, and on reproductive health services, 13th August 2008, phone interview
Nompu, house mother/ HBC at a small church-run hospice for women with HIV/ AIDS, Durban, 4th August 2008, field visit and interview

Table 1
Selected characteristics of South African professional nurses, associate professional nurses, and domestic workers, South Africa, 2007

	PN*	APN*	Domestic worker		
			Men	Women	Total DW
Number	32 340	128 479	125 090	939 930	1065213
% (men and) women	91	89	12	88	100
% of all employed (men and) women	1	2	2	16	
Age					
20 – 29	10	13	27	15	17
30 – 39	32	31	45	29	31
40 – 49	34	31	14	27	25
50 – 59	18	20	10	26	24
60 – 69	5	3	2	2	2
Education					
No schooling	0	0	4	12	11
Some primary	5	0	35	35	35
Some secondary	22	41	61	52	53
Some tertiary	74	59	0	1	1
Marital status, percent					
Married	52	53	27	28	28
Living together	0	8	15	14	14
Widowed	5	6	4	11	10
Divorced/ separated	3	5	4	7	7
Never married	40	28	51	40	41
Race					
African	54	68	97	91	91
Coloured	22	9	3	9	8
Indian	1	6	0	0	0
White	23	17	0	0	0

***** There were insufficient numbers of male PNs and APNs to warrant disaggregation by sex.

Source: LFS 2007

Table 2
Work security for professional nurses, associate professional nurses, and domestic workers, South Africa, 2007

	PN*	APN*	Domestic worker		
			Men	Women	Total DW
Number	32 340	128 479	125 090	939 930	1065213
% (men and) women	91	89	12	88	100
% of all employed (men and) women	1	2	2	16	
% with written contract	94	93	51	34	36
% with unemployment insurance	52	56	47	30	32
% with medical aid	66	78	0	0	0
Own	24	16			
Someone else's	37	49			
	5	13			
% with pension fund	89	88	4	13	12
Own					
Someone else's					
% trade union member	77	74	0	3	2

***** There were insufficient numbers of male PNs and APNs to warrant disaggregation by sex.

Source: LFS 2007

Table 3:
Monthly income of nurses and comparator categories, South Africa, September 2007, percentages

Income group	Prof. nurse 91% female	Prof. engineer 92% male	Assoc. prof. nurse 89% female	Assoc. engineer (technician) 68% male
R1 – R1000	5	1	3	2
R1001 – R6000	31	13	52	39
R6000 – R16000	55	29	33	42
R16001 plus	1	36	1	8
Unknown	8	20	11	9
Total	100	100	100	100