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MAPPING SOUTH AFRICA'S CARE REGIME: PATHWAYS TO A CARE-FOCUSED SOCIAL POLICY

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1. INTRODUCTION

The COVID-19 pandemic brought into sharp focus the essential role of care work in sustaining the economy and structuring the delicate balance between paid employment, personal relationships, and broader social life (Hassim, 2021). The widespread closures of schools and childcare facilities significantly increased caregiving responsibilities, emphasising the necessity of accessible and high-quality care services. Moreover, the pandemic exposed the inherent vulnerability of life, a realisation with deep political implications (Orozco, 2022). This heightened awareness of our collective vulnerability underscores the fundamental interdependence of human existence, challenging neoliberal tendencies to downplay these relational aspects (Ghandeharian and FitzGerald, 2022). Consequently, the pandemic and its aftermath present a critical opportunity to centre the inherent vulnerability and interdependence of life within policy discussions, particularly in economic and social planning.

In South Africa, the care economy is integral to the broader socio-economic landscape, shaping labour force participation, gender equality, social welfare, and broader economic outcomes for all individuals. Amid persistent inequalities, high unemployment, and changing demographic dynamics, understanding the country's care regime is essential to addressing systemic issues and fostering inclusive growth. This paper examines the multifaceted dimensions of South Africa's care economy, focusing on its implications for social equity, economic development, and gender equality, and advocates for a transformative national care policy that embraces vulnerability and interdependence as cornerstones of a just and inclusive society.

Building on the foundation laid by the first paper in this series, Engaging the Care Economy in the Global South: Debates and Contestations, this paper delves more deeply into the care economy's critical role in South Africa. The previous paper provided a comprehensive framework for understanding the care economy, offering valuable insights into its socio-political significance and contemporary relevance. It emphasised the importance of contextual variation and the need for transformative policies that prioritise the well-being of care workers. These themes are further explored in this second paper.

By integrating policy analysis with real-world implications, this paper offers a nuanced understanding of how care is structured, valued, and experienced in South Africa. This holistic approach not only underscores the critical role of care in society but also proposes pathways for policy reform that acknowledge and elevate the essential work of caregivers. The analysis presented here aims to inform policy making and interventions that enhance the role of the care economy in South Africa's development and social well-being, particularly in the wake of the COVID-19 pandemic.

2. WHAT IS THE CARE ECONOMY?

The care economy is a complex ecosystem that encompasses activities, labour, and social relations aimed at supporting and maintaining the physical, social, mental, and emotional well-being of all people. It involves essential tasks that maintain, support, and repair our world, which are fundamental to the ongoing creation and recreation of our societies (Dowling 2022). Central to the care economy is care itself. There are three principal aspects of care. First, there are the relationships of care and social reproduction found within kinship, friendships, and community networks, which are integral to our daily lives. We depend on these relationships to varying degrees to sustain our lives and livelihoods. Second, there are care needs specific to certain physical or mental conditions or life stages, which are essential for a person to thrive, and may require more formal care relationships. Third, care is also viewed as an affective disposition or a moral imperative (Dowling 2022)

The care economy, encompassing all three dimensions of care, plays a vital role in society. Crucially, it supports other industries by allowing individuals to fully participate in the labour market with the assurance that they themselves, as well as their dependents, are well cared for. It also provides substantial employment opportunities, especially for women, and makes significant contributions to economic output (Elson 2017). Despite its critical importance, the care economy is undervalued and underfunded. This results in challenges to the quality and accessibility of care received, difficulties in providing care, and a range of negative social, mental, and physical

Care is intrinsic to the reproduction of society and serves as a crucial infrastructure that underpins social cohesion and continuity. Without caregiving, both life and societal structures would falter: care is not merely a supportive element, but fundamental to our existence. (Photo: Paul Jeffrey / Alamy Stock Photo)

outcomes, particularly for women (Rai *et al.* 2014). Additionally, it negatively impacts economic outcomes related to job participation and time poverty. Care is intrinsic to the reproduction of society and serves as a crucial infrastructure that underpins social cohesion and continuity. Without caregiving, both life and societal structures would falter: care is not merely a supportive element, but fundamental to our existence.

Concretely, the care economy can be understood in various ways, but it is generally described as encompassing the paid and unpaid labour and services that support caregiving in all its forms (Addati *et al*. 2018). Activities range from those performed within households to services provided externally. Formal market caregivers, such as childcare providers, health workers, and teachers, typically work outside their personal home environments and receive monetary compensation. Similarly, informal market caregivers, including nannies, also operate in paid capacities, albeit often within private household settings.

In contrast to paid labour and activities, a significant portion of the care economy involves unpaid caregiving, which predominantly occurs within the home. This includes various domestic tasks such as cooking, cleaning, and caring for family members, tasks that are integral to the daily maintenance of household welfare. According to time-use survey data from 64 countries, representing 67% of the world's working-age population, 16.4 billion hours are spent on unpaid care work every day. This is equivalent to two billion people working eight hours per day without remuneration (Coffey *et al*. 2020). If such services were valued at an hourly minimum wage, they would represent 9% of global GDP, amounting to approximately US$11 trillion at 2011 purchasing power parity (ILO 2018). Unpaid care work makes a substantial contribution to countries' economies and to individual and societal well-being, meeting the vast majority of care needs worldwide.

Traditionally, the care economy has been categorised through this simplistic dichotomy of paid versus unpaid labour. However, this classification fails to fully capture the scope and nuances of this economy, and particularly its deep-rooted connections to broader economic structures and gendered norms (Dowling 2022). To fully comprehend the care economy, it is essential to move beyond the basic categorisation of work as either paid or unpaid and to delve into the political and economic contexts that shape caregiving practices. For instance, in the Global South, caregiving is predominantly managed by families and market-based provisions, with minimal state intervention, a situation heavily influenced by historical, colonial, and postcolonial legacies. In contrast, in many Global North countries significant portions of care needs have historically been provided by the state, although these countries have seen a more recent shift towards privatised care, as a result of financialisation and neoliberal policies which have altered gender roles and reduced state support. These regional differences highlight the need for a nuanced understanding that considers the varied manifestations of care across different settings (Stevano *et al*. 2021).

The previous paper in this series argues for a broader, more informed understanding of the care economy. It emphasises that it is not merely a collection of caregiving tasks but a complex system shaped by policy choices, gendered norms, and the overarching influence of capitalism and patriarchy. This approach underscores the importance of examining the intersections of economic structures, care relationships, and caregiving labour to fully grasp this complex ecosystem. Understanding the political economy of care involves examining how economic systems, policies, and practices are shaped by political institutions, power relations, and social forces, and how these economic processes, in turn, influence the political and social structures of the care economy. This requires us to ask critical questions such as why care has been marginalised, why it is predominantly performed by women, and why this work is often regarded as having little economic and social value. These inquiries help uncover the systemic undervaluation of care work, shaped by historical gender biases and economic policies that overlook the labour traditionally done by women.

Expanding the definition of the care economy beyond its traditional confines (viewing it merely as a sector comprising paid and unpaid work) is essential to understanding its full scope. It involves not only complex labour processes but also the social interactions dedicated to addressing a variety of human needs. To fully appreciate this broader perspective on care, two important streams of feminist thought provide invaluable insights.

The first stream, rooted in Marxist feminist theory, positions care as a crucial component of social reproduction that sustains the capitalist system. From this perspective, care work—encompassing both unpaid domestic labour and paid care services—ensures the daily and generational renewal of the labour force, thereby supporting the relations of inequality and production necessary for profit-making (Bhattacharya 2017). Social reproduction, in this context, describes the institutionalised separation between productive and reproductive activities within capitalist economies. Reproductive labour, which includes unpaid and underpaid activities that reproduce labour power and sustain life in the capitalist economy, is critical yet often overlooked or undervalued (Bakker 2007). The cost of reproducing labour power is a burden that capital seeks to minimise, either by commodifying social reproduction or by rendering it invisible as work, thereby externalising its costs (Dowling 2016). A core question here is who bears the cost of reproducing labour power and life in the capitalist economy, a question that highlights the centrality of care work within capitalism (Dowling 2022).

The second stream, emerging from feminist care ethics, emphasises the social dimension of care that connects the state, society, and the market. Tronto (1998) argues that care—whether paid or unpaid—is not merely an activity but an ethic that sustains relationships and underpins the fabric of society. This perspective sees care as transcending its function within the capitalist system, emphasising its emotional and relational dimensions that are vital for building and maintaining connections. Care, in this view, extends beyond the family and is a distinct form of work that supports the broader social order, through its unique capacity to foster human relationships and social cohesion.

The conceptual relationship between care and social reproduction can be confusing, especially as the terms are often used interchangeably (Dowling 2022). Therefore, integrating these two streams of feminist thought, while acknowledging their distinct analytical contributions, is crucial for a comprehensive understanding of the care economy. The analytical lens of "care" offers qualitative insights into the affective dispositions and ethical commitments that shape and organise relations of support and assistance throughout life. The lens of social reproduction highlights all the labour necessary for the reproduction of labour power and the production of economic value.

A key structural dynamic of the capitalist economy is the imperative to keep the costs of reproducing labour power low by exploiting unpaid and underpaid labour. Without mitigation, this dynamic results in a moral paradox: some of the most important activities for maintaining life are those that are the least valued. This structural dynamic also leads to systemic instability, if efforts to ensure profitability deplete the resources required for care and social reproduction (Rai *et al.* 2013; Fraser 2016). Care work is thus both a site of social reproduction and well-being and a terrain where relations of power and inequality are produced and contested.

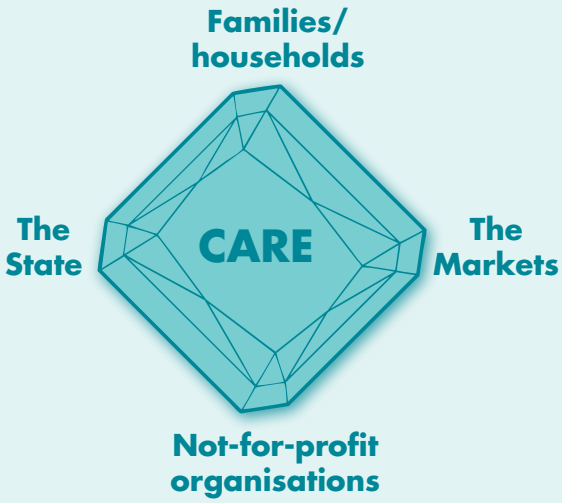
The care economy encompasses both the physical activities of caregiving—whether paid or unpaid—and the emotional and ethical relationships involved, all within the context of capitalist relations and social inequalities. These aspects are deeply interwoven and cannot be easily separated. This comprehensive understanding illustrates the crucial role of the care economy in shaping social order and driving social change, underscoring the importance of care in our collective vision of a good life and a just society.

The conceptual understanding of the care economy can be deepened by examining the various agents involved. It comprises a complex network of institutions, including families, the state, the market, and nonprofit organisations. The "care diamond" is a theoretical framework that helps analyse how care responsibilities are distributed among these four key pillars of welfare (Razavi 2015).

The care diamond, as illustrated in Figure 1, highlights how care is distributed and delineates the roles of different institutions in providing care within society. While each institution depicted in the diamond contributes to the welfare and care of individuals and communities, the state holds a distinct and pivotal role. The state's influence on these institutions, particularly families and NGOs, is qualitatively different from other sectors (Razavi 2015). The state assumes a unique position as a decision-maker, determining the responsibili-

ties allocated to other agents within the matrix. It not only determines policy design, regulation, and funding priorities but also ensures the implementation of these policies (Razavi 2015; Noddings, 2015). Consequently, the state's decisions have a significant impact on the operations of other institutions within the care matrix.

Figure 1: The care diamond



Source: Razavi, 2011

For example, the state's implementation of austerity measures as part of its macroeconomic policy framework, such as reducing funding for key care sectors like health and education, can lead to political pressure to privatise these responsibilities, shifting the burden of care from the public sphere of the state to the private sphere of families, particularly women. Austerity is often viewed by economists as a technical tool for managing the economy and promoting growth while reducing debt (Blyth 2013); this tends to overlook the political implications of such measures. Fundamentally, austerity measures uphold the capitalist economy by ensuring that the majority of working people bear the brunt of economic adjustments, while maintaining the prosperity of a select few (Mattei 2022).

In this context, privatisation often results in the transfer of care responsibilities from public institutions to families, disproportionately affecting low-income and working-class women who are less able to afford privatised services (Razavi 2011). As a result, the burden of care is increasingly placed on families, who must manage these responsibilities within the home. At the same time, non-governmental and non-profit sectors often become overstretched, compromising the quality and reach of the services they provide. This overextension forces these organisations to use resources sparingly, further burdening workers who are frequently underpaid. Thus, the state occupies a unique position within the care diamond, significantly shaping how care is perceived and administered through its macroeconomic and social policies. The state sets foundational principles that influence fiscal and monetary policies, which in turn directly impact social policy and care provisions (Razavi 2007). Understanding this dynamic is crucial for comprehending the broader care economy and the roles of various institutions within it.

Social policy plays a crucial role in defining the state's involvement in the care economy. Feminist scholar Eva Feder Kittay (2017) describes social policy as interventions by governments or other public institutions aimed at promoting the well-being of society's members or addressing social issues. Social policy directly reflects and enacts the state's role in the care economy, yet this role is often mediated within a broader system that upholds and perpetuates patriarchal norms and values. The pervasive nature of global patriarchy is evident in the sustained sexual division of labour and the consistent undervaluation of care work. Maria Mies (1986) highlights how patriarchal institutions and national accounting systems fail to account for the full contributions of women, rendering unpaid care work invisible in mainstream economics. This devaluation is deeply rooted in entrenched norms that shape gendered dynamics of care provision, where care work—both paid and unpaid—is perceived as low value.

The state's role in perpetuating these patriarchal norms is apparent in the formulation and implementation of social policies. These policies often fail to recognise the true value of care work, reinforcing the notion that it is less important than other forms of labour. This reflects a broader societal undervaluation of this work and the individuals, predominantly women, who perform it. By neglecting to address these inherent biases, the state perpetuates the patriarchal structure that devalues and marginalises care work, thereby maintaining the status quo of gender inequality.

Integrating an ethic of care into social policy transforms it into care policy. Broadly defined, care policies are public policies designed to allocate resources specifically to support caregiving activities, aiming to dismantle persistent cycles of inequality.

Orthodox economic discourses further entrench these patriarchal values. Historically, traditional economic models have been dominated by the concept of the 'economic man'—an idealised figure who is invariably male, self-sufficient, and devoid of emotional or familial ties (Marcal 2015). This image continues to influence social, political, and economic decision-making. Such models diminish the value of traits like altruism and care, traditionally seen as feminine, thereby perpetuating gender roles and economic disparities. These ideals prioritise rationalism, self-interest, and individual accountability, overshadowing values like reciprocity and interdependence that are critical in the realm of care (Tronto 1998). Thus, the intersection of patriarchy and orthodox economic discourses reinforces the systemic devaluation of care work and the gendered dynamics that sustain it. Economic discourses, global patriarchy, and the social and macroeconomic frameworks we adopt are deeply intertwined and entrenched, necessitating continuous scrutiny. This paradigm marginalises the social and emotional aspects of human life, which are crucial to understanding and addressing societal needs (Marcal 2015).

Social policy does not merely respond to social issues; it is also shaped by economic theories that often fail to recognise our interconnectedness and the societal value of care. The implementation of any social policy, therefore, carries normative implications, asserting the superiority of one approach over others, and is deeply rooted in specific ethical values, such as self-sufficiency and individualism (FitzGerald 2020). This approach not only shapes the kind of care provided but also influences who is deemed responsible for caregiving, thereby having tangible effects on the structure of social support systems and the allocation of resources within the economy. Social and economic policies play a critical role in shaping and reshaping responsibilities for care, determining who carries out caring activities, under what conditions, and on whose terms, as well as addressing—or failing to address—who is cared for and who is not.

Integrating an ethic of care into social policy transforms it into care policy. Broadly defined, care policies are public policies designed to allocate resources specifically to support caregiving activities, aiming to dismantle persistent cycles of inequality. These policies span various sectors, including health, education, social protection, labour markets, and care-related infrastructure such as water and sanitation. The objectives of care policies are multifaceted: targeting poverty alleviation, boosting labour force participation, creating employment opportunities, and fostering the development of future generations' human capabilities. Unlike traditional social policies, care policies champion an ethic of care, emphasising the redistribution and recognition of care as central tenets (Esquivel 2021). These concepts will be explored in further detail in the last section of this paper.

Care in South Africa, and the institutions within the care diamond, have been shaped by various political and social contexts, which have influenced economic and social policies that significantly impact the everyday realities of caregiving. This demonstrates the deep interconnection between policy decisions and caregiving practices. The next section will focus on how state policy and racialised capitalism shaped care dynamics in apartheid South Africa, and how these dynamics persist in post-apartheid South Africa, paying special attention to the migrant labour system. This system exemplifies how state decisions have configured the distribution of care responsibilities, with enduring impacts across generations. Following the end of apartheid, the transition from the Reconstruction and Development Programme (RDP) to the Growth, Employment, and Redistribution (GEAR) strategy marked a crucial shift in policy focus. This shift has had significant implications for caregiving, often placing a disproportionate burden on women and the elderly. By exploring these policy changes, we further uncover how state-led strategies have distinctly shaped caregiving dynamics, determining who provides care and under what conditions.

3. APARTHEID AND POST-APARTHEID DYNAMICS IN THE MIGRANT LABOUR SYSTEM AND THE IMPLICATIONS FOR CARE

A policy of racial segregation was consistently employed by all South African governments until the democratic transition in 1994, significantly disadvantaging the Black population through discriminatory measures. Scholars researching care in South Africa widely cite the migrant labour system, employed by both colonial and apartheid governments, as contributing extensively to the composition of Black households in South Africa, and subsequently informing contemporary dynamics of care.

While several segregationist policies were already in existence from the early decades of the twentieth century, it was the rise of the National Party to power in 1948 that signalled the initiation of apartheid. Apartheid was characterised by the implementation of the most severe and legalised racist measures and functioned as a multifaceted economic, political, and ideological mechanism that implemented a strategy of "partial proletarianisation" (Legassic and Wolpe 1976, p. 78). The migrant labour system was a crucial component of this strategy. Black men were forcibly removed from their families, predominantly based in rural areas, to work in mines, factories, and other industries in urban centres (Gouws and Van Zyl 2015). These workers were housed in single-sex dormitories or hostels near sites of employment, with permission to return home rarely granted by site managers. Contracts in the mining industry, for example, only made provisions for a maximum of four weeks leave per year (less if travel time is deducted) (Budlender and Lund 2011).

The migrant labour system resulted in the emergence of a relative 'surplus' population, mostly women, who played a crucial role in sustaining the productive capacity of pre-capitalist economies and the social structure of African societies (Wolpe 1972). Thus, the process of partial proletarianisation had distinct advantages for the apartheid state and the economy. 'Homelands' remained outside the purview of development interests. The National Party government shut down most mission schools and hospitals and replaced them with new state education and health services, which were of poorer quality. The health services dealt only with preventable diseases associated with poverty, and school curricula taught that Black children were only suitable for serving the white minority (Lund 2010). By not educating and supporting the children of migrant workers or caring for ill or elderly workers, the apartheid regime shifted these costs to the homelands, mainly inhabited by women, children, and the elderly, where the minimum standard of living was lower (Burawoy 1976).

With male family members and fathers away from the homestead for prolonged periods, women often took on traditionally 'male' spheres of labour, such as cattle herding (Bozzoli, 1999). Thus, women became responsible for a larger share of care responsibilities in addition to their existing contributions, for example, subsistence farming, cooking, and childrearing. In addition to expanded responsibilities in the realm of unpaid care, many Black women moved to urban areas and became engaged in 'dual caregiving', by taking up jobs as domestic workers for colonial administrators and white households. White women were much more likely than women of colour to hold managerial and executive positions, and were significantly less likely to be employed in 'unskilled' jobs, such as domestic work or agricultural labour (Casale and Posel 2011). According to the 1991

census data, nearly half of all employed Black women were working as either service workers (35%) or in manufacturing roles (11%) (Maconachie 1993).

Given this pattern of labour force participation, middle-to-upper-class white households considered care to be a service to be paid for, while the majority of Black women relied on kinship structures to fulfil the deficiencies of care in their absence. A dualism began to emerge: care could either be paid for or it was to be performed by the family, particularly by women and girls. Colonial influence and state formation during apartheid, ultimately, contributed to and reified the construction of care as a 'private' aspect of life (Manicom 1992).

In addition, the absence of male partners and fathers, particularly in Black African households, resulted in fundamental changes to the sexual division of labour, family dynamics, and socialisation patterns. High rates of extra-marital childbearing and lower rates of marriage manifested in widespread instability and insecurity among children and women. The implementation of the migrant labour system ultimately resulted in a break-down of family structures, with extended family networks becoming increasingly fragmented and weakened (Gouws and Van Zyl 2015).

The reality of women in countries such as South Africa demonstrates that the content of 'care' differs mark-edly from the majority of women in high-income countries. Owing to apartheid-era policies and infrastructural constraints, such as limited access to basic utilities, women were, and continue to be, responsible for tasks beyond narrow conceptions of 'care,' such as childcare and household duties. They carry out unpaid care work in areas like fetching water and gathering firewood. This labour often serves as a subsidy to fill the gaps of poor government administration and under-resourced public services.

Owing to apartheid-era policies and infrastructural constraints, such as limited access to basic utilities, women were, and continue to be, responsible for tasks beyond narrow conceptions of 'care,' such as childcare and household duties. (Photo: Peter Titmuss / Alamy Stock Photo)

Casting the realm of reproductive labour as 'domestic' also had far-reaching effects on relationships between men and women. The colonial practice of using African men as migrant labourers reshaped both the economic and domestic landscapes, fundamentally altering gender roles and dynamics. As Gouws and Van Zyl (2015) detail, this shift had significant implications for reproductive and caregiving roles. Colonial policies entrenched the 'native' man as the 'head of the household,' positioning men as the primary economic providers and decision-makers. This official designation bolstered a patriarchal structure within families and communities, confining women's roles largely to reproductive functions. Compounding this marginalisation, 'native' women were characterised not as caregivers but as a "sexualised construct and a social problem" (Manicom 1992 p. 456). This depiction focused excessively on Black African women's reproductive functions. The label of women as a "social problem" perpetuated a colonial narrative that treated women's reproductive roles as issues needing management and control, thereby ignoring their autonomy and broader contributions to community life.

The apartheid state ultimately situated care in the private sphere, enforced a divide between public and private, social reproductive and productive, and racialised caregiving through its policies (Manicom 1992). While the pass laws, which restricted the movement of the Black population, were formally abolished in 1986, the migrant labour system entrenched distinct patterns of care, through transforming the composition of the household and cementing a distinctly gendered division of labour.

The remnants of apartheid-era policies, such as the migrant labour system, are prevalent in contemporary South Africa in many ways. However, they are particularly evident in the disproportionate burden of care on women, particularly Black women. In contemporary South Africa, low rates of marriage, high rates of extra-marital childbearing, and the absence of fathers remains among the key features of family life (Moore 2020). Evidence shows that belief in women's *primary* responsibility for childcare is much stronger among Black children than children of other races. Among the various population groups in South Africa, only 32% of Black children are raised with their biological fathers at home. This compares with 51% of Coloured children, 86% of Indian or Asian children and 80% of white children (Statistics South Africa 2018). This suggests that, while men are less engaged in caregiving in general, in Black African households fathers are more likely to be non-resident members, which poses challenges to involvement in caregiving (Hall and Mokomane 2018).

The higher likelihood of fathers living apart from their children, compared with mothers, can be attributed to male-dominated labour migration patterns and specific institutional limitations during the apartheid era. These constraints prevented Black African men from permanently settling in urban areas with their families. Due to the contractual nature of employment and the imposed restrictions, many labourers found it challenging to establish stable homes in these urban areas, leading to family separation (Hatch and Posel 2018). Following the end of apartheid laws and residential restrictions in post-apartheid South Africa, numerous Black male labourers chose to continue working as migrants, periodically returning to their rural homes. This decision was influenced by economic factors, as urban areas faced a lack of affordable housing, and job insecurity remained high. This was due to mechanisation of the labour process and past apartheid policies that led to an excess of labour supply, manifesting in high unemployment levels (Posel 2010).

For many, maintaining a rural homestead served as a safety net and held emotional and family ties. Consequently, non-resident fathers, as a result of male labour migrancy, became prevalent in many Black families in South Africa, due to a combination of economic necessity, practical considerations, and personal choices (Ratele 2018). As Ratele (2018) notes, it is important to emphasise that the absence of men, particularly fathers, in the households of Black African children is a result of multiple historical and socio-economic factors that collide with race, but does not hinge solely on racial identity. The combination of economic resources (such as money or well-paid employment), social capital (access to supportive social networks), and cultural norms (shaped by historical influences) plays a significant role in explaining this relationship.

During apartheid, Black African women had limited access to education and training and were often excluded from formalised employment opportunities. As a result, the so-called 'helping professions'—teaching, nursing, and later social work—were among the few avenues that offered stable employment opportunities and career advancement for Black women (Lund 2010).

In addition to women's disproportionate responsibility for childcare, they are also at the centre of care through the prevalence of female-headed households. It is important to note that the idea of assigning sole responsibility for a household to a single household head is flawed, because different members may have distinct roles in managing, and making decisions for, the household. Responsibilities can be shared among household members, including non-resident adults (Hall and Mokomane 2018). However, the concept does possess analytical value in assessing the fragility of households where there are "only adult women and no adult men, or where there are both women and men, but a woman is identified as being the nominal household head" (Hall and Mokomane 2018). Female-headed households are by no means a new phenomenon. During apartheid, it was recorded that over 50% of African households in the rural homelands were headed by women (Hall and Mokomane 2018).In 2023, over two-fifths (42%) of all households were headed by women, with female-headed households being most common in rural areas (Statistics South Africa, 2024). Due to unequal access to the labour market, these households are significantly more vulnerable to crises, as they are more likely than male-headed households to have no employed residents and to rely heavily on social grants as their primary source of income. In 2023, approximately 58% of female-headed households depended on a social grant, often supporting multiple generations (Statistics South Africa 2024).

The absence of men in households, particularly among the Black African population, and the high proportion of female-headed households, also indicate that women not only provide the bulk of unpaid practical caregiving, but are more likely to take on a financial caregiving role. The traditional gendered division of labour in childcare involves women taking on the primary responsibility for the physical care of children, while men primarily contribute through financial support (Hatch and Posel 2018). Since the mid-1990s, South Africa has seen a significant rise in women's participation in the labour force, outpacing the slower increase in male participation. This trend, particularly during the first two decades of democracy, has led to a feminisation of the labour force. While women's participation and employment in the labour market has grown more rapidly than men's, it hasn't been sufficient to fully absorb all the new female entrants into the workforce (Posel and Casale 2019). As women's participation in both the formal and informal labour markets has increased, shifts in the traditional gendered division of labour have occurred. Men are no longer the sole 'breadwinners,' as many women now contribute significantly to household expenses, making this division of labour more flexible.

Using nationally representative data from the National Income Dynamics Study (NIDS), Hatch and Posel (2018) examine cost-sharing patterns for child care among different racial groups in South Africa. Their findings indicate that, for non-Black African children, financial responsibility for child care is generally more evenly distributed between men and women when both are members of the household. In contrast, for Black African children, women bear a significantly larger share of this financial burden. Specifically, the study estimates that around 72% of Black African children have their education expenses paid by women, highlighting a pronounced gender disparity in financial responsibilities within these households (Hatch & Posel 2018).

The historical legacy of apartheid has also informed Black African women's overrepresentation in the paid care sector. During apartheid, Black African women had limited access to education and training and were often excluded from formalised employment opportunities. As a result, the so-called 'helping professions'—teaching, nursing, and later social work—were among the few avenues that offered stable employment opportunities and career advancement for Black women (Lund 2010). In 1995, only 69,000 Black African women were re-

ported to be working in professional occupations or as legislators, senior officials or managers (Casale and Posel 2011). This historic legacy still influences the overrepresentation of Black women in paid care sectors today.

Prior to colonial imposition and the establishment of the apartheid system, care and social reproductive labour were subject to varying degrees of stratification, primarily through gender and age. A variety of systems of female subordination existed across the country, forming what Bozzoli (1999) described as "a patchwork quilt of patriarchies". In all Bantu-speaking societies, regardless of the difference between matrilineal and patrilineal systems, women were subject to some degree of control, particularly by the heads of families or chiefs. For example, in Zulu society, women were often prohibited from owning cattle, reinforcing their exclusion from the primary source of wealth. Women were socialised into accepting "a position of inferiority" through material controls and bore the brunt of agriculture, childcare, cooking, cleaning, and household maintenance (Bozzoli 1999).

The apartheid system, laid on top of these pre-existing patriarchal norms, has led to a particular dimension of caregiving in South Africa that is racialised, classed, and gendered. Owing to apartheid-era policies and infrastructural constraints, such as limited access to basic utilities, women were and continue to be responsible for tasks beyond narrow conceptions of 'care,' such as childcare and household duties. They carry out unpaid care work in areas like fetching water and gathering firewood. This labour often serves as a subsidy to fill the gaps of poor government administration and under-resourced public services.

The forging of modern patriarchy in South Africa must be interpreted as the result of the interplay between state formation processes and the historical givens of pre-existing societies. This contextual consideration of various forms of patriarchal control does not reduce the impact of the migrant labour system in entrenching unequal gender relations and reifying specific gender norms. Instead, it highlights that the seeds of oppression against women in South Africa were not solely sown by capitalist infiltration, but were deeply intertwined with global patriarchy, pre-existing pre-colonial patriarchies, and the apartheid system, which together shaped the country's social and macroeconomic frameworks.

The interplay of historical policies and economic models under apartheid and its aftermath has therefore fundamentally shaped the care landscape in South Africa. The migrant labour system, a hallmark of these policies, has set lasting patterns of caregiving that predominantly affect women, children, and the elderly among the Black population. It is against this backdrop that democratic-era care policy must be viewed.

The next section examines the significant policy shift in South Africa's early post-apartheid transition from the Reconstruction and Development Programme (RDP) to the Growth, Employment, and Redistribution (GEAR) strategy. This transition has critically influenced caregiving dynamics, placing an increased burden on specific demographics. By delving into these changes, we aim to better understand how state-led strategies have distinctly crafted who provides care and the conditions under which they do so, reinforcing certain societal norms and expectations around caregiving roles.

4. SOCIAL POLICY AND THE CARE DIAMOND IN POST-APARTHEID SOUTH AFRICA

Since the advent of democracy in South Africa, the nation's macroeconomic policy landscape has experienced significant shifts, reflecting a dynamic approach to addressing the complex legacies of apartheid. From the Reconstruction and Development Programme (RDP) initiated right after apartheid to the more recent National Development Plan (NDP), each policy paradigm has sought to tackle pressing social and economic challenges in varying ways. Key programmes include the Growth, Employment, and Redistribution (GEAR) strategy, the Accelerated and Shared Growth Initiative for South Africa (ASGISA), and the New Growth Path (NGP), each marking a distinct phase in the country's developmental agenda.

Importantly, the transition from the RDP to GEAR marks a seminal shift in the post-apartheid era, often characterised by scholars such as Van der Westhuizen (2015, 19) ,as setting South Africa on a path of "self-imposed structural adjustment". This transition has significant implications for the care economy, as seen in the White Paper on Social Welfare (WPSW), in understanding how broader economic shifts have informed dynamics within the care diamond. Social and macroeconomic policies have explicitly shaped the roles within the care diamond, by outlining the responsibilities and expectations of these actors. This approach highlights the systemic implications of macroeconomic policies for caregiving structures, demonstrating that shifts in economic strategies profoundly affect the distribution and quality of care, thereby reinforcing particular gendered approaches to caregiving, which manifest in social and economic inequality.

Care ethicists such as FitzGerald (2020), Sevenhuijsen (2004), and Robinson (2011) emphasise the profound link between the prevailing arrangements, practices, and dynamics of care and the contents of social policy documents. As noted by Sevenhuijsen *et al*. (2003), policy documents serve as "vehicles of normative paradigms," necessitating a critical examination to reveal how contemporary care dynamics are systematically shaped and entrenched. In this light, each macroeconomic framework, often perceived as neutral and objective, inherently carries a specific blueprint that influences the ideological and material investments in care. This examination is vital as, according to Budlender and Lund (2011, p. 925), "social policies themselves, explicitly or implicitly contain a model of family life. Such a model expresses the care roles of men and of women, and the role of paid and unpaid work in earning income and providing for the material security and well-being of family members." Therefore, understanding these policies in relation to care involves scrutinising how they support or undermine the caregiving roles assigned to different members of society, particularly in terms of gender distribution and economic impact. By focusing on the pivotal shift from RDP to GEAR, and examining the White Paper on Social Welfare, we are able to unearth the approaches to care that have been endorsed or neglected, offering insights into how these policies have sculpted the current state of care in South Africa.

The RDP, originally the ANC's 1994 election manifesto, was introduced as a transformative agenda aimed at redressing the social and economic inequalities entrenched by decades of apartheid. It was heavily focused on social welfare, healthcare, housing, and providing basic services, with an emphasis on improving the lives of the disenfranchised majority. The programme aimed to democratise the provisioning of services and ensure a

GEAR fundamentally redefined the state's role from direct provider to facilitator in economic and social realms, advocating reduced state intervention and greater market orientation (Isaacs 2014).

more equitable distribution of resources, which included significant efforts towards improving education and health services as integral components of social care (Sevenhuijsen *et al*. 1997; Parenzee and Budlender 2015; Patel and Triegaardt 2008).

However, South Africa was not immune to the global spread of developmental and neoliberal ideas that significantly influenced social policy during the 1990s (Patel 2012). The adoption of the Growth, Employment, and Redistribution (GEAR) policy in 1996 exemplified this trend, aiming to attract foreign direct investment and integrate the South African economy into the global economic system after years of isolation, economic turmoil, and indebtedness. GEAR marked a departure from the social objectives of the RDP, emphasising social development through job creation and enhancing productive capabilities. GEAR leaned towards neoliberal policies in response to pressures from influential business and capital interests, steering the country towards a path focused on macroeconomic stability, growth through trade, and fiscal discipline (Patel 2012).

This shift was characterised by a reduction in government spending, liberalisation of trade, and an increased focus on attracting foreign investment. This strategic pivot prioritised economic efficiency and growth, reshaping the landscape of social welfare by advocating for a reduced state role in the economy (Visser 2009). GEAR suggested that economic growth should be driven primarily by the private sector. This involved privatising state-owned assets, curtailing government expenditures, and fostering an export-oriented economy that could compete internationally. Moreover, GEAR called for the relaxation of exchange controls and a restructuring of social service delivery budgets and municipal infrastructure programmes more effectively to meet the basic needs of the poor (Adelzadeh 1996). It also proposed that social services which were either not universally available or could be more efficiently managed by the private sector, such as social assistance grants for impoverished children, should be reduced or eliminated (Meyer 2000). The central government would unilaterally determine the priorities and funding allocations for social and sectoral policies, indicating a profound departure from the RDP's emphasis on direct social support, and fundamentally altering the management of care responsibilities and social support within the country (Bond 2000).

The WPSW of 1997 emerged during this pivotal shift in South Africa's macroeconomic strategy. It stands as a seminal document shaping social welfare in the democratic era. This policy framework not only aimed to rectify historical disparities, but also sought to conceptualise the role of social welfare within the broader context of social development. It was founded on a 'social development' or 'developmental social welfare' approach. This approach underscores the interconnectedness between economic growth and social progress, emphasising the importance of investing in crucial social services to advance overall wellbeing (Midgley 1995). Within this paradigm, an ideal citizen is characterised by self-reliance, independence, and active economic participation (Bozalek *et al*. 2007). While this perspective views social security and services as investments leading to economic benefits, it raises concerns about aligning welfare with economic imperatives rather than societal needs, undermining the rationale for welfare programmes (Bond 2014).

The linkage between GEAR's neoliberal framework and the WPSW provides a nuanced understanding of the evolution of social policy post apartheid. GEAR fundamentally redefined the state's role from direct provider to facilitator in economic and social realms, advocating reduced state intervention and greater market orientation (Isaacs 2014). This paradigm shift significantly influenced the structure and objectives outlined in the WPSW, embedding a similar neoliberal philosophy that emphasised privatisation, market-driven solutions, and reduced fiscal spending on direct social services.

The WPSW, under this influence, stressed the importance of family and community responsibility in the pro-

vision of welfare services, reflecting GEAR's ethos of minimising public sector provision in favour of market solutions and private sector engagement. This approach is clearly outlined in the WPSW, which suggests that the availability and quality of care are to be managed through a blend of private initiative and minimal state intervention. The document underlines the state's role as an enabler rather than a provider, which aligns closely with GEAR's principles that view economic growth and efficiency as precursors to social development.

Furthermore, both GEAR and the WPSW share a conceptual approach, in which policy is framed as objective and rational, emphasising economic efficiency over social equity. This is critiqued for masquerading as ethical and moral considerations under the guise of economic rationalism, in which policies are presented as neutral, despite inherently involving value-laden decisions that affect social outcomes. This link, between economic policies under GEAR and social policies as shaped by the WPSW, illustrates a continuity in the application of neoliberal principles, where the overarching goal is to integrate social policy into a broader economic framework that prioritises market mechanisms and individual responsibility over collective welfare and state-driven support. This synthesis of GEAR's macroeconomic policies into the social policy arena through the WPSW demonstrates a clear pathway that continues to influence the fabric of the South African social policy landscape, echoing neoliberal tenets that have profound implications for the distribution of care responsibilities and the conceptualisation of welfare and social services in the nation.

Social policy and care scholars, such as Sevenhuijsen (2003), have analysed the WPSW through the lens of care as a social practice, as a moral practice, and as a political practice, further providing a comprehensive view of the state's policy approach to care. The WPSW broadly acknowledges that caregiving, particularly for women,

The link between economic policies under GEAR and social policies as shaped by the WPSW, illustrates a continuity in the application of neoliberal principles, where the overarching goal is to integrate social policy into a broader economic framework that prioritises market mechanisms and individual responsibility over collective welfare and state-driven support. (Photo: Zoonar/Sunshine Seeds / Alamy Stock Photo)

can have burdensome aspects, noting that extended time spent on care "can lead to financial vulnerability and increased psychological stress" (Department of Welfare, 1997, p. 32). Further, the WPSW recognises how social relief programmes can contribute to reducing this burden of care. However, acknowledgement of the burden of care and the potential of social relief programmes is eroded, as the White Paper ultimately stresses a "familialist understanding of care", in which the practice of care is largely "relegated to the separate, private sphere of 'households' and 'families'" (Sevenhuijsen *et al*. 2003, p. 306). This familialist approach positions the family as the primary provider of care, emphasising its role in development, protection, and security, but overlooks the gendered division of labour within families, where women disproportionately shoulder caregiving responsibilities. In the sections on family, the allocation of care to the family is made explicit. The WPSW notes that "The family is the basic unit of society. Family life will be strengthened and promoted through family-oriented policies and programmes" (Department of Social Welfare 1997, p. 39).

The turn to a familialist approach to care is well demonstrated in the context of care for older people. The WPSW problematises the overreliance, particularly among the white population, on institutional care for older people and the "inappropriate emphasis on the Government's responsibility for the care of the aged" (Department of Welfare 1997, p. 69). The White Paper argues that the family should be "the core support system for the elderly", thus shifting away from the notion of "care for the aged" to ageing within the family unit. Ultimately, the WPSW fails to acknowledge the disproportionate time and labour commitments made by women within families to manage, provide, and perform unpaid care, particularly for older persons and those requiring extensive assistance. The WPSW argues that women should receive support in their caregiving roles, without examining the gender divisions in caregiving through the lens of gender justice. Additionally, it overlooks the fact that older people are often caregivers themselves. In parts of the White Paper, where women's disproportionate role in caregiving is vaguely acknowledged, it is referenced in terms of contributions to the community and the extent to which these efforts "have generally been invisible to social planners and policymakers" (Department of Welfare 1997). This kind of recognition is largely instrumentalist: it views women's caregiving roles as useful to development outcomes, but does not address societal wellbeing or the wellness of the women themselves.

The overarching failure to adequately make visible the complexities of unpaid caring work is evident in the situational analysis of women. In the chapter on social security, one proposed strategy to support and preserve the 'family unit' is the "promotion of policies to fully integrate women into the economy" (Department of Welfare 1997, p. 36). Meanwhile, other sections emphasise the crucial role of women as caregivers within the family and community. The WPSW acknowledges that women's contributions, particularly as primary caregivers to family members with special needs, have "not been previously acknowledged" (Department of Welfare 1997, p.37). It is suggested that options such as "employment opportunities and financial support" should be explored to recognise or compensate for this 'invisible' contribution.

However, the WPSW fails to explore the challenging balance between women's entry into the labour market and their care responsibilities. It does not adequately address the need to reduce or redistribute these responsibilities. This oversight results in a contradiction: promoting women's labour force participation, while simultaneously relying on their unpaid labour, threatens to increase the burden of care on women. This dual expectation places a double burden on women: they are expected to succeed in the labour market without sufficient state support to alleviate their caregiving duties.

The WPSW and its provisions reflect a distinct neoliberal shift, as outlined in GEAR, particularly in its reliance on families—and predominantly women—for providing care. This is exemplified by its ambiguous delineation of public responsibilities for care, which calls for "an intersectoral response … within Government and between Government and civil society to adequately address welfare needs" (Department of Welfare 1997, p. 2). While the Department of Welfare (now the Department of Social Welfare) is tasked with coordinating among stakeholders, reviewing policy, planning, establishing norms and standards for social services, developing financial

The WPSW's familialist orientation, combined with neoliberal economic priorities and a heavy reliance on women's unpaid labour, significantly undermines its potential to effectively address the multifaceted dimensions of care.

management systems, and overseeing the implementation of social welfare services (Department of Welfare 1997, pp. 25-26), the actual burden of care often shifts to families due to vague policy directives and underfunded public initiatives. This policy orientation aligns with GEAR's broader economic reforms that emphasise market efficiency and reduced state involvement, effectively placing greater responsibility on non-state actors, including families and civil society organisations, to manage and provide care.

The alignment between GEAR's neoliberal framework and the WPSW reveals a consistent theme of reduced state intervention in public provisioning. GEAR, as South Africa's macroeconomic strategy, advocated a minimised role for the state, championing private sector-led growth and a more restrictive fiscal policy. This philosophy deeply influenced the WPSW, steering it towards a shift from robust, state-led welfare initiatives to more market-oriented solutions.

The WPSW emphasises this shift, with Sevenhuijsen et al. (2003) observing that the paper "remains quite vague in the end about who should be responsible for the availability and quality of care on a social scale." The absence of state involvement in setting care benchmarks and the failure to clearly define the state's proactive role have profound implications across practical, moral, and political dimensions of care, mirroring the neoliberal ethos of reducing direct state involvement in social services. This vagueness results in significant care provision gaps, especially affecting the most vulnerable populations. The state's approach, characterised by shifting responsibilities downward to individuals and families without adequate support, framed in terms of communitarianism and familialism, implicitly relies on women's unpaid or underpaid care work. This disconnect between policy intentions and the caregiving realities in South Africa highlights significant gaps (Sevenhuijsen *et al*. 2003; Gouws and Van Zyl 2014; Makina 2009).

Furthermore, the WPSW's focus on self-reliance, and its limited recognition of the intersectional pressures of gender, race, and class in care provision, perpetuates existing inequalities. By framing care as a private, familial responsibility rather than a public and collective one, the policy effectively depoliticises care. This stance ensures that care remains marginalised in broader socio-political discussions, contradicting the arguments that advocate recognising care as a critical political and social activity necessitating active state intervention and robust public policy support. This approach, emblematic of GEAR, underscores a broader neoliberal agenda that not only prioritises economic efficiency over social equity, but also systematically undermines the capacity of the state to act as a guarantor of social welfare.

Today, the WPSW's treatment of care has numerous implications for South Africa. The White Paper is among the few policy documents that elaborates on a framework for social welfare in the post-apartheid context. However, it exemplifies a male orthodoxy in policy-making that does not sufficiently highlight the dynamics of care within our social and welfare systems. Similarly, GEAR, a seminal macroeconomic policy in South Africa's history, set a firm path of austerity, with poor recognition and valuation of care.

As noted in Section 2.2 of the WPSW, traditional economic models, dominated by the concept of the 'economic man,' prioritise rationalism and self-interest, while diminishing the value of care and altruism, traditionally seen as feminine (Marcal 2021; Tronto 1994). This patriarchal approach marginalises the social and emotional aspects of human life, reinforcing the systemic devaluation of care work and perpetuating gender roles and economic disparities. Consequently, economic policies like the WPSW and GEAR, grounded in these orthodox economic discourses, undervalue care work and exploit caregivers—predominantly women—under the guise of economic efficiency and familial responsibility. This approach fails to alleviate the burden of care and reinforces the socio-economic disparities the policies originally sought to mitigate.

The WPSW's familialist orientation, combined with neoliberal economic priorities and a heavy reliance on women's unpaid labour, significantly undermines its potential to effectively address the multifaceted dimensions of care. By emphasising family-based care within a neoliberal context, the policy inadvertently contributes to a care crisis, and perpetuates the marginalisation of women's unpaid labour. This approach can be likened to a "well-calculated form of care extractivism", which exacerbates inequalities and exploitation within caregiving dynamics (Wichterich 2020). The concept of care extractivism, analogous to resource extractivism, shifts the focus from productive and industrial value creation to reproductive and affective work. It highlights how neoliberal policies adopt strategies of care extractivism to address crises in social and biological reproduction—such as shortages of caregivers and teachers—without imposing additional costs or social responsibilities on the state. Through this lens, care workers are constructed as cheap labour in care markets, navigating social hierarchies of gender, class, and race. This exploitation of women leads to their well-being being compromised and their time poverty exacerbated, negatively impacting their economic outcomes linked to caregiving.

In terms of the care diamond, and delineating the responsibilities of all actors, the WPSW illustrates the immense reliance on women's unpaid care labour without adequately laying out a blueprint for other actors, particularly the state. In the next section, we delve into the ways in which NGOs emerge as a "stop-gap" in many ways, supplementing the failure of the state in its provision and often overburdening volunteers, the majority of whom are women within these organisations. This next section explores the welfare system and its implications based on these normative and policy discourses. This will involve a detailed examination of the landscape of social welfare and social assistance, ranging from social grants to social services. By understanding the interplay between these policy frameworks and the actual provision of welfare, the subsequent sections provide insight into the broader implications for equity, social justice, and the quality of care in South Africa.

This exploitation of women leads to their well-being being compromised and their time poverty exacerbated, negatively impacting their economic outcomes linked to caregiving. (Photo: Lucas Ledwaba / Alamy Stock Photo)

5. THE SYSTEM OF SOCIAL PROVISION: SOCIAL SECURITY, WELFARE SERVICES AND GRANTS

Shaped by a predominantly neoliberal framework, social policies were crafted within a specific ideological and socio-political context during the establishment of South Africa's first democratic welfare system. Understanding this link between ideology and policy content is crucial for comprehending the adopted models of social provisioning. The previous section delved into the ideological foundations and 'normative vocabularies' retained in social policy documents, such as the WPSW; this section examines the actual contents of social welfare policies (Sevenhuijsen *et al.* 2004). It also explores their implications for caregiving dynamics in the care diamond, including the household, non-profit sector, public sector, and private sector.

In 1994, the newly-elected government established a far-reaching, ambitious mandate for transforming South Africa's welfare system. Faced with a mountain of urgent issues inherited from the racist apartheid regime, three critical priorities were identified: eliminating bureaucratic barriers to disability grants for Black African individuals, expanding legal access to grants for supporting impoverished children in Black African families, and reforming funding for residential institutions, particularly those catering to the elderly (Button *et al.* 2018). However, due to austerity measures and macroeconomic policies such as GEAR during the formation of social welfare and attendant programmes, the list of achievable goals was further compromised. As a result, reforming social welfare for special target groups and social security (social insurance) became the core goal (Patel 2008). This linkage underscores how the broader economic framework, including self-imposed structural adjustments, constrained the scope and effectiveness of social welfare reforms. South Africa's welfare system can be broadly understood as consisting of two 'arms': social security and social welfare services. These are critically evaluated in this section.

5.1 Social security

Social security, sometimes referred to as social protection, refers to "a wide range of public and private measures that provide cash or in-kind benefits" (Patel 2000). The 1992 Social Assistance Act dispensed with all discriminatory provisions and expanded social pensions and grants to all South Africans (Woolard and Leibbrant 2010). A total of seven grants have been de-racialised and extended, and in some cases established, in the post-apartheid context: the Child Support Grant (CSG), Old Age Pension (OAP), Disability Grant, Foster Care Grant, Grant-In-Aid, War Veterans Grant, and the Care Dependency Grant. Since the Covid-19 pandemic, the Social Relief of Distress (SRD) grant has been made semi-permanent. These social grants are primarily tax-funded, unconditional, and mostly means-tested cash transfers, aimed at providing support to specific groups considered 'deserving,' such as children, the elderly, and individuals with disabilities (Moore and Seekings 2019).

According to the South African Social Security Agency (SASSA 2023), as of 2023, 47% of the population relies on a monthly grant. In contemporary South Africa, social cash transfers are associated with positive effects on poverty and inequality (Patel 2023). Research and evidence indicate that social grants and social protection

Research also suggests that grants, despite their multiplier effects, often give rise to unforeseen consequences on care relationships, a concern shared by various experts in social policy.

programmes in South Africa play a crucial role in poverty reduction (Posel and Rogan 2012), improving child educational outcomes (Heinrich et al. 2012), fostering dignity among older individuals (Sagner and Mtati 1999), and enhancing the wellbeing of mothers and children (Wright et al. 2015; Zembe-Mkabile et al. 2015). Additionally, studies suggest that social grants are frequently utilised to subsidise and support livelihood activities and other productive endeavours in the market (Granlund and Hochfeld 2020). Due to the high levels of unemployment in South Africa, and the lack of benefits for the unemployed, social grants often serve as a primary source of income (Moore 2020).

Research also suggests that grants, despite their multiplier effects, often give rise to unforeseen consequences on care relationships, a concern shared by various experts in social policy (for example, see Moore and Seekings 2019). They do this in two main ways: first, through a distinctly gendered dimension, and second, due to the targeted nature of cash transfers.

Grants in South Africa display a distinct gendered dimension. Prior to the introduction of the COVID-19 SRD grant, approximately 14 million grants were paid to women, with only 3 million paid to men (Moore and Seekings 2019). The majority of those receiving a monthly cash grant from the state are recipients of the CSG. This grant serves as a progressive innovation intended to deviate from the traditional 'male breadwinner model' that has historically shaped social protection policies in South Africa. It introduced the innovative 'Follow the Child' principle, wherein the primary caregiver of the beneficiary child, regardless of their identity, receives the grant on behalf of the child (Patel and Hochfeld 2011). In 2022/2023 it was recorded that approximately 13 million children were recipients of the CSG, with the majority of these grants being paid out to women (Statistics South Africa 2022).

Consequently, the originally gender-neutral and child-focused cash transfer, the CSG, has taken on a 'feminised' character. This shift has occurred due to the prevailing societal expectation that women should assume the primary caregiving role for children. In general, research indicates that households receiving the CSG are more vulnerable than non-CSG households due to various factors. CSG households tend to be larger in size, have limited access to essential services, primarily consist of Black South Africans, possess lower levels of education, and face challenges in accessing employment or generating income (Delany *et al*. 2008). The CSG is primarily used to offset the costs of food and other necessities for children as well as other household members. It is well documented that households experience positive effects from receiving the CSG. This is particularly the case for child beneficiaries in enhancing nutritional intake (Agüero *et al.* 2006) and increasing school attendance rates (Samson *et al.* 2008).

However, the value of grants such as the CSG (set at R530 per month per child in 2024) is insufficient to support, or adequately compensate for, the reality that "women mediate social assistance and deliver it on behalf of the state [and further that] they claim it, collect it and are then expected to turn it into food, shelter, clothing, education, health and other aspects of a child's maintenance through their own labours" (Goldblatt 2005, p. 242). Due to gendered norms of caregiving, women (including some girls) who lack jobs or resources are expected to provide childcare services to society, without receiving anything in return. However, they often lack the means to support themselves or provide for their own necessities. The distinct gender dimensions of grants in South Africa thus yield specific dynamics of caring. Although the professed intention of these provisions is often centred around the welfare of families and children, the actions of states, and the terms under which benefits are provided, contain within them a different set of outcomes. These policies, and the

subsequent modes of social security that emerge from them, inadvertently endorse specific family models and gender dynamics (Razavi 2007). While the original intent of the CSG did not involve directly tackling or reshaping household gender dynamics, it has nonetheless exerted a substantial influence on gender roles, by strengthening the already present caregiving obligations that women bear.

A study conducted by Patel, Hochfeld, and Moodley (2012) aimed to assess the gendered impact of the CSG in Doornkop, Soweto, a low-income urban community. They surveyed 343 households using systematic sampling, with findings applicable to other similar urban areas with high CSG uptake levels. The study revealed that the CSG effectively targets poor households, especially the most impoverished ones. In these households, the CSG serves as the primary income source, supplemented by pensions, disability grants, income from small business activities and casual work, and limited support from family and external agencies. Despite its modest amount, the CSG significantly reduces income poverty among the most vulnerable, particularly in female-headed households.

However, to fully realise its intended impact, the study suggests scaling up coverage and improving access to basic services. For instance, initiatives like the City of Johannesburg's social package, which offers free water, electricity, and sanitation services to all CSG beneficiaries, would be beneficial. Additionally, providing improved access to free school uniforms, school nutrition programmes, and education is crucial for CSG beneficiaries. A comprehensive and holistic package of social welfare, combining direct cash transfers with social welfare services such as those mentioned, would have two positive outcomes. First, such a package would enhance the effectiveness of the CSG, ensuring that the grant is spent on improving the life outcomes and well-being of children, rather than acting as a subsidy for inadequate social infrastructure. Second, these services would reduce the labour and time invested in unpaid care, primarily shouldered by women.

Initiatives like the City of Johannesburg's social package, which offers free water, electricity, and sanitation services to all CSG beneficiaries, would be beneficial. (Photo: Constantinos Pliakos / Alamy Stock Photo)

For example, women in villages across South Africa walk approximately 6 km daily to collect water from open sources for their families. This water is often contaminated, and they then need to walk back with 20-25 litres of water on their heads (Hemson 2007). This unpaid work could be eliminated by investing in water and sanitation infrastructure, provided access is affordable, thus reducing the burden of care and yielding numerous benefits, particularly for women's well-being. Rural electrification in South Africa, for instance, reduced the time women spent on tasks such as collecting firewood, boosting their participation in paid work by 9% and improving their autonomy (Ferrant et al. 2014).

Such a comprehensive package advances care policy by fulfilling the second 'R' (reduction) and facilitating the redistribution of care responsibilities to the state (Elson 2017). In other words, it would reduce the time, labour, and emotional and mental load of unpaid care work. Additionally, it would set in motion a broader socialisation of care work, by ensuring that the state and the public sector take on an active care role, through effective and accessible provisioning. The CSG alone is an example of a welfare programme that has not retained a sufficient care lens or met the requirements of a comprehensive care policy. While the CSG has been successful in improving child nutrition and schooling, it lacks a caregiver component, failing to recognise the essential work women do to make it effective. This prompts an examination of whether women have benefited, or faced disadvantages, from their caregiving roles, as well as potential other unintended consequences (Patel 2012).

Similarly, the provision of the OAG or 'pension grant' is a core social policy response to poverty and welfare provision in South Africa. Approximately nine out of ten older people receive the OAG at a rate of R2,080 per month (Statistics South Africa 2023; Moore and Seekings 2019). Moore and Seekings (2019) explain that, due to the crisis of unemployment and pervasive joblessness in the country, grants, particularly the OAG, are used as the main source of income in many households. This is unsurprising in a context in which nearly 80% of households are headed by an elderly person and multigenerational living is the norm (Moore and Seekings 2019). Due to the way in which the OAG is allocated in households, it has been a successful mechanism in reducing poverty and improving the economic stability of grant recipients' households, with older family members being positioned to provide care.

However, the usage of the OAG differs between men and women. Older women use the OAG to support their younger relatives and often assume the position of "financial caregivers" in their families (Moore 2020; Cantillon et al. 2021, p. 197). In contrast, while there is limited research on how men specifically utilise the OAG, evidence suggests a distinct pattern: women's management of the grants typically results in a notable increase in expenditure on food, with less spent on transportation, alcohol, and tobacco (Duflo, 2000). This shift in spending priorities reflects the caregiving role of women and significantly enhances child nutrition, underscoring the impact of women's financial decision-making on household welfare (Moore 2021). Such spending patterns reveal how state policies and welfare programmes inadvertently maintain traditional caregiving roles within families, reinforcing the position of older women as both practical and financial caregivers. This linkage between the allocation of grants and the support of traditional family roles highlights the critical impact of older women's spending habits on family welfare, contrasting with the less targeted spending patterns observed among male recipients of the OAG (Moore 2021).

Aside from the OAG and the CSG, the provision of cash support in South Africa has been limited. Before the introduction of the COVID-19 SRD grant in 2020, the nation's social welfare system did not cover an estimated 16 to 22 million impoverished adults who are able-bodied and of working age (IEJ, 2022). These individuals, despite being structurally marginalised from the economy, were deemed ineligible for social aid due to the targeting mechanisms of the welfare system (IEJ 2022). This exclusion not only adversely affects them, but also places additional financial burdens on their families. Often, those receiving grants are forced to extend their limited benefits to the support of ineligible family members. This situation underscores the importance of understanding the broader context in which these grants operate: they exist in an environment where paid

Due to the nature of grants in South Africa, as means-tested cash transfers, individuals that do not meet the criteria but are nonetheless poor have little-to-no access to non-wage forms of subsistence.

employment opportunities are scarce and public perception is mixed. Some view these grants as a critical lifeline, while others see them as a system that inadvertently encourages "dependency" (Dubbeld 2013). This dichotomy highlights the complex role of social grants within the socio-economic framework of the country.

Research suggests that the label of grants as 'hand-outs' often triggers feelings of resentment and injustice among those who do not receive them (Surender *et al.* 2009). Such views may lead some to regard grant recipients as 'lazy' or undeserving, fostering negative stereotypes and stigmatisation. This adverse perception can intensify community tensions and sow discord within family and kinship networks. Scholars such as Moore and Seekings (2019) highlight the tangible impact of these perceptions, noting that means-tested or criteria-based grant systems can disrupt traditional communal values. These scholars contend that while targeted social assistance programmes are effective in alleviating poverty, they can also strain household relationships by creating conflicts over financial support and caregiving responsibilities. This underscores the complex social dynamics that these programmes can engender, affecting not just economic but also social and familial structures.

Due to the nature of grants in South Africa, as means-tested cash transfers, individuals that do not meet the criteria but are nonetheless poor have little-to-no access to non-wage forms of subsistence. As a result, tensions arise as some individuals are granted access to grants while others are not. The prevailing grant structure thus has the potential to intensify dependence on kin, especially among those that are recipients of grants (this is particularly prevalent in households where grants are the main form of income). The underlying issue is that most grants (with the partial exception of the CSG) "confer rights on selected individuals without any acknowledgement of their social responsibilities or obligations to other kin" (Moore and Seekings 2019, p. 6).

Grant-sharing, given the economic and social landscape, is extremely prevalent in South African households but is usually understood through a classical economic lens. This means that the household is viewed as being a site of altruistic virtues: kindness and willingness to share. However, Mosoetsa (2011) explains that "it is not consistent to argue that individuals who are wholly selfish in the marketplace, as proposed by many economists, would be selfless within the household". Contrary to popular belief, sharing is not the natural disposition of the home, particularly in times of crisis. In fact, family life "is shifting and is a somewhat unpredictable mixture of selfishness and altruism" (Mosoetsa 2011, p. 58). While income might be pooled, its distribution remains contingent upon traditional roles informed by gender and age. As a result "tensions arise not only around the redistribution of social grants to dependent kin but also around the distribution of care" (Moore and Seekings 2019, p. 3).

The current grant-structure is extremely important to the system of social provisioning and poverty alleviation in South Africa. However, social cash transfers can only realise their full potential within a welfare system that strives to provide high quality and widely accessible social care, and quality public services (such as healthcare). In reality, the state has over the decades rapidly withdrawn from the provision of state-funded care, particularly for older people and people with disabilities. In the absence of strong infrastructural capacity and a distinct commitment to the provision of socially-provided care, the state increases the unpaid burden of care—which predominantly falls onto women—and households, communities, and individuals become *de facto* shock absorbers.

5.2 Social welfare

The adoption of a policy that emphasised fiscal restraint and economic liberalisation, as discussed in earlier sections, has had profound implications for the provision of social welfare, particularly social welfare services (Patel 2012). Social welfare services refer to a range of organised public or private services that are designed to support individuals and communities in meeting their social, educational, and health needs. These services aim to enhance the well-being of individuals, especially those who are vulnerable, disadvantaged, or experiencing various forms of social, economic, or emotional difficulties. These services are intended to provide relief, promote social functionality, prevent further hardship, and facilitate social inclusion, contributing to the overall social stability and cohesion of a community or society.

For a number of reasons, the provision of, and investment in, social welfare services by the state has received considerably less attention than social assistance, and specifically the rollout of social grants. Welfare services include a wide range of programmes including services for children and families, older people, people with disabilities, and people affected by HIV/AIDS, as well as for Gender Based Violence prevention and assistance, crime prevention, and restorative justice services. Patel (2005) observes that the execution of the redesign towards developmental welfare and social work has been a challenging and gradual process. This can largely be attributed to three main factors. First, the growth of social security alongside the inadequate funding of welfare services resulting in a stagnant welfare services sector. Second and related, the insufficiency of human resources, knowledge, and skills necessary to implement the new developmental welfare approach. Third, after the initial progress, a policy vacuum regarding social welfare services that persisted for nearly a decade. In contemporary South Africa, access to social welfare services is fragmented and uneven, often reflecting inequalities based on socio-economic status and urban/rural location. Factors such as the remnants of apartheid, migration, and structural unemployment have put significant strain on these support mechanisms, leading in some cases to their deterioration (Patel 2005).

The approach to social welfare services in the post-apartheid period marked a shift from the social treatment model, which focused on addressing individual needs through professional intervention, to a developmental service delivery model (Patel 2005). This new model aligns with the ideological framework for social assistance and emphasises the role of families, households, and community-based and home-based welfare services. However, the delivery of social welfare services is significantly supported by non-profit organisations (NPOs) and non-governmental organisations (NGOs) that operate in various capacities.

NPOs are the major providers of care services for specific target groups in South Africa, especially in poor communities. They are conceived by the government as their main partners in the delivery of services. NPOs operating in the welfare sector are diverse and have varying contractual relations with the state and donor agencies; these include public service contractors (PSCs), donor-funded NPOs, faith-based organisations (FBOs), and community-based organisations (CBOs). Some organisations fall into more than one of these categories, receiving contracts from the government as well as donor funds (Patel 2009).

As explored in the previous section, the WPSW retains a largely familialist approach to caregiving, allocating the responsibility for care primarily to the family, particularly women. The White Paper proposed a partnership between the state, NPOs, families/households, communities, and the private market (welfare pluralism or a mixed economy of social welfare). However, the precise balance between these components in the welfare architecture was not clearly defined. NPOs, despite poor recognition, continue to carry out the bulk of social welfare services. Similar to the reliance on women for unpaid care work without adequate resourcing, NGOs and NPOs face comparable neglect and lack of attention. The central commonality is their role in addressing and fulfilling care needs (Sevenhuijsen et al. 1997).

The financial ecosystem for these NPOs involves a mixture of government contracts, donor funds, and community support. However, challenges persist across all types of organisations, particularly due to financial

constraints imposed by government policies and complex, often restrictive, funding criteria that do not always align with operational needs or community priorities (Patel 2005). For instance, the Department of Social Development (DSD) transfers a significant portion of its budget to NPOs for service delivery, yet this funding is not consistently adequate or timely, leading to service disruptions and financial strain for many NPOs.

Welfare and care services in South Africa have long suffered from chronic underfunding, especially when compared to social security spending, a situation that has been widely contested by NPOs and CSOs. In 2012, approximately 90% of the social development budget was allocated to social security, leaving only 10% for welfare services—a distribution that varied across provinces (Patel, 2012). By 2014/15, the government had intensified austerity measures, in line with the broader macroeconomic policies of GEAR, further exacerbating the financial strain on welfare services (IEJ, 2021).

The severe consequences of these austerity measures were tragically highlighted by the 2016 Life Esidimeni tragedy, where 143 mentally ill patients died after being transferred from a long-term private facility to under-equipped NGOs. This move, driven by cost-cutting measures, led to gross neglect, with patients suffering from malnutrition and hunger as the NGOs lacked the necessary funds for basic provisions. The situation was further worsened by delayed subsidy payments from the Gauteng health department.

Nearly a decade later, the allocation for social welfare services remains critically low. Persistent issues such as late or absent subsidy payments to organisations providing essential services—including elder care, support for gender-based violence, and disability services—continue to plague the sector (IEJ, 2021). This ongoing underfunding and mismanagement highlights a systemic failure to prioritise and adequately support vital social services. Moreover, the precarious and insufficient funding of NPOs has inevitably led to unstable and illegally low wage levels, particularly affecting migrant women who are overrepresented in these roles. These women often face wage insecurity, lack of legal protections, and exploitation, further entrenching their vulnerability in the labour market. The undervaluation of care work, coupled with inadequate labour protections, has resulted in a workforce that is not only underpaid but also undervalued, perpetuating cycles of poverty and inequality, especially among women and migrants.

The 2024 National Budget has introduced severe cuts to government spending, particularly impacting the social sector's wage bill. The relationship between NGOs and the government has become increasingly dependent, stifling the autonomy and flexibility of these organisations (Vetten 2024). This dependency is intensified by neoliberal economic policies that prioritise cost-cutting and efficiency over the quality and accessibility of social services. Effective social services require human interaction, empathy, and sustained engagement, which cannot be replaced by automated systems or short-term measures (IEJ 2024). The undervaluation of social care work underpins many challenges NGOs face in securing adequate funding and support to meet the real needs of their communities.

The crisis worsened last year when the Gauteng government cut budgets and withdrew funding from more than 100 NPOs, accusing them of not aligning with DSD's annual mandate, or failing to comply with legislation. The budget for NPOs was reduced from R2.4 billion to R1.96 billion, causing significant trauma for beneficiaries and damaging the trust between NGOs and the DSD (Vetten 2024). These budget cuts reflect a shocking disregard for the rights of vulnerable individuals to social care services, and demonstrate a lack of ethical care.

Fiscal consolidation threatens the viability of many NPOs, risking a reduction or complete cessation of services at a time when economic conditions have heightened the demand for social welfare services. Over 11.9 million South Africans are unemployed, and a significant portion of the population faces poverty and inadequate access to essential services (Vetten 2024). NPOs and NGOs grapple with financial instability and policy constraints that hinder their ability to effectively serve the most vulnerable populations. The Care Crisis Committee, representing more than 60 NPOs in the Gauteng province, noted that 30,000 beneficiaries in the disability sector

alone were at risk of losing services, while hundreds of NPOs and thousands of beneficiaries were left in limbo due to the social development funding crisis. According to Lisa Vetten, chair of the Care Crisis Committee, a significant issue is the governmental misunderstanding of the labour-intensive nature of social welfare work, which has been underscored by the systemic challenges faced by NGOs and NPOs (Vetten 2024).

The landscape of social welfare services in South Africa, shaped by decades of economic liberalisation and fiscal restraint policies such as those initiated following the cementing of the GEAR strategy, is characterised by underinvestment and limited accessibility. These policies, while aimed at achieving financial stability, have unfortunately sidelined critical investments in social welfare services, leaving a fragmented and uneven system in their wake.

The implications of this deficient landscape are profound, particularly for women who overwhelmingly bear the burden of unpaid care work. Chronic underinvestment in social welfare contributes to a deeply inequitable system across health, education, and social care sectors. The bifurcated system starkly divides access to care, with wealthier individuals enjoying high-quality, market-based services, while the majority depend on inadequate state-subsidised care. This division perpetuates and deepens socio-economic disparities, challenging the principles of equity and social justice that are supposed to underpin the post-apartheid social landscape.

The model reflects a political economy where neoliberal priorities overshadow social welfare needs. The state's reliance on NGOs as primary care providers, without adequate support, mirrors the broader economic approach that undervalues social services. This relationship, between the paradigm in the WPSW and the neglect NGOs face, highlights the systemic issues within South Africa's social policy framework. The consequences of this model include increased pressure on NGOs, limited effectiveness of social welfare programmes, and perpetuation of socio-economic inequalities. In the next section, we explore these socio-economic disparities in greater detail, examining how the current social welfare policies affect equity, social justice, and the quality of care in South Africa.

Chronic underinvestment in social welfare contributes to a deeply inequitable system across health, education, and social care sectors. (Photo: / Alamy Stock Photo)

5.3 Public/private divide

What is particularly relevant in the South African context is that the flourishing of private care services, alongside austerity measures in public care, highlights a broader systemic issue. South Africa, one of the most unequal countries globally, showcases stark disparities in social care, health, and education access, aligning predominantly along race and wealth lines (World Bank 2018). The slow transformation in policy since the end of apartheid has allowed these divides to persist, leading to the bifurcated and deeply unequal care system. This disparity in care resources perpetuates social inequalities, making quality care a privilege for the wealthier segments of the population. The juxtaposition of well-funded private care and under-resourced public care exacerbates these inequities, underscoring the urgent need for significant policy interventions to address and bridge these deep-rooted socio-economic divides (Fakier and Cock 2009).

This section uses Early Childhood Development (ECD) as a case study to discuss the emergence of the highly unequal and bifurcated care system, which impacts both caregivers and care receivers. The political economy of ECD in South Africa reveals how economic policies and social structures have led to disparities in access and quality of care, perpetuating socio-economic inequalities.

ECDs play a fundamental role in shaping a child's cognitive, emotional, social, and physical development from birth to nine years old. South Africa recognises ECD as a comprehensive approach involving parents and caregivers, aimed at protecting children's rights and enabling them to realise their full potential (Department of Social Development 2023). ECD holds significant national and global importance due to its critical impact on a child's formative years. Rapid cognitive and emotional growth occurs from birth until the start of Grade R in South Africa, making these early years a vital period (Mbarathi et al. 2016).

The majority of ECD services in South Africa are informal and often run by private entities, including NPOs, small-scale social enterprises, and self-sustaining entrepreneurs (Atmore et al. 2012). These facilities primarily serve disadvantaged communities and are typically small, unregistered, and operate with minimal resources and job security, predominantly employing women (Atmore 2023). ECD facilities heavily rely on parent fees as their main source of funding, with limited operational subsidies provided by DSD for registered centres. Stringent registration and subsidy eligibility criteria exclude many centres from financial aid.

According to the 2021 Early Childhood Development Census, only 40% of ECD programmes were registered or conditionally registered, highlighting a significant gap in formal registration. The sector's sustainability largely depends on student enrolment, making it vulnerable to fluctuations in attendance, especially during crises and economic hardships. The main form of government support is a small subsidy of approximately R17 per child per day. Subsidised ECD programmes maintain lower fees, averaging around R208 per month, while non-subsidised centres charge a significantly higher average of R649 per month (Metelerkamp 2022).

According to the General Household Survey 2024, only 31.5% of children aged 0-4 years attend grade R, preschool, nursery school, creche, or educare centre. Approximately 55.5% stay at home with a parent or guardian. In South Africa, the ability of a household to afford fees is a major determinant of whether children access Early Childhood Care and Education (ECCE) services. Higher fees are typically charged for younger children, particularly those aged 0-4 years. The lower average fee for children over five years could be attributed to state subsidisation for Grade R, or the need to compete with free Grade R provisioning in many public schools.

Despite the high costs of childcare being a barrier, a large proportion of families are willing to pay for these services, indicating a strong demand. However, even low-cost services tend to be unaffordable for those in the poorest income categories. Without adequate government funding for childcare, the financial burden falls on families. In South Africa, a market approach to ECCE provisioning is followed, with a large share of private providers charging fees. This approach leads to significant inequalities in provisioning, where poorer children may not access quality ECCE services due to their parents' or caregivers' inability to afford more expensive programmes (Wills and Kika-Mistry 2022).

The main form of government support is the R17 subsidy, which has not increased in six years, decreasing its real value by a quarter. During the same period, food prices have increased by about 39%, making it even more difficult for ECD programmes in poor communities to provide a safe environment, nutritious food, decent working conditions, and age-appropriate stimulation (Wills and Kika-Mistry 2022).

Moreover, the subsidy reaches less than half of eligible children attending an ECD programme. Over 1 million children attending close to 50,000 unregistered township and rural ECD programmes do not qualify. These programmes require government support to meet registration requirements. The R58 million cut to the infrastructure component of the ECD conditional grant in the 2023 budget left only R44 million for support for unregistered ECD programmes in 2023/24. Although the allocation is set to increase to R157 million in 2024/25 and R161 million in 2025/26, much more needs to be done to ensure that provincial education departments can provide the necessary support for registering ECD programmes on a mass scale (Ilifa Labantwana 2024).

The current landscape of early childhood care in South Africa, characterised by a burgeoning private sector and the consequential gaps in service provision for low-income and marginalised groups, can be directly linked to the economic path charted by the Growth, Employment, and Redistribution (GEAR) framework. With its emphasis on market-led growth and fiscal austerity, GEAR set the stage for a reduction in state involvement in essential services, including public childcare.

The practical outcomes of these policies, as detailed by Wills and Kika-Mistry (2022), are that the growth of private childcare services under a market-driven model has not led to equitable access to quality care. Instead, it has often resulted in service duplications and significant gaps, particularly impacting disadvantaged communities. This scenario underscores the long-term effects of GEAR's emphasis on privatisation and reduction of public expenditure in social services, which Dowling (2021) describes as 'double privatisation.' This phenomenon not only forces a larger portion of personal income to be spent on privatised services, but also increases the burden of unpaid care work, typically shouldered by women. Thus, the legacy of GEAR in contemporary South Africa vividly illustrates the challenges and inequalities perpetuated by stringent adherence to neoliberal principles in social policy.

The neoliberal care fix of privatising social reproduction exacerbates these issues. According to the Africa Care Economy Index, childcare and other forms of care are still far from being partially or fully socialised (Valiani 2022). The state does not retain an adequate role in caregiving for ECDs. It relies on a small and insufficient stipend instead of active engagement in establishing, for example, a central coordinating agency driving the main national programmes that fall across the responsibilities of different government departments and social sectors. Without this agency, significant improvements in nutrition, education, and related social outcomes are unlikely.

The combined impacts of austerity, poor governance, and the privatisation of ECD services have severe consequences. Young children, particularly Black children, often miss essential developmental milestones, limiting their future opportunities and overall quality of life. Additionally, the high costs and limited access to ECD services place a disproportionate burden on women, who are left to fill the gap when these services are unavailable (IEJ 2021). The COVID-19 pandemic starkly illustrated this phenomenon. With the closure of ECD centres from 18 March 2020, families—especially women—experienced a dramatic increase in childcare responsibilities, averaging an additional five to nine hours of care per day (Casale and Posel 2020). Research shows that, even before the pandemic, women in South Africa spent significantly more time on unpaid housework and care work than men, with this gap widening in households with young children. During the pandemic, this disparity intensified, as early data from the NIDS-CRAM Wave 1 (2020) indicated that women spent over four additional hours on childcare compared to pre-lockdown levels, underscoring the increased caregiving burden that women bore during the crisis (Casale and Shepherd 2021).

The lack of state intervention in the marketisation of ECD services, and the impacts of austerity measures, have

exacerbated these challenges. Marketisation has led to a reliance on private providers, which often charge high fees, making quality care inaccessible to low-income families. Austerity measures have further strained public resources, reducing the availability and quality of state-supported ECD services. As a result, the caregiving burden has intensified, particularly for women, who must balance increased unpaid care work with limited support. These factors highlight the urgent need for comprehensive state intervention to ensure equitable access to quality ECD services. Without such measures, the disparities in care provision will continue to widen, perpetuating socio-economic inequalities and placing an unsustainable burden on women.

As we transition from focusing on structural inequalities within the provision of care and education, the next section delves deeper into the personal dimensions of this systemic divide, by asking, "Who does care?" This inquiry explores the critical roles played by women, both in paid and unpaid capacities, and older people, particularly older women, within the care economy. We aim to uncover how these individuals navigate and are impacted by the disparities in care access—a legacy of apartheid and ongoing inequitable policies. This section critically examines the support structures that exist for these caregivers and the obstacles they face, shedding light on the real-world implications of policy gaps and financial constraints.

The caregiving burden has intensified, particularly for women, who must balance increased unpaid care work with limited support. (Photo: Dirk Bleyer / Alamy Stock Photo)

6.WHO CARES?

The policies guiding social welfare in South Africa highlight a significant disconnect in recognising and valuing care labour. This marginalisation and peripheral status of care work in economic policy discussions are not remnants of outdated policy attitudes; rather, they are actively perpetuated by current economic strategies that prioritise cost-cutting and efficiency over the genuine needs of care work. This systemic undervaluation has profound implications, particularly for women who form the majority in both unpaid and paid caregiving roles, underscoring a deep-seated gender bias in the structuring of the labour market.

6.1 Value of the care workforce

In contemporary South Africa, women predominantly assume the role of primary caregivers, responsible for tasks such as childcare, elder care, household maintenance, and family support. On average, women dedicate almost double the amount of time to these tasks, with the disparity even more pronounced in households with young children. When young children are present, women tend to allocate substantial portions of their day to household maintenance and caregiving, far exceeding the time spent by men on these activities. The prevalence of women's caregiving roles is a multifaceted outcome of historical, social, and economic processes.

This dynamic of unpaid caregiving extends into the realm of formal employment. Women are more likely than men to be employed in private households, community and social service industries, and in domestic work occupations (Statistics South Africa 2023). South Africa's paid care economy accounts for 13.8% of total employment in the labour market, with women comprising approximately 84% of the workforce in this sector. In South Africa, care services are provided by both public and private entities, in the formal and informal markets, with a significant portion of care work being carried out by nonprofit organisations (Shai 2021).

Paid caregiving is often divided into two categories: nurturant care workers (including doctors, nurses, nursing attendants, childcare workers, teachers, and social workers) and non-nurturant care workers (including domestic workers, cooks, cleaners, and some managers and administrators in care institutions) (Folbre 2014). Women's heavy involvement in both nurturant and non-nurturant roles reflects the extension of their unpaid caregiving responsibilities into their professional lives. This sector, while offering employment opportunities, also mirrors the undervaluation seen in unpaid care, with many of these positions being low-wage, having lower status, and often involving challenging working conditions. Thus, the interplay between unpaid and paid caregiving forms a continuous spectrum, where the skills and burdens of care are both carried over and intensified, underscoring the deep-rooted gender norms that shape women's experiences in both domains.

The overrepresentation of women in the paid care sector in South Africa is a result of various factors. First, owing to the inscription of gender roles and expectations over time, women are responsible for caregiving roles within the family, such as raising children, taking care of the elderly, and supporting those in need. These patriarchal cultural and societal norms often influence women's career options and lead them towards professions that align with these gendered expectations, including paid care sectors such as nursing, social work, and early childhood education. Second, paid care work is often characterised by informal employment arrangements, such as part-time or temporary work, which may provide more flexibility for women who may have additional caregiving responsibilities at home. This flexibility can make paid care work more appealing to women (given their role in unpaid caregiving) who need to balance work with family responsibilities, especially in a context where formal employment opportunities are limited (Casale and Posel 2002). Lastly, as discussed in Section 3, stemming from the historical legacy of apartheid, Black women, excluded from formal employment and with limited access to education and training, found few options for earning a living. Paid care work became one of

Domestic work in South Africa is highly gendered and racialised with a disproportionate number of impoverished Black African women working in this sector.

the primary avenues for employment, leading to the overrepresentation of Black women in caregiving sectors today. Professions like teaching, nursing, and social work offered stable employment and career advancement opportunities for Black women during and after apartheid.

By examining two sectors of the care economy, domestic work and nursing, we can gain a clearer understanding of the entrenched precariousness of paid care work in South Africa, along with its gendered, class-based, and racialized dynamics. It is important to note that data on employment in the paid care sector in South Africa is not centralised. For example, Statistics South Africa's Quarterly Labour Force Survey (QLFS) "does not define a separate industry category for the care sectors and instead captures the majority of these within the community, social and personal services job category" (Shai 2021, p. 9). This category includes educational services, human health services, social work activities, and other services, but notably excludes domestic work, which is reported separately within the private households industry.This fragmented approach to data collection not only overlooks the distinct nature of care work but also contributes to its marginalisation by making it difficult to accurately measure and understand employment conditions within the sector. The lack of disaggregated data hinders efforts to address the specific needs and challenges faced by care workers and to advocate for their rights and improved working conditions. However, feminist scholars have long recognised and attempted to chronicle the challenges faced by domestic workers and others within the social care sector (Ally, 2009; Gaitskell et al. 1983; Maqubela, 2016). Through detailed studies and advocacy, these scholars have highlighted the exploitative working conditions, low wages, and lack of formal recognition that characterise much of the paid care economy. This body of work provides invaluable insights into the lived experiences of care workers, pushing for policy changes and greater visibility for these essential yet undervalued roles.

Domestic work in South Africa is highly gendered and racialised with a disproportionate number of impoverished Black African women working in this sector. The domestic work industry accounts for a large amount of female employment, around 12% of all working women, recorded as 826 000 workers in the first quarter of 2024 (Statistics South Africa, 2024). The average salary of domestic workers in South Africa remains alarmingly low, contributing to ongoing poverty and economic hardship for many of these workers. As of recent estimates, domestic workers in South Africa earn an average of around R2,700 to R3,700 per month, depending on the region and specific employment conditions. This income level is far below the national minimum wage and significantly below the living wage required to meet basic needs such as food, housing, and healthcare.

Many domestic workers, especially those in rural areas, earn even less, further exacerbating their vulnerability to poverty (Statistics South Africa, 2022). The very low pay of domestic workers frequently leaves them and their families in poverty. Beyond the low wages, many individuals in low-skilled care jobs have limited access to social protection and scant opportunities for training, skill development, or career advancement. In addition, a substantial proportion of the paid domestic workforce in South Africa consists of migrant workers from rural areas within the country or from neighbouring countries, particularly in the less formalised segments of the industry. The undervaluation of domestic work stems from the gendered perspective that categorises unpaid domestic work, mostly carried out by women, as part of the "household and care economy", rather than recognising its intrinsic economic value.

The undervaluation of domestic work persists even when it is commodified, largely due to gender stereotypes and the perception of care as a 'natural' inclination of women, rather than a skilled and valuable form of work that requires formal education or training (Hunt and Samman 2020). As Huws (2012, p. 6) notes, "skills which

all women are supposed to possess as a necessary condition for fulfilling their designated role in the domestic division of labour have, by definition, no scarcity whatsoever on the labour market". This perspective results in domestic work being undervalued, as it is associated with gendered conceptions of 'productive' and 'unproductive' work. Unpaid domestic work, primarily conducted by women, is often seen as stemming from women's 'natural' abilities rather than acquired skills or education. Consequently, it is not viewed as having intrinsic economic value and is often not regarded as 'actual work'. These views transfer to paid domestic work, which is subsequently underpaid and undervalued.

However, the undervaluation of domestic work in South Africa is deeply influenced by intersecting factors of gender, race, and class. The perception of domestic work as auxiliary and the societal view of women, particularly Black women, as inherently maternal and caring, significantly contributes to its undervaluation. In South Africa, the historical use of specific racial and cultural groups as 'servants' and 'slaves' has ingrained a low social status for domestic work. This dynamic is exacerbated by the racialised relationships between Black domestic workers and their white employers, a legacy that persists even after the end of apartheid. Additionally, the migrant labour system, which historically segmented the workforce along racial lines, further complicates these dynamics, as it has shaped labour relations and perpetuated econThe undervaluation of domestic work in South Africa is deeply rooted in the intersecting factors of gender, race, and class. Historically, domestic work has been perceived as auxiliary, with societal norms framing it as an extension of the natural roles of women, particularly Black women, who are often viewed as inherently maternal and nurturing. This perception significantly contributes to the ongoing undervaluation of domestic work. The legacy of apartheid, where specific racial and cultural groups were historically exploited as 'servants' or 'slaves,' has entrenched a low social status for domestic work, a dynamic that persists despite the end of apartheid.

This undervaluation is exacerbated by the racialized relationships between Black domestic workers and their predominantly white employers, maintaining a hierarchy that mirrors the apartheid era's oppressive structures. The migrant labour system, which historically divided the workforce along racial lines, further complicates these dynamics by perpetuating economic disparities that continue to affect the care sector today (Ally, 2009). The complex interplay of these gendered, racial, and class norms creates an environment where domestic workers are often regarded as having an inferior status. This is further intensified by the lack of formalised labour protections for domestic workers, many of whom are migrant women from neighbouring countries. These workers face not only economic and social precarity but also heightened vulnerability to violence and abuse within their employers' households. As Ally (2009) highlights, the image of a Black domestic worker labouring for a white family remains a powerful symbol of apartheid's racial logic, embodying the enduring unequal and exploitative dynamics of that era.

In contemporary South Africa, domestic work continues to expose the inequalities between women of different races and socio-economic statuses. While overall labour force participation among women has hovered around 55.8%, Black African women remain the most vulnerable, with an unemployment rate of 40% as of Q2:2024 (Statistics South Africa 2024). Access to domestic work, which could potentially alleviate some of the burdens of care responsibilities, is itself negotiated through the lenses of race and class. This creates a scenario where the emancipation of some women, particularly those from middle-to-upper-class backgrounds, is often premised on the labour of lower-class (predominantly Black) women. As Huws (2019, p. 134) succinctly states, "the needs of the time-poor are met by the labour of the money-poor."

The introduction of labour-saving services has afforded middle-to-upper-class women greater autonomy and freedom from domestic tasks. However, the entrenched 'madam/maid' dynamic in South Africa means that while domestic workers tend to the upbringing of children in affluent suburbs, they are often unable to care for their own families. This stark contrast highlights the deep-seated inequalities within domestic work, reflecting not only the gendered burden of care but also the enduring racial and class disparities that have been carried forward from the apartheid system (Ally 2009).

Nursing in South Africa exhibits similar trends to domestic work. However, due to its formalised nature, it presents better avenues for claim-making and organising. Nursing "involves attending to all the physical, mental, and emotional needs of the patient, including curative, preventive and 'promotive' care" (Lund 2010, p. 499). Despite nursing being traditionally undervalued as work that is associated with femininity, it evolved into a prestigious middle-class career for women from diverse backgrounds in South Africa during the latter half of the 20th century, which conferred relative status on nurses compared to other women in the country. However, from 1990 onwards, nursing, both internationally and locally, encountered significant challenges due to healthcare system restructuring, the adoption of new management practices, evolving socio-political expectations of healthcare delivery, and the erosion of the profession's historical values.

In the mid-1990s, South Africa embarked on an ambitious transformation of its healthcare sector, with the goal of expanding access through free primary healthcare services and a district healthcare system. Although the policy was well-intentioned, it was not implemented effectively, lacking adequate support in terms of staffing and training. This rapid and poorly supported implementation resulted in significant setbacks for nurses, diminishing their status and respect—a loss from which the profession has yet to recover. According to Joyner et al. (2014), "nurses bore the brunt of the pressures of increased attendance at hospitals and clinics when the new policy was rapidly introduced in a government health system that was unprepared". Nurses, who account for nearly 77% of the healthcare workforce, are crucial to South Africa's health system. Despite women constituting 51.2% of the overall population in 2018, over 90% of nurses were women, with Black African women representing the largest category of public sector nurses at 83% in 2006 (Oxfam 2020).

The pay difference between nursing and non-care-related jobs highlights how care work is systematically undervalued. A 2009 study by Lund and Budlender examined the earnings of professional and associate nurses

According to Joyner et al. (2014), "nurses bore the brunt of the pressures of increased attendance at hospitals and clinics when the new policy was rapidly introduced in a government health system that was unprepared". (Photo: John Robinson / Alamy Stock Photo)

and compared them to professional and associate engineers, taking into account education, skill level, and gender distribution. The study revealed that care workers generally earn less than those in non-care-related fields, a phenomenon known as the "care penalty" (England et al. 2002). Budlender and Lund's research showed that 91% of professional nurses were women, whereas 92% of professional engineers were men. Among associate professionals, 89% of nurses were women, compared to 68% of engineers who were men. Despite having similar educational and skill requirements, nurses were paid significantly less than engineers. For example, only 1% of professional and associate nurses earned over R16,000 per month, while 8% of associate engineers reached that earnings level. This discrepancy highlights the intersectionality of race and gender, with Black African women being overrepresented in care work and facing additional issues like discrimination and limited career advancement (Lund and Budlender 2009).

Furthermore, even within public works programmes, care-related jobs are often undervalued and underpaid. The wages for Home-Based Care workers (HBCs) and other 'volunteer' care workers vary widely depending on the programme, departmental standards, and donor funding (Patel 2009). According to Samson (2008), HBC workers' incomes in 2008 ranged from R500 to R1,500 per month, while Mitchell (as cited by Budlender 2009) found that those in care-related public works programmes earned between R9 and R80 per day. This is much lower than the R30–R120 daily wages in infrastructure programmes, which are typically male-dominated, indicating that the care penalty persists even in public works initiatives. Discrimination against women in the workplace, including limited opportunities for career advancement, also pushes women towards occupations that are perceived as more 'female-oriented,' such as care work.

Additionally, many nurses and care workers are compelled to seek employment in the Global North due to better economic opportunities and improved working conditions, exacerbating the shortage of skilled care workers in South Africa. This flight of care workers further strains the already burdened care system in South Africa, leaving many vulnerable populations without access to quality care. Factors such as precarity, undervaluation, and poor working conditions are prevailing features of paid care work in South Africa, which extends beyond nursing and domestic work to social workers, community-based care workers, and so on.

Revisiting the care diamond discussed in Section 2, it is clear that the state plays a pivotal role in care provision that significantly surpasses that of markets and nonprofits, functioning as both a major employer of care workers and a decisive policy-maker influencing the responsibilities of other sectors. Its actions as a provider, funder, and regulator of paid care are central to determining the employment conditions of care workers. The participation of Black women in care work, marked by poor remuneration, wage inequality, harsh working conditions, and inadequate employment terms, can be directly linked to broader macroeconomic and social policy paradigms.

The intertwining of austerity and familialist discourses in South Africa's political economy continues to echo the exploitative dynamics of the apartheid labour regime, which relegated Black African women to low-wage, precarious employment. This neoliberal shift toward contracting out has further intensified labour demands, reduced wages to minimal levels, and stripped workers of essential benefits, exacerbating their marginalisation. For example, the 2024 National Budget indicates significant cuts in social services spending, forecasting a decrease from R5,381 per public healthcare user in 2023/24 to R4,864 in 2026/27. These austerity measures place an even greater burden on the already strained care workers, particularly Black women who often juggle multiple roles within their personal and professional lives (IEJ, 2024).

Post apartheid, the burden of both paid and unpaid labour continues to be disproportionately shouldered by Black women, reinforcing their economic vulnerability. In the workplace, the occupational hierarchy remains distinctly racialised and gendered; Black African women are largely confined to domestic roles, Coloured individuals more often occupy supervisory positions, and white individuals tend to hold managerial roles. This stratification underscores the persistent racial and gender biases that systematically undervalue the labour of Black African women.

The systematic retreat of the state from public services, through global trends of deregulation, has emphasised reliance on market or nonprofit sectors, often at a significant cost to care workers' well-being.

Moreover, the rhetoric of economic efficiency, often employed to rationalise neoliberal policies, effectively conceals these deep-seated disparities, framing them as mere outcomes of institutional restructuring rather than as manifestations of systemic injustice. As a result, the present and future conditions of Black women in domestic work are severely limited by these historical and ongoing injustices.

The transfer of care responsibilities to individual households not only has significant social implications, heightening intra-household and community tensions, but also exacerbates issues like substance abuse and domestic violence. Familialist policies, which exalt the family as the primary care unit, overlook the severe economic pressures and systemic inequalities that burden families, especially those headed by Black women.

The systematic retreat of the state from public services, through global trends of deregulation, has emphasised reliance on market or nonprofit sectors, often at a significant cost to care workers' well-being. For instance, the ongoing commercialisation of public social services as a cost-cutting measure under structural adjustment policies has resulted in detrimental outcomes in terms of employment and service quality, as well as access.

This precarious situation is exacerbated by the ongoing global trend of increased deregulation and reduced state involvement in care, leading to a reliance on subsidised market or not-for-profit providers, where public subsidies often cover only a fraction of the actual cost of care. This reliance frequently forces care workers, especially women who are likely to be among the economically disadvantaged, into positions where they must absorb these costs through self-exploitation. This unsustainable situation not only harms their own health and well-being, but also diminishes the quality of care they can provide, particularly in contexts where these women already face extensive demands on their time.

The next section delves more deeply into the role of another group - older people and their contribution to caregiving. Exploring the role of older people is crucial for an understanding of the full spectrum of care responsibilities and the distribution of these roles across different demographics. By examining the conditions that shape the roles of older people in the care economy, we aim to illuminate the broader implications of social and economic policies on these critical, yet often overlooked, contributors to societal well-being.

6.2 Care is undertaken by older persons

In South Africa, older people, particularly within the Black African population, occupy a critical yet often fraught position in caregiving. Despite their own care needs, older individuals frequently provide both intergenerational care (caring for younger people) and intragenerational care (caring for other older people). Older persons, defined as those over the age of 60, make up 9.2% of the population, approximately five million people (Statistics South Africa, 2022). In 2017, it was reported that older persons spent around 75% of their time caring for others (Statistics South Africa, 2017). This caregiving role is upheld by cultural norms, familial connections, and principles of reciprocity, where older persons are traditionally seen as central figures within extended, multigenerational households due to their active participation in family life and significant roles in the life cycle.

Extended household living, particularly multigenerational arrangements, is prevalent in South African society but is highly racialized and gendered. A significant majority of Black African elderly (more than two-thirds) and a considerable number of Coloured elderly individuals (approximately 54%) live in multigenerational families

(Statistics South Africa, 2017). Furthermore, women are more likely to live in extended households than men, with nearly 70% of women versus 40% of men living in such arrangements (Button and Ncapi, 2019). This prevalence of multigenerational households underscores the caregiving responsibilities of older people, particularly older women, which extend beyond just living arrangements and are deeply influenced by cultural and societal norms, such as communitarianism, Ubuntu, and reciprocity.

The caregiving role of older persons is reinforced by social and economic factors, such as the Old Age Pension grant, which many households rely on to meet financial needs and support younger family members, as discussed in Section 5.1. Additionally, the caregiving dynamics have been profoundly shaped by the HIV/AIDS epidemic, which disproportionately affected younger generations and resulted in high mortality rates among adults in their prime working years. From 2000 to 2005, approximately 330,000 people in South Africa died prematurely due to HIV/AIDS (Statistics South Africa, 2006). This crisis left many elderly people vulnerable, lacking care from the generation below them, while simultaneously increasing their responsibilities for childcare, often of orphaned grandchildren.

The epidemic's impact on caregiving dynamics highlights broader socio-political factors shaping family care arrangements in South Africa. As Hall and Mokomane (2018, p. 71) note, "the deaths and illnesses of working-age adults from HIV in previous decades have contributed to older people assuming the role of caregiver for their co-resident grandchildren and for these children themselves to perform care when elders could not." Moreover, the epidemic has "eroded the principal sources of financial and material support for older people" (Lombard and Kruger, 2009). In many families, there are "no children or other relatives to care for the elderly; ironically they themselves often have to take care of sick children, later becoming the primary caregivers for their orphaned grandchildren" (Lombard and Kruger, 2009). The vast majority of older people live in households with younger kin, with a "high proportion living in 'skip generation' households" due to the HIV/AIDS epidemic (Hall and Mokomane, 2018, p. 71).

These factors collectively provide a deeper understanding of the socio-political and economic elements shaping caregiving arrangements in South Africa, illustrating the vulnerability and resilience of older caregivers who navigate complex care responsibilities amid ongoing social and economic challenges.During the COVID-19 pandemic, the role of grandparents and older kin in childcare, for example, was again made starkly apparent. While parents started to return to paid work during the lockdown, many childcare providers remained closed. As a result, it is likely that kin and grandparents took on additional childcare responsibilities (Moore 2023). In addition, due to wide-scale job losses, more family members had to rely on the OAG. The role of policy initiatives, as well as attached norms, and the devastating impact of the HIV/AIDs epidemic have informed and cemented the role of older people, particularly women, in caregiving.

7. DISCUSSION: FROM SOCIAL POLICY TO A TRANSFORMATIVE NATIONAL CARE POLICY

The current landscape of social policy and care in South Africa is marked by significant shortcomings, particularly in its failure to address the intersectional inequalities of gender, race, and class that permeate the care economy. Despite a progressive constitutional framework, social policies have historically been gender-blind, neglecting the specific needs and contributions of women, especially Black women, within the (care) economy. South Africa's focus on economic growth often comes at the expense of gender-responsive social welfare and equity. This approach, characterised by self-reliance, androcentrism, and the stigmatisation of interdependence, is deeply rooted in the historical context of apartheid, the migrant labour system, and neoliberal reforms such as the Growth, Employment and Redistribution (GEAR) strategy. These frameworks have systematically marginalised care work while simultaneously relying on it in unsustainable ways, resulting in adverse outcomes for women and society at large.

The legacies of apartheid and the migrant labour system have entrenched caregiving responsibilities primarily on women, particularly low-income Black African women, reinforcing a deeply gendered division of labour that persists today. Neoliberal austerity measures, epitomised by the GEAR strategy, have further undermined state investment in critical social infrastructure such as healthcare, education, and childcare services. This retrenchment of public funding has not only intensified the familial burden of care but also exacerbated social and economic disparities, particularly for women. The withdrawal of state support disproportionately affects sectors heavily dependent on public funding, where women and marginalised groups are overrepresented, thereby amplifying gendered, racialized, and class-based inequalities.

The White Paper on Social Welfare (WPSW) highlights how positioning families—and, by extension, women—as the primary providers of care has often served as a stopgap for state shortcomings in care provision. This policy orientation reflects a broader ideological shift towards self-reliance that overlooks the inherently interdependent nature of care. Social welfare programmes, shaped within this ideological framework, frequently fail to engage with the complexities of South Africa's care regime, including diverse household compositions and the gendered division of labour. As a result, these programmes often prove inadequate and inappropriate for addressing care inequalities, both financially and practically, between men and women, leaving many care needs unmet.Social grants are the predominant form of support for care within this context. While these cash transfers provide crucial financial assistance to low-income households, they fail to address the deeply rooted structural dynamics of unpaid care work. For example, the Child Support Grant offers only minimal financial relief, often supporting entire households. Despite its essential role in mitigating hunger and poverty, the grant does not account for the extensive unpaid care labour predominantly performed by women. This labour remains largely invisible and undervalued, with significant consequences for women's health, mental well-being, and labour market participation. The limitations of these social programmes underscore the need for a more nuanced and comprehensive approach to care policy—one that recognizes the multifaceted nature of care and actively works to redress gender inequalities in care responsibilities.

The intersection of ideological frameworks, policy discourse, and social welfare programmes reveals the inadequacies in how care is currently conceptualised and supported.

The South African social welfare system, shaped by neoliberal austerity and self-reliance discourses superimposed on the legacy of apartheid, increasingly displaces care responsibilities onto individuals and families, particularly women. The contraction of public services has paved the way for market-driven solutions that prioritise profit over the well-being of care workers and recipients, further commodifying and devaluing care labour. This trend highlights the urgent need for a paradigm shift in care policy—one that recognises the intrinsic value of care work, addresses entrenched structural inequalities, and reframes care as foundational to social and economic sustainability.

The intersection of ideological frameworks, policy discourse, and social welfare programmes reveals the inadequacies in how care is currently conceptualised and supported. A critical examination of these intersections is essential to developing a comprehensive care policy that not only acknowledges the socio-economic dimensions of care work but also seeks to dismantle the deeply entrenched inequalities perpetuated by existing systems. Such a transformative approach would reorient social policy towards a more equitable and inclusive model that elevates care as a central pillar of societal well-being.

What is critically missing from South Africa's social welfare framework is a national care policy that is transformative and inclusive, explicitly acknowledging the central role of care work in sustaining society while addressing the deep-seated inequalities of gender, race, and class. There is a glaring absence of recognition of the specific dimensions of care in South Africa—such as who performs this care, the socio-economic drivers behind their participation, and the systemic forces sustaining these dynamics. Current social welfare and policy measures not only overlook these complexities but also perpetuate existing inequities, reinforcing a cycle where care work remains marginalised, invisible, and poorly compensated. A robust national care policy is urgently needed to dismantle these inequalities and reposition care work as vital to the nation's social and economic fabric.

Care policy, as conceptualised by scholars like Esquivel (2014), leverages the framework established by Sustainable Development Goal (SDG) 5, which focuses on achieving gender equality. Target 5.4 under this goal urges countries to acknowledge and value unpaid care and domestic work by improving public services, infrastructure, and social protection policies. Such a policy diverges from general social protection measures, which primarily secure a minimum level of consumption, by actively enhancing the quality and accessibility of care and directly challenging the often-discriminatory dynamics within care relationships.

Care policies are essential in addressing the disproportionate burden of unpaid care and domestic work, a major driver of gender inequality. Excessive caregiving responsibilities can lead to economic impoverishment for caregivers, primarily women, through lost time and reduced earnings. A transformative care policy would recognise these burdens and implement strategies to reduce them, thus enabling women to participate more fully in the labour market and society (Esquivel 2014). A comprehensive care policy would incorporate the 4R framework—recognition, reduction, redistribution, and revaluation—proposed by Diane Elson (2017). Recognition involves acknowledging the vital role of unpaid care and domestic work in supporting all economic systems. Reduction strategies aim to decrease the total amount of unpaid care required, through investments in both physical and social infrastructure. Redistribution seeks to address the uneven allocation of care responsibilities, promoting a more equitable sharing of these duties between genders. Revaluation challenges existing norms and economic models that have traditionally undervalued care work, leading to better societal recognition and improved status for those engaged in this vital work (Elson, 2017).

The 4R framework, while comprehensive, has been revealed to have certain limitations, particularly in the context of the COVID-19 pandemic. The pandemic exposed significant gaps in how these concepts are put into practice, especially when it comes to addressing the intersectional dimensions of care work. During this crisis, a stark divide became apparent between those who could work from home and those who could not, the latter including low-wage workers with limited rights and individuals in 'essential' jobs, including healthcare, grocery store workers, and informal sector employees. Many of these essential workers were people of colour, women, and migrants, highlighting the gendered, racialised, and classed nature of care work. Despite being labelled as 'essential' and celebrated for their contributions, these workers often continued to face unsafe working conditions and inadequate protection, underscoring their disposability during times of crisis (Stevano *et al*. 2021).

This scenario highlights the need for a more nuanced approach to care policy, one that integrates the principles of the 4R framework while also considering the complexities of recognition and redistribution. Drawing on Nancy Fraser's (2007) critique of the politics of recognition and redistribution, it becomes evident that addressing gender issues in care work requires balancing both cultural and economic justice. Fraser critiques the false dichotomy between viewing gender-related struggles as purely economic (class-based) and purely cultural (identity-based), suggesting instead that these struggles involve both dimensions simultaneously.

In this context, the politics of recognition should not be pursued in isolation, as it often leads to unintended consequences. For instance, recognition that focuses solely on affirming women's roles as caregivers can inadvertently reinforce gender stereotypes, positioning women as primary caretakers and perpetuating a gendered division of labour in care. This form of recognition, which Fraser (2007) describes as "identity politics," aims to challenge and replace demeaning androcentric views of femininity with new self-representations crafted by women. While this can lead to a positive sense of self and collective identity, it risks reifying particular aspects of femininity, such as the expectation that women are naturally suited to caregiving roles (Fraser 2007).

Recognition that focuses solely on affirming women's roles as caregivers can inadvertently reinforce gender stereotypes, positioning women as primary caretakers and perpetuating a gendered division of labour in care. (Photo: Tiaan Gerber / Alamy Stock Photo)

However, Fraser (2007) argues that recognition should be understood not merely as the affirmation of feminine identity but as the recognition of women's status as equal participants in social life. In this status model, misrecognition is not just about devaluing femininity; it is also about the social subordination that prevents women from participating as equals in all spheres of life. Therefore, a feminist politics of recognition should not be reduced to identity politics; rather, it should aim to overcome subordination by establishing women as full members of society, capable of participating on an equal footing with men.

Applying this to the care economy, recognition must go beyond simply valuing women's traditional roles as caregivers. It should focus on challenging the institutionalised patterns of cultural value that place women in subordinate positions, both in the home and in the workforce. To redress these injustices, care policies should aim for a politics of recognition that redefines women's roles beyond traditional caregiving, ensuring that they are seen and treated as equal participants in all areas of social life. This involves examining how cultural norms and institutional practices perpetuate the gendered division of labour in care, and challenging these norms to establish true parity between men and women. For instance, policy measures could include promoting shared caregiving responsibilities between men and women, improving the working conditions of all care workers, and ensuring that care work is valued equally with other forms of labour. Ultimately, a care policy informed by this status model of recognition would seek to dismantle the androcentric norms that devalue care work and keep women in subordinate positions. It would promote institutional changes that ensure women can participate equally with men in both public and private spheres, thus achieving not just recognition, but true equality in status and opportunity (Fraser 2007).

Emma Dowling's (2016) exploration of 'valorisation' and 'value' offers crucial insights into how we can craft a robust and meaningful care policy, prompting a deeper examination of the 4R framework. In Marxist terms, valorisation refers to the process by which waged labourers produce and increase capital, driving the incorporation of more areas of social and ecological life into the capitalist system to generate surplus value. On one end of the spectrum lies 'value,' which refers to the intrinsic worth of care work—its essential role in maintaining social and emotional well-being. On the other end is 'valorisation,' which focuses on how labour is commodified and leveraged to generate profit within capitalist economies (Dowling 2016).

Significant advances have been made in feminist literature, particularly within feminist economics, to grant care both recognition and value. This includes efforts to account for care work in GDP calculations, giving it the status of productive work that generates economic value. However, in the contemporary era of financialised capitalism, the push to recognise care work and make it visible in national economies often inadvertently leads to its commodification and marketisation. While well-intentioned, this recognition can embed care within profit-driven structures, leading to the exploitation of care workers rather than genuinely valuing their contributions.

This issue became particularly evident after the 2007/8 global financial crisis, when austerity measures and the shifting costs of social reproduction led to the care sector being recognised as a significant field for market expansion. New business models and financial products emerged, with entities like public asset managers taking over public assets, and private entities stepping in to 'rescue' public services. In this context, accounting for care can unintentionally entrench processes of valorisation—focusing on profit generation—rather than truly valuing care for its intrinsic worth. As a result, this process of valorisation frequently leads to the devaluation of care work, as the emphasis shifts from the well-being of care recipients and providers to the pursuit of profit. The commodification of care within these frameworks often reinforces the very economic structures that devalue care work, leading to further exploitation and inequality (Dowling 2016).

In South Africa, the marketisation of care work within capitalist frameworks has led to its systematic devaluation. The prevailing economic system prioritises profit over the intrinsic value of care, reducing it to a commodity that generates capital rather than recognising its essential role in sustaining human life and society. This

dynamic is starkly evident in the South African care sector: the private sector, driven by market imperatives, is relatively well-funded, while the public sector remains severely underfunded due to austerity measures. The private sector's focus on profitability often results in the exploitation of care workers through low wages and precarious employment, while the public sector grapples with chronic under-resourcing and struggles to deliver adequate care services.

This crisis underscores the urgent need to rethink the recognition and valuation of care work within economic and policy frameworks. While integrating care work into these frameworks is essential, doing so within capitalist structures can inadvertently perpetuate the very inequalities it seeks to address. For instance, initiatives that recognise and monetise care work, such as performance-based incentives for caregivers, may seem empowering but often reinforce the commodification of care. These programmes typically shift the emphasis from the intrinsic worth of caregiving to its economic output, aligning the value of care with market dynamics rather than its social and ethical significance.

A genuine revaluation of care work requires moving beyond economic valorisation. Valuing care should not be confined to how it can be commodified or made profitable; instead, it should focus on its inherent social and moral importance. Care work must be acknowledged as foundational to human life, not merely an economic function. This approach necessitates a critical resistance to the subordination of care to capitalist imperatives and challenges traditional economic discourses that treat expenditures on social reproduction—such as salaries for teachers or nurses—as costs rather than as essential investments in social infrastructure and collective well-being.

Achieving this paradigm shift necessitates a framework centred on redistribution that fundamentally reorients care away from being an individual or familial responsibility and towards a collective, socialised endeavour. A transformative care policy extends beyond redistributing care responsibilities, such as simply shifting care work from women to men, as this approach, while valuable, fails to fully address the systemic undervaluation and commodification of care. In this context, structural economic reforms are crucial, particularly those that directly counteract austerity measures, which often result in cuts to public services and disproportionately impact sectors dependent on state funding, including health and social care. As feminist theorist Nancy Fraser (2016) argues, austerity represents a form of "privatisation by default," where the erosion of public services transfers the burden of care onto families and communities, thus reinforcing traditional gender roles and deepening existing inequalities.

Anti-austerity measures play a crucial role in advancing the full socialisation of care by shifting the focus from individual responsibility to a collective societal obligation. Reversing neoliberal austerity policies and securing robust funding for public services are essential steps toward establishing a comprehensive care infrastructure that supports both paid and unpaid care work. This approach involves advocating for progressive taxation, ensuring that wealthier individuals and corporations contribute equitably to public finances, thus empowering the state to adequately fund social infrastructure. By expanding public investment, such measures help decommodify care, reframing it as a public good essential to social cohesion and societal well-being. This reorientation underscores the principle that care policy should be grounded in a thorough analysis of the needs of both caregivers and care recipients, rather than being constrained by what is deemed fiscally affordable for the state. Prioritising public investment in care recognises care work's inherent value and challenges market-driven models that reduce care to a mere commodity, instead positioning it as fundamental to a thriving and equitable society.

Embracing an anti-austerity framework as part of a transformative care policy is not just about improving and expanding public service provision but about fundamentally transforming the societal approach to care. This paradigm envisions care as an essential part of the social contract that should be collectively supported and publicly funded. Such an approach challenges market-driven models that commodify care and places the value

To achieve meaningful change, care policy must advance beyond the narrow focus on labour market participation as the sole solution to women's subordination.

of care work within a framework of social justice and collective responsibility. Through sustained investment in public services, a more equitable and sustainable model of care can be realised, one that recognises care as central to both social and economic life and essential to achieving broader goals of social equality and inclusion. By advancing policies that emphasise the socialisation of care, we can dismantle the individualised burden of caregiving and promote a more just and inclusive society where care work is valued as a critical component of human and societal flourishing.

Care policy, within this transformative approach, extends beyond mere recognition of the importance of care work; it seeks to dismantle the deeply entrenched productivist assumptions that underpin current economic models and envisions an emancipatory future centred on human and planetary well-being. A robust care policy prioritises welfare arrangements and support structures that recognise and value the essential reproductive labour sustaining society, advocating for a paradigm shift that redefines care as a collective societal responsibility rather than an individual or familial duty.

Such a policy framework directly challenges traditional economic models rooted in the concept of 'homo economicus'—the notion of a rational, self-interested economic actor that neglects the social, relational, and emotional dimensions of human existence. These models are not only reductive but also inherently biassed, particularly against women, as they devalue the care work that predominantly falls on women. This bias is reflected in policy frameworks like the White Paper on Social Welfare (WPSW) and GEAR, which emphasise economic efficiency, self-reliance, and fiscal restraint while neglecting the intrinsic human conditions of dependency and interdependence that define the care economy.

By challenging these conventional economic models, a transformative care policy would advocate for the full socialisation of care, decentering the individual responsibility of caregiving and redistributing the burdens of care across society through well-funded public services and support systems. This approach aligns with anti-austerity measures that resist the privatisation of care, advocating instead for sustained public investment that recognises care work as a public good essential to societal flourishing. Ultimately, such a policy reorients economic and social priorities towards an inclusive and equitable future where care is valued not as a commodified service but as the foundation of human well-being and social cohesion.

A care policy grounded in an ethic of care would fundamentally shift this paradigm. It would recognise that care is not merely a set of tasks but a relational practice that is crucial to sustaining human life and social bonds. Drawing on the work of care ethicists like Joan Tronto, such a policy would acknowledge that all individuals, at various points in their lives, are dependent on others for care. This recognition disrupts the notion of the independent, self-sufficient economic actor, and instead emphasises the essential role of interdependence in human societies.

To achieve meaningful change, care policy must advance beyond the narrow focus on labour market participation as the sole solution to women's subordination. It should recognise that simply increasing women's employment is insufficient, without addressing the broader social and economic conditions that perpetuate inequality. At the same time, care policies have the potential to generate substantial employment, particularly for women, with greater efficacy than investments in physical infrastructure. More importantly, they prioritise the well-being of women, ensuring that they are seen not merely as tools for economic development but as central figures in shaping policy decisions.

Furthermore, an effective, transformative care policy would position the state as a key player in the caregiving landscape, with clear responsibilities for responsiveness, attentiveness, responsibility, and competence—phases of care outlined by Tronto. The state should not only provide services but actively participate in the caregiving process, ensuring equitable distribution of care that meets the needs of all citizens. This approach would require the state to build and maintain the necessary social infrastructure to support care work, treating both caregivers and care recipients with dignity, and prioritising their well-being. Ultimately, a care policy grounded in these principles would challenge the limitations of traditional economic models and promote a more inclusive, equitable, and compassionate society. It would recognise that care is not just an economic necessity but a fundamental human need, integral to the health and well-being of society as a whole.

Acknowledging the complexity of implementing robust care policies, particularly in the Global South, underscores the need for a transformative approach that goes beyond current frameworks. While formalised care policies, as understood in the Global North, may not be fully integrated or even exist in many parts of the Global South, the principles that guide effective care strategies are crucial. These principles—recognition, reduction, redistribution, and revaluation—serve as essential guides for developing strategies that can address deeply ingrained inequalities. A truly transformative care policy in the Global South would take into account the deep context of the social and economic systems that have historically structured care, aiming to enact meaningful transformation. For example, in South Africa, any such policy must grapple with the enduring legacy of apartheid and colonialism, which have left profound marks on the organisation of care work, often relegating it to marginalised groups, particularly Black women. By acknowledging and addressing these historical injustices, a transformative care policy would not only rectify past wrongs but also create a more equitable and just framework for the future.

Moreover, a comprehensive care policy can have profound implications for both caregivers and care receivers. This relationship is central to the caregiving experience and must be recognised and valued within any transformative care framework. For older persons for example, who often find themselves simultaneously in need of care and providing care to younger generations, care policies can help alleviate the overwhelming responsibilities they shoulder. By centering the caregiving dynamic, care policies can alleviate the tension between adequately supporting paid caregivers in health or education for example while ensuring equitable access and high quality service for care receivers.

For the paid care workforce, which predominantly consists of women, especially Black women in South Africa, care policies can offer much-needed formal recognition and protections. These policies can advocate for fair wages, access to social protections, and improved working conditions, thus ensuring that care workers are not exploited but rather respected and valued for their essential roles. Recognising the caregiver-care receiver relationship emphasises the need to maintain the dignity and agency of both parties, fostering a care environment built on respect and mutual benefit. By centering this relationship, care policies can also promote a more holistic approach to care that moves beyond mere economic considerations, recognising the emotional, social, and relational dimensions of caregiving. This recognition can drive the development of supportive measures such as training for care workers, mental health support, and the inclusion of caregivers in decision-making processes that affect their work and well-being. Ultimately, a care policy that brings to light the dynamic and reciprocal nature of the caregiver-care receiver relationship will create a more equitable and compassionate care system, benefiting both those who give and those who receive care.

Brazil's recent efforts to develop a National Care Policy and a National Care Plan provide a valuable example of how a nation can commit to a transformative care policy. Brazil's initiative, which aligns with the 4R framework, demonstrates the potential of a comprehensive care policy to address systemic inequalities by ensuring that care work is recognised, valued, and supported by the state (Ministry of Labour and Employment Brazil, 2023). Similarly, Kenya has taken significant steps in this direction. The State Department for Gender and Affirmative Action is in the process of coordinating the development of a National Care Policy that will provide a comprehensive

framework to mitigate issues around unpaid care and domestic work (Goga, 2023). The policy aims to recognise, reduce, and redistribute unpaid care work and reward care workers through favourable employment and social protection measures. It also prioritises gender-responsive public services and cultural shifts to address the disproportionate burden of care work on women. South Africa can learn from the approaches of both Brazil and Kenya by developing a similar national care policy that prioritises the well-being of care workers and care recipients, while challenging the structural inequalities that have historically marginalised these groups.

A transformative national care policy in South Africa must fundamentally challenge and dismantle the entrenched economic and social paradigms that have long devalued care work. By reimagining care as a collective societal responsibility rather than an individual or familial burden, such a policy would address the deeply rooted gendered, racialized, and class-based inequalities within the care economy while fostering a more equitable and inclusive society. Leveraging frameworks like the 4Rs—recognition, reduction, redistribution, and revaluation—this policy would prioritise the inherent value of care, ensuring it is adequately supported through robust public investment and a decisive shift away from austerity measures. Reframing care as a public good essential to societal well-being would challenge the commodification of care and promote its recognition as vital to both economic stability and social cohesion.

As care needs intensify and demand increase, South Africa must commit to a care policy that is both ambitious and grounded in the principles of ethical care, one that addresses historical inequities while forging a path toward a more just society. Centering the needs of caregivers and care recipients alike, this policy would not only elevate the status of care work but also enhance the overall quality of life for all persons. A truly transformative care policy would recognise that the strength and health of society lie not in treating care as a commodity but in embracing it as the cornerstone of human dignity and social progress. South Africa has the opportunity to redefine care, setting a powerful precedent for a society where care work is valued, respected, and supported as the foundation of a thriving, equitable, and inclusive nation.

(Photo: Andrew Aitchison / Alamy Stock Photo)

8. REFERENCES

Addati, L., Cattaneo, U., Esquivel, V., and Valarino, I., 2018. *Care work and care jobs for the future of decent work.* International Labour Organisation (ILO).

Aguero, J., Carter, M. and Woolard, I., 2006. *The impact of unconditional cash transfers on nutrition: The South African Child Support Grant.*

Ally, S., 2005. *Caring about care workers: Organising in the female shadow of globalisation.* Labour, Capital and Society/Travail, capital et société, pp. 184-207.

Bakker, I. 2007. 'Social reproduction and the constitution of a gendered political economy', *New Political Economy*, 12(4), pp. 541-556.

Bhattacharya, T. (ed.) 2017. *Social Reproduction Theory: Remapping Class, Recentering Oppression*. London: Pluto Press.

Blyth, M., 2013. *Austerity: The History of a Dangerous Idea.* New York: Oxford University Press.

Bozalek, V., Henderson, N., Lambert, W., Collins, K., and Green, S., 2007. *Social services in Cape Town: an analysis using the political ethics of care.* Social Work/Maatskaplike Werk, 43(1).

Budlender, D., and Lund, F., 2011. *South Africa: A legacy of family disruption.* Development and Change, 42(4), pp. 925-946.

Burawoy, M., 1976. *The functions and reproduction of migrant labor: Comparative material from Southern Africa and the United States.* American journal of Sociology, 81(5), pp.1050-1087.

Button, K. and Ncapi, N., 2019. *Older women as caregivers in South Africa: The implications of social policy for older women living in multigenerational households.* Journal of Southern African Studies, 45(6), pp. 1017-1032.

Button, K., Moore, E., and Seekings, J., 2018. *South Africa's hybrid care regime: The changing and contested roles of individuals, families, and the state after apartheid.* Current Sociology, 66(4), pp. 602-616.

Cantillon, S., Moore, E., and Teasdale, N., 2021. *COVID-19 and the pivotal role of grandparents: Childcare and income support in the UK and South Africa.* Feminist Economics, 27(1-2), pp. 188-202.

Casale, D., and Posel, D., 2002. *The continued feminisation of the labour force in South Africa: An analysis of recent data and trends.* South African Journal of Economics, 70(1), pp. 156-184.

Casale, D., and Posel, D., 2019. *Gender and the economy in post-apartheid South Africa: Changes and challenges.* Agenda, 33(4), pp. 3-10.

Casale, D., and Posel, D., 2020. *Gender and the early effects of the COVID-19 crisis in the paid and unpaid economies in South Africa.* National Income Dynamics (NIDS)-Coronavirus Rapid Mobile Survey (CRAM) Wave, 1.

Casale, D., and Shepherd, D., 2022. *The gendered effects of the Covid-19 crisis in South Africa: Evidence from NIDS-CRAM waves 1–5.* Development Southern Africa, 39(5), pp. 644-663.

Chatzidakis, A., Hakim, J., Littler, J., and Rottenberg, C.2020. *The Care Manifesto: The Politics of Interdependence*. London: Verso Books.

Chisale, S.S., 2018. *Ubuntu as care: Deconstructing the gendered Ubuntu.* Verbum et Ecclesia, 39(1), pp. 1-8.

Cobble, D.S., 2010. *More intimate unions.* Intimate labours: Cultures, technologies, and the politics of care, pp. 280-95.

Coffey, C., Espinoza Revollo, P., Harvey, R., Lawson, M., Parvez Butt, A., Piaget, K., Sarosi, D., and Thekkudan, J., 2020. *Time to Care: Unpaid and underpaid care work and the global inequality crisis.* Oxfam.

Delany, A., Ismail, Z., Graham, L. and Ramkissoon, Y., 2008. *Review of the child support grant: Uses, implementation and obstacles.* Johannesburg: Community Agency for Social Enquiry, pp. 1-65.

Dowling, E. 2016. 'Valorised but not valued? Affective remuneration, social reproduction and feminist politics beyond the crisis', *British Politics*, 11, pp. 452-468.

Dowling, E. 2022. *The Care Crisis: What Caused It and How Can We End It?* London: Verso Books.

Dubbeld, B., 2013. *How social security becomes social insecurity: Unsettled households, crisis talk and the value of grants in a KwaZulu Natal village.* Acta Juridica, 2013(1), pp. 197-217.

Duflo, E. 2003. *Grandmothers and granddaughters: The impact of old age pensions on child nutrition in South Africa*. World Bank Economic Review, 17(1), 1-25.

Ehrenreich, B. and Hochschild, A.R. (eds.) 2003. *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. New York: Macmillan.

Elson, D., 2017, May. Recognize, reduce, and redistribute unpaid care work: how to close the gender gap. In *New Labor Forum* (Vol. 26, No. 2, pp. 52-61). Sage CA: Los Angeles, CA: Sage Publications.

Elson, D., 2018. *Plan F: Feminist plan for a caring and sustainable economy.* In Feminist Global Political Economies of the Everyday (pp. 133-135). Routledge.

Esquivel, V. 2021. 'Care policies in the global south', in *The Routledge Handbook of Feminist Economics*. London: Routledge, pp. 400-408.

Fakier, K. and Cock, J., 2009. *A gendered analysis of the crisis of social reproduction in contemporary South Africa.* International Feminist Journal of Politics, 11(3), pp. 353-371.

Ferrant, G., Pesando, L.M., and Nowacka, K., 2014. *Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes.* Boulogne Billancourt: OECD Development Center.

FitzGerald, M., 2020. *Reimagining government with the ethics of care: a department of care.* Ethics and Social Welfare, 14(3), pp. 248-265.

Fontana, M., and Elson, D., 2014. *Public policies on water provision and early childhood education and care (ECEC): do they reduce and redistribute unpaid work?* Gender & Development, 22(3), pp. 459-474.

Fraser, N. 2016a. 'Capitalism's crisis of care', *Dissent*, 63(4), pp. 30-37.

Fraser, N. 2016b. 'Contradictions of capital and care', *New Left Review*, 100, pp. 99-117.

Fraser, N., 2007. *Feminist politics in the age of recognition: A two-dimensional approach to gender justice.* Studies in social justice, 1(1), pp. 23-35.

Ghandeharian, S. and FitzGerald, M., 2022. COVID-19, the trauma of the 'real'and the political import of vulnerability. *International Journal of Care and Caring*, *6*(1-2), pp.33-47.

Gouws, A., and Van Zyl, M., 2015. *Towards a feminist ethics of ubuntu: Bridging rights and ubuntu.* Care ethics and political theory, pp. 165-186.

Gronbach, L., Seekings, J., and Megannon, V., 2022. *Social protection in the COVID-19 pandemic: lessons from South Africa.* CGD Policy Paper, 252.

Hall, K., and Mokomane, Z., 2018. *The shape of children's families and households: A demographic overview.* Children, families and the state, 32.

Hassim, S., 2021. Why care?. *Transformation: Critical Perspectives on Southern Africa*, *107*(1), pp.53-66.

Hemson, D., 2007. *'The Toughest of Chores': Policy and Practice in Children Collecting Water in South Africa.* Policy Futures in Education, 5(3), pp. 315-326.

Huws, U. 2019. *Labour in Contemporary Capitalism: What Next?* London: Palgrave Macmillan.

Huws, U., 2012. *The reproduction of difference: gender and the global division of labour.* Work organisation, labour and globalisation, 6(1), pp. 1-10.

International Labour Organization (2023) *The Care Economy*.

Isaacs, G. 2014. 'The myth of "neutrality" and the rhetoric of "stability": macroeconomic policy in democratic South Africa'.

Joyner, K., Shefer, T., and Smit, E., 2014. *Discourses and practices in institutionalised nursing in South Africa: Challenges for care.* South African Review of Sociology, 45(3), pp. 34-52.

Keller, J. and Kittay, E.F., 2017. Feminist ethics of care. In *The Routledge companion to feminist philosophy* (pp. 540-555). Routledge.

Legassick, M. and Wolpe, H., 1976. *The Bantustans and capital accumulation in South Africa.* Review of African Political Economy, 3(7), pp. 87-107.

Lombard, A., and Kruger, E., 2009. *Older persons: the case of South Africa.* Ageing International, 34, pp. 119-135.

Lund, F. 2010. 'Hierarchies of care work in South Africa: Nurses, social workers and home-based care workers', *International Labour Review*, 149(4), pp. 495-509.

Maconachie, M., 1993. *Women and the economy.* Agenda: Empowering Women for Gender Equity, No. 18, pp. 41-47.

Majokweni, A., 2023. *Gauteng's vulnerable left in limbo as nonprofits fight for survival.* The Citizen. [online] 26 July.

Manicom, L., 1992. *Ruling Relations: Rethinking State and Gender in South African History.* The Journal of African History, 33(3), pp. 441-465.

Maqubela, L.N., 2016. Mothering the 'other': the sacrificial nature of paid domestic work within Black families in the post-Apartheid South Africa. *Gender and Behaviour*, *14*(2), pp.7214-7224.

Marçal, K. 2016. *Who Cooked Adam Smith's Dinner?*. New York: Simon and Schuster.

Marcal, K., 2015. *Who Cooked Adam Smith's Dinner?* London: Portobello Books.

Mattei, C.E. 2022. *The Capital Order: How Economists Invented Austerity and Paved the Way to Fascism*. Chicago: University of Chicago Press.

Mbarathi, N., Mthembu, M. and Diga, K., 2016. *Early Childhood Development in South Africa: Inequality and Opportunity in a Precarious Environment.* Early Childhood Education Journal, 44(5), pp. 501-508.

Mezzadri, A., Newman, S., and Stevano, S., 2022. *Feminist global political economies of work and social reproduction.* Review of International Political Economy, 29(6), pp. 1783-1803.

Moore, E., 2020. *Financing Social Reproduction: Women's responsibilities in financing and undertaking household social reproduction in multigenerational households in South Africa.* Revue internationale des études du développement, (2), pp. 37-62.

Moore, E., 2023. *Family care for older persons in South Africa: heterogeneity of the carer's experience.* International Journal of Care and Caring, 1(aop), pp. 1-22.

Moore, E., and Seekings, J., 2019. *Consequences of social protection on intergenerational relationships in South Africa: Introduction.* Critical Social Policy, 39(4), pp. 513-524.

Mosoetsa, S. 2011. *Eating from One Pot: The Dynamics of Survival in Poor South African Households*. New York: NYU Press.

Noddings, N., 2015. *Care ethics and "caring" organizations.* Care ethics and political theory, pp.7 2-84.

Oxfam, 2020. *The right to dignified healthcare work, a right to dignified healthcare for all*. Oxfam South Africa.

Parreñas, R.S., 2000. *Migrant Filipina domestic workers and the international division of reproductive labor.* Gender & society, 14(4), pp. 560-580.

Patel, L. and Hochfeld, T., 2011. *It buys food but does it change gender relations? Child Support Grants in Soweto, South Africa.* Gender & Development, 19(2), pp. 229-240.

Patel, L., 2005. *Social Development.* OUP Catalogue.

Patel, L., 2008. *Getting it right and wrong: An overview of a decade of post-apartheid social welfare.* Practice, 20(2), pp. 71-81.

Patel, L., 2009. *The gendered character of social care in the non-profit sector in South Africa.* Centre for Social Development in Africa, UNRISD and Centre for Social Development Research in Africa, University of Johannesburg, Johannesburg.

Patel, L., 2013. *Poverty, gender and social protection: Child support grants in Soweto, South Africa.* Poverty, Income and Social Protection. Routledge, pp. 106-120.

Pérez Orozco, A. 2022. *The Feminist Subversion of the Economy: Contributions for a Life Against Capital*. Common Notions.

Posel, D. and Rogan, M., 2012. Gendered trends in poverty in the post-apartheid period, 1997–2006. *Development Southern Africa*, *29*(1), pp.97-113.

Posel, D., 2010. *Households and labour migration in post-apartheid South Africa.* Studies in Economics and Econometrics, 34(3), pp. 129-141.

Posel, D.R. and Casale, D.M. 2011. 'Relative standing and subjective well-being in South Africa: The role of perceptions, expectations and income mobility', *Social Indicators Research*, 104, pp. 195-223.

Rai, S.M., Hoskyns, C. and Thomas, D., 2014. Depletion: The cost of social reproduction. *International Feminist Journal of Politics*, *16*(1), pp.86-105.

Razavi, S., 2007. *The return to social policy and the persistent neglect of unpaid care.* Development and Change, 38(3), pp. 377-400.

Razavi, S., 2011. *Rethinking care in a development context: an introduction.* Development and Change, 42(4), pp.873-903.

Razavi, S., 2015. *Care and Social Reproduction.* The Oxford Handbook of Transnational Feminist Movements, p. 422.

Sevenhuijsen, S., Bozalek, V., Gouws, A., and Minnaar-McDonald, M., 2003. *South African social welfare policy: an analysis using the ethic of care.* Critical Social Policy, 23(3), pp. 299-321.

Shai, L., 2021. *Public employment programmes in the care economy: The case of South Africa (No. 29).* ILO Working Paper.

Spaull, N., and Van der Berg, S., 2020. *Counting the cost: COVID-19 school closures in South Africa and its impact on children.* South African Journal of Childhood Education, 10(1), pp. 1-13.

Statista Research Department, 2023. *South Africa: Share of Medical Aid Scheme members, by Population Group*. Statista.

Statistics South Africa, 2017. *Vulnerable Groups Series II: Social Profile of Older Persons: 2011–2015.* Report No. 03–19–03. Pretoria, South Africa: Statistics South Africa.

Stevano, S. 2024. *The Devaluation of Essential Work: An Assessment of the 2023 ILO Report*. Development and Change. London: Wiley.

Stevano, S., Ali, R., and Jamieson, M., 2021. *Essential for what? A global social reproduction view on the re-organisation of work during the COVID-19 pandemic.* Canadian Journal of Development Studies/Revue canadienne d'études du développement, 42(1-2), pp. 178-199.

Stevano, S., Mezzadri, A., Lombardozzi, L., and Bargawi, H., 2021. *Hidden abodes in plain sight: The social reproduction of households and labor in the COVID-19 pandemic.* Feminist Economics, 27(1-2), pp. 271-287.

Torkelson, E., 2022. *Deserving and Undeserving Welfare States: Cash Transfers and Hegemonic Struggles in South Africa.* Journal of Southern African Studies, 48(1), pp. 43-60.

Trafford, Z., and Swartz, L., 2023. *The Care Dependency Grant for children with disabilities in South Africa: Perspectives from implementation officials.* Development Southern Africa, 40(2), pp. 259-272.

Tronto, J.C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

Tronto, J.C., 1998. *An ethic of care.* Generations: Journal of the American Society on Aging, 22(3), pp. 15-20.

Valiani, S., 2022. *The Africa care economy index*. Nairobi: FEMNET and UNDP.

van der Westhuizen, C., 2015. Setting the scene: public works employment from the RDP to the NDP. *Who cares*: South Africa's Expanded Public Works Programme in the social sector and its impact on women.

Vetten, L., 2024. *What Life Esidimeni and Gauteng's late payment of NGOs have in common*. News24. [online] 22 July.

Von Gliszczynski, M., and Leisering, L., 2016. *Constructing new global models of social security: How international organisations defined the field of social cash transfers in the 2000s.* Journal of Social Policy, 45(2), pp. 325-343.

Wichterich, C., 2020. *Who cares about healthcare workers? Care extractivism and care struggles in Germany and India.* Social Change, 50(1), pp. 121-140.

Wills, G., and Kika-Mistry, J., 2022. *Early childhood care and education access in South Africa during COVID-19: Evidence from NIDS-CRAM.* Development Southern Africa, 39(5), pp. 781-799.

Wolpe, H., 1972. *Class, race and the occupational structure.* In Collected Seminar Papers. Institute of Commonwealth Studies (Vol. 12, pp. 98-119). Institute of Commonwealth Studies.

Woolard, I., and Leibbrandt, M., 2013. *The evolution and impact of unconditional cash transfers in South Africa.* Development Challenges in a Postcrisis World, p. 363

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