The London School of Economics and Political Science

Impact of South Africa's home community-based care on female caregivers' livelihoods and empowerment

Yen Nee Wong

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Abstract

Public work programs (PWPs) gained increasing recognition among governments and international development agencies for their contributions towards women's empowerment, combining aspects of (1) job creation, (2) skills development, (3) income generation, (4) service provision, and (5) credit from social protection into a single scheme. Of particular interest to the PWP community, consisting of development agencies, government agencies, donors, policy makers, community-based organisations, planners and evaluators, is the extent to which a social care agenda increases the gender responsiveness of PWPs in the Global South. I seek to investigate the above issue through examining the unique case of South Africa's home community-based care (HCBC) programme, a social care service implemented as part of South Africa's Expanded Public Works Programme (EPWP).

South Africa's EPWP is a pioneer in (and to date one of very few cases) adopting a social service dimension through the HCBC and Early Childhood Development (ECD) interventions. In this study, I question the impact of HCBC on community caregivers' (mostly females) empowerment. Triangulating a systematic review of the literature against findings from my semi-structured interviews collected in Cape Town, South Africa, and background data from government reports, I evaluate the extent to which HCBC achieved its five action areas targeting women's empowerment, in particular increased (1) access to employment opportunities, (2) employability, (3) income generation which promotes poverty alleviation, (4) community participation, and (5) access to service provision. My findings show the HCBC's capacity to promote women's economic and political empowerment to be constrained, albeit providing a partial route to socio-psychological empowerment through increasing women's visibility and social recognition within the community and women's self-esteem.

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South Africa

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Chapter One

Women's socio-economic empowerment through Public Works Programmes

1.1   Introduction

In the most recent decade, the economic participation of women has become a key focus of development agencies/governments promoting women's empowerment, with interventions mainly targeted at increasing opportunities for marginalised poor women to participate in economic growth processes. Two approaches are favoured by donors, bilateral and multilateral agencies, namely that of (1) increasing poor women's access to credit (e.g. micro-financing) to support and encourage female micro-entrepreneurs and (2) increasing women's access to waged employment. Both these interventions are combined with a third approach implemented by the State, which is social protection targeted at poor women. Common forms of social protections are conditional/unconditional cash transfer programs or public work programs (PWPs).

PWPs have a long, global history, entering mainstream policy in the 1970s as an instrument for employment creation and poverty alleviation targeted at poorer segments of the population. PWPs offer various benefits such as (1) income - which can improve household food security, alleviate poverty, vulnerability and income shocks (2) employment, (3) skills acquisition (4) a means of accumulating productive assets, and (5) improvements in productive public infrastructure which stimulates increased economic growth through higher demand for goods and services. As a means of capturing the able-bodied, albeit lowly skilled and poor members of the society, PWPs are preferred over cash transfers since people are working for their entitlements instead of being perceived as a drain on taxpayers. Furthermore, Ravallion (1990) describes PWPs as 'self-targeting' as the work requirement discourages access by the better off. According to McCord (2009b), PWPs have the potential to (1) combine social protection with employment creation, (2) increase household productivity and (3) broaden economic growth, while at the same time address the concerns of fiscal unsustainability and dependency which a cash transfer type social protection may provoke.

The ability of PWPs to (1) combine all three aspects of increasing women's access to credit, employment and social protection into one intervention, and (2) garner acceptance among taxpayers due to rewarding the poor for their labour contributions, encouraged their adoption for promoting women's empowerment through economic participation.

The subject of this thesis will be to examine the economic impact of PWPs on women's livelihoods and the extent to which PWPs contribute towards women's empowerment, with a focus on the case of South Africa's Expanded Public Works Programme (EPWP). I draw on (1) a feminist agenda of power and agency, and (2) the Pathways of Women's Empowerment Research Programme Consortium's understanding of empowerment as "a journey" constituting the economic, legal and socio-political aspects, to conceptualise my working definition of empowerment as an interplay of power and agency across key spaces of the state, institution, community, household and individual in the economic and socio-political contexts (further discussed in Chapter 2).

1.2   Background and rationale for the study

To date, there is a vast literature examining the consequences of PWPs on poverty reduction and the factors contributing to success (Subbarao 2003, del Ninno, Subbarao and Milazzo 2009), albeit with most studies concentrated on large scale, anti-poverty national employment programmes with long histories, such as Ethiopia's PNSP[1], India's MGNREGA[2] and Rwanda's VUP[3]. Moreover, most studies measure indicators of coverage and uptake to evaluate compliance, lacking a disaggregation of outcomes by gender and a measurement of women's power to control the income earned through public works. The above limitations in existing literature are evident in McCord and Slater's (2009) critique that the preference for PWPs by donors and governments over other programmes may be driven by political and organisational interests, rather than evidence-based practices, as existing findings on macro-and micro-economic outcomes of PWPs are inadequate and inconclusive. Inconclusive findings on the impact of PWPs on women's livelihoods may be attributable to (1) insufficient systematic studies and research on the macroeconomic, microeconomic and labour market impact of PWPs (McCord 2012), and (2) limited studies adopting a gendered lens to investigate the outcomes of PWPs (Quisumbing and Yohannes 2005).

Among the limited studies adopting a gender analytical approach, there is a general consensus that main economic benefits come from programmes that include gender

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[1] PNSP is Ethiopia's Productive Safety Net Programme which integrates public works with food or unconditional cash transfers.
[2] India's Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was implemented in 2005 with aims to create job opportunities and improve livelihoods through the provision of economic and social infrastructures.
[3] Rwanda Vision 2020 Umurenge Programme (VUP) is a flagship government owned and led social protection programme launched in 2000, with public works employment and unconditional cash transfers, having the key objective to accelerate the reduction of extreme poverty.

equality into its policies and practices. There are eight major studies adopting a gendered lens to examine the impact of PWPs on the socio-economic circumstances of female participants, carried out on PWPs in a number of developing countries including Ethiopia, India, Rwanda, East and Southern Africa, all of which rely on qualitative methods. The findings are quite mixed. In a study of PWPs implemented across 27 countries between 1995 and 2013, Tanzam and Gutierrez (2015) find gender responsive projects to be more effective in improving women's socio-economic circumstances in terms of access to resources, increased decision-making power within the household and community as well as increased visibility in the traditionally male-dominated, public domain of infrastructural and road works. Despite Tanzam and Gutierrez's (2015) global coverage of PWPs through a desk assessment, reported findings demonstrate heterogeneity, but discussion on the ways in which programme implementation and environmental contexts influence PWPs' achievement of gender equality in different countries is limited.

On the contrary, five other studies which focus on specific country contexts provide greater insights into specific issues limiting women's benefit from PWPs. For example, Kabeer (2008) finds that despite promoting equal access to employment opportunities through PWPs, women's participation remains limited except among the poorest and lower caste populations in India, as programmatic designs do not factor in women's reproductive responsibilities. Two studies (Quisumbing and Yohannes 2005, Holmes and Jones 2011) on Ethiopia's PNSP find different issues from that of Kabeer (2008), identifying social norms which support gender-biased segregation of work, unequal wages and women's lack of control over their earned incomes to be the main limiting factors on women's empowerment. Similarly, Antonopoulos (2007) points to varying issues within the context of South Africa and India, identifying gender-biased pay rates to be limiting women's earning abilities, and targeting of household heads to be reducing the work opportunities for women in male-headed households. Reporting on Rwanda's VUP, Pavanello et al. (2016) suggest that female participants experience an increase in financial access and control, albeit having issues of unequal access to PWP opportunities due to their reproductive roles and inconsistencies in the targeting of beneficiaries which excludes the poorest (usually women) from the programme.

It is evident from the above studies that the socio-political and economic environments of women act as key determinants of the types of problems they face in their PWP participation, revealing difficulties in generalising findings across low-income countries. The above reveals a need for more gender focused studies on PWPs situated within

different developing countries to inform more contextualised gender responsive implementation. Furthermore, in programmes such as South Africa's Expanded Public Works Programme (EPWP) where multiple sectors and job types are involved, findings such as that of Antonopoulos' (2007) tend to provide a general understanding of programmatic outcomes which is detached from the nature of the jobs offered in different sectors. In so doing, gender and job specific problems encountered by women within the smaller scale, female-dominated sectors of the EPWP, such as social care, tend to go unnoticed and under-researched.

Given that women's participation in income-generating PWPs is constrained by their responsibilities for domestic work and childcare, McCord (2005), Antonopoulos (2007) and Holmes and Jones (2011) suggested incorporating a social care dimension to PWPs, remunerating women for carework which enhances their overall participation in PWPs. Despite this evidence, only a small number of PWPs aimed to expand their scope beyond physical and social infrastructure and community services (e.g. safety monitoring and public space cleaning), to incorporate a social service dimension (Tanzam and Gutierrez 2015). To date, I found only three instances of PWPs with social care, namely (1) South Africa's EPWP which include healthcare and childcare, (2) Rwanda's Vision 2020 Umurenge Program which targets childcare and child development, and (3) the Red Cross Home Based Care programme in Zimbabwe and Malawi. The small number of cases explain the limited number of studies conducted on the subject. Moreover, existing studies are more concerned about the extent to which a social care dimension impact women's participation in PWPs, rather than how they benefit from PWP employment in carework. My study aims to contribute to the gap in the literature by adopting a feminist, social development lens to conduct a focused study on caregivers in the female-dominated home community-based care programme (HCBC), which is a branch of South Africa's EPWP.

Four key studies show unitary support for a social care agenda for its ability to (1) reduce burdens on unpaid work, remunerate women for carework, create jobs in the social sector (Antonopoulos 2007), (2) increase visibility of women's carework in policies (Holmes and Jones 2011), and (3) reduce women's time poverty and increase women's access to PWPs (Tanzam and Gutierrez 2015). The recommendations of Antonopoulos (2007), Holmes and Jones (2011) and Tanzam and Gutierrez (2015) for social care in PWPs are however based on a gendered policy critique of existing PWP practices, and not substantiated by empirical analysis. Similar support is however provided by McCord

(2005, 44) based on empirical studies of South Africa's HCBC and the Red Cross HBC in Zimbabwe, which conclude that social sector programmes can bring about "sustained income transfers to workers, while also offering a social service".

Unfortunately, McCord (2005) focuses on the income aspect and has not covered broader gender issues such as (1) gender-differentiated needs, (2) women's time poverty and mobility patterns, (3) gender differences in employability and education, and (4) gendered impact of poverty and vulnerability. Nor is there sufficient evidence on the impact of HCBC on women's power and agency within the broader spaces of the institution and state in which women act. I address the above gaps in my case analysis on South Africa's HCBC, potentially contributing to discourses shaping the institutionalisation of unpaid care into PWP policy frameworks, an issue which is all the more essential in view of Chopra, Kelbert and Iyer's (2013) finding, in a review of social protection and early development policies across 144 low and middle income countries, that care is often disregarded in policies. Chopra, Kelbert and Iyer (2013) call for more research on the different actors, norms and discourses shaping the policy frameworks.

1.3   Research question and sub-questions

In this study, I aim to investigate the extent to which PWP with social care promote women's empowerment. To do so I focus on South Africa's home community based care (HCBC) which is part of the Expanded Public Works Programme (EPWP). The key question of my research is:

What is the impact of South Africa's HCBC on caregivers' empowerment?

With two sub questions:

1. What is the impact of HCBC on income and economic well-being of home community-based caregivers?
2. If there have been economic gains, to what extent have these been translated into socio-political gains?

1.4   Research aims and objectives

The main aim of my thesis is to examine whether the inclusion of social care in PWPs contributes to empowerment. To do so, I conduct an in-depth case study of South Africa's HCBC. I begin by critically reviewing the literature on empowerment in order to develop a framework for an analysis of South Africa's HCBC. I then investigate the impact of

HCBC on female caregivers' livelihoods, focusing on socio-economic aspects of empowerment drawing mainly on the narratives of HCBC caregivers. By doing so, I aim to:

1. Contribute a gendered analysis to the PWP literature, and draw attention to the HCBC programme
2. Potentially inform PWPs about the value of including a social care agenda through community carework

1.5   Research methodology

My research consists of two phases: desk based research followed by a case study of South Africa's HCBC programme. This analysis will be supplemented by findings from a small number of interviews carried out among township residents and caregivers in Cape Town, South Africa.

1.5.1   Desk-based research

I will devise and develop the framework for empowerment by drawing on existing policy documents and reports and assessments, in addition to the academic gender literature.

1.5.2   Case study approach

I use my framework for women's empowerment in a single case study of South Africa's home community based-care programme, which is part of the Expanded Public Works Programme (EPWP). I conduct a meta-analysis of empirical studies, both qualitative and quantitative, on the HCBC to evaluate its impact on the empowerment of participating caregivers. Findings from my meta-analysis will be triangulated against (1) data collected during my observational study of the HCBC in Masiphumelele township, (2) visits to various townships, where I conducted interviews and personal conversations with caregivers and residents, and (3) existing government reports of the HCBC.

According to Gerring (2007, 20), a case study approach involves

> *'an intensive study of a single case where the purpose of that study is - at least in part - to shed light on a larger class of cases (a population)'.*

Similarly, my study involves an in-depth and contextualised examination of the HCBC in South Africa targeted at poor, marginalised women. Through examining the real-life experiences of women involved in HCBC, I analyse its impact on women's empowerment, findings which can potentially be representative of the larger population

of female participants who already are, or will potentially be, involved in community carework across Africa and other low income countries. An intensive study of South Africa's HCBC may potentially influence the strategies of a large class of PWPs implemented across developing countries, especially in relation to the social service dimension in promoting the empowerment impact of PWPs.

Most studies measuring the impact of development interventions on women's economic empowerment adopt a number of quantitative indicators. Quantitative data is however limited on its own as it fails to capture the nuances of gendered power relations relating to change, nor can it assess the subjective experiences of individuals, such as for example a sense of agency and self-worth. As my study is interested in both the economic and social dimensions of women's empowerment, questions relating to why, for whom and in what ways interventions are devised and either work or fail need to be addressed. Such an endeavour will require drawing on qualitative studies and the socio-cultural context within which gender relations and social interactions are played out.

1.5.3   Case: EPWP's home community based care in South Africa

The case selected for analysis is the HCBC in South Africa's EPWP. This policy was designed to address the widespread unemployment, underemployment and poverty since democracy in 1994, and was subsequently expanded in 2004. The EPWP is the government's short to medium term programme targeted at job creation and the development of soft and hard infrastructure. South Africa pioneered the incorporation of HCBC provisions into its PWP framework, creating a category of stipend-paid community caregivers to provide physical, psychosocial, palliative and spiritual care in patients' homes. It is in part driven by the AIDS epidemic which led to the urgent need for a cost effective solution to social care provision so as to cope with the pressure placed on hospitals.

As part of the EPWP, the HCBC programme seeks to create work opportunities in HCBC sites managed by non-governmental/civil based/faith based/non-profit organisations. HCBC aims to provide job opportunities, training and stipends of varying amounts for participants to carry out compassionate care and fulfil the basic needs of the ill, usually within the confines of patients' homes. HCBC participants are usually unemployed women. HCBC is thus perceived as a means to enable poor, unemployed women to participate in employment, to acquire basic nursing skills, and to earn a stipend designed to alleviate poverty and allow asset accumulation.

1.5.4 Quantitative data

Quantitative data forming the background data of my study will include National Treasury data on budgets and expenditures across sectors, provinces and municipalities, quarterly reports of the EPWP prepared by Department of Public Works (DPW). I also include Statistics South Africa (SSA) time use surveys conducted in 2000 and 2010 to compare differences in time allocation between men and women before and during the implementation of the EPWP. Time use surveys will provide information about whether HCBC influences time spent by women in unpaid carework.

1.5.5 Qualitative data

EPWP policy and legislative documents provide insights into the theoretical underpinnings of HCBC and show the context under which concepts of gender equality and economic empowerment came to be adopted and used in the EPWP. To evaluate the effectiveness of these polices, qualitative data will be collected through a comprehensive search of the empirical literature to identify evaluative studies of the HCBC programme. An analysis of selected empirical studies will enable a more complete understanding of the implementation and outcomes of HCBC as perceived through the subjective experiences of programme participants.

As empirical work on the HCBC is limited in and of itself, and even more so when it comes to studies which adopt a gendered perspective, selected empirical studies would include those which do not adopt a gender focus. Studies without a gendered lens would still be relevant in view of the considerably high level of female participation in the HCBC. In addition, taking into consideration all documented/published studies of the HCBC would enable a more reliable, valid and conclusive evaluation of the programme. I also triangulate data collected from my field scoping trip in Cape Town, South Africa into my meta-analysis of the existing empirical literature. Particular attention will be paid to the perceptions, experiences, narratives and expectations of HCBC caregivers and the extent to which reported outcomes meet the criteria for empowerment as outlined in my theoretical framework.

1.6 Contributions of the research

Conceptually, my research aims to make a contribution to exploring both theoretically and empirically the relationship between women's participation in community care work and women's experience of empowerment. It provides a theoretical framework which can potentially be used to evaluate the impact of job opportunities and income generation,

arising from the externalisation of care, on community caregivers' livelihoods. In practice, my study draws attention to the dimensions which PWP-driven social service interventions would need to take into consideration, in order to achieve the goals of empowerment for female caregivers. It can potentially inform PWPs in the Global South on the effectiveness of incorporating a social agenda, and provide suggestions for the third phase of South Africa's HCBC. In terms of policy implications, my research draws attention to the need to take into account the 'fractured privations in women's lives at the grassroots' (Chant, 2006, p.210), in order to address multidimensional aspects of power and poverty when questioning the contributions of women's participation in community carework to their empowerment. Findings of the study can potentially provide a guidance to the policy frameworks of governments intending to incorporate a social dimension into PWPs, and its supporting international and national donor agencies.

1.7   Structure of the thesis

Chapter One introduces South Africa's HCBC as a strategy to increase the gender responsiveness of public works programmes in both policy and practice. By this in-depth analysis of HCBC, I am to assess the extent to which the scheme contributes to empowerment through the perspectives of participating caregivers. The rest of this chapter discusses the core research questions, aims and objectives, methodology, conceptual framework, potential contributions of the study to academia, policy and practice, and lays out the structure of the thesis.

In **Chapter Two**, I examine women's economic empowerment as a concept arising out of the gender and development literature. I highlight its interchangeability of use with development vocabularies which surfaced since the 1970s, such as that of gender equality, empowerment, pro-poor growth, poverty reduction and economic growth. Despite several more radical turns in the gender and development literature, I argue that the present practice of development continues to adhere to the Women in Development (WID) approach in the 1970s, albeit with a transition of language to that of women's economic empowerment. In particular, WID's approach to target women's education and employment as the means to economic participation and growth persists into policy practice of today. I demonstrate that such a stagnation in policy practice may be attributable to the ability of WID ideologies to support the neoliberal orientation which has dominated development thinking since the 1980s. I show that development has remained market driven, with new vocabularies often developed to repackage existing concepts, and continue to promote the neoliberal development agenda.

In response to the instrumentalism of empowerment within the policy literature, I revisit the writings of feminist and social science researchers to propose a framework which reinjects a feminist discourse on power back into the concept of empowerment. It takes the discourse on empowerment beyond that presently adopted by international development agencies which focuses on the material advancement of women through waged employment, to investigate the concerns of academics over the contributions of these interventions towards social aspects of power and agency and the inclusion of women into different spaces across which they can act out this power.

Chapter Three elaborates on the research methodology used for an analysis of HCBC in South Africa. I discuss challenges I faced on my pilot study in South Africa, Cape Town, and demonstrate how my proposed method for a meta-analysis of existing studies on the HCBC, supplemented by findings from interviews collected on my pilot study and background data from existing government reports, can address the difficulties I faced. In **Chapter Four**, I apply my framework to the HCBC, drawing on concepts of power and agency to critique the HCBC's objectives reported in government documentations, and identify different dimensions of the programme that influence different aspects of empowerment. I discuss my findings in the following two chapters.

Chapter Five focuses on the economic dimension of women's empowerment, examining the ability of HCBC to impact on women's (1) employment, (2) employability, (3) poverty alleviation through income generation, and (4) access to urban and social services. I first contextualise HCBC against the broader background of the EPWP and the social sector, before providing an overview of my findings. I then direct my attention to examining the impact of HCBC on the income and economic well-being (employment, skills training, service delivery) of caregivers.

In **Chapter Six,** I turn my attention to the socio-political aspect of empowerment, beginning with how the lack of control over economic resources hinders women's ability to exercise decision making power over household consumption and bargaining power within intimate and work relationships. Despite an elevation in self-esteem, the translation of caregivers' 'power within' themselves into 'power with' the community through (1) active community participation in healthcare, and (2) activism and resistances against HCBC policies, remains challenging. Nonetheless, I demonstrate the ability of HCBC to promote social capital formation, with these social networks facilitating community support of caregivers' work which influences their experience of

empowerment. There is however a social cost to conducting care in a close-knit community.

Chapter Seven sums up key conclusions of the study. I make suggestions for both policy and practice of PWPs in the Global South seeking to incorporate a social service provision agenda to promote women's empowerment. I also identify areas for future research on empowerment and home community based care in the Global South.

Chapter Two

From WID to economic empowerment: Where has power gone?

2.1   Introduction

The concept of women's economic empowerment has gained much momentum in recent years, especially in low income countries. Despite its popularity in policy literature, there is yet to be a universal definition of women's economic empowerment and the term is often used rather loosely in programmatic interventions. Distinct overlaps in the efforts of multilateral agencies to conceptualise women's economic empowerment appear, with common themes such as agency, opportunity structure and control/power over resources. Perhaps rather tellingly from the naming of the concept, aspects of power, agency and opportunity are often discussed by international development agencies [4] in wholly economic terms. For example, World Bank (2006a, 4) defines women's economic empowerment as 'making markets work for women (at the policy level) and empowering women to compete in markets (at the agency level)'. Similarly, OECD-DAC (2011, 6) conceives of women's economic empowerment to be about increasing women's 'capacity to participate in, contribute to and benefit from growth processes in ways that recognize the value of their contributions'. Women's power and agency to participate in market processes are considered a necessary precursor to women's economic empowerment.

While a focus on the economic aspect may not necessarily be a negative move if discussed as a subset of other aspects such as political and social, this is rarely done in policy literature. The policy tendency to equate women's empowerment with gender equality within market economics has been critiqued by academics as (1) "promoting an economically utilitarian version of gender equality" which exploits the economic benefits of women's participation in markets (Chant 2016, 9, Chant and Sweetman 2012), (2) instrumentalising gender as a "conduit for policy" (Chant 2012, Molyneux 2006, 2007), (3) obstructing the achievement of gender equality in the feminist, non-economic sense of the term (Elson 2012), and (4) lacking a commitment to highlight gender biases of macroeconomic policy agendas (Razavi 2012).

Within policy documents, the economic focus on empowerment and its largely instrumental approach to gender equality, have led to the loss of socio-political

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[4] Agencies include the World Bank (WB), Department for International Development (DFID), International Development Research Centre (IDRC), Organisation for Economic Co-operation and Development's Development Assistance Committee (ODEC-DAC), International Centre for Research on Women (ICRW) and Swedish International Development Cooperation Agency (SIDA),

dimensions underlying the empowerment concept first proposed by feminist and social science researchers. This chapter is motivated by an identified need to revisit the works of feminist and social science researchers to examine how the institutionalised concept of empowerment focused on women's economic participation may be expanded to incorporate socio-relational dimensions. The chapter will be divided into three sections, the first examining the empowerment frameworks of social science and feminist researchers. Findings in the first section will inform a critical analysis of developments in the empowerment agenda within policy frameworks in the second section, and the proposal of a framework to resituate empowerment within policy literature to its feminist and social science origins in the third section.

2.2   Empowerment from a feminist, social science perspective

The instrumentalist agenda to empowerment within international development agencies has been criticised by Eyben (2010, 61), stating that "women's empowerment is often treated by international agencies as something that can be designed as a policy blueprint, rolled out and scaled up", The above critique underlies the Pathways of Women's Empowerment Research Programme Consortium's (Pathways) (2011, 2-3) perspective of empowerment as "a journey, not a destination", and "one that is framed by lived experience rather than stereotypes". Informed by a feminist lens, the fluid nature of Pathways' definition provides space for diverse approaches to the concept of empowerment. As my study seeks to explore the multidimensional (social, political and economic) aspects of empowerment, I take Pathways' understanding of empowerment as unique journeys as the starting point for my analysis. The above choice is further informed by Kabeer's (2011) comment that the Pathways' definition of empowerment constitutes multidimensional processes of transformations encompassing different spheres of women's lives.

Conceptualising empowerment as a process which entails multidimensional shifts draws attention to the multiplicity of spaces in which women act, and the patriarchal structures which disempower them. It shifts the focus away from institutions and bureaucracies as the drivers of empowerment in the international development policy arena (Eyben 2010) to consider women's resistances against the broader societal structures which supress their voice. The above understandings are reflected in early feminist writings (Sen and Grown 1988, 26, Kabeer 1994, Batliwala 1994) which attribute women's subordination to existing societal structures that are 'deeply ingrained in the consciousness of both men and women', suggesting that systematic social change is necessary for women's

empowerment. Batliwala (1994, 132), Kabeer (1994, 253) and Young (1993, 158), focus on the social aspects to suggest that empowerment is about (1) strengthening women's agency, self-confidence and abilities, (2) liberating women from their self-imposed mental constraints, and (3) enabling women to influence change through collective action in women's grassroots mobilisations.

The above feminist researchers demonstrate empowerment to originate from an interplay between different spheres of women's lives, such as the (1) individual aspect of women's minds as perpetrators of their own subordination, (2) personal expansion in abilities to formulate strategic choices, and (3) collective power to participate in decision-making which influences change. The multiple arenas through which empowerment acts out is comprehensively documented in Deshmukh-Ranadive's (2005) framework. Deshmukh-Ranadive (2005, 115-116) identifies three interconnected levels, the macro (global, national, regional), meso (village, community), and micro (domestic, individual), through which a multidimensional process of empowerment is enacted, emphasising the importance of linking the different levels, commenting that 'the connection from macro to meso to micro has to be made to ascertain the empowerment effects of development interventions'.

Deshmukh-Ranadive's (2005) three levels show that empowerment does not function only on the level of the individual, but also on a collective front involving a diverse range of actors such as the state, institutions, communities and households. The above is reflected in Kabeer's (2005, 16, 1999) emphasis on the importance of women's collective action to bring about 'transformative forms of agency that do not simply address immediate inequalities but are used to initiate longer-term processes of change in the structures of patriarchy'. There is an implication that individual improvements are a step change towards collective action necessary for empowerment to take place. Stromquist (1995) reinforces the above argument, describing empowerment to be a socio-political concept involving the psychological, cognitive, political and economic components. In particular, Stromquist (1995, 14-15) adds that through the cognitive component of 'understanding the self and the need to make choices that may go against cultural or social expectations', women's psychological transformations would enable them to participate in the political component of collective action which 'is fundamental to the aim of attaining social transformation'.

Similar to Stromquist's (1995) work which alluded to the multiple components of psychological, cognitive, political and economic through which empowerment is experienced, Deshmukh-Ranadive's (2005, 115-116) framework include a consideration for physical, economic, sociocultural and political environmental contexts which influence individual's access to and control over the spaces in which they act. The importance of environmental contexts in influencing women's empowerment is reinforced by Kabeer's (1999, 461) finding that increasing women's ability to make choices may not necessarily lead to positive outcomes of freedom to choose, as the conditions under which women act on their choices can impact on whether women 'challenge and destabilise social inequalities or merely express or reproduce these inequalities'. Similarly, Cornwall and Edwards (2010, 2) draw attention to the importance of context in 'making sense of empowerment', stating that movements in social, cultural and political contexts of women's lived realities can 'impinge on the possibilities for women's empowerment - facilitating and enabling but also blocking and restricting possibilities'. It is apparent from the above studies that the extent to which women experience empowerment is largely dependent on the ways in which socio-cultural, political and economic factors interact to facilitate or block transformations in women's livelihoods.

Examining empowerment through a power analysis, Foucault (1978, 92-93) explains that shifts in power have to be analysed across multidimensional spaces within multiple contexts, since power 'pervades the entire social body' and is 'omnipresent', with the whole of social life being caught up in a network of power relations from macro-scale social structures to the micro-scale of the individual. Foucault (1980, 133) suggests that in order to 'detach the power of truth from the forms of hegemony, social, economic and cultural, within which it operates at the present time', power has to be understood as a dispersed, decentralised, socialised construct which is exercised on an everyday basis within social interactions, cultural representations and institutional practices. Aligning with Foucault's (1980) understanding of power, empowerment would involve an examination of power dynamics in the daily socialisations of women, a move Cornwall (2007) considers to be vital towards identifying factors which help and hinder women's empowerment.

Foucault (1980) considers power to be fluid and exercised through the normalisation of dominant knowledge. A deconstruction of accepted social norms can therefore bring about power shifts through a de-subjectification of the subjectified, subordinated 'other'

(Foucault 1980). An escape from hegemonic power through knowledge deconstruction is evident in Sardenberg's (2008, 2010) work on women in a low-income neighbourhood in Brazil. Sardenberg (2008, 23, 2010) reports that with a recognition of the limitations of conjugal relationships and their positions within matrifocal domestic arrangements, women's newly constructed knowledge destabilised their subjectified position to the patriarchal norm, 'creating a space for women that could lead to consciousness-raising and collective action in the direction of "liberating empowerment"'. Similarly, Batliwala (1994) emphasises the space of the conscious relating to women's self-confidence and self-esteem. Batliwala (1994, 131) suggests that in order for women to (1) challenge the dominant knowledge of patriarchal relations, and (2) construct a consciousness which 'recognise[s] the ideology that legitimises male domination and understand how it perpetuates their oppression', it is first necessary that they deconstruct their understanding of social norms from within.

Evident from the above studies is that the conceptualisation of empowerment as power transitions within social relations enables a contextualised evaluation of women's psychological and physical well-being within specific socio-economic, cultural and political environments. The works of feminist and social science researchers demonstrate that transitions in an individual's physical and psychological well-being are closely related to multidirectional shifts in their economic, social, cultural and political environments across all three levels of the macro, meso and micro, and that these shifts influence the extent to which women experience empowerment.

For example, interventions targeting women's economic gains through paid care work may succeed in improving their financial situation through effecting changes in the economic space at the micro level of the individual, albeit stopping short at transforming (1) policies and markets (political and economic environments in the macro and meso spaces) which economically disadvantage women, or (2) the economic environment at the micro household space which involves women's control over their incomes. A lack of change in the macro/meso levels may mean that economic benefits enjoyed by women may be temporal or limited to the intervention. A stagnation in the micro level where differential gendered power relations are played out can contribute towards women's persistent lack of control over their increased incomes. Both the above outcomes can influence women's psychological sense of self-esteem. Under the above circumstances, women who have successfully expanded their economic environment in the individual space may not necessarily have experienced empowerment since other environments: (1)

political and market economy, (2) sociocultural norms influencing agency, and (3) economic circumstances within households, continue to remain unaddressed.

The importance of the legal politico space is supported by Foucault's (1979) concept of 'disciplinary power' which is present in administrative systems and social services to openly discipline and conduct surveillance on people, subjugating physical bodies through a definition of the acceptable normative. For example, within legal-politico spaces, public policies lacking in a gendered perspective of women's productive and reproductive roles may exert an invisible power disciplining practitioners and participants to accept bodies of knowledge with gender biased norms that confine women to the unpaid care economy. Cornwall, Harrison and Whitehead (2008, 3) discuss Foucault's (1979) 'disciplinary power' as 'interpretive power' constituting 'institutional and individual power' which contributes towards shaping legal-politico spaces. A struggle for 'interpretive power' is essential for the reframing of knowledge and the engagement of alternative recourses for transformations (Cornwall, Harrison and Whitehead 2008).

Cornwall, Harrison and Whitehead's (2008) study reinforces the importance of collective action for empowerment, discussed above by Batliwala (1994), Kabeer (1994) and Young (1993). In addition to gaining psychological awareness of the presence of 'disciplinary' and 'interpretive' power, women need to demonstrate collective resistance against the disciplinary power of institutionalised social norms to achieve social transformations in the distribution of carework. Through resistance against disciplinary power within legal-politico spaces, women can potentially be provided with opportunities to satisfy Moser's (1989) 'strategic' interests which are those acquired through women challenging their subordination, as well as 'practical' interests which are those assisting women to conduct their gender assigned roles more easily. The importance of targeting the legal politico spaces of women's empowerment is emphasised in Netsbitt-Ahmed et al.'s (2015), writing for IDS, call for increasing the visibility of women's unpaid care work within policy spaces. Netsbitt-Ahmed et al. (2015) propose a feminist political economy approach to transforming the public policy agenda. Within the context of Bangladesh and India, Netsbitt-Ahmed et al. (2015) report that gender-sensitive policies recognising the economic contributions of female caregivers are essential for gender equality and women's economic empowerment. It is evident from the above example that to advocate for an equal distribution of carework, a transformation of societal attitudes towards care needs to be accompanied by engagement in a policy space which influences fiscal space. A recognition of women's unpaid care work in public policies may inform fiscal support

in the allocation of resources towards social protection, urban services and care provisions, potentially serving to reduce women's care burdens and avail them for paid work.

Active translation of policy into practice is integral in order for influence on the legal politico space to be effective. In the case of Action Aid's Women's Rights to Sustainable Livelihoods (WRSL) project for example, an incorporation of unpaid care work into the legal politico space had limited impact on influencing gender responsive budgeting. WRSL convinced the Rwandan and Ghanaian governments to include unpaid care as a policy issue, and transformed the distribution of care within households and communities. Despite achieving policy changes accompanied by social transformations, WRSL remains unsuccessful in influencing budgetary reallocations to gender responsive provisions targeting the reduction of care burdens on households (Kandyomunda, Morales and Millard 2015).

Empirical studies demonstrate that successful translation of policy into institutional practices can be accompanied by shifts in gendered norms determining the division of responsibilities. For example, Chopra and Nazneen (2016) report that the 2015 Emergency Cash for Work[5] project in Iraq provides opportunities for temporary paid work which are socially acceptable for women[6], targeting these opportunities at female heads of households. With policies ensuring equal wages for men and women in the programme regardless of the nature of their tasks, the intervention is successful in (1) encouraging women's participation through reducing their reproductive responsibilities, (2) increasing societal (especially male) acceptance of women's participation in work programmes, (3) transforming societal valuation of women's care work, and (4) increasing women's bargaining power and respect within the community (Chopra and Nazneen 2016). The above changes show transformations at the legal-politico level of the state to have brought about transitions in power relations at the levels of the household and community, thereby enabling a more holistic experience of empowerment.

Public work programmes (PWPs) which successfully translated its gender responsive policies into practice were also reported to bring about positive socio-economic impacts on women's empowerment in the legal-politico, community and household spaces. An

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[5] Public work programme targeted at integrally displaced peoples, returnees and host communities in Iraq
[6] These work opportunities include indoor maintenance of schools and community buildings, cooking for male labourers and childcare for women participating in the Emergency Cash for Work programme

example is in five public works programmes (e.g. MEGA and MGNREGA in India, REOPA in Bangladesh, NSPS in Cambodia and VUP Social Transfer Programme in Rwanda) identified by Chopra, Kelbert and Iyer (2013) to be providing support to women through maternity leave, access to childcare services (crèches), equal wages and increased access to work opportunities. All of the above interventions were reported to be successful in providing solutions for women's unpaid work burdens and encouraging women to participate in work schemes (Chopra, Kelbert and Iyer 2013).

Evident from the above works of feminist and social science researchers, a multidimensional approach to empowerment facilitates a contextual understanding of power shifts, giving voice to the multiplicity of journeys lived and travelled by diverse women. The following section investigates the extent to which a policy perspective to empowerment aligns with the works of feminist and social science researchers.

2.3   Conceptualising empowerment across the decades: WID to post-2015

Gender issues first emerged in 1970 in the international development discourse, owing in part to Danish economist Boserup's[7] (1970) argument that development agencies need to better integrate women into economic development. Through a Women in Development (WID) approach, advocates promote: (1) legislative reforms[8] to achieve egalitarian outcomes; (2) strategies to reduce gender discrimination in the productive economy (Rathgeber 1990, 490); and (3) training to increase women's economic productivity (Razavi and Miller 1995a). WID advocates adopted a language of efficiency[9] (Moser 1993, 63) to promote the usefulness of women and cost effectiveness (low investments,

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[7] Adopting a liberal feminist framework to question the modernisation literature through her research on the sexual division of labour in agrarian economies, Boserup (1970) critiqued the omission of women's contributions to development through their productive roles and questioned the idea that benefits gained from development will trickle down to women.

[8] Examples are the Percy Amendment of 1973 and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Percy Amendment of 1973 'required gender-sensitive social impact studies for all development projects which aim to integrate women into national economics of their countries' (Connelly, et al. 2000, 57). CEDAW was institutionalized in 1979 by the UN General Assembly as a commitment towards gender equality. It is an international bill of rights defining the domains of discrimination against women and lays out the framework for action against these forms of discrimination. CEDAW 'explicitly acknowledges that "extensive discrimination against women continues to exist", and emphasizes that such discrimination "violates the principles of equality of rights and respect for human dignity". […] discrimination is understood as "any distinction, exclusion or restriction made on the basis of sex...in the political, economic, social, cultural, civil or any other field". The Convention gives positive affirmation to the principle of equality by requiring State parties to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men"(article 3)' (UN Women 1979).

[9] A detailed discussion of the various politics and issues in the process of institutionalising WID approach are discussed in the works of Maguire (1984), Moser (1989), Jaquette and Staudt (1989) and Tinker (1990)

high pay-offs) of gender redistributive policies, to overcome bureaucratic resistance towards a gender focus.

A WID approach which engendered the poverty reduction strategies of international development agencies gave rise to women-only "technological fix" projects targeting poor women's employment and income generation (Buvinic 1986, 660, Rathgeber 1990). In subsuming a radical language of equity first adopted by liberal feminists, WID remains limited in challenging gendered, social relational aspects of power and agency. WID is critiqued for 'shift[ing] the focus of gender policy advocacy away from politicising women's needs and interests in development to calculating what development needs from women' (A. M. Goetz 1994, 30). Rowlands (1996, 5) adds that an isolated focus on women's productive capacities 'was (and continues to be) an approach that "instrumentalises" women. As will be shown in the discussion below, WID's focus on women's work and income emerged more strongly in current policy thinking through the concept of women's economic empowerment, proving Rowlands' (1996, 5) comment to be an insightful forecast of the cyclical pathways taken by development thinking.

In the mid-1970s, a Women and Development (WAD) approach was inspired by perceived insufficiencies in the institutionalised WID approach to address unequal power relations in the marketplace, community and household. WAD argues that rather than being left out of development as suggested by WID, women were always part of development processes but their contributions were made "invisible" in development plans due to structural and gender inequalities (Rowlands 1996, 5). Theoretically, WAD is concerned with unequal household distribution of resources, lack of recognition for women's reproductive role and systemic structures which downplay women's economic contributions. In practice however, WAD's interventions have a similar preoccupation with WID's over the productive domain, tending to focus on income-generating opportunities for women due to perceived benefits of greater economic efficiency and social returns, rather than as a means to achieve livelihood improvements (Moser 1993). WAD's singular focus on the inclusion of women into the productive economy is critiqued for (1) neglecting the constraints women face in their productive capacities due to their reproductive responsibilities (McSweeney and Freedman 1982, Roberts 1979), (2) adopting a binary understanding of the gender division of labour which omits elements of mutual benefits and cooperation in complementary gender roles (Kabeer 1992, 14), and (3) falling short of providing a complete picture of the relationship between different spheres of production, patriarchy and women's lack of power (Rathgeber 1990).

Drawing from the literature discussed, it seems possible to conclude that whilst having increased the awareness of structural inequalities and asymmetrical gender relations in society, WID/WAD approaches are less effective in (1) unpicking the unequal social relations between men and women across the familial and market spaces, and (2) questioning the impacts of such inequalities on women's experience of the development process. The above may be attributable to an engendering of the mainstream development agenda which required the shelving of radical undertones which challenge existing power hierarchies and advocate for increases in women's power and freedoms. Frustrations with the aforementioned lack of progress in the WID/WAD policy brought about the Gender and Development (GAD) approach which seeks to move beyond the integration of women to incorporate an analysis of social structures and institutions (Rathgeber 1990, 495). GAD engages constructively yet critically with neo-liberalism to (1) identify gender biases in associated policies, and (2) suggest ways to improve women's position within such policies. Unlike its institutionalised predecessors, GAD draws on the works of feminist economists [10] and social science researchers [11] to emphasise (1) women's productive and reproductive contributions, and (2) gender biases within the household. GAD critiques public policies for overlooking women's unpaid reproductive work and neoliberal economic policies for intensifying women's burdens, arguing for an engendering of economic and social policies to increase women's status in the economic and legal domains (Moser 1989).

GAD's focus on a feminist power agenda to transform the marginal position of women aligns with the empowerment concept emerging from the standpoint of 'Third World women [12] (Moser 1993, 74, Sen and Grown 1988). With its main concerns in the redistribution of power to allow women a say in development (Sen and Grown 1988, Moser 1993), and its introduction of socio-relational aspects into the development discourse (Rathgeber 1990), GAD aligns closely with the works of feminist and social science researchers discussed above (section 2.2). Through an 'empowerment' approach, GAD marks a leap in development thinking, expanding (1) the emphasis on women's productive work to incorporate the intersecting influences of women's reproductive roles,

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[10] (Appleton, et al. 1991, Elson 1991, Palmer 1991, 1992, Collier 1989)

[11] (A. M. Goetz 1989, Kabeer 1992, Young 1993, 1991, Whitehead 1990)

[12] The 1980s was also characterised by increased research and policy in the South which seeks to challenge the dominant, monolithic white, middle class Northern feminism's perspective of incorporating women into development. Tensions between Northern and Southern feminists will not be discussed in my work as they have been well elaborated on in the works of post-colonial/postmodern/post-development writers (C. Mohanty 1991, Mohanty, Russo and Torres 1991, Parpart 1995, 2002, Marchand and Parpart 1995, McEwan 2001, Anthais and Yuval-Davis 1992, Hooks 1984, McIlwaine and Datta 2003).

and (2) the sphere of influence beyond legislative aspects to include social relations within the household, communities and institutions. Prominence is placed on helping women to acquire power across the different spaces in which they act, since 'equality for women is impossible within the existing economic, political and cultural processes that reserve resource, power and control for small groups of people' (Sen and Grown 1988, 20).

Regrettably, GAD's emphasis on both fundamental structural changes to the dominant systems of patriarchy and capitalism, and the strengthening of women's positions within development strategies, proved to be too radical for institutionalisation by mainstream development agencies (Parpart 1995). Multilateral and bilateral agencies continue to identify and target problems using the WID/WAD approach (Rathgeber 1990). Development programmes using the GAD approach were difficult to come by in mainstream practice (Moser 1989, 1993), and relegated to (1) isolated cases for example of projects designed by African field researchers (Rathgeber 1990), (2) grassroots organizations in developing countries, such as Grameen Bank in Bangladesh, Self-employed Women's Association (SEWA) in India and the Gabriela in Philippines (Moser 1993), and (3) NGOs adopting bottom up approaches (Young 1993, 158-162). The transition to a holistic, feminist perspective of women's empowerment evolving around concepts of power and agency was short-lived, its demise marked by its entry into mainstream development discourse. A reinterpretation, translation and instrumentalisation of GAD, referred to as gender mainstreaming[13], was conducted in 1995 at the Beijing Platform for Action[14] (BPA). The empowerment concept found its way into policy texts at the BPA, stating that:

> *'The Platform for Action is an agenda for women's empowerment. It aims at [...] removing all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making. Empowerment of women and equality between women and men are prerequisites for achieving political, social, economic, cultural and environmental security among all peoples.' (UN Women 1995, Para 1, 41)*

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[13] Gender mainstreaming attempts to integrate competing goals of economic growth advocated by the mainstream and gender equality proposed by GAD into a single framework, discussed by the United Nations Economic and Social Council (ECOSOC 1997) resolution of 18 July 1997 as: 'a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres […] to achieve gender equality'.

[14] Signed in 1995 by 189 governments at the 4th UN Conference on Women in Beijing, the Beijing Platform for Action commits its signatories to the practice of gender equality in terms of ensuring women's equal access to decision-making, leadership and participation.

Despite being 'grounded in feminist theoretical frameworks' (Rao and Kelleher 2005, 59) and encompassing promises of 'gender-sensitive institutional change' (A. M. Goetz 1997, 2) in the BPA's development policy, empowerment lost its radical edge through the implementation of gender mainstreaming [15]. Feminist advocates (Hannan 2004, Macdonald 2003, Moser and Moser 2005, Zalewski 2010) raise concerns over a loss of the political and transformative aspects of gender mainstreaming which originated in the BPA through the process of bureaucratic institutionalisation. Arnfred (2001, 76) comments on gender becoming 'an issue of checklists, planning, and "political correctness"', while Baden and Goetz (1998) consider gender mainstreaming to be a means of pacifying gender activists. Yet others (Mukhopadhyay 2004, Razavi 1997, Kabeer 1999) adopt a more nuanced approach and suggest that cooperation and compromises by feminist advocates, necessary for the development of strategic alliances with the mainstream, may in part be responsible for differential outcomes between policy and practice.

For example, Mukhopadhyay (2004, 97) states that feminist advocates enter the 'familiar conceptual territory of welfare, poverty and efficiency' of policy-makers to garner support for the institutionalisation of empowerment. Feminists who take on the 'anti-poverty' stand adopt a 'feminisation of poverty' discourse to convince multilateral and bilateral agencies, policy makers and NGOs that gender mainstreaming can be the solution to gender equitable income distribution which alleviates women's poverty (Baden and Goetz 1998, 23). Advocates of the 'efficiency' argument promote gender mainstreaming as having good "pay-offs". Both the above arguments are evident in the World Bank's (1994, 22) justification that:

> *'investing in women is critical for poverty reduction, it speeds economic development [...], produces significant social returns, [...]; and it has considerable intergenerational payoffs'*

Through the 'anti-poverty' and 'efficiency' agendas, economic aspects replaced social-relational aspects of power distribution as the key focus of gender mainstreaming. The more limited scope of focus is in contrast with the broader emphasis of the feminist agenda to 'empowerment' on socio-cultural, political and economic transformations

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[15] Various critiques and disappointment over the gender mainstreaming approach emerged since the late 1990s from academics in the disciplines of development, political science and international relations. See the works of Bacchi and Eveline (2003), Bessis (2004), Goetz (2004), Obiora (2004), Daly (2005), Squires (2005), Benschop and Verloo (2006), Roggeband and Verloo (2006), Cornwall and Edwards (2010), Cornwall and Brock (2005), Verloo (2005), Mukhopadhyay (2014), Perrons (2005), Woodford-Berger (2004), Marchand (2009), Razavi and Miller (1995b)

across the spaces of the household, community, institution and state. In addition, international development agencies are attentive to the emerging human development and capabilities framework first introduced by A. Sen (1999, 10), and tend to narrow in on the economic aspect when discussing capabilities in policy formulation.

For example, writing for the World Bank, Alsop, Bertelsen and Holland (2006, 1) define empowerment as 'the process of enhancing an individual's or group's capacity to make purposive choices and to transform those choices into desired actions and outcomes'. The above definition draws on inputs of feminist academics, in particular Kabeer's (1999) framework of empowerment which constitutes three aspects of resources, agency and achievements. Alsop, Bertelsen and Holland's (2006, 1) definition reflects Kabeer's (1999) understanding that women's achievement of transformational outcomes is largely dependent on the capabilities (agency) they possess which enables them to draw on their resources. However, rather than focusing on collective action to bring about social transformations, Alsop, Bertelsen and Holland (2006, 1) are more concerned about collective activities which leverage on collective capabilities to facilitate the achievement of economic security. The above deviates from an understanding of collective action among feminist researchers such as (1) Sharma's (1991-92, 29) 'collective resistance, protest and mobilisation that challenge basic power relations', and (2) Batliwala's (1994) collective action for the transformation of relationships between individuals and social groups.

Another example is the UN's Millennium Development Goals (MDGs) and subsequently the Sustainable Development Goals (SDGs) which continue to gain traction among multilateral and bilateral aid agencies (Fujikake 2010). MDG3 advocates for *'Promoting Gender Equality and Women's Empowerment'*, targeting to achieve these goals through eliminating gender disparity in primary and secondary education, and inequalities in paid employment, while MDG 5 seeks to improve maternal health (UN 2013). The targeting of education, health and employment reflects a focus on expanding the capabilities of women to achieve economic security. The narrow and singular approach of focusing on education, employment and health is critiqued by Kabeer (2005), albeit adding that development indicators have at least demonstrated a broader scope in encompassing the dimension of political representation (SDGs further discussed below).

Despite the creation of new terminologies and strategies by feminist advocates to incorporate the relational and structural aspects of women's empowerment into the

development agenda, few radical transformations seem to have occurred owing to the appropriation of these concepts by both policy and practice. Instead, the mainstream development circle seems to be evolving and stretching new concepts to encompass existing ideologies which feed the neoliberal agenda while redefining new boundaries within which the feminist agenda is allowed to interact. The above is evident in the reinterpretation of the empowerment concept by international development agencies (discussed above) to support a pre-existing WID/WAD focus on education and health as the means to facilitate women's participation in the paid economy.

Feminist academics[16] critique the omission of a power agenda in the institutionalised empowerment concept, with Eyben and Napier-Moore (2009, 287) describing the discourse of international development agencies to be 'an eclectic mixture of old and new clichés assembled together through a complex process of political negotiations, compromises and strategising', where 'long-established notions may have to be jealously defended'. Cornwall and Brock (2005) and Batliwala (2007) comment on a de-politicisation of the 'empowerment' approach by international development agencies, questioning the ability of interventions to transform inequitable power relations and promote gender equality. Others (Mohan and Stokke 2000, Parpart 2002, Wong 2003) criticise the instrumentalism of empowerment for its focus on productivity, efficiency and maintenance of a status quo, being more concerned with what the poor can do for development instead of how development can increase the power of poor women. Still others (Halfon 2007, Sardenberg 2008) lament at a loss of the collective aspect of political mobilisations, stating that the institutionalised empowerment discourse is more concerned with individual aspects of capabilities and status. Community-based projects by NGOs have also been critiqued for (1) romanticising community-based power to the exclusion of questioning power relations and gender inequalities within local networks (Pointer 2004, Wong 2003), and (2) the "NGO-ization" of feminism and grassroots mobilisation (Choudry and Kapoor 2013, Murdock 2008, Silliman 1999, Alvarez 1999, 1998, Alvarez, Friedman, et al. 2003).

Drawing on the above feminist critiques, it is possible to conclude that a power agenda has been divorced from the policy literature on empowerment, with women's productive

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[16] In my discussion of these authors, my intention is to demonstrate a de-politicisation of the empowerment concept. I am not discrediting the importance of education and employment for women, but rather suggesting that an over emphasis on both these aspects may have contributed towards a downplaying of other socio-relational aspects of power transitions.

capabilities instrumentalised as a means to gender equality and poverty reduction. The institutionalisation of empowerment, with a shift away from GAD concerns for gendered power structures within both the productive and reproductive spheres, point to a backtracking of policy thinking to the WID/WAD era. In particular, development continues to focus on women's access to paid employment through capability development, a WID strategy which emerged as a reaction against the treatment of women as welfare receiving agents of reproduction. Mcfadden (2010) and Sharma, Parthasarathy, and Dwivedi (2007) support the above argument, expressing disappointment over a disregard of the nature of power, with a relegation of women's empowerment to one involving an upward economic mobility of the underprivileged 'other' who is disadvantaged by the neoliberal economy.

The concept of empowerment adopted by international development agencies further realigned to an economic perspective with the language of economic empowerment. Economic empowerment was first mentioned in the World Bank's (2006a, 1) Gender Action Plan (GAP) 2007-2010 which seeks to 'advance women's economic empowerment [...] in order to promote shared growth […] this is nothing more than smart economics'. World Bank (2006a) promotes a growth oriented approach to empowerment through a 'smart economics' framework which links economic empowerment to women's market participation for the achievement of poverty reduction, faster growth and gender equality. GAP's commitment to women's economic empowerment is reiterated in the succeeding World Bank (2010, 12) report which seeks to 'continue making the "business case" forcefully for gender equality as smart economics'. Symposiums and publications commissioned by the World Bank reflect an instrumental approach to economic empowerment.

For example, Tembon and Fort's (2008, xvii) World Bank commissioned report on gender equality in education established as its opening endpoint the importance of women's economic empowerment for 'economic development, growth, and poverty reduction not only because of the income it generates, but also because it helps to break the vicious cycle of poverty'. The above perspective fused together the language of gender equality, economic development, growth and poverty reduction which were created across four decades, and injected it with a female face. Women's economic empowerment came to be portrayed as the panacea to break the poverty cycle and provide a window of opportunity for women to be included into the growth process.

The World Bank's perspective on economic empowerment, and 'smart economics' justification has been echoed by various international development organisations. For example, in a 2010 joint workshop on women's economic empowerment between the United Nations Inter-Agency Network on Women and Gender Equality (IANWGE) and the OECD-DAC Network on Gender Equality (GENDERNET), economic empowerment was promoted as 'good economics' due to its perceived contributions to household productivity, gender equality and economic growth (UNIDO 2010, 6). OECD-DAC (2011, 6) considers economic empowerment to constitute women's inclusive participation in market processes to achieve a fair distribution of growth benefits. Similarly, in a collaborative publication with Oxfam, Thorpe et al. (2016) suggest that women's increased participation in market processes gave rise to the adoption of economic empowerment and gender equality objectives into market systems programs, due to perceived returns on investing in women.

Evident from the above conceptualisations of economic empowerment by World Bank, OECD-DAC and Oxfam, a feminist agenda of empowerment as structural and socio-relational is further subsumed under an economically driven perspective in the policy literature, now marketed as 'smart/good economics' by international development agencies. Increasing the capabilities of women to pursue financial independence through employment takes precedence over women's shifts in power relations. Women's power or status eludes discussion, with income generation and disrupting the vicious cycle of poverty taking on centre stage. In the aforementioned definitions, there is an implicit assumption that women's employment would bring about financial independence and increased well-being, thereby economically empowering women to disrupt the generational cycle of poverty.

Academics critique the conflation of empowerment, well-being and economic development by international development agencies to support an 'efficiency' approach. For example, Duflo (2012, 1051) comments that the empowerment-development/growth 'inter-relationships are probably too weak to be self-sustaining, and that continuous policy commitment to equality for its own sake may be needed to bring about equality between men and women'. The above argument points to the need to examine gender equality and empowerment in terms of power and rights, rather than in economic terms of growth and development. Similarly, Chant and Sweetman (2012, 521) critique international development agencies for using women and girls as quick fixes to the world's poverty crisis, commenting that research demonstrates the unfeasibility for poor women to attain

economic growth, poverty alleviation and gender equality concurrently. Chant and Sweetman (2012, 524) elaborate with an example of cash transfer programmes targeted at women and girls, stating that such interventions increase the labour burdens of women and perpetuate the myth of 'female altruism', instead of having any positive impacts on women's livelihoods, financial independence, experience of gender equality or economic empowerment.

A focus on the economic aspect of empowerment has enabled international development agencies such as World Bank and OECD-DAC to avoid (1) confronting structural inequalities contributing to women's difficult circumstances, and (2) dealing with the discomforting and unwelcomed topic of unequal power relations. One wonders at this point if compromises made by feminist advocates pushing for the institutionalisation of a gender agenda may be an excessive backward step, that in giving an inch, mainstream discourse have taken a mile in pushing the 'efficiency' approach.

Further analysis suggests that unlike the World Bank and OECD-DAC, organisations such as ICRW, SIDA and DFID mention power, rights and control in their definitions of economic empowerment. For example, writing for the ICRW, Golla et al. (2011, 4) describe an economically empowered woman as one who "has both the ability to succeed and advance economically and the power to make and act on economic decisions'. In a later publication, ICRW (2016, 4) justifies the importance of advancing women's economic empowerment as being a necessity to 'business innovation, productivity, risk management and market growth'. An economic rather than rights-based rationale is adopted by ICRW to encourage private sectors to champion gender equality and tackle structural and systemic obstacles to women's economic advancement.

Similarly, Tornqvist and Schmitz (2009, 7) write on behalf of SIDA to define women's economic empowerment as 'the process which increases women's real power over economic decisions that influence their lives and priorities in society', implying that power over economic resources is the key element enabling women to experience empowerment and freedom to make choices in their lives. Writing for DFID, Hlanze (2012, Slide 2) defines women's economic empowerment as 'a process that increases people's access to and control over economic resources and opportunities including jobs, financial services, property and other productive assets (from which one can generate an income), skills development and market information'.

A feminist language of power is evident in the definitions of economic empowerment offered by ICRW, SIDA and DFID. However, unlike the feminist perspective of empowerment proposed during the GAD era, ICRW, SIDA and DFID's power analysis is confined to aspects of control over economic resources and the allocation of unpaid, reproductive labour, with power transformations in the socio-political aspects having secondary importance. Furthermore, in focusing on power in terms of access to and control over material resources, the DFID addresses equality of opportunities but not of outcomes. Branisa, Klasen, and Ziegler (2010) find that social institutions shape gender norms, gender division of labour and women's significance in the market. Women who achieve equal access to opportunities in employment and education can still be disadvantaged by gendered patterns in labour market behaviours (such as the opportunity costs from care), which can contribute to gendered inequalities in outcomes relating to job advancement and wages (Branisa, Klasen and Ziegler 2010, Chopra 2015).

Chopra (2015) adds that there is evidence of a 'feminisation of informal labour' whereby women are concentrated in low, irregularly paid, insecure and unsafe informal industries such as (1) domestic/home-based work, (2) construction, (3) labour-intensive manufacturing such as beadwork, shoe/garment manufacturing, handicrafts and (4) packaging. The above studies demonstrate that attaining equality in opportunities is not a guarantee for equality in outcomes. The exclusion of a relational dimension in the policy discussion of economic empowerment by international development agencies point towards quick fix solutions which are limited in contributing towards the goals of poverty alleviation and gender equality.

What remains evident in this last decade is that 'efficiency' and 'anti-poverty' arguments used to promote the institutionalisation of empowerment since 1995 have been further developed into the concept of economic empowerment since 2005. Different conceptualisations of economic empowerment offered by international development agencies point towards an economic driven perspective, focusing on women's access to productive work and control over economic resources to the exclusion of power transformations in other non-economic aspects. It is evident that the empowerment agenda drastically derailed from its radical possibilities first proposed by feminist and social science researchers. Through the relatively new concept of economic empowerment, international development agencies advance the neoliberal economic agenda which perceives of women as potential economic actors readily harnessed upon to maintain economic resilience and growth.

In light of the above, I question what hopes the post-2015 development discourse hold for the revival of a feminist agenda, for the neutralisation of a strong positivist conceptualisation of economic empowerment which predominates the mainstream development agenda of today. The post-2015 agenda (Sustainable Development Goals (SDG)) consisting 17 goals and 169 targets, incorporated proposals by development networks (Gender and Development Network, Plan International) for a twin track approach[17] to gender equality, and dropped the preceding economic terminology to revert to empowerment (UN System Task Team 2012). International development agencies consider the SDGs to be a more holistic approach than the MDGs to gender equality and empowerment. For example, UN Women (2013, 3) suggests that the SDG framework needs to 'address the structural foundations of gender-based inequality' and be 'comprehensive', 'transformative', 'universal' to rectify the shortcomings of the MDGs. Similarly, the United Nations Secretary-General's (UN General Assembly 2013) report promotes a rights-based vision for the SDGs which calls for eradicating extreme poverty, environmental protection, social inclusion and economic opportunities for all. The ambitious goals shift away from a purely economic focus to encompass social and environmental dimensions. In a later report, UN Women (2015, 1) adds that the post-2015 agenda aims at 'transforming our world' and expanding the breadth and depth of its 'plan for action'. The above responses demonstrate a policy commitment to a human-rights approach which emphasise social transformation for girls and women.

A more in-depth policy analysis however suggests that a revival of transformative power relations subsumed under the economic empowerment agenda has not occurred. There is little consistency in the holistic incorporation of economic, social, political and environmental dimensions. For example, United Nations' (2015) goal 5 promotes empowerment short of the economic terminology, with gender equality included into SDG 5 which targets to 'empower all women and girls'. Yet, aspects of empowerment are limited to the areas of education, work and wages, with three of its eight targets (1) 5.4 on reducing unpaid care, (2) 5.6 on access to reproductive health and rights, and (3) 5.a on access to economic resources, pointing to a strong focus on the economic aspect of facilitating women's workforce participation. Women's economic empowerment also emerged as a goal in other targets, such as in target 1.4 which promotes equal rights to economic and material resources and services between men and women, and target 8.5 to

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[17] The twin track approach includes a transformative standalone goal of gender equality, complemented by gender equality mainstreamed across all goals and targets in the post-2015 framework.

achieve productive and decent work for men and women. The focus on work, wages and education in SDG 5 identified by Kabeer (2015) align with the concept of women's economic empowerment and the WID/WAD agenda.

Despite the more limited consideration for women's non-economic aspects, a focus on the economic, productive role of women has enabled SDG 5 to assign visibility to the dimension of unpaid care work, which was missing in the MDGs and in most development policies (2015). The above change is credited to the strong, sustained lobbying efforts of the Institute of Development Studies (IDS), together with its partners, ActionAid International, OxfamGB and Asia Pacific Forum on Women, Law and Development (APWLD) (ibid.). In particular, SGD 5 points to gross inequalities in women's access to paid employment in some areas, with 'sexual violence and exploitation, the unequal division of unpaid care and domestic work, and discrimination in public decision making' significantly hindering women's participation in the market economy (UNDP 2015).

As such, while SDG rekindled a focus on the economic aspect of women's empowerment, a single-minded focus on women's economic participation can effectively draw attention to specific non-economic, socio-cultural and political dimensions which hinder women's productive role. Examples include the emerging emphasis on unpaid care work and violence which hinder women's participation in the market. In particular, the SDGs give greater emphasis to key focuses of the economic empowerment concept, which are (1) women's contributions to reproductive work, and (2) alleviation of women's time poverty to pursue productive work through an externalisation and commodification of carework. The current attention given to women's reproductive roles in the policy literature marks a significant progress in development thinking from the 1970s, where a focus on women's productive roles to the exclusion of their reproductive responsibilities informed the institutionalised WID/WAD approach. Despite visible progress in acknowledging women's reproductive roles within the policy literature, feminist academics continue to critique the SDGs for failing to revive and incorporate transformative power relations into its framework.

For example, Chopra and Müller (2016, 7-8) critique Goal 5 relating to gender equality to be a 'watered-down vision of feminist demands', adding that the SDGs are focused on economic growth and is unable to 'recognise reproductive and sexual health and rights in their entirety'. Chopra and Müller's (2016) study reveal a stagnated focus on the

economic agenda in the SDGs despite a shift away from the concept of economic empowerment, with the lack of a socio-political dimension hindering a feminist agenda of a holistic approach to empowerment. Similarly, Esquivel (2016, 11-12) suggests that the post-2015 framework maintains 'a traditional take on growth [which] assumes growth happens on its own', and 'aims at "transforming our world", but intends to get there without substantially opposing the powers that be. Power relations are the big elephant in the room of Agenda 2030'. Again, feminist academics critique the maintenance of power hierarchies, suggesting that transformations are impossible without challenges to existing power structures which disadvantage women.

Yet others give recognition to the transformations afforded by the SDGs, albeit suggesting that a downplaying of the economic focus is necessary for the achievement of greater socio-political advancements. For example, Koehler (2016) and Razavi (2016) credit the SDGs for transitioning development away from narrow economic processes to encompass social and political dimensions, albeit adding that the plans for action are still limited to a focus on economic growth. Koehler (2016) suggests that the 'logic of a capitalist model' persists, as areas relating to women's economic empowerment such as unpaid care work and women's rights to economic resources are spelled out in policy terms, whereas other areas relating to socio-political dimensions remain vague in implementation. Razavi (2016) considers the SDGs to only be 'a "good enough" starting point for policy elaboration and political contestation', suggesting that the agenda is not yet transformative enough to bring about structural changes through policy implementation.

Evident from the above critiques, the post-2015 framework provides a timely opportunity for a revisiting and rethinking of the development path, and a repositioning of women's rights and the gender equality agenda within the development framework. The post-2015 points towards an unquestionable need to return the political and social dimensions back to the empowerment agenda. Yet, economic empowerment continues to dominate the development framework which is very much driven by a capitalist economic rationale. More visibly implementable policies accompany targets pointing towards increasing women's participation in the productive economy and access to economic resources. On the other hand, socio-political aspects of the post-2015 agenda is vaguely addressed in policies, with Razavi (2016, 32) adding that the 'onus falls on women's rights advocates to keep the spotlight on the structural constraints and push policy towards their removal'.

The key question shifts away from examining the extent to which a power agenda has been incorporated into development, to investigating how feminist advocates can creatively exploit the currently more reflective phase of the mainstream agenda to promote a feminist agenda of transformative social change. How might feminist activists use the human-rights approach promoted by the post-2015 framework as an entry point to return the discussion of women's empowerment to one which involves (1) unveiling the nuances of gendered power relations and attitudes, and (2) exploring the extent to which access to opportunities and resources translates into strategic choices women make? The following section proposes an alternative framework which seeks to inject a feminist agenda of power back into empowerment as conceptualised in development policy.

2.4   A response to the Post-2015 framework: Reframing empowerment

Implicit in the enthusiasm of international development agencies to promote women's empowerment is the assumption that enhancing women's material resources through market inclusion will contribute to reducing household poverty and increase human capital and capabilities (World Bank 2012, Kabeer 2003, Quisumbing 2003). The above perspective informs the support of international development agencies for PWPs which promote women's employment. The above exclusion of social processes detracts from the perspective of empowerment proposed by social science and feminist researchers. In view of the above deviations, I seek to unite both the above perspectives in my conceptualisation of empowerment. I apply a more nuanced analysis of power across different social spaces (individual, household, community, institutional, legal-politico) in which women act to examine the impact of social care provision through HCBC on caregivers' empowerment.

Rather than rejecting the economic aspect for its imposing presence on the socio-political aspect, I consider women's economic empowerment to be essential for an attainment of the socio-politico agenda. I return to a feminist perspective of empowerment which takes into account the social, economic and political aspects, and is concerned about how empowering changes in one dimension may trigger changes in others. Drawing from my genealogical analysis of the policy literature above, I find UNIFEM's (2000) understanding of empowerment to align most closely with the feminist perspective. I draw on UNIFEM's (2000) work to develop my framework for empowerment, synthesising a feminist agenda of power and agency into UNIFEM's (2000, 20-21) definition of empowerment as:

'put[ting] social transformation at the centre of the agenda for human development and progress of women. [...] it means negotiating new kinds of relationships that are based not on power over others but on a mutual development of creative human energy. [...] It also means negotiating new kinds of institutions, incorporating new norms and rules that support egalitarian and just relations between women and men.'

UNIFEM's (2000) definition transcends concerns for material needs and instead emphasises a process of social change involving power as central to women's empowerment. It turns our attention to the potential impact of empowerment on changes across different spaces, from the level of familial relationships between men and women to the broader institutional spaces which influence resource distribution. Contrary to current conceptualisation of empowerment adopted by international development agencies, UNIFEM (2000) left out the economic aspect in its focus on social dimensions.

In reconceptualising empowerment, I differ from UNIFEM's (2000) understanding to insist on attributing equal importance to the economic dimension. My decision is informed by the Pathways' multidimensional approach which emphasises the importance of examining the social, political and economic aspects of empowerment. I consider material resources to be necessary in facilitating women's push against the boundaries to redefine new fields of possibilities. An empirical example of my argument is provided by Sholkamy's (2014) study on the Egyptian conditional cash transfers (CCTs) project. Sholkamy (2014) attributes the introduction of a feminist design into the project to have facilitated the targeting of female household heads. The Egyptian CCT ensures women are not disadvantaged in having to act as conduits for the transfer of funds to the betterment of their households (Sholkamy 2014), a phenomenon which is often evident in CCTs in Mexico (Molyneux 2006), Costa Rica (Chant 2008), and Argentina and Chile (Tabbush 2010). Rather, women who participated in making the project successful were financially compensated for their time, with the recognition of women's reproductive/carework increasing their right to social security and citizenship (ibid.).

The Egyptian CCTs demonstrate that a gender responsive distribution of economic resources is central to women's poverty alleviation and empowerment, reinforcing the importance of the economic aspect in contributing towards women's empowerment. In particular, women's receipt of payment for their often undervalued, un(der)paid carework can potentially (1) increase female family caregivers' social recognition within institutions, communities and the self, and (2) absorb the opportunity costs of care borne

by poor women. Through the provision of economic resources, social aspects of empowerment were indirectly facilitated.

UNIFEM's (2000) definition of empowerment advocates for a 'change in relations between men and women' within the household and community spaces, as well as transformations in institutional ideologies. Comparing UNIFEM's (2000) definition to the work of feminist and social science researchers discussed above, it appears that (1) the psychological consciousness of the individual, and (2) legal politico space of the state, were omitted in UNIFEM's (2000) understanding of empowerment. I recognise the importance of both these spaces as arenas where power relations are acted out to facilitate or constrain women's experience of empowerment, as have been demonstrated in the works of feminist and social science researchers. I seek to incorporate the micro level of the individual and macro level of the state into my conceptual understanding of empowerment. In so doing, I respond to Charmes and Wieringa's (2003) suggestion that a measurement of women's empowerment needs to be conducted across all three levels of macro, meso and micro.

Drawing on Deshmukh-Ranadive's (2005) understanding of empowerment as a multi-dimensional, multi-spatial concept, my proposed framework will consist of three different levels in which women act, the macro, meso and micro. I identify five key spaces across the three levels for analysis, namely the micro level of the individual and household, meso level of the community, and the macro level of the institution and state. As discussed earlier, I seek to examine women's livelihood improvements in the economic, socio-cultural and political dimensions across the five spaces in which they act (see Figure 1).
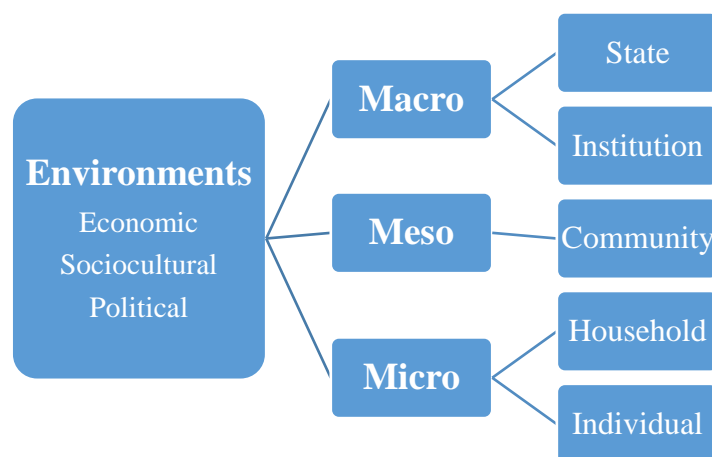
Figure 1: Locations of empowerment

Source: Author's own

Aligning with the perspectives of feminist and social science researchers, I consider both the (1) individual aspect of women's self-consciousness at the micro level and (2) collective aspect involving the actions of/with others at the meso and macro levels, to be essential for the attainment of women's empowerment with a transformative agenda. However, rather than considering individual improvements to be a prerequisite for social transformations through collective action as discussed in the works of feminist and social science researchers above, I propose that the process of empowerment is far more complex. Empowerment can also begin from the construction of new forms of knowledge within the macro level of institutions, which can then have the effect of destabilising dominant norms and enabling women to question their self-perceptions and self-confidence on the individual level.

As such, I suggest that rather than understanding empowerment in terms of the binary divisions of individual and collective, the concept should be examined in terms of fluid power shifts across the spectrum of individual to collective. Unlike conceptualisations proposed by international development agencies, power would be central to my concept of empowerment. I align with Foucault's (1980) understanding of power as one which is circulated to be exercised rather than possessed, shifting between individuals and groups within different environments in response to the forms of resistances being invoked. Such a model of power is fluid and complex, one which presents multiple possibilities as well as boundaries in relation to the specific circumstances/environments of individuals and groups.

Empowerment is not merely about feeling powerful, but a reshaping of social limits to redefine alternative possibilities for women. Rather than a measure of the degree of power one possesses, I consider empowerment to be a measure of the power acquired through social change. A conceptualisation of empowerment would therefore involve an understanding of power, in particular the (1) circulation of power, (2) different forms of power, (3) exercise of power to redefine possibilities within given power relations/asymmetries, (4) boundaries, containers of impossibilities constructed through power, and (5) normalisation of existing power structures which reaffirm the disempowered state of the powerless. In my framework of empowerment, I am concerned about the differential impacts of power asymmetries on women's livelihoods and the ways in which women resist against normative social limits (either as an individual or a group) to redefine the possibilities for change within their livelihoods.

Focusing on the exercise of power to expand the limits of what is possible for women, I move beyond the key concerns of international development agencies on individual choice and resource distribution. Looking beyond power over resources and individual gains, I explore the socio-relational dimension of power differentials. Rowlands' (1996) understanding of power resonates with my choice to examine empowerment as constituting different dimensions of power exercised differentially across different environmental contexts. In my empowerment framework, I embrace Rowlands' (1996) positive sum' approach to power which recognises the contributions of individual consciousness (power within) to struggles against gendered norms (power to) through collective understanding and action (power with). Rather than examining these three forms of power as a linear process whereby individual change leads to collective action, I seek to examine these three forms of power as individual dimensions having a fluid flow, mapping out power shifts across the individual/collective spectrum.

Rowlands (1996) rejects 'power over' as a dualistic relation of control and domination within traditional, mainstream understanding of power. I however choose to include 'power over' into my analysis. My decision is supported by Corte's (2008, 79, 89) understanding of 'power over' people and resources as a form of 'acquisitive instinct' in which 'healthy stimulation […] in relation to all material phenomena' is necessary to ensure the continuing growth and progress of the human species, in the absence of which would 'only [point] towards the direction of debilitating age or death.' An expansion of power into 'power within', 'power with' and 'power to' is useful towards a social relational analysis of the ways power can shape relationships and influence women's agency across different social spaces.

The dimension of 'power over', on the other hand, is more appropriate for assessing the distribution of economic resources which are finite, with the allocation of economic benefits to one often entailing a removal/reduction of benefits from the other. Relating the above to the field of development, increases in marginalised women's 'power over' financial resources may result in a decrease in the 'power over' such resources among more privileged individuals, demonstrating 'power over' material resources to be a zero-sum game. Corte's (2008) 'power over' dimension which is inherently 'zero sum' would be appropriate for a discussion on economic resources, while Rowlands' (1996) other three faces of power would be useful towards examining transformations of power in everyday relationships across the process of empowerment. In so doing, I am able to examine the economic, social and political aspects of empowerment.

The four faces of power and its corresponding outcomes will be discussed as follows in my conceptual framework encapsulated in Figure 2:

Individual ←——————————————————————————→ Collective

Power/Levels	within	over	to	with
Self (Micro level)	Self-esteem/ dignity Self-confidence Independence	Economic resources	Human capabilities Social capital	
Household (Meso level)			Decision-making over household consumption Bargaining power	
Community (Meso level)		Infrastructure Assets Services	Bargaining power	Community mobilisation/ activism and resistance/ participation Social capital
Institutional (Macro level)			Decision making in participation	
Legal/ political (Macro level)			Social and economic policies legislation	

Collective

Figure 2: Faces of power across space
Source: Author's own

1. 'Power over' relates to women's increase in access to material resources/assets from savings, loans, employment or household production. This form of power often involves power over material resources at the micro level of the individual, made possible by transitions in economic policies at the macro level of the state or interventions targeting women's economic gains at the macro level of institutions.

2. 'Power to' is the potential to exploit material resources to (1) acquire non-material, knowledge based (capabilities) and social (capital) resources, (2) gain opportunities at the micro level of the individual, and (3) take action to influence the social hierarchies and norms within the meso and macro spaces of the household, community, institutions and state in which women act and are acted upon.

3. 'Power with' refers to increased power through collective action, and will be demonstrated by women's abilities to organise collectively at the meso level of the community (e.g. cooperatives, unions, savings groups) to achieve/increase the 'power to' dimension at the macro level of the institution and state, or the meso level of the

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household and community. On the other hand, the macro level of the institutions such as NGOs may facilitate the flow of power from individuals to the collective, through creating an environment which is favourable for promoting a transformative agenda.

4. 'Power within' constitutes individual consciousness, sense of self-worth and dignity, self-belief for individual improvement and sense of entitlement (knowledge of one's predicament, position and rights). Psychological changes at the micro level of the individual is often involved.

Adopting Rowland's (1996) multidimensional approach to empowerment, I am able to examine multiple power and levels across the individual/collective spectrum. In particular, power consists of four dimensions, with 'power within' being an individual aspect, and 'power with' on the other end of the spectrum as a collective endeavour. In my framework; the four different forms of power discussed above are analysed across five different spaces which empowerment operates, namely the macro level of the state and institution, the meso level of the community and the micro level of the household and individual. Women's experience of holistic empowerment encompassing the social, political and economic aspects is marked by their ability to act on the collective ends of both the power and level dimensions.

Having looked at how the concept of empowerment has both evolved in the feminist literature and been interpreted and deployed by policy makers, in this chapter I have developed a framework which aims to unite the economic and social aspects. In the following chapters, I use this this framework to examine the extent to which South Africa's home community-based care (HCBC) contributes towards female caregivers' empowerment.

Chapter Three

Research methodology for an evaluation of EPWP's HCBC

This research examines the economic and socio-political impacts of HCBC, which forms parts of South Africa's EPWP, on the livelihoods of caregivers. The overriding question is the impact of South Africa's HCBC on women's empowerment. To address this question, I first develop a framework for analysing empowerment. I then apply this framework to the HCBC, identifying the different dimensions of the programme that contribute to different aspects of empowerment. I seek to address these questions by a meta-analysis of studies on the HCBC carried out between 2004-2015, and supplement this analysis with interview material carried out in my pilot study and background data from government reports. The framework for analysis is developed in Chapter Four. In this chapter, I briefly explain why I chose to carry out a meta-analysis having encountered difficulties in my pilot study. I narrate on my experiences on the field, and in the final part of the chapter I explain the specific methodology of my meta-analysis.

3.1   Challenges encountered on the pilot study

I conducted pilot study in Cape Town, South Africa, and I interacted with residents in three informal settlements for one month. Through my contacts with civil-based organisations and non-government organisations in the three townships, namely Masiphumelele, Mshini Wam and Sheffield Road, I gained access to residents participating in various projects such as sewing, home-community based care and the upgrading of informal settlements. Informal interviews were conducted with a total of 11 residents from across the three townships, mostly through referrals made by the NGOs/CBOs with two interviewees contacted through snowballing. I also include data from four personal communications I gathered on the field.

Although the purpose of my study was to examine the impact of home-community based care from the perspectives of community caregivers, I was also interested in the context under which HCBC was being conducted, so I tried to gain an understanding of life in the townships from the perspectives of residents and included people who were willing to share their stories about the community as well as those involved in HCBC. I interviewed township residents from a diversity of backgrounds and living conditions, including men who had participated in a woodwork training project organised by a now defunct NGO.

On other occasions, I interacted with female students from the sewing community, the volunteer teacher once a student herself but now owns an informal shop in the township

selling her hand-sewn crafts, as well as her only employee likewise a former student who relied on the work to support her grandchildren. I also benefitted from speaking with volunteers in the Masiphumelele Library as well as residents in Mshini Wam and Sheffield Road townships who had participated in the informal settlement upgrading programme. Last but not least, I had the opportunity to sit in the training workshops conducted for home-community based caregivers from the Living Hope church, enabling me to carry out participant observation and interact with caregivers to establish future contacts for interviews. Through the above activities, I collected a total of 11 interviews and four personal communications (see List of Interviewees), a process which posed various challenges for basing my research on primary empirical data as my methodology. I elaborate on the challenges faced as I recount and reflect on my field experiences. Permission was granted by my interviewees for me to share their inputs on account that their identities be kept confidential. I will therefore be using pseudonyms to refer to my participants.

3.1.1 Gaining access through my positionality as an outsider

I encountered various challenges as well as opportunities linked to my positionality. I became aware of how particular cultural contexts and individuals can either allow or hinder access, influence relationships and trust among township residents. A first instance of how I came to be more aware of my ethnic background and how it influenced my access is through my interactions with friends in Cape Town who volunteered their time at the townships, commenting as such:

> *"You are Asian, so it is easier for you to be in the townships than for us. Because we are Whites, so if we are new faces, I think they still see us as a threat, and sometimes it can be more dangerous for Whites to visit the townships on our own. They will be more welcoming to you. Also, because you don't look as different, you will not stand out like we do". (Becca, Female, 42, artist and volunteer)*

A similar sentiment was expressed in another personal exchange with an acquaintance giving advice on visiting a township:

> *"You got dark skin, you look more exotic and different. You will blend in better, so it is safer for you than us. Remember not to carry any valuables, dress modestly, and if possible always go around with a local, and don't stay till dark, can be dangerous and it is not lit so you can get lost". (Andy, Male, 78, retired)*

Through these exchanges, I became aware for the first time, of how my ethnicity could be a privilege helping me to gain access, an advantage premised upon a history of

apartheid which continues to assert a mental segregation within the minds of individuals. Evidently, the cultural and social backgrounds of researchers are a key element of the dialectic that can either facilitate or impede researchers from getting 'inside' the studied group, and also influence their perceptions of the group. With a cultural background which is evidently (through my physical appearance) not of transgressors of their past, I was to be granted access, to be welcomed as an outsider having no hand in the transgressions once inflicted.

I was born in Singapore, a small faraway island which my 'studied' group had little knowledge, considered to be comparatively wealthy as I could afford overseas education in London, and more importantly I was of Asian origin, a non-White. With the above knowledge which my 'studied' group had of me, I was considered to be a cultural outsider, originating from a very different cultural, social, ethnic and linguistic background from my 'studied' group. Yet, despite having less issues with access than a local white South Africa would have, my outsider position posed multiple challenges and dilemmas to me. In particular, I was constantly aware that access did not equate with trust, rapport, unconditional knowledge sharing or mutual understanding, that perhaps a welcoming response premised on my alien status carried with it various assumptions about my alien self and how to behave with outsiders. Taking a reflexive stance on my experiences, I had on various occasions felt that my respondents were perhaps reflecting performative elements of their culture and livelihoods, showing how they would like to present themselves to me as an outsider 'other', rather than sharing their knowledge with me as an insider equal. Yet, having the above thoughts also made me wonder whether it was my own positionality as an outsider, the acknowledgement of my position as a 'privileged 'other' trying to understand the livelihoods of individuals living in poverty which had led me to doubt the genuineness of my respondents' behaviour. In the following sections, I practice reflexivity as I relate the various dilemmas I faced as an outsider, dilemmas relating to issues of detachment, trust and rapport. I also narrate on my feelings of vulnerability, guilt and pleasure which I felt during the process of knowledge acquisition.

3.1.2   In but out: Lacking insider knowledge

In my study, I intended to give meaning and voice to the perspectives of female caregivers living in the townships. The maintenance of a reflexive consciousness is key to such an endeavour as researchers need to be aware of their personal subjectivity when interpreting and representing the views of participants in the research process. In particular, through

the use of self-reflexivity, I maintained an awareness of how my social and cultural identity may influence my process of inquiry. As discussed above, my social and cultural identity have positioned me as a cultural outsider in the study. Yet, unlike common perceptions of the outsider position as one hindering access, I managed to gain access through my outsider status, albeit not in a form which I considered to be ideal for my study.

I draw attention to two forms of access identified by academics, and discuss my degree of access in relation to both these forms to draw attention to the challenges I face as an outsider. The first form of access is one discussed by Merton (1972, 40) as 'monopolistic access' whereby the researcher has exclusive knowledge of, or privileged access to the community. When taking into consideration the interactive process of knowledge seeking, I would find it challenging to consider myself as having gained monopolistic access to knowledge. In particular, I consider Agar's (2008, 94) suggestion, that outsiders unable to communicate in the vernacular are akin to 'professional strangers' detached from the realities of the communities being studied and hence not able to claim hidden knowledge of the group like an insider, to be more reflective of my experience during my fieldwork.

Being an outsider, I felt like a stranger, unable to possess the intimate knowledge of shared experiences and cultural knowledge which an insider would have access to. Despite having the privilege of social access, my cultural detachment and language disability meant that gaining the privilege of knowledge access would be challenging. I was unable to interpret the Zulu culture, had little shared understanding of the normative rules of the community, and hence was little able to use insiderness to develop rapport and shared knowledge with my informants. My outsider predicament was different from researchers in selected empirical studies I reviewed, many of whom either had years of contact with their studied group as volunteers and researchers, or were locals conducting research for a university thesis and therefore had a shared language and culture with the township community.

3.1.3 The supplication of an invited outsider

I was an invited outsider, a little-known individual with a rather fluid identity which allowed me to be positioned rather differently in different settings by respondents as I was invited to participate in their personal spaces (Rose 1997, 316). As an invited outsider, I straddled between several spaces, being neither a part of the South African

township spaces, nor the homes of my South African/Dutch hosts, nor could I return to my personal familiar space as a detached researcher. I was politically positioned in these in-between spaces where access was constantly being negotiated and acted out. I came to be aware of the power my respondents and 'studied' community had in shaping the direction of the research and the production of knowledge as various encounters were being planned and arranged for me, while I was dissuaded from going to others.

For example, as I wandered aimlessly around Masiphumelele on my own trying to get a sense of the place and to observe the everyday living practices of residents, my access was rather limited as I acted in the position of a detached observer, watching from without and not having the opportunity to participate in the everyday activities of those I observe. The above experience was drastically changed when I was shown around by an acquaintance who was local and well-recognised by the community with some social standing as a community leader. I trampled on the paths which a local would have taken, using shortcuts to get to planned destinations, peeking into backyards as I squeezed along the in-between spaces of shacks, having the opportunity to observe everyday life through traversing the everyday spaces of the people, getting greetings along the way, stopping at roadside shops for short chats, and more importantly, feeling secure and safe as I was confident of taking the road well-travelled. I was invited to my local acquaintance's house for tea, and an interview.

As an invited outsider rather than an aimless wanderer, my experience was transformed, I was allowed the opportunity to observe the everyday practices of residents. Yet I felt that I would never gain such an access by myself, being an individual sharing no cultural and language connection to the residents. My visit was planned, perhaps even scripted. I became aware that the security which I felt also made me more vulnerable, not in the sense of the physical danger I felt when I was walking alone, but rather in terms of my powerlessness to determine what I wanted to see, the turns I would like to have taken, or the houses I would like to have visited. I was vulnerable to the power of my acquaintance as the knower, the one who possesses, regulates my access to, and potentially produces and performs knowledge.

I developed Smith's (1988) relationship of supplication with my local acquaintance, where I acknowledge my dependence on my research subject as the knower with the ability to provide insight into the shape and structures of everyday lived realities of residents. In so doing, I was able to avoid Stanley and Wise's (1993, 168) caution against

'treating people like objects –sex objects or research objects', dealing with my potentially exploitative position of power as a researcher by shifting the power to my 'studied' group. In performing a researcher-as-supplicant relationship, I was however concerned that wide power differentials between my local acquaintance and other members of the community also existed. I was uncertain whether my engagement with my local acquaintance may perhaps exacerbate the power gap, as the community may consider being connected to a perceptibly more privileged foreigner as a form of power. Also, I was unsure if my connection with my local acquaintance as an invited, supplicated outsider may have enabled me to, in the words of Jackson (1985, 157), 'convey the inner life and texture of the diverse social enclaves and personal circumstances of societies', considering the differential power status of community members and my inability to navigate my own interactions. In my visits to other informal settlements where I was with representatives from an NGO, my experience of being an invited outsider was on a similar scale to that in Masiphumelele.

In the following section, I discuss how at times I felt that my meetings were perhaps scripted, and that access may have been granted to certain individuals to make up for the lack of access to others. A reliance on the insider knowledge of the 'researched' seemed to me to be inadequate, unless supplemented by the insider knowledge of the researcher which enables an understanding of the nuances of the community. It is under such circumstances that I considered a change in methodology to be necessary, that I had the responsibility towards my subjects of accurate representation, and that a reliance on the insider knowledge of both local researchers and their subjects would better reduce the possibility of misrepresentation. This was one of the reasons why I choose to carry out a systematic review, one which draws on the large amount of data collected mainly by researchers with insider knowledge, the other reason discussed below relates to the problem of drawing on NGOs for access.

3.1.4 Doubting the integrity of interviews as performances

The negotiation and construction of power in discourse is a continuous process between researchers, participants and their gatekeepers. According to Fairclough (1989), power is one which constraints or controls the participation of less powerful individuals in discourse by more powerful actors. Wang (2006) adds that within the context of interviews, power can be presented either through the enforcement of one's agenda onto others and their opinions, or controlling the expression of opinions by others. In my pilot study, I approached NGOs and FBOs to gain access to the townships. There may thus be

a possibility that respondents who were referred to me were selected for their alignment with the agenda of gatekeepers, or that they had been advised on the opinions they may present.

As a supplicated researcher, not only did I not have the power and knowledge to question the degree of truth in the responses, I also felt guilty for my scepticism and for doubting the truthfulness of my respondents. For example, all caregivers with whom I interviewed described their eagerness to help others experience the love of Jesus Christ and encourage others to follow God as a key motivation for their caregiving. The universality of the motivation led me to wonder if my interviewees were (1) performing in a way which meets the expectations of the faith-based organisation (FBO), (2) selected for the interviews due to their alignment with the agendas of the FBO, and/or (3) advised to prioritise the FBO's agendas in their responses. I was perturbed by the similarity in convictions especially since interviewees whom I approached on my own accord, who were from the same community but participated in activities of other CBOs, did not present a strong faith-based motivation despite having the same religion. In particular, a male interviewee in the woodwork programme expressed a desire to help others as such:

> *"My dream was to upgrade the community, I had it since I was young cause we grew up with this apartheid and it was really strong in those times, but as times change and as things change, I feel like I can make it change. That is why if you ask me who is my role model, I will say Martin Luther King, I have been trying to follow his footsteps for a while. I have a passion for my people, like come on guys, we can become better, don't look down on yourselves because of what happened before, there is always oppression, there is poverty, but it is all in the mind I realise. […] if I look at Living Way community, I think it is about helping people, everybody shares, it is quite a good place. I want to be providing jobs for people, I want to help them do something, those who want to get trained I will train them, that is my vision, really to help them. […] Those guys that got nothing to do, they end up doing crime. I think about how to get them out of the corner streets so they don't rob people." (Bongani, Male, 27, woodworker)*

Various other interviewees I have approached have also expressed a desire to help, in particular to help future generations excel, to create jobs that can occupy youths and keep them out of drugs, gangs and crime, although none of the interviewees expressed their desire to contribute as one which was mainly faith driven, even though faith was often part of the motivation for wanting to make a difference. On further probing of my interviewees who were caregivers and participating in their activities, I learnt that religion was an integral part of caregivers' day to day activities, as caregivers started their day with group prayers and were expected to perform spiritual counselling for patients. It was

thus difficult for me to uncover (1) whether religious teachings were internalised or merely performed to meet organisational expectations, (2) the extent to which their performance had extended into the interview itself, and (3) the impact of faith on the conduct of community care. Caregivers were adamant about how knowing Jesus had changed their lives and expressed convictions towards spreading the love of their saviour to the poor, sick and destitute, to the extent that my further questioning of their faith and motivations would be considered to be overly intrusive, perhaps disrespectful and dismissive. For example, I observed that interviewees appear to echo the convictions of the Chaplain (Retha, female, 30) involved in the HCBC, which she expressed as such:

> *"I can say that I am here to preach the good news of Jesus Christ, and I am here to encourage people to follow Him and love Him, I am here to bring hope to those who don't have hope through his ways, and I love my work because I believe when I went to study at seminar, I had a calling that the way that was revealed to my heart was that I need to commit myself to Him full time. In the healthcare centre that I am working in, there are sick people there, [...] my heart goes deeply to those who are sick, because I believe this is a time whereby you need somebody who can tell you about love, or who can encourage you and tell you it is not the end of the world, even if physically it is like you suffering, but there is hope, that if you got Jesus Christ in your heart, you have eternal body".*

The alliance in ideologies across the organisation is reaffirmed by the chaplain's discussion as such:

> *"Each staff member knows that she is committed to share the way of God, before she or he start the work, then that is the responsibility of the chaplain to know that the spiritual level or spiritual sense is still going. [...] It is not a church, but they learn more about preaching and encouraging others. [...] Our home-based carers, we train them how to share the word of God."*

Comparative studies of several HCBCs with different implementing agencies, such as civil-based, non-governmental and faith-based organisations may reveal the impact of faith-based practices on caregivers' articulation of their motivation. The above is achievable through systematic reviews of studies conducted on a large number of HCBCs with a diverse typology of implementing agencies.

Advocates of self-disclosure consider the strategy effective in managing unequal power relations between the interviewer and respondent (Kvale 1996), and prompting and empowering respondents to share especially when discussing sensitive issues (Reinharz and Chase 2003, Eder and Fingerson 2003). In my pilot study, I engaged in self-disclosure for two main reasons, (1) to try develop mutual rapport and trust to facilitate sharing, and

(2) to reduce the power differential between me and my research participants, by positioning them as the knower in our relationship. While a more flexible, conversational style in which both me and my interviewee were allowed to share has enhanced interaction, I found that the process also attracted undue attention to myself and set me apart from my interviewee. In particular, I found that through disclosing information about myself, especially hints of my 'middle-class luxuries' (Kobayashi 1994, 76), I have unwittingly set myself apart from my participants who struggle with extreme socio-economic hardships. I felt that the differences led my interviewees to respond in a way which renegotiated their positioning with respect to me, placing me as a privileged other having the ability to support their hard work and efforts to escape the vicious cycle of poverty. My perceived repositioning of my interviewee in turn led me to react in a way which negates self-disclosure, as I felt like I had to be less transparent so as not to widen the gap and disrupt mutual rapport and trust. Yet, perhaps due to my outsider status, intrigue about my origins were inevitable, and my minimal sharing so as not to reveal economic differences were not helpful as respondents could quite easily infer that I was from a different background. For example, part of my conversation with Chikondi (Female, 37, sewing teacher) was as such:

> *Chikondi: Where are you from?*
>
> *Me: Singapore*
>
> *Chikondi: Are you living there now, you are here to visit?*
>
> *Me: I am living in London now. Yes, I am here for a visit.*
>
> *Chikondi: Wow, is that in England? You come from very far, so you take an aeroplane here? I have not been on an airplane. I only use the train here; it is not cheap. Flying to Johannesburg is too expensive for me, I have not been there, but one day I will, I hope I can.*
>
> *Me: Yes, I had to fly here. I see, I have not been to Johannesburg myself.*

It is evident that from the minimal self-disclosure, a wide economic gap was being established by my interviewee. Later into the interview, perhaps influenced by the above conversation, I sensed that my interviewee was performing the role of a motivated, albeit financially strapped individual requiring resources to seek excellence. For example, the later part of my exchange with Chikondi (Female, 37, sewing teacher) was as such:

Chikondi: I teach the girls to sew. I teach two days a week, they pay me to teach. Sometimes I help them on my own, I let them put their work in my store to sell. I want to employ them, give them work but it is difficult.

Me: Why do you want to employ your students, and what difficulties do you face?

Chikondi: I want to create jobs for them, I want to contribute back to society, help the girls to live better. Sewing helped me to get this far, before I had no job and no skills, but the sewing café gave me free classes to learn to sew, and encouraged us to set up a business. I started making things and people liked my bags and clothes, they sold well and I saved some money. Now I open this shop here, I also make baby clothes (showing me her clothes collection), I enjoy making nice patterns, I like selling my work, I am happy and I feel I have achieved a lot. Now I want to help others to be like me. I only managed to employ one of my students so far (pointing to her shop assistant). She is very good, she sews very well and helps me take care of the shop. She is a grandmother, and has to take care of her family, so she is happy that she has a job to support them. I hope I can hire more. But I need more machines. I have only two here, me and my assistant. If only I can have 20 machines, then I can bring my girls to work here but they are very expensive, I cannot afford to pay for these machines myself. Maybe someday I will get help from someone, or an NGO, for me to help my girls.

The above appeal for assistance led me to question if my self-disclosure had influenced my interviewee's positioning of herself, that perhaps I had led her into performing the position of a needy but motivated and inspirational individual due to the perceived differences between our economic status. The above experience was also reflected in several other interviews I conducted, leading me to wonder if perhaps my outsider positionality may have confounded the findings, possibly causing an over-exaggeration of and overemphasis on poverty and the economic aspect. I was also uncertain how a possible over-emphasis on the economic dimension may also influence my understanding of the socio-economic impacts of HCBC on community caregivers. This was a further reason why I decided to carry out a systematic review which enables me to compare my findings against that of an insider researcher, relying on data collected by insiders to validate my understanding of the HCBC intervention. The other reason was language discussed below.

3.1.5 Language barrier

The conceptual definition of insiderness and outsiderness may also be premised on language, with the politics of language and representation often presenting itself in most interactions. Throughout the three townships I visited, Xhosa was the first language spoken by residents, with the command of English often determined by the level of schooling. The younger generation who had a matric level of education tended to be more

eloquent in English, while most of the residents were not able to express themselves freely in English. The choice of English as our common language of communication therefore tended to infantilise the interactive experience for many of my interviewees.

On two occasions, I was fortunate to be able to rely on my local acquaintance as a translator, enabling me to speak to people who had no command of English language, and possibly the more disadvantaged individuals in the population. However, the introduction by my local acquaintance, as well as personal conversations between my interviewee and my acquaintance were not translated. I also had little power over the conversation they exchanged, and was unsure how I was being positioned to my interviewee. On the other hand, I felt that having a familiar interpreter facilitating the conversation, my interviewee told me how she left her abusive husband and raised her children alone, so drawing attention to her poverty and exploring possibilities for assistance.

Language barriers significantly influenced communications and interviewee selection, and the use of an interpreter introduced uncontrollable elements into the relationship as I did not understand Xhosa. Furthermore, apart from language differences, I found that the different use of a common language was also difficult for an outsider to grasp. For example, in one of my interviews, a respondent clarified her use of terminologies as such:

> *"Over in Masi, we do not say HIV/AIDS. We use TB. It is taboo to say HIV/AIDS. We have TB too, many people have TB here, so we call everything TB, it is more acceptable. I myself have TB, so does my child". (Farai, Female, 33, support group facilitator/caregiver)*

The culturally specific use of terminologies was not explained by other interviewees, perhaps demonstrating some contextual knowledge to be taken for granted and hence not needing specification. Furthermore, there seems to be a sense of secrecy and confidentiality when dealing with HIV/AIDS. From the above experience, I became more aware of my outsider status, and felt inadequate in detecting various nuances in language use, even when the language was familiar to me.

3.1.6   Diversity in the socio-economic backgrounds of caregivers

Rather than focusing on an individual, researchers often deal with an entire community/township, which in the case of South Africa's informal settlements, are often non-uniform in their social, economic and demographic characteristics. For example, through my personal communication and interviews with some of the local residents, I later learnt that the location of one's shack within Masiphumelele township can often be

indication of one's degree of poverty, with one respondent describing the urban spatial segregation of her township as such:

> *"Here in Masi, our town is divided into three sections. In section D, it is much lower, so it is always flooded when there is a lot of rain. The flood can be very bad, sometimes into the bedrooms and people's possessions will be floating around inside the water, they use buckets to throw the water out, but sometimes if they can afford electricity, they use heater to dry the shack. But because there is so much flooding, TB come from there. People who are infected by the TB, they are those that live in the wetlands, because their shacks are so close to each other. People there have less money so they build their shacks in the wetlands, we don't go there when it floods."*. (Lesedi, Female, 28, unemployed)

Kagiso (Female, 27, caregiver) suggested that the community is often judgemental as to the financial situation and status of individuals within the settlement as such:

> *"If you live in informal settlement, you don't get attention because people know you more, they know you not working, they know you struggle to get food, so you are hungry and still seating here. […] We are judging each other according to our status that if you coming from the poor family, I know your mother was drinking that time you were coming. […] You see now, we have so many beautiful flats, they say that no, the people who are living in the flats are the foreigners. But they go and live in shacks, and let the foreigners rent their house to get money, so why they are still complaining."*

It is evident from the above statement that even within the same township, there are distinct differences in economic status, social distinction/segregation. In particular, poorer residents from the community living in the more disadvantaged geographic areas of the township are trapped in a vicious cycle of poverty, whereby they tend to have less access to urban and social care services and are more susceptible to diseases. Their increased vulnerability to diseases may then result in stigmatisation, creating a social divide as others associate individuals from more disadvantageous areas with poverty and illness.

I am concerned that such distinct, yet often little articulated differences, within a single township can confound interviews with caregivers. In particular, I question if the socio-economic divide may also extend to one's access to home community-based care, either as a caregiver or a patient. In particular, dire economic circumstances may hinder participation in community caregiving, while social discrimination may work against poorer individuals who may be stigmatised as diseased and hence not suitable as caregivers. The above issues however, do not seem to be mentioned in my interactions with caregivers, and it remains uncertain whether such issues are not pertinent, or whether

the most disadvantaged population may have been left out of the HCBC programme and hence underrepresented. Unfortunately, though, the rather small number of community caregivers present in each organisation meant that it would be difficult to ascertain whether discrimination may have been in place in the selection of community caregivers. In an interview with one of the caregivers however, it seems that the selection criteria for community caregivers are somewhat stringent. Mbali (Female, 25, caregiver) described how she came to be a caregiver after realising she possessed the necessary criteria as follows:

> *"This man working at a station, he saw a post. He knows that I am looking up and down for work. He took the paper off and came back and said I got this for you, can you try. Then when I went home I read and it says you must have home-based care, working in the community, grade 10. And I said, I have nothing to do, it was 2 days before the deadline. I got what they need and I wanted to be a nurse when I was younger, but I cannot afford to study after my matric, I have to take care of my children. I drop my CV, but I didn't have hope because in many places they just take the CV and throw it away."*

Mbali's narrative contradicts the common perception that community caregiving is a job with a low entry barrier and low skill requirements, often taken up by unemployed and un(der)educated women. The screening procedures which applicants were subjected to by Living Hope as an FBO suggest that participants are often selected based on their education levels, experience as well as faith, possibly indicating that individuals from poorer segments of the community with limited education, information, experience and perhaps religious differences may have been unwittingly filtered out of the programme, and therefore under-represented in interviews and in the studies analysed.

In view of both concerns about my own positionality and the difficulties of identifying issues arising from HCBC from analysing how it operates in only a small number of locations - given their diversity - an extensive study of HCBC interventions across a broad range of sites in South Africa would generate more convergent findings that can help to filter out the impact of contextual diversities. It is with the intention to rule out, as much as possible, the impact of divergent contextual factors on caregivers' experience of the HCBC programme that I decided to do a systematic review. A systematic review can potentially gather together large number of responses of caregivers from a broad number of HCBC sites across the entire of South Africa, not only enabling more reliable identification of convergences, but also enabling cross-comparisons to be made between individuals across different socio-economic and geographic contexts.

3.1.7 Justifying the case selection of EPWP's HCBC

Despite the aforementioned challenges I faced on the field, my selection of the EPWP's HCBC for an in-depth case analysis is informed by my intentions to evaluate the impact of social care on the empowerment of female PWP participants, question the value of including social service into PWPs in the global South, and evaluate the extent to which South Africa's HCBC has achieved its goals of gender equality and empowerment. Three reasons justify my selection of South Africa's HCBC for in-depth analysis, namely its (1) unique implementation as a PWP initiative, (2) deviation in practice (positivist agenda) from its policy (feminist agenda) approach to empowerment (3) focus on the empowerment impact of women's employment in carework. Implemented outside of the PWP context, the concept of home community-based care is not new, and has been adopted as a coping mechanism for the provision of care under resource-limited settings, especially in countries affected by the HIV/AIDS epidemic (Corbin, Mittelmark and Lie 2012). Home community-based care practiced under such scenarios (not as part of PWP initiatives) often involves providing sustainable and effective care by family members, community-based organisations and healthcare professionals within patients' homes.

Rather than as a mechanism for job creation, skills development and poverty alleviation such as in the case of South Africa, home community-based care conducted in other parts of the Global South focus on benefitting sick patients through (1) increasing their access to care in non-institutional settings, and (2) supporting family caregivers in caring for the sick within their homes. Little consideration is made to (1) recognise the reproductive labour of family caregivers, or (2) provide community caregivers in CBOs with access to jobs, income or training to enhance their employability. Studies on home community-based care conducted outside of the PWP setting in low income countries focus on (1) the engagement of community-based organisations in programmatic implementation (Rachlis, et al. 2013, Wilson, Lavis and Guta 2012, Barton-Villagrana, Bedney and Miller 2002), and (2) the impacts of home community-based care on patients (Chang, et al. 2009, Nsutebu, et al. 2001). As an intervention with a focus on the well-being of patients rather than caregivers, studies examining the impact of non-PWP initiated home community-based care on caregivers' empowerment are limited.

South Africa's HCBC is thus an exceptional case, it being part of a PWP initiative which focuses on the empowerment of participants functioning as community caregivers. The selection of South Africa's HCBC is informed by its unique context which grants legitimacy to community caregivers and advocates for their empowerment. My research

evaluates the effectiveness of South Africa's HCBC in contributing towards women's empowerment via a framework I develop in Chapter 2. The findings of my study can potentially contribute towards informing the development and implementation of HCBC programmes as a part of PWP initiatives in resource-limited environments.

EPWP's five key policy objectives emphasise the importance of gender equality and poverty reduction. To do so, they target job creation, skills development, poverty alleviation, community participation and service provision. The above five objectives are applied to HCBC which is part of the EPWP. In policy terms, HCBC is unique in its multidimensional approach to gender equality and poverty, aligning with a feminist, social development perspective to empowerment. In practice however, HCBC is influenced by the empowerment agenda of international development agencies which places social security and employment as its core pillars, seeking to integrate both dimensions into a single intervention centred around carework. A case analysis of HCBC can inform an understanding of how deviations between policy and practice influence the achievement of a feminist empowerment agenda within the context of carework.

My study can potentially contribute more insights to inconclusive findings on the impact of employment on women's livelihoods. Several empirical studies[18] report positive measurable impacts of women's productive work which point towards empowerment. For example, Kabeer, Mahmud, and Tasneem's (2011) empirical study finds women's empowerment through formal, paid and protected work helps them escape poverty, reduces vulnerability, and have spill over effects on their autonomy, self-esteem, agency, social well-being and political participation. By contrast, studies evaluating the livelihood impact of credit schemes[19] supporting women's productive work as micro-entrepreneurs report inconclusive outcomes. Irrespective of incomes earned, schemes which support

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[18] Kabeer (2011, 2005, 2001), Eyben, Kabeer and Cornwall (2008), Dickson and Bangpan (2012), Kabeer, Mahmud and Tasneem (2011), UNFPA (2006)

[19] For example, many studies on microcredit have reported varied findings on the effectiveness of such interventions, with Abiola and Salami (2011), Afrane (2002), Ebimobowei et al. (2012), Hossain and Knight (2008), Khandker (2001) and Wright (2000) showing beneficial impacts of microcredit on socio-economic outcomes such as decreased vulnerability, employment, increased stability and growth, reduced income inequality, increase in social capital, nutrition, health, and school attendance among children. On the contrary, studies by Bateman and Chang (2009), Copestake (2002) and Buckley (1997) find microcredit to be exploiting women, increasing income inequality, maintaining poverty levels, increasing workloads, increasing burdens through high interest rates and loan repayment and increasing dependencies. More mixed results were reported in the studies of Ihugba et al. (2013), Rutherford (1996), Karnani (2007) and Mayoux (1999) which suggested that microcredit gives the poor more control to manage their finances but is unable to increase income adequately or to empower women. An argument against microcredit interventions as being exhaustive of resources is made by Karnani (2007), adding that the resources could have been better used towards supporting labour intensive industries in job creation.

women's abilities to manage their own enterprises are demonstrated to have more positive outcomes on women's power over economic resources (Kantor 2005), than those reported to perpetuate patriarchy in recruitment, selection and lending procedures and having a key concern in financial sustainability of the programme (Rahman 2001). Inconclusive findings draw attention to the need for more studies examining the impact of employment on women's empowerment, especially within the context of employment opportunities in social care provided through PWPs. Also, where evaluations on South Africa's EPWP is concerned, little attention is paid to the social sector. The focus is on the much larger infrastructure sector, making the applicability of findings to the social sector debatable, since duration, training, implementation and wages differ across programmes.

In addition, the literature on women's employment and empowerment report a negative impact of unpaid care work on women's empowerment. Yet, studies generally focus on women's productive work outside of the care realm. For example, Kabeer, Mahmud and Tasneen (2011) and Chopra (2015) point to unpaid care work being a limiting factor in women's market participation as it influences the forms and locations of work women can take on, which in turn limits their experience of empowerment. Given the time consuming nature of unpaid carework, Nesbitt-Ahmed and Chopra (2015) comment on women's lack of time to seek education, training opportunities or leisure, while Chopra (2014) draws attention to the lack of recognition of carework in social protection policies and programming. An in-depth questioning of South Africa's HCBC, a scheme which provides women with employment and social cash transfers through the care industry, would contribute an alternative perspective to women's experience of empowerment through their productive role, conducted within the reproductive sphere. My study adds to the debate on whether an externalisation of carework can contribute towards more gender equitable participation in the productive economy, such as in the case of caregivers providing care through PWPs.

A systematic review can address the challenges faced during my pilot study, as it provides a large number of responses from individuals across South Africa, mainly collected by local, independent researchers who are familiar with the context. Furthermore, local researchers would also struggle less with language use as well as differences in positionality, hence potentially abler to get representative data. Also, a systematic review has yet to be conducted across studies on the HCBC, despite the lack of consensus among these studies. My systematic review can thus enable cross-study comparisons to be made, possibly interpreting the contradictory findings. Last but not least, the broad scope of my

identified dimensions would be more adequately covered through data collection across an extensive number of sites, evident in the existing studies which did not include all my identified dimensions for analysis. A systematic review would be able to provide more comprehensive understanding of the contributions of HCBC towards women's empowerment in multidimensional aspects, and identify specific areas where improvements are necessary. In view of the above, I followed a systematic review methodology but I also intersperse findings from my pilot study to help interpret the data collected by the researchers in these studies. Below, I discuss in greater detail the process through which the systematic review was conducted.

3.2 Systematic review

I followed the principles of the systematic review methodology to ensure that a comprehensive search of the literature was conducted and as much relevant data identified as possible. Relevant resources included studies which sought to demonstrate the impact of the EPWP HCBC programme on women's empowerment together with appraisals, evaluations, research reports and assessments conducted by both government agencies and academic researchers alike. The review process consists of three stages as follows:

3.2.1 Stage 1: Initial search of the literature

I devised a search strategy to identify studies of the EPWP HCBC programme that report outcomes for women's empowerment. These studies did not necessarily focus on women's empowerment, but could have empowerment, growth and development as wider objectives. Academic literature as well as government reports were searched, with the thematic dimensions discussed in section 4.4.5.

3.2.1.1 Inclusion and exclusion criteria

To be included in the scope, studies met the following criteria, constructed in accordance to the "PICO" method which defines the Population, Intervention, the appropriate Control/Comparator and the Outcomes of interest (Wright, et al. 2007). Using the "PICO" elements to describe the inclusion criteria, my study was able to focus on important questions to ensure transparency and reproducibility (ibid.). "PICO" provides a framework to determine eligibility, data extraction, analysis and interpretation.

    (i)   Language: be in the English language only

    (ii)   Geographical location: be conducted in South Africa only

(iii)   Intervention: the EPWP HCBC programme with its goal to target women's socio-economic empowerment

(iv)   Population: focus on working age women or report outcomes for this population group. Studies which do not explicitly state a gender focus but include female participants as part of the analysis will be included, taking into consideration the limited number of studies adopting a gendered lens. Furthermore, with the high gender quota of at least 55% females, studies without a targeted focus on women will still apply to them.

(v)   Study design: evaluation/assessment/review to be included. Conceptual reports, commentaries or editorials which did not include/use empirical qualitative or quantitative data were however excluded from the study

(vi)   Outcomes: report outcome data (primary or secondary) on women's empowerment (e.g. quantitative data on access and distribution of material and non-material assets). Report process data (e.g. qualitative data on the social, psychological, political aspects of project implementation)

(vii)   Publication date: 2004-2016, the period of EPWP HCBC implementation

(viii)   Publication type: Government reports, academic journals, grey literature

3.2.1.2 Key search terms

Search terms are determined by the thematic dimensions discussed above and the inclusion and exclusion criteria. The search strategy was tested against studies already identified via hand searching. The search involved the use of key search terms in two main aspects of the analysis for the creation of strings of terms and synonyms (see Appendix A for full list of search term variations and search term combinations). One of the key search terms relates to the intervention of interest, the EPWP HCBC, with variations such as PWP, EPWP, HBC, HCBC, community based public work, community based care, community health worker, CHW, community based worker, CBW, community development worker, CDW, caregiver, carer, secondary caregiver, careworker, healthcare volunteer, community caregivers. The other key search term describes the population of interest, which is women, using the following terms and variations such as woman, young woman, female, girl, daughter and mother. In databases where Boolean searching was not possible, hand searching will be conducted (see Table 3.1) (a full description of hand search combinations is in Appendix A).

Table 3.1: Hand search terms

Women	Empowerment	EPWP
women	Empowerment	South Africa
woman	Income	public work programmes
female	Financial	expanded public work programmes
	Social	
	political	
	Power	
	Agency	

3.2.1.3 Search locations

The search locations in which keyword searches were being conducted include a range of academic databases, organisational websites, Google and Google Scholar. 11 databases, websites of five donor agencies and 18 development agencies were searched (see Table 3.2 for full list of databases and organisations). Citations of studies to be included were also checked for related studies which were included if they matched the search criteria. In addition, reference checking and forward reference checking were also conducted during the more in-depth reviewing stage to ensure that all possible sources were identified. In particular, further searches were generated based on leads suggested by the above studies.

Table 3.2: Research methodology: Databases and organisations searched

Bibliographic databases
African Women Bibliographic database
Applied Social Sciences Index and Abstracts
British Library for Development Studies
BRIDGE
Ebscohost
Eldis
International Bibliography of the Social Sciences
PsychInfo
Pubmed
Sociological Abstracts
WHOLIS
Donors
Department for International Development
Swiss Agency for Development and Cooperation
Global Fund for Women
United Nations Capital Development Fund
USAID
Organisations
African Development Bank
African Women's Development and Communication Network

Asian Development Bank
Department of Public Works (South Africa)
Governance and Social Development Resource Centre
Human Sciences Research Council
Institute of Development Studies
International Centre for Research on Women
International Development Research Centre
International Labour Organisation
Levy Institute
Overseas Development Institute
Poverty Action Lab
Sabinet
Southern Africa Labour and Development Unit
South African Cities Network
UNESCO
World Bank

3.2.1.4 Screening studies

The inclusion and exclusion criteria were applied to the (1) titles, (2) abstracts, and (3) full reports which were obtained for studies that meet the criteria. In total, 83 papers consisting of published journals, NGO reports, government reports and Masters and PhD dissertations from South African academic institutions were identified for review. The term reached 'saturation point' when the searching generated studies that had already been identified. Studies which met the selection criteria were analysed in the next stage.

3.2.2 Stage 2: Narrowing the field

After abstracts were screened for methodological and conceptual relevance, the papers were retrieved and full texts were assessed based on a coding tool used to further narrow the field of inquiry. The coding tool (see Table 3.3) scores studies based on the: clarity of aims and purposes; validity and reliability of data collected; extent to which female respondents were involved; degree to which biases were minimised, and finally the strength of the data analysis discussion. The coding tool allowed a judgement to be made on the quality of articles in terms of the aims, focus, population characteristics, research methods and data analysis.

Table 3.3: Coding tool

Title				
Author				
Quality criteria		Score		
	Lots	Some	None	Comments
	1	0.5	0	
Does the study have clear aims?				
Are the purposes of the study well specified?				
Are there clear qualitative/quantitative research questions?				
Did the study identify women as the focus group?				
Did the study identify the deliverers of the intervention?				
Is there information on sampling?				
Is there details of interview guides, tools, questionnaires?				
Is data analysis described?				
Did the study attempt to minimise bias?				
Total Score				

Based on the scoring principles assigned by the coding tool, reports that scored 3.5 or more points were selected for further assessment based on a Mixed Methods Appraisal Tool (MMAT) (see Figure 3) designed by Pluye et al. (2011) for the appraisal phase of systematic reviews. The MMAT is relevant for my purpose as it provided a framework for the evaluation of research quality based on criteria set out for three methodological approaches considered in my study, qualitative, quantitative and mixed. Reports which scored two or more points in the MMAT were considered for the systematic review. On the basis of this approach, 35 studies were selected after the quality assurance process.

PART I. MMAT criteria & one-page template (to be included in appraisal forms)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			Comments
		Yes	No	Can't tell	
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Figure 3: MMAT criteria
Source: Pluye et al. (2011)

3.2.3 Stage 3: Review of included studies

35 relevant empirical studies published between 2004 and 2016, that evaluated the impact of EPWP HCBC on empowerment, were identified in the search. I noticed throughout my narrowing process that a significant proportion of the studies on the EPWP were focused on the infrastructure sector. 34 quarterly and 1 five year monitoring and evaluation report

produced by the Department of Public Works (DPW) across the period 2004 to 2015 were also included as background data for the analysis. Out of the 35 unduplicated empirical studies, 5 used quantitative, 27 qualitative and 3 used mixed methods. Shortlisted studies were categorised across thematic dimensions defined by my framework, with some areas better represented than others, although at least one study was found in each of the dimensions. Most studies evaluated the effectiveness of HCBC on employment creation and training. Strengths of the studies include reporting on outcomes in both the economic and social aspects, and focusing on the unique needs, circumstances and perspectives of caregivers. A majority of the studies used either snowball or convenience sampling, thereby limiting the extent to which the conclusion can be generalizable. All of the studies were also cross-sectional as opposed to longitudinal, and as such limited in providing knowledge on the long-term outcomes of caregivers who had exited the programme.

In this Chapter, I have restated my key research question and discussed the methodology, explaining why after encountering difficulties in my pilot study I decided to do a systematic review. I have explained the process through which this was done and in the next chapters discuss my analytical framework for analysis and my findings.

Chapter Four

An analytical framework for South Africa's home community-based care

In this chapter, I seek to provide a more detailed elaboration on the EPWP programme itself and how my framework for empowerment may be used to evaluate the HCBC.I first set the context under which the NPWP and EPWP came to be adopted as a means to address evolving issues of gender equality, poverty alleviation and empowerment, a rather ambitious goal as compared to PWPs in other parts of the Global South. I then conduct a broad critique of the EPWP's objectives as stated in government documentations [20] between 2004 to 2014, proposing a framework for analysing the different objectives of employment creation, poverty alleviation, community participation and service provision. The proposed adoption of a gendered agenda, together with the inclusion of a social care component, sets South Africa's EPWP apart from other PWPs in the Global South, providing a justification for an in-depth case analysis.

4.1   Evolution of a gender agenda in South Africa's policy frameworks

Increasing focus on women within the development discourse of international development agencies has been echoed by South Africa during the period of political transformation from apartheid to post-apartheid through the involvement of strong feminist activism. In particular, there has been growing recognition that women's equality is central to the realisation of a democratic, effective and participative government (McEwan 2003, Beall 2004, Albertyn 1995). As a '"moral touchstone" of the new democracy', the construction of women's citizenship rights in South Africa have been carried out by both the State and civil society (Albertyn 2003, 595). Women's activism and struggles to end apartheid and ensure the institutionalisation of gender rights in the newly created nation have secured them significant representation and political power throughout the past two decades (Waylen 2007). The transition of women from social movements to positions of power in civil service sectors and parliament is preceded by legislative structures and political mechanisms adapted from international practices, such as the CEDAW and the Beijing Declaration and Platform for Action, which accord more

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[20] These documents include the EPWP contractor 'learnership' programme, Management plan for labour intensive construction learnerships (DPW 2006), EPWP social sector plan (DoSD; DoE; DoH; 2004), PWP infrastructure sector plan (DPW 2004c), Guidelines for the implementation of labour intensive projects under the EPWP (DPW 2005a), EPWP infrastructure sector incentive grant manual (DPW 2009a), environment and culture sector plan (DPW 2004b), the non-state sector plan (DPW 2011b) and the environment and culture sector EPWP phase II log frame 2010-2014 (DPW 2011a).

rights to women (Albertyn 2003, Kithatu-Kiwekete 2011). I first discuss this broader context and the inclusion of gender issues within South African politics and the overall Reconstruction and Development Plan (RDP) before considering the more specific aspects of the PWPs.

Apart from adopting international constitutions, South Africa has also been active in developing its own legislation to empower women, such as the Bill of Rights of the South African Constitution in 1996, the Employment Equity Act and the Maintenance Act in 1998, the Promotion of Equality and Prevention of Unfair Discrimination Act in 2000, the Maintenance Act in 1998 as well as two concerning body politics, the Choice on Termination of Pregnancy Act in 1996 and Domestic Violence Act 1998. This is accompanied by South Africa's National Policy Framework for Women's Empowerment and Gender Equality and the National Gender Machinery to provide guidelines as well as a machinery for the implementation of programmes which promote gender equality (Mokgope 2008, 9). In addition, a gender mainstreaming approach towards legislative reforms and political participation, such as that instituted by international development agencies, has been adopted in South Africa.

Despite the efforts invested into gender mainstreaming of polices and legislation, the impact of newly acquired gender rights on the status and quality of life of marginalised, poor women remains limited. While the adoption of a gendered lens has facilitated two of the main liberal, internationally motivated goals, namely (1) women's political gains and (2) gender representation in legislation, the above gains have the tendency to benefit individual, often more privileged, women (Hassim 2006, Erlank 2005, Gouws 2008, Gouws 2004) and have as such, not adequately 'address[ed] issues of substantive gender equality' (Budlender 1997, Erlank 2005, 199). Specifically, the democratic government's notion of 'gender victory', measured by women's political representation, has not materialised within the lives of a large majority of South African women. Despite an impressive legislative structure and increases in the number of women in positions of power, gender inequalities still persist in South Africa and many women continue to confront these inequalities on a daily basis (Benjamin 2007).

Similar to the international gender mainstreaming approach of the 1990s, South Africa has, apart from its struggles for gender equality through political representation, also focused on the economic aspects of development. Portraying themselves as a 'third world democracy' (Erlank 2005, 200), the new African National Congress (ANC) assumed the

international practice of associating gender with inequalities and poverty (Razavi 1999), and adopted the international anti-poverty agenda of individually targeted provisions (Erlank 2005). Since 1994, pro-poor polices have been effected mainly in the areas of housing, social security, education, healthcare and employment. In particular, the impact of gender differences on needs, poverty and livelihoods which first emerged in the WID/WAD and GAD (discussed in Chapter Two) (Moser 1987, 12, Moser and Peake 1994, Chant 2003) gained prominence within South Africa's development discourse, emerging first in the state-driven development initiative of the RDP, which guides the policy framework and implementation of South Africa's PWPs, further discussed below.

4.2   Gender equality, poverty alleviation and empowerment through PWPs

Through the RDP, South Africa's new commitment to gender equality and empowerment of women was established, with Nelson Mandela in a *State of the Nation Address* (ANC 1994) presented on 24 May 1994 advocating:

> `the emancipation of the women of our country. […] freedom cannot be achieved unless the women have been emancipated from all forms of oppression. […] the objectives of the Reconstruction and Development Programme will not have been realised unless we see in visible and practical terms that the condition of the women of our country has radically changed for the better and that they have been empowered to intervene in all aspects of life as equals with any other member of society'.

The ANC's agenda for empowerment, participation, equality (across race, class and gender) and poverty alleviation has been motivated by both its (1) long apartheid history of political strife, segregation, poverty and (2) strong feminist activism. The institutionalisation of an NPWP with redistributive and participatory capabilities was considered to be one of the key solutions to the problems of (1) long term poverty, (2) apartheid-created infrastructural inequalities, and (3) unemployment. NPWP seeks to accomplish the RDP goals of achieving development in the 21st century while redressing the inequalities created by apartheid policies.

According to the RDP (ANC 1994, sections 2.3.5 to 2.3.6), NPWP can potentially fulfil four main objectives which are key to South Africa's pursuit of democracy, economic growth and development and poverty alleviation, namely that of (1) employment creation for the poor and unemployed through the promotion of labour based technology adoption whenever economically and technically possible, (2) employability through educating and training of participants to enable them to acquire post project employment, (3) infrastructural/services provision through building, rehabilitating and maintaining

infrastructure or improving the natural environment, and (4) strengthening local institution and community participation 'so that they are empowered to contribute to their own governance'. Gender equality is addressed by the RDP (ANC 1994) in terms of providing poor marginalised women with (1) equal opportunities to participate in the NPWP, and (2) access to infrastructure/services created through the NPWP. In particular, RDP (ANC 1994, paragraph 2.3.7, own emphasis added) states that:

> '[t]he public works programme must maximise the **involvement of women** and youth in the poorest rural households and most deprived regions to **create assets** such as water supply, sanitation and clinics. This must have significant **socio-economic benefits**, particularly with respect to **production which meets women's basic needs** (such as child-care facilities)'.

From the above, it seems evident that the focus of NPWP lies with enhancing women's productive capacities while socio-political empowerment within the community to promote self-governance seems to take secondary importance. In view of the above, South Africa's NPWP policy echoes the institutionalised WID/WAD ideologies and the current focus of international development agencies in the promotion of women's empowerment in the economic aspect as key to gender equality and poverty alleviation, discussed in Chapter Two.

Despite commitment to the NPWP through (1) funding community based public works programmes (CBPWP) implemented by community based organisations (CBOs), (2) national government's running of environmental PWPs, and (3) more localised provincial and municipal PWP initiatives, unemployment and infrastructure backlogs continue to persist into the new millennium, and were perceived to be a threat to South Africa's new democracy. In 2002, the ANC proposed a massive expansion of employment intensive construction through the EPWP, a target which the NPWP had already proven to be too challenging to implement on a large scale[21]. Subsequently, a Growth and Development Summit (GDS)[22] in 2003 led to an agreement on the use of EPWPs as a means to

> 'provide poverty and income relief through temporary work for the unemployed to carry out socially useful activities. These EPWPs will be designed to equip participants with a modicum of training and work experience, which should enhance their ability to earn a living in the future.' (Nedlac 2003, paragraph 2.3.1).

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[21] See Philips (2004), McCutcheon (2001) for more elaborate discussion on the complexities faced by NPWP of implementing a labour intensive construction method on a major scale.
[22] The GDS brings together labour, community, business and government constituencies to generate solutions for addressing the problems of unemployment.

Despite the renaming, the EPWP has similar objectives to the NPWP, albeit at a more ambitious level involving a vision to ensure 'economic opportunities for all, poverty is eradicated, income inequalities are reduced and basic services are available to all' and, to ''halve unemployment by 2014' (Nedlac 2003, paragraph 2.1.2 and 1.2.3c). The EPWP was formally announced by President Thabo Mbeki in his *State of the Nation Address* in February 2003 and adopted by the Cabinet in November 2003, where, Mbeki (2003) commented that:

> *'[t]o address this investment in social infrastructure, the government has decided that we should launch an Expanded Public Works Programme. This will ensure that we draw significant numbers of the unemployed into productive work and that these workers gain skills while they work, and thus take an important step to get out of the pool of those who are marginalised.'*

A further commitment to address unemployment through EPWP was made in Mbeki's (2003) *State of the Nation Address* which announced that the programme would create at least one million job opportunities in its first five years.

4.3   EPWP: Structure and implementation

The EPWP is a nationwide programme to be implemented by all spheres of government and state-owned businesses. Adopting a broad framework which accommodates a wide variety of programmes, EPWP provides state funds towards poverty alleviation and employment by creating temporary jobs combined with training targeted towards the poor. The Department of Public Works (DPW) is responsible for the overall coordination of departments overseeing different sectors in the EPWP (see Appendix B for detailed discussion on the organisation chart). EPWP is implemented across three phases, each lasting a period of five years across five key areas which were identified initially as having the potential to create substantial employment opportunities, namely (1) infrastructure, (2) environment, (3) social, (4) economic, and (5) non-state (refer to Appendix B for more detailed discussion of the different sectors and phases).

There are three phrases of job opportunities each lasting 100 workdays, with a target of 1.3 million in the first phase, 4.5 million in the second and 6 million in the third. Across all three phases, the infrastructure and environment sectors were the main focus, both contributing towards at least 60% of the total opportunities and being allocated a significant portion of the total EPWP budget (refer to Appendix B for details). On the other hand, the social sector created a comparatively limited number of work opportunities and received a much smaller budget. However, the social sector appears to

be able to provide more substantial training and longer lengths of employment than the other sectors (discussed further in Chapter Five) (see Appendix B).

Despite the seemingly more meagre investments in the social sector, the EPWP remains to be one of very few programmes incorporating a social care dimension into its interventions. Even so only a limited number of studies explore the benefits of this agenda. An in-depth analysis of the EPWP's social sector programmes would therefore contribute towards a greater understanding of how PWPs may potentially impact on the livelihoods of women. The focus on women's livelihoods would be particularly relevant given the EPWP's gendered agenda and emphasis on achieving gender equality and empowerment through its intervention. In the following section I outline my framework for evaluating the socio-economic impacts of EPWP's social provision intervention on women's livelihoods, focusing on the five key EPWP goals of (1) employment creation, (2) employability/skills development, (3) infrastructure/service provision, (4) community participation, and (5) poverty alleviation.

4.4   Questioning the impact of social care provision on women's empowerment

An analysis of the structure and implementation of EPWP show the focus to be on the physical and environmental infrastructure, environment and culture sectors. The provision of social infrastructure which refers to childcare, home-based care, adult literacy and community crime prevention makes up less than a fifth of the EPWP in terms of targeted jobs. For this reason, I argue that it is important to have a specific analysis of social provision since a general evaluation may overlook the contribution of the social sector which is not only much smaller but also has a different focus, being more concerned with providing training through 'learnerships' [23] than with expanding employment opportunities (see Appendix B). Furthermore, the social sector is presumed to have a higher female participation rate and more likely to benefit poor women. I hope that this more in-depth examination of the social sector can potentially enable an understanding of the EPWP's impacts through a gendered lens, and be useful to other

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[23] According to the DoSD, DoE and DoH (2004), 'learnerships' bring together structured learning and on the job experience, and is one of the route towards acquiring an accredited qualification registered under the National Qualifications Framework (NQF) by the South African Qualification Authority (SAQA). 'Learnerships' often take at least a year to finish and is made up of a specified number of credits, short courses. Assessment is often by a mentor, coach, trainer or assessor. Graduates of 'learnerships' are presumably able to demonstrate practical competencies within an employment context, making it a programme which is designed specifically to help unemployed individuals access job opportunities.

PWPs in the Global South as to the value of incorporating a social care agenda into interventions.

Focusing on the HCBC which is the social care arm of the EPWP, multidimensional and ambitious objectives relating to aspects of women's empowerment is evident in the policies. Aligning with the new poverty agenda's notions of (1) poverty as being multidimensional[24] and (2) cash transfers on their own as being insufficient for addressing the gendered dimension of poverty and inequality, the HCBC promotes itself as being able to address inequalities in economic and social dimensions, albeit having a stronger focus on the economic dimensions of poverty alleviation, service provision and employment. In particular, the five key objectives targeting women in the HCBC policies are in the economic dimensions of (1) employment creation to provide poor, jobless women with employment, and possibly (2) short term poverty alleviation, (3) increasing women's employability through skills development, (4) increasing women's access to environmental infrastructure and social services, and socio-politico dimension of (5) promoting women's social inclusion through community participation. In adopting a multidimensional definition of poverty and seeking to include the socio-politico aspect, the HCBC's policy framework bear echoes of a social development perspective to women's empowerment. This section adopts a more in-depth questioning of whether the HCBC achieved its overall objectives and with respect to the social care dimension specifically, whether it suggests a model for policies elsewhere.

4.4.1 Employment creation

Unemployment is addressed by the EPWP in many ways, such as (1) increasing aggregate employment through increasing labour intensity of government funded infrastructure projects (DPW 2004c) and developing small, micro and medium enterprises (SMME) to change the structure of the labour market (DPW 2011b, 3), (2) creating work opportunities (DFID 2011, DPW 2011a, 2009b, DoSD; DoE; DoH; 2004), and (3) creating decent work on exit (DPW 2011b). Large scale dependency on government employment appears questionable considering the fiscal allocation necessary for such an intervention, which the government has failed to demonstrate capability to fulfil[25]. HCBC

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[24] Beall, Crankshaw and Parnell (2002, 24) draw our attention to the multiple dimensions of poverty relating to material poverty, economic poverty and social exclusion/disadvantage.

[25] According to DPW (2014b), direct government contributions towards the EPWP in the financial year 2013/14 constitutes 0.86% of the National Treasury's (2013) reported government expenditure and 0.26% of GDP. The above enabled EPWP to provide 0.8% of the SSA (2013b) reported labour with the equivalent of a year of full time employment, within the context of a 25.2% unemployment rate. Other low income countries allocate more resources to PWPs, such as Ethiopia's 2005 PSNP allocation of 2.0% of GDP

documentation paint a positive picture of its achievements of employment targets but given the limited budget and the scale of unemployment it is important to investigate further the ability of HCBC to provide sufficient temporary job opportunities. In sum, to investigate the degree to which HCBC has increased participants' propensity to acquire decent work upon exit. To what extent does the HCBC reabsorb people into full time equivalent employment or increase the duration of work for capable individuals?

HCBC's monitoring and evaluation reports are focused on the quantitative aspects of employment targets and gender quotas, tending to absorb poor, Black African women into temporary employment. The above begs the question of whether HCBC is adequate in enabling women to participate in the productive economy in a manner which would bring about livelihood improvements. In particular, there is a need to consider whether women's economic gains through employment may be compromised by inequalities perpetuated by gendered social norms, especially when analysed from a long-term perspective. An analysis of the employment creation aspect of HCBC would need to take into consideration the ways in which social aspects of women's position and status within the workplace influence their employment outcomes. In particular, in what ways did the HCBC create observable improvements in women's employment opportunities/status and were there circumstances whereby these improvements were compromised? Was there an observable pattern of 'feminisation of labour' in South Africa and to what extent has HCBC addressed or perpetuated the phenomenon? A more focused analysis of the HCBC in terms of the (1) number of job opportunities created, (2) employment status of graduates, (3) career potential, and (4) financial well-being of graduates is necessary in order to address the above questions.

4.4.2 Poverty alleviation

Poverty alleviation features as a core rationale for the HCBC, contributing to the broader objectives of government which are 'poverty reduction, transformation, empowerment, urban and rural development, growth and job creation' (DPW 2009d, 11). The main emphasis of the HCBC is on the reduction of unemployment as a means to poverty alleviation, providing relief in the form of temporary employment with an aim 'to target women who bear the brunt of poverty and unemployment' (DoSD; DoE; DoH; 2004, 8). As part of the EPWP, the HCBC is expected to function as a supplement to the

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(McCord 2007b), and India's 2005 NREGA which constitute 0.4% of GDP in 2007/08 (McCord and Farrington 2008).

government's medium to long term interventions which involves addressing poverty through (1) economic growth, (2) education and training, and (3) creating an enabling environment which supports industrial growth (ibid.). In particular, the EPWP social sector plan (DoSD; DoE; DoH; 2004) states that the HCBC 'will continue to exist until these medium-to-long term programmes are successful in reducing unemployment', making the HCBC appear to be a temporary measure providing short-term relief while waiting for more positive longer term outcomes to manifest. There seems to be an implicit assumption that medium term measures are likely to manifest as planned, and that the HCBC is only needed on a more immediate and short term basis.

There is a need to assess if HCBC offers a route out of poverty, and if so, whether power over economic resources may translate into other forms of power exercisable within social spaces, such as (1) power to make decisions on household consumption, (2) bargaining power and (3) self-esteem. Adopting a feminist social development lens to an understanding of empowerment, the above three dimensions are necessary for the government's objectives of empowerment and transformation. Yet, the social dimensions of decision making over household consumption, bargaining power and self-esteem do not seem to feature as important elements in the HCBC government documentations, despite its emphasis on women's empowerment. The above draws attention to the need to incorporate these social components into an evaluation of the extent to which HCBC achieved its goal of promoting women's empowerment.

4.4.3   Skills development

The EPWP aims to increase the capacity of participants so as to 'provide the most needed skills as we empower participants to fend for themselves beyond their involvement in this programme' (DPW 2009d, ii). EPWP emphasises skills training and work experience as one of the key components to increase the employability of participants on exit. In particular, DPW (2004b, 17) reiterates the Growth and Development Summit's claim that 'job creation without skills development, upgrading and training, does not lend itself to sustainable employment and will have no long-term economic impact on the lives of the unemployed.' However, with the short employment period of 100 workdays provided through the EPWP, the number of days allocated to paid training is limited to 8-12 days, which DPW (2004c) evaluates to be insufficient for the skilling of workers. General training in life skills, labour markets and the working environment, and awareness of HIV/AIDS is instead provided to all EPWP participants regardless of the tasks/sectors they were assigned to (DPW 2004c). McCord (2007a, 2009a) and Meth (2011) reported

that while generic training is useful in enabling participants to grasp livelihood interventions, it has little relevance to gaining real employment in the labour market and hence little impact on women's employability.

HCBC seems to be an exceptional case, taking on a more flexible approach towards the length of participation, it being conducted often on a more voluntary basis or at a lower and more irregular stipend rate. A longer employment period has enabled additional training which is more job targeted. The different training structure adopted by HCBC leads one to question the extent to which evaluative reports on the impact of EPWP on participants' employability can be generalizable to the HCBC. Furthermore, unlike the HCBC, other sectors in the EPWP have a larger proportion of male participants, and reports on these sectors may be less reflective of women's experiences and needs, hence the need for specific study of HCBC with a larger proportion of women.

4.4.4 Community participation in service delivery

Through the social care agenda, in particular the HCBC, EPWP seeks to improve the delivery of health and social services (DoSD; DoE; DoH; 2004) and community assets (DPW 2009a, 2011b), via the participation of local communities (DPW 2012b), which echoes the ANC's RDP document equating community engagement with empowerment, stating that RDP:

> *'is focused on our people's most immediate needs, and it relies, in turn, on their energies to drive the process of meeting these needs. [...] Development is not about the delivery of goods to a passive citizenry. It is about active involvement and growing empowerment. [...] This objective [improving quality of life of most poor] should be realized through a process of empowerment which gives the poor control over their lives and increases their ability to mobilize sufficient development resources, including from the democratic government where necessary (ANC 1994).*

Evaluations of EPWP focus only on the delivery of goods and services, providing an accurate quantification of infrastructure delivered such as the (1) distance of road paved, (2) number of toilets provided to households, (3) amount of alien (non-native) plants cleared or (4) number of community clinics and childcare centres set up. While EPWP policy advocates for the delivery of physical infrastructures to support education and healthcare provision, it is unclear how such provisions support HCBC caregivers in their carework. This question cannot be addressed adequately through data from the General Household Survey of SSA (2015a) which only provides a documentation of the mode of transport for work/school, and the accessibility of different types of telecommunication networks such as landline, mobile line and internet. As for access to social infrastructure

such as healthcare facilities and services, SSA (2015a) did not provide a specific analysis on the HCBC. Other aspects of progress remain unknown, such as the impact of infrastructure and social services on the livelihoods of caregivers, or a gendered analysis of infrastructure use such as public transport use by caregivers for providing home community-based care to patients.

There is need for more in-depth analysis into whether HCBC meets the practical and strategic needs of caregivers. In particular, to what extent are caregivers' participation in HCBC a choice? Or is it a survival mode of caregiving conducted under circumstances of poverty and in the absence of institutionalised care? Or could it perhaps be a last resort for coping with the structural realities of unemployment, gender inequalities, lack of opportunities, inadequate capabilities and poverty? In particular, does HCBC's participatory process impose a third burden on female caregivers as claimed by Moser (1993), or does it encourage the formation of social capital which support caregivers' activism and resistance and influence over policies?

Apart from focusing on the participation of caregivers, it is also necessary to question the extent to which HCBC encourages community participation and the extent to which it influences caregivers' experience of HCBC. In particular, to what extent is the community involved in decision making on (1) caregiver selection, (2) the types and locations of services/assets/activities to be created, (3) whom services/assets/activities are to be catered for, and (4) the benefits pertaining to such services/assets/activities. In what ways do community engagement support the carework of HCBC caregivers?

4.4.5 Evaluative framework for the HCBC programme

In the preceding discussion, a range of questions have been raised relating to the potential for HCBC to increase women's employment and employability, alleviate women's poverty and increase their control over material resources and services and encourage women's political participation. When taking into account both the economic and socio-political aspects of empowerment discussed in Chapter Two, HCBC's five key objectives can be expanded for an analysis of its impact on women's empowerment, encapsulated in Figure 4 below:
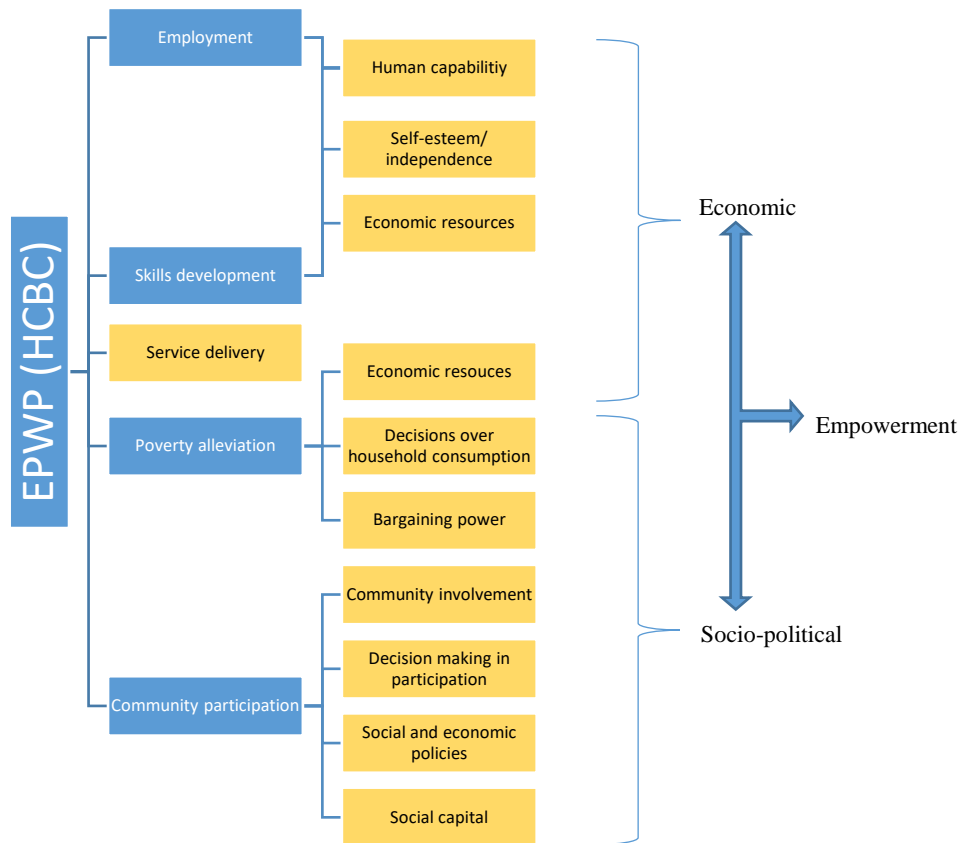
Figure 4: Framework for evaluating HCBC's impact on women's empowerment

The series of questions which I raise above and seek to address in my work through my framework of empowerment in Chapter Two are summarised in Table 4.1 below.

Table 4.1: Questioning the effectiveness of HCBC

EPWP goals	Key question	Sub-questions	Dimension in framework
Employment	Has HCBC created more job opportunities?	To what degree are job opportunities lasting?	Economic resources
		To what extent has HCBC increased participants' employment chances on exit?	Human capability
		Are there opportunities for reabsorption into full-time employment?	Economic resources
		Can HCBC provide jobs with longer duration?	Economic resources
		Does HCBC increase women's labour market participation?	Economic resources

		Are there changes in women's status in the workplace?	Human capability Self-esteem
		To what degree does HCBC reinforce or challenge gender employment stereotypes?	Human capability Social and economic policies
		What is the career potential of HCBC?	Human capability
Poverty Alleviation	Is HCBC sufficient for cushioning poverty due to chronic unemployment?	How lasting is the impact of poverty alleviation?	Economic resources
		Does HCBC's brevity hinder poverty reduction?	Economic resources
		To what extent does women's increased power over resources translate into other forms of power?	Bargaining power Decision-making over household consumption
Skills Development	To what extent does HCBC increase capabilities and job performance?	What are women's experiences of training?	Human capability
		Is training adequate for job performance?	Human capability
		Is training relevant/ responsive to market needs?	Human capability
		What is the impact of skills development on self-esteem?	Self-esteem
Community participation in service delivery	To what degree does community participation support carework?	Are physical infrastructures delivered through EPWP via community participation effective in supporting care?	Service delivery
		How does community involvement in decision-making influence carework?	Decision-making in participation
		What is the impact of HCBC on social capital formation and activism and resistance of caregivers to influence policies?	Social capital Community involvement Decision-making in participation Social and economic policies
	How do HCBC caregivers benefit from participation in community care?	To what extent is community caregiving a choice?	Decision-making in participation
		To what degree is HCBC a survival mode of caregiving to cope with poverty and lack of institutionalised care?	Decision-making in participation
		To what extent is HCBC an employer of last resort?	Decision-making in participation
		Does HCBC impose a third burden on women?	Decision-making in participation

Chapter Five

Impact of HCBC on employment, poverty alleviation and service delivery

This Chapter and Chapter Six contain the findings from my analysis. In this chapter I focus on the economic dimensions, specifically the impact of home community-based care on employment, poverty alleviation and skills development. In Chapter Six I focus on the social dimensions of community participation, social capital and bargaining power which are key towards women's empowerment.

5.1   Home community based-care for job creation and poverty reduction

In this chapter, I examine the ability of EPWP's home community based care (HCBC) programme to increase the economic/material aspects of (1) employment and employability, (2) poverty alleviation of caregivers, and (3) increased access to urban and social services. The chapter is organised in seven parts: the first contextualising the HCBC against larger social sector provisions in the EPWP, the second elaborating on the HCBC programme itself, the third providing an overview of findings from the meta-analysis of selected empirical studies on the HCBC. In the remaining three sections, I draw on government evaluations, my meta-analysis of existing studies and findings from my pilot survey to address (1) the contributions of HCBC towards employment, (2) changes in caregivers' control over economic resources and access to urban and social services, and (3) the impact of economic resources and service delivery on caregivers' self-esteem.

5.2   EPWP Social sector

The EPWP social sector comprises a large variety of programmes across five different categories, namely (1) education involving early childhood development (ECD), mass literacy campaign Kha Ri Gude, school nutrition programme, (2) social development including food and social security, social auxiliary workers, (3) health such as home community based care (HCBC) and other expansion programmes such as community development workers (CDW), nursing/pharmacy assistants, nutrition advisors, (4) sport and recreation and (5) community safety consisting of volunteer social crime prevention, community-based crime prevention projects, schools patrols (DPW 2012a). The main parameters of the EPWP were set out in Chapter Four. Despite the variability of programmes, ECD and HCBC are the main focus of governments' policies since the first phase of the EPWP because it will expand employment and potentially provide a cost

effective solution to the increased pressure placed on hospitals due to the HIV/AIDS epidemic (DoSD; DoE; DoH; 2004).

In shifting the responsibility and context of care from hospital to home, DoH (2001, 2) proposes that HCBC has the ability to address six key issues relating to healthcare shortages, namely (1) reduce shortage of hospital beds, (2) relieve shortages in professional medical nursing and healthcare staff in the public sector, (3) address lack of resources for drugs/treatment, (4) reduce high costs of institutional care, (5) relieve overcrowded, overstretched hospitals to improve quality of care for terminally/chronically ill and (6) address demands on institutional care for curable conditions. Approximately one third of the EPWP social sector budget is allocated to HCBC (DPW 2014b) (see Appendix C). The focus on health is observable across seven out of nine provinces, the exception being Gauteng which focuses on education, sports and recreation and Mpumalanga with a more general focus on social development (see Appendix C). The emphasis on HCBC, together with its long history and lack of consensus among existing studies, explain the focus of my research. In the following sections, I use findings from background data in government reports, my meta-analysis of the HCBC and my pilot study to provide a more coherent understanding of the (1) socio-economic outcomes of HCBC on female caregivers, and (2) the impact of incorporating a social care agenda into PWPs.

5.3   HCBC programme

The WHO's (2001) definition of HCBC, which has been adopted by the DoH (2001), will be used for the purpose of my research. According to DoH (2001, 1), HCBC entails

> *'the provision of comprehensive services, which include health and social services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximal level of comfort, function and health including care towards a dignified death. […] Community-based care is the care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people […]'.*

Based on the above definition three types of caregivers may be identified, namely (1) primary caregivers who are usually family members and thus commonly referred to as family caregivers, (2) secondary caregivers who are often family or community members providing support to the primary caregivers and (3) community caregivers who are usually community members trained by home-based care organisations to provide care to

the community (Akintola 2008b). This chapter is interested in the community caregivers who according to Akintola (2004), make up the backbone of the HCBC programme.

HCBC is conducted across three phrases, funded by the government via provincial DoHs who allocate funds to NGOs/NPO/CBOs/FBOs as service providers (see Figure 5). Training is offered to HCBC caregivers through partnership with the Health and Welfare Sector Education Training Authority (HWSETA). A clear progression plan is mapped out in terms of qualifications, job title, services provided, stipends, training and exit opportunities, with three types of work opportunities offered across three levels of the National Qualifications Framework (NQF) (see Figure 6). Participants exit at the end of the 12 to 24-month work placement opportunity or continue training at the next level. Training opportunities are more limited and competitive at higher levels, which require longer training duration and higher costs per work opportunity.

Figure 5: Roles and responsibilities of EPWP stakeholders
Source: DoSD, DoE and DoH (2004, 23)
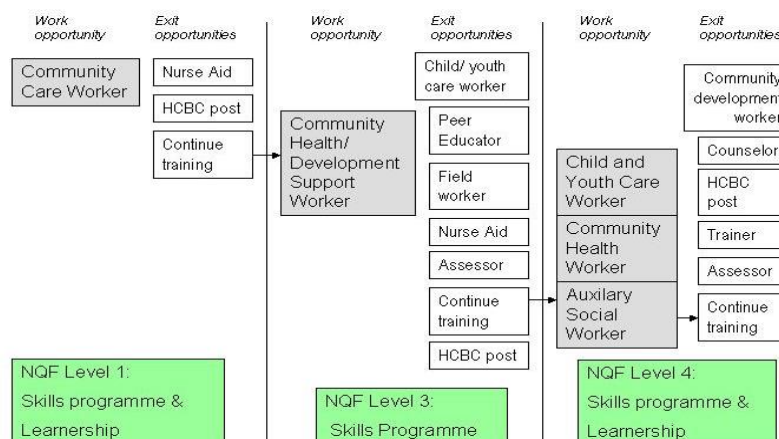
Figure 6: HCBC training and career progression path
Source: DoSD, DoE and DoH (2004, 15)

5.4   Meta-analysis

The rationale for the meta-analysis and the selection of studies for further analysis was outlined in Chapter Three (section 3.2). As a consequence of this initial analysis, 35 were selected for detailed scrutiny with respect to the economic and socio-political dimensions of empowerment identified in section 4.4.5. Following the selection criteria identified in section 3.2, the initial 83 studies were reduced to 35 having allowed for duplicates. Across the 35 studies, all ten economic and socio-political dimensions of empowerment identified in section 4.4.5 have been substantially discussed (see Table 5.1). Some dimensions, such as (1) human capability relating to employment/employability (N=30), (2) control over economic resources (N=30), (3) self-esteem/independence (N=29), (4) social capital (N=33) and, (5) service delivery (N=32) gained more attention than others. On the other hand, dimensions such as (1) decisions over household consumption (N=18), (2) bargaining power (N=15), and (3) influence over social and economic policies (N=14) received least attention, while decision-making in participation (N=20) and community participation (N=21) received moderate focus.

Table 5.1: Reported outcomes of more frequently discussed HCBC empirical studies

No	Study	Method	HC	Poverty alleviation					Community participation			SP
			HC	$	DHC	BP	SE	SC	CP	IPM	IP	AI AS
1	Assessing community health services: Challenges faced by poor people with disabilities in a rural community in South Africa Grut et al. (2012)	Qualitative	✓					✓				✓
2	An evaluation of the implementation of integrated community home-based care services in Vhembe District, South Africa Moetlo, Pengpid, and Petltzer (2011)	Mixed	✓	✓				✓	✓	✓		✓
3	Community home –based care programme: A marginalised key community resource Qalinge (2011)	Qualitative	✓	✓			✓	✓		✓	✓	✓
4	Community home-based carers: Voicing their needs, voicing their challenges Davids et al. (2009a)	Qualitative		✓	✓		✓	✓		✓		✓
5	Evaluation study of the psycho-social needs of volunteer community home-based carers Davids et al. (2009b)	Mixed	✓	✓	✓		✓	✓	✓	✓	✓	✓
6	The experience of volunteers involved in home-based care of people living with HIV/AIDS Sobuce (2007)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7	Gendered home-based care in South Africa: More trouble for the troubled Akintola (2006) Defying all odds: Coping with the challenges of volunteer caregiving for patients with AIDS in South Africa Akintola (2008a) A gendered analysis of the burden of care on family and volunteer caregivers in Uganda and South Africa Akintola (2004)	Qualitative	✓	✓	✓	✓	✓	✓		✓		✓

#	Study	Type	1	2	3	4	5	6	7	8	9	10
8	Community response to HIV/AIDS: The role of volunteers in home-based care for people living with HIV/AIDS in South Africa Akintola (2005) A gendered analysis of the burden of care on family and volunteer caregivers in Uganda and South Africa Akintola (2004)	Qualitative	✓	✓	✓	✓	✓	✓				✓
9	Perceptions of rewards among volunteer caregivers of people living with AIDS working in faith-based organisations in South Africa: A qualitative study Akintola (2010)	Qualitative	✓	✓			✓	✓	✓			✓
10	Acceptance and disclosure of HIV status through an integrated community/home-based care program in South Africa Ncama (2007) Community impact of HIV status disclosure through an integrated community home based care programme Ncama and Uys (2006)	Quantitative					✓	✓	✓			✓
11	"Most they don't practice what they preach": Exploring personal vulnerability and risk perceptions amongst AIDS caregivers in Ekurhuleni, South Africa Dworzanowski-Venter and Smit (2008)	Qualitative	✓	✓		✓	✓		✓			
12	The plight of HIV and AIDS care givers in Thohoyandon in South Africa Morwe, Klu, and Tugli (2013) Morwe and Ramaila (2012)	Quantitative	✓	✓			✓				✓	
13	Understanding the agency of home-based volunteers: Establishing identity and negotiating space in AIDS-home-based care in rural KwaZulu-Natal, South Africa Naidu and Sliep (2012) The social construction of identity in HIV/AIDS home-based care volunteers in rural KwaZulu-Natal, South Africa Naidu, Sliep, and Dageid (2012) Contextual reflexivity: Towards contextually relevant research with South African HIV/AIDS home-based care volunteers Naidu and Sliep (2011)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
14	Stigma, burden, social support and willingness to care among caregivers of PLWHA in home-based care in South Africa Singh et al. (2011)	Quantitative		✓				✓				✓
15	Supporting people with AIDS and their carers in rural South Africa: Possibilities and challenges Campbell, Nair, et al. (2008)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓		✓
16	Caring for home-based care workers. Understanding the needs, fears and motivations of front-line care workers in South Africa Zerden, Zerden, and Billinghurst (2006)	Mixed	✓			✓	✓	✓	✓			✓
17	A case study. Makhuduthamaga home/community-based care umbrella programme Byenkya, Sebastian, and Oti (2008)	Qualitative	✓	✓				✓	✓			✓
18	'It's in our veins': Caring natures and material motivations of community health workers in contexts of economic marginalisation Swartz and Colvin (2015) Legacy, legitimacy, and possibility Swartz (2013)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
19	From manual to makeshift. The practice of community health work in Wallacedene and Bloekombos informal settlements Vale (2012a) 'You must make a plan or […] some story': Community Health Workers' Re-appropriation of the care manual Vale (2012b)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
20	Community health workers and the response to HIV/AIDS in South Africa: Tensions and prospects Schneider, Hlophe, and van Rensburg (2008)	Qualitative	✓	✓			✓	✓	✓	✓	✓	✓
21	"She is my teacher and if it was not for her I would be dead": Exploration of rural South African community health workers' information, education and communication activities Zulliger, Moshabela, and Schneider (2014)	Qualitative	✓					✓	✓	✓		✓
22	Frustrated potential, false promise or complicated possibilities? Empowerment and participation amongst female health volunteers in South Africa Campbell et al. (2009)	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

#	Study	Method	HC	SP	$	DHC	BP	SE	SC	CP	IP	AIAS
	Building contexts that support effective community responses to HIV/AIDS: A South African case study Campbell, Nair, and Maimane (2007) 'Dissemination as intervention': Building local AIDS competence through the report-back of research findings to a South African rural community Campbell et al. (2010) Hearing community voices: Grassroots perceptions of an intervention to support health volunteers in South Africa Campbell, Gibbs, et al. (2008) Mismatches between youth aspirations and participator HIV/AIDS programmes in South Africa Gibbs et al. (2010) Social contexts and building capital for collective action: Three case studies of volunteers in the context of HIV and AIDS in South Africa Gibbs et al. (2015)											
23	Making connections: Towards a holistic approach to the training of women volunteers in community home based care Thabethe (2006)	Qualitative	✓	✓	✓	✓	✓	✓	✓			✓
24	The burden of care: A study of perceived stress factors and social capital among volunteer caregivers of people living with HIV/AIDS in KwaZulu-Natal Hlengwa (2011)	Quantitative	✓		✓		✓	✓	✓	✓		✓
25	Unpaid volunteers and perceived obstacles in ensuring care and support for people living with HIV/AIDS Kezaabu and Sliep (2011) Taking back practices-creating reflexive spaces to increase response-ability Sliep and Kezaabu (2011)	Qualitative	✓	✓			✓	✓	✓			✓
26	Perceived stress and burnout among volunteer caregivers working in AIDS care in South Africa Akintola, Hlengwa, and Dageid (2013)	Quantitative		✓			✓	✓		✓		✓
27	In-forming care: A study of HIV/AIDS caregiving interventions in KwaZulu-Natal, South Africa Lance (2010)	Qualitative	✓	✓		✓	✓	✓		✓	✓	✓
28	Challenges faced by Phuthanang home based care in providing care and training in Mankweng township, Limpopo province Muwaniki (2009)	Qualitative	✓	✓		✓	✓	✓	✓			✓
29	Case Study: Community based workers and HIV/AIDS in Bloemfontein, South Africa Mdhluli (2006)	Qualitative	✓	✓	✓		✓	✓		✓	✓	✓
30	Experiences of social support among volunteer caregivers of people living with HIV/AIDS Fynn (2011)	Qualitative	✓	✓	✓		✓	✓		✓		✓
31	Generative metaphor in community-based action research: Making culturally relevant connections Naidu (2011)	Qualitative	✓	✓			✓	✓				
32	Organising health home and community based workers in South Africa Samson (2008)	Qualitative	✓	✓	✓		✓	✓	✓	✓	✓	✓
33	Support for the volunteer caregivers and its influence on the quality of CHBC in Eastern cape, South Africa Morton, Mayekiso, and Cunningham (2015) South African Eastern Cape contexts influencing the quality of community home based care Morton, Mayekiso, and Cunningham (2013)	Qualitative	✓	✓	✓	✓		✓	✓			✓
34	Challenges in organising informal workers: A case study of gendered home-based care work in post-apartheid South Africa Munakamwe (2009)	Qualitative	✓	✓	✓	✓	✓	✓		✓	✓	✓
35	Community care workers, poor referral networks and consumption of personal resources in rural South Africa Sips et al. (2014)	Qualitative		✓	✓		✓	✓				✓
Total		Qualitative:27 Quantitative: 5 Mixed: 3	30	30	18	15	29	33	21	20	14	32

HC = Human capability, SP = Service provision, $ = Control over economic resources, DHC = Decision over household consumption, BP = Bargaining power, SE = Self-esteem, SC = Social capital, CP = Community participation, IPM = Intervene in programme implementation, IP = Influence over policies, AIAS = Access to infrastructure/ assets, services

Most of the studies (N=27) adopted a qualitative methodology, with a limited number of quantitative (N=5) and mixed methods (N=3) approach. The selected qualitative studies provide an insight into non-measurable and process oriented, socio-political dimensions such as the (1) collective aspects of community participation, influence over policies and programmatic implementation, and (2) individual aspects of decision making over household consumption and bargaining power, issues that are often left out of quantitative studies due to the difficulty of quantifying such processes. Instead, these studies focused on the stipends received by caregivers and the extent to which they had control over these resources. Some of the quantitative studies have however sought to measure social dimensions of social capital and self-esteem through the use of structured questionnaires with constructs and Likert-type scales. Such studies are however limited in explaining the dynamics of social influences and the impacts of gendered norms on female caregivers' experience of HCBC. Both types of studies are included in my review as they complement each other, the quantitative in providing more measurable, evidence-based impact assessments, and the qualitative in enabling an explanation of the quantitative data through the lens of caregivers working in the field.

The following sections in this chapter seek to synthesise (1) findings from my meta-analysis of 35 selected studies with (2) government reports on the EPWP, and (3) empirical findings from my pilot study, to examine the impact of HCBC on economic dimensions of empowerment, with Chapter Six covering the socio-political aspects.

5.5   Human capability through employment and employability

This section discusses the potential of HCBC to increase human capability in three ways, namely: (1) provision of employment opportunities, (2) transition in employment status through training, and (3) labour market absorption.

5.5.1   Employment opportunities

5.5.1.1   HCBC Phase 1

The HCBC aims to create 122 240 work opportunities[26], which amounts to 9.46% of the EPWP phase one's promise of 1.3 million jobs (detailed calculation in Appendix B). DPW (2009c) reports that EPWP exceeded its target by 116%, but this is mainly attributable to the environment and culture and economic sectors which exceeded their

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[26] A work opportunity is equivalent to paid work created for an individual on an EPWP project for any period of time. 'Learnerships' are considered to be a work opportunity in the case of social sector projects such as the HCBC.

targets by 231% and 170% respectively, and in part to the infrastructure sector which over-performed at 106%. The HCBC, on the other hand, underperformed and achieved 92.6% of its target. Overall, the social sector only contributed 10.78% of the EPWP target (1.6 million jobs), with HCBC comprising 7.0% of the total number of jobs created (see Figure 7). On the other hand, the environment and culture sector overachieved significantly to become a major provider of work opportunities for the EPWP. Thus, HCBC only makes a small contribution to employment creation given the scale of unemployment in South Africa.
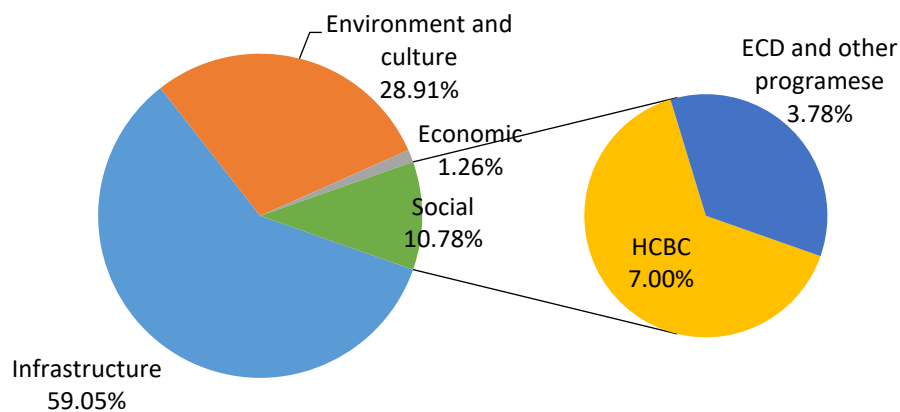
Figure 7: Achieved work opportunities in EPWP phase 1
Source: Author's own calculation with data from DPW (2009c)

The contribution of the social sector looks more optimistic however, if the person years of work (including training) are considered. The social sector contributed 21.79% to the person years of work (see Figure 8), despite lower number of work opportunities owing to the longer period of employment offered by the HCBC - approximately one to two years, as opposed to the other sectors which usually lasts for about four months.
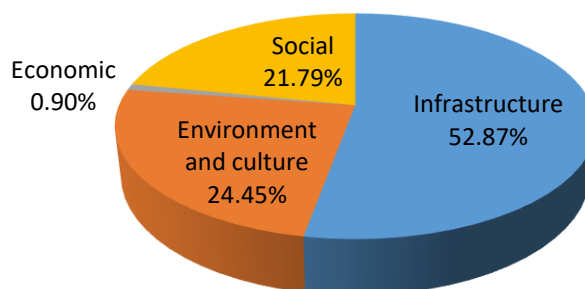
Figure 8: Achieved person years of work in EPWP phase 1
Source: Author's own, from data in DPW (2009c)

5.5.1.2   HCBC Phase 2

The second phase of the HCBC has a more ambitious target than the first, seeking to contribute towards 15.24% of the total target of 4.5 million work opportunities and to provide a quarter of the 2 million FTEs (see Appendix B for more details). Evident across the two phases of the EPWP between the period of 2004-2014 is that while HCBC may appear rather inadequate in making a difference to South Africa's unemployment statistics, the opportunities provided are more substantial, stable and longer term than the ones provided by other sectors in the EPWP. The benefits of longer term work opportunities are supported by World Bank's (2000) finding that short term PWP employment is insufficient where unemployment is chronic, and that long term solutions such as cash transfers are more sustainable. One can therefore conclude that even though the HCBC may create fewer jobs than other EPWP programmes, it presents greater potential for more permanent 'decent work' opportunities, making a difference to the human capability and economic situations of a select few.

The impact of HCBC on job creation is however difficult to quantify for several reasons, although a measure of HCBC work opportunities and FTEs as a percentage of the overall EPWP targets gives a better indication. First, the implementation and reporting processes of HCBC appears to be complicated and inconsistent (Parenzee and Budlender 2007, cited in Samson 2008, 10), so the reported work opportunities (DPW 2014a) may misrepresent the actual number of work opportunities. Second, as the programme is not directly implemented by the government but by NGOs, NPOs, CBOs and FBOs, different models of home community-based care are adopted, with different funding mechanisms, varied use of caregivers, different levels of services/resources and different reporting mechanisms (Muwaniki 2009, B. Ncama 2005, V. Naidu 2005) further complicating monitoring and evaluation. In particular, the ambiguity in tasks, benefits, rights and employment status assigned to caregivers, which is often dependent on the location and external implementing agencies, make it difficult to determine whether the reported work opportunities accurately reflect jobs based on the definitions of employment as laid out in the Basic Conditions of Employment Act (BCEA) and the Code of Good Practice for Employment and Conditions of Work for Special Public Works Programme (DPW 2014a).

Third, it is evident from the selected studies that different typologies are assigned to caregivers, all of which entail different levels and forms of remunerations, from unpaid carers who are not in fact employed despite working, to volunteers/community

caregivers/home-based caregivers who may receive some training and incentives, to community health workers who are stipend and trained through funding from government subsidies. HCBC organisations tend to use a combination of different types of caregivers depending on funding available. As such, the reported number of work opportunities is likely to differ from the actual number employed, as it is difficult to ascertain how many of the employed caregivers are paid. It is uncertain whether HCBC provides some informal short term work (referred to as "piece jobs" in the South African context) that has not been reported. Fourth, underreporting occurs where smaller HCBC organisations lack visibility and accountability (Friedman 2005, Ogunmefun, et al. 2012).

Evident from the above studies is that the monitoring and evaluation of HCBC is of dubious validity with many inconsistencies and inaccuracies, and it remains difficult to quantify accurately the number of employment opportunities (defined in the BCEA) that HCBC provides. In view of the funding limitations and heavy reliance on volunteering, it is also questionable whether HCBC organisations actually abide by the employment conditions met out by BCEA when implementing and reporting on the progress of their HCBC activities, especially since implementation guides laid out by the National government are not binding on provincial governments. Potentially, HCBC organisations adopt unfair employment practices in contracting caregivers, as raised by several of the selected studies (discussed in the later sections). As such, the actual number of HCBC work opportunities that can be considered as 'decent work' may well be less than that reported to DPW, undermining the function of HCBC to create jobs. Despite the uneven practices, statistical reports demonstrate that HCBC provide work opportunities to a small population of beneficiaries, although the nature of the work and number of job opportunities remains inconclusive. The following section will elaborate on the types of beneficiaries and benefits in terms of employment status and human capabilities.

5.5.2 Employment status

Apart from creating jobs, it is also important that HCBC opportunities facilitate the development of human capabilities which potentially raise caregivers' employment status outside of the programme. In my pilot study, people I interviewed were mostly unemployed and relied on welfare grants (Child Support and/or Older Person's) prior to their carework. Several completed matric educations, but still expressed difficulty in finding more permanent, stable forms of employment. These characteristics of my interviewees fit in with most HCBC participants interviewed in the empirical studies analysed, with many reported to be unemployed, employed in part time domestic work or

hairdressing or the informal economy of street trading (Akintola 2006, 2008a, 2004). Apart from a select few participants who were university graduates or retired nurses, most of the HCBC caregivers in both my pilot and analysed studies received limited education (matric level or below) and had not been employed in formal work. Many commented that given their circumstances of unemployment, un-employability and poverty, community caregiving was a means of avoiding idleness and of creating an opportunity for personal growth and future employment (Akintola 2010, 2011, Qalinge 2011, Davids, Setswe, et al. 2009b, Sobuce 2007). Two of my interviewees reflected on their work and migration experience prior to becoming a home-based caregiver as such:

> *"Originally I am from Eastern Cape. I came here in Cape Town about 1989. So my aim to come here in Cape Town was to get more studies or to work, because I am coming from the impoverished province and impoverished family. So my aim was to improve myself, I was only in my 20s. Because of my circumstances, no family and nothing, so I try to make some friends, at least to get a shirt over my head. I got a restaurant job. Because I had no support, I couldn't get to school. I had a child, in 1993 I got married to the father of my child, I got another 2 more boys. Now I am a single woman, because I divorced, because my husband was so abusive towards me. After I divorce in 2007, I started to go to school, because I was doing domestic work at least to put something on the table. I finished night school 2009, I passed matric, then I decided I still can go more, so I decided to register to do social work with UNISUR, I am in my third year now. I am still working as a domestic worker to support my boys. After, I hope to get a better job, to be a social worker, work with the kids." (Neo, Female, 43, caregiver/social work student)*

> *"I was struggling at home, I decided it is best if I just look for a job, and then I work in a restaurant, the bay-side restaurant in Fish Hoek. I work from 2004 after school until 2005, because at that time I was sick only to find out I had TB. [...] I have to drop out of work because I was sick and my parents couldn't stand it. [...] restaurants are people with no future, because you only go there to earn something, not because you see your future you going to end up in a restaurant. That is how we see things, even domestic work here is for people who have nothing, but we do have young people like myself who are working in domestic work, but because they have no choice, it is better than doing things we are not supposed to do, like doing drugs. [...] I wasn't working 2006, 2007 I fell pregnant [...] I have to raise him. 2008, 2009, 2010 I am sitting at home doing nothing. And then 2011, I started working for Living Hope as a community care worker. [...] everything went well, now I am the supervisor." (Mbali, Female, 25, caregiver)*

Evident from the above respondents are that participation in HCBC is not only driven by circumstances of poverty, unemployment and lack of familial support, but also by the motivation and desire to excel and seek personal development. In particular, while informal jobs such as domestic and restaurant work were available to help caregivers get

by, such jobs were not highly valued as they did not provide any opportunities for development or career advancements, which caregiving perceptibly offered.

Even though caregivers in both my interviews and meta-analysis stated the need to be on the move and to prevent idleness as key motivators for caregiving, Berner and Philips (2005) cautions against misinterpreting financially poor, unemployed women as having an abundance of time on their hands to conduct community caregiving. Instead, there is a need to question if community caregiving may be a forced alternative to an enforced idleness. Esquivel et al. (2008), Benería (2003) and Elson (2000) state that existing time use survey data in both (1) developed countries such as United Kingdom, Australia, New Zealand and (2) developing countries such as India, South Africa, Tanzania, Nicaragua and Mexico, demonstrate women around the world, and especially so in developing countries, spend long hours performing unpaid work, while Ogden, Esim and Grown (2006, 333) add that the gap is exacerbated in the context of HIV/AIDS. Similarly, the South African Time Use Survey (SATUS) 2010 (SSA 2013a) shows women, especially the unemployed who are of productive working age, to spend disproportionately more time than men on household maintenance and care of persons within the household (see Appendix D for detailed discussion).

In view of gendered inequalities in the distribution of social reproductive work in South Africa, I suggest that feelings of idleness reported by caregivers may possibly be felt by women in the sense of not having a productive job outside the domestic sphere, rather than not having any forms of labour, and according to Munakamwe (2009, 90) and Naidu and Sliep (2012, 147), may possibly be an indication of women attributing little value to their reproductive work in the home. Despite the limitations of HCBC work, caregivers nonetheless consider it as having some potential to act as a stepping stone to further employment and as a means of tiding them over periods of hopelessness and desperation until they chance upon better opportunities (Rosenberg, et al. 2005, Sobuce 2007, Vale 2012a, 2012b). Despite the limited job opportunities, HCBC is still perceived by caregivers as a means of transit from their unemployed status to employment with financial gains. However, one of my interviewees (Kagiso, Female, 27, caregiver) suggested that feelings of empowerment did not follow this shift:

> *"Empowerment means women today, we don't look down on ourselves, also it means that we can have the same policies as men. […] It is okay with me since I have a stable job, but also there is another side because I am not happy at home, not having a place of my own is also haunting me."*

Kagiso's response suggests that HCBC's contribution is limited to that of employment, by no means having the potential to transform other aspects of caregivers' livelihoods which they consider to be empowering, such as gender equality in policies, power within the household, and the ability to exit the poverty trap. The above shows the importance of examining the socio-political dimensions of empowerment, as the lack of socio-political transformations in the meso and macro levels, such as in the case of Kagiso, can disrupt female caregivers' experience of empowerment.

In presenting more practical motivations for caregiving, caregivers in both my interviews and meta-analysis reject England's (2005) 'commodification of love' whereby caregivers feign their expressions of love as their driving force for caring for the sick, in exchange for financial gains. However, the above does not imply that caregivers conduct care merely for personal gains, as my interviewed caregivers suggested care and concern, and the desire to spread the love of God as one of their main motivations for caregiving[27]. Similarly, caregivers in Sobuce (2007) and Akintola (2005, 10-11) show that apart from being driven by one's own employment needs, women's conduct of caregiving may also be motivated by their desire to contribute to the perceived needs of their communities. In my own empirical work, altruism acted as a strong motivation for providing care, with Retha (Female, 30, chaplain) suggesting that:

> *"I feel sad sometimes, I feel like, oh my God, can you do something for this people who live in this situation. It is not safe. Inside their rooms, they getting cold and then when they start putting their heaters, you know they burn their old stuff whatever. I am praying that even then; God can provide for them".*

The discussed studies point to the multidimensionality of women's motivations to care, that female caregivers' decision to care are not simply motivated by their need to cope with a double tragedy of poverty and unemployment, but are influenced by the complex intermingling of both a moral imperative of altruism and of fulfilling their self-serving needs for employment. As such, caregivers often find themselves sandwiched between their pursuit of survival needs, desire for self-advancements and the impetus to display altruism and labour of love (discussed in section 5.6). In particular, the moral imperative to care may discourage caregivers from quitting HCBC to advance to alternative career opportunities, as such impeding women's career development. Unfortunately, the lack of follow up studies investigating employment outcomes of HCBC programme graduates

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[27] There is however an overemphasis on a faith-driven motivation as discussed above, possibly due to the nature of the implementing agency being a faith-based organisation.

limits my ability to assess the effectiveness of HCBC in enhancing women's employment status.

Examining the career progression of my interviewees however, it appears that HCBC provides an avenue for advancements in the programme itself, as two of my interviewees who were unemployed before the programme have, at the time of interview, taken on greater leadership responsibilities, one as a HCBC trainer and the other as a full-time qualified health assistant, suggesting that HCBC has some positive outcome on women's employment, although subsequent career opportunities for programme graduates remains unknown. An understanding of the potential for HCBC to increase human capabilities may however provide some insights into the possible career paths for women exiting the programme. In my study, I examine human capabilities in terms of both possessing adequate skills to be hired in the labour market, and availability of time an individual has in order to seek and participate in productive work. HCBC work often straddles the domains of home and health facilities, formal and voluntary (informal) work, state and non-state sectors, and the traditional understanding of care as Ubuntu[28] as well as a remunerated job opportunity.

Out of the 30 studies discussing the impact of HCBC on human capabilities, 10 studies[29] find that as a home-based care activity, HCBC imposes a time burden on caregivers and reduces the time they have to seek employment, as such reducing their employability. The key concern of these 10 studies are that women invest more time than they are contracted for into carework, as such competing with the time they have to do productive work, seek personal development and search for jobs. The lack of control over time commitment is also described by one of my respondents as such:

> *"Yes they [FBO] pay for 5 hours of our work. […] if you work overtime they don't pay you. You have to do it because maybe working in the weekends, some other people if you go to their house during the week you won't find them […] you can't make someone do home visit at 7pm, you going to make the family uncomfortable because some people they don't disclose to the family about their status. […] to avoid that some of the people we go on the weekends, we are not going to get paid for that, we are just doing it for the people." (Kagiso, Female, 27, caregiver)*

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[28] Ubuntu is a traditional South Africa spirit of valuing the community above self-interest. It embodies the spirit of service, of striving to help others, collective respect for others, equity among people, honesty and trustworthiness.

[29] Hlengwa (2011), Fynn (2011), Mdhluli (2006), Munakamwe (2009), Akintola (2004, 2006, 2008a), Morwe, Klu and Tugli, (2013), Kazaabu and Sliep (2011), Sliep and Kezaabu (2011), Vale (2012a, 2012b), Schneider, Hlophe, and van Rensburg (2008)

The above perspective reflects Budlender's (2004) perspective that in shifting carework from the clinical setting to the community, HCBC encourages women to assume unpaid carework within the domains of patients' homes, which in turn has the negative impact of impinging on the amount of time women have to do other things such as productive labour. Budlender's (2004) understanding contradicts Antonopoulos' (2009, 6, 2008), who suggests that HCBC moves caregiving out of the private space of the home into the public domain of the community, as such incorporating a gendered lens which recognises women' contributions to reproductive labour into HCBC policies. My meta-analysis and interviews support both the above perspectives, reporting that HCBC provides a limited number of job opportunities (section 5.5.1) through the externalisation of carework as suggested by Antonopoulos' (2009, 6, 2008), albeit also having the negative impact of imposing a time poverty on women which impacts on their employability outside of HCBC, as identified by Budlender (2004). Both Budlender's (2004) and Antonopoulos' (2009, 2008) work are on opposite sides of the same coin, complementing each other in revealing the reality of HCBC implementation and the diverse livelihood circumstances of its participants. Instead of being an absolute advantage/disadvantage, caregivers' employability can often be enhanced or compromised by HCBC to various extents depending on circumstances, such as policy, level of remuneration received (see section 5.6) and amount of financial and time resources invested into carework (see section 6.1).

My meta-analysis suggests that in some instances, HCBC caregivers support Folbre's (2006) and Budlender's (2004) views, that women are subsidising the state financed social sector, presenting their caregiving work as a transfer or a 'gift' from the household/family to the market and the state. Yet in another context, HCBC may present caregivers with a last glimmer of hope for employment, career advancements and income (see section 5.6). Furthermore, while HCBC may limit caregivers' availability to participate in productive labour, it would be inaccurate to maintain that caregiving hinders women from seeking future job opportunities which can increase their employment status. On the contrary, caregiving acts as a coping mechanism used by women to increase their human capabilities and chances of finding paid employment. For example, in 13 out of 30 studies[30] reporting on the dimension of human capability, participants described their

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[30] These participants are documented in several studies such as Munakamwe (2009), Swartz (2013), Swartz and Colvin (2015), Vale (2012a, 31, 2012b), Schneider, Hlophe, and van Rensburg (2008), Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell, Nair, and Maimane (2007), Campbell et al. (2010), Gibbs et al. (2010), Thabethe (2006), Hlengwa (2011), Lance (2010), Mdhluli (2006), Morton, Mayekiso, and Cunningham (2015, 2013), Akintola (2004, 2005)

motivations for caregiving as a means of 'getting by', a way of securing upward mobility, a stepping stone into formal employment such as nursing careers, and an 'improvisatory tactic' for a stable job with minimal entry requirements. A similar sentiment is expressed by one of my interviewees, discussing her future career goals as such:

> *"I wish to learn more from what I do today, so that in future I can be lifted to other directions, instead of doing the same job for so long." (Farai, Female, 33, support group facilitator/caregiver)*

Caregiving is often treated as a means to an end (employment), with caregivers in Akintola (2004, 2005) and Thabethe (2006) revealing the intention to quit once employment is found/secured, while several caregivers in Mdhluli (2006) and Lance (2010) left their positions to find employment when no tangible benefits emerged from their caregiving roles. One of my respondents presented similar sentiments as the above caregivers, suggesting that before caregiving became a paid opportunity for her, she took it up only as a side job so she could secure time for productive work outside of carework:

> *"I got my matric in 2007, then I come here and volunteer in the life skills here at Living Hope. Because at that time I was after money, as I was after something that I want, so I volunteer I think for two months, then I got a job as a waitress so I can get some money so I can buy some stuff. That was how I first got to work with Living Hope, [...] in the community." (Kagiso, Female, 27, caregiver)*

Caregivers also consider carework to be a space for developing social and professional networks with more well-resourced people, which potentially opens up opportunities for employment[31] (further discussed in section 6.4), with an exception in Samson (2008, 26) whereby caregivers were bitter about management not considering them for jobs in the clinic so as to retain volunteer labour. The above begs the question of whether South Africa's labour market presents opportunities for HCBC graduates to enter formal employment. If so, to what extent does HCBC reinforce a 'feminisation' of labour which supports Chen et al.'s (2005) claim that women's socially assigned role as unpaid caregivers tends to channel them into similar occupations and industries in the paid economy, such as healthcare, childcare, domestic services, clothing and textile? The EPWP social sector (see section 5.2) is highly feminised, and demonstrated in the policy document whereby men are absent or appear only as trainers (see DPW (2012a)), conveying an implicit message that the programme caters mainly for women. HCBC's

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[31] Swartz (2013), Mdhuli (2006), Swartz and Colvin (2015), Thabethe (2006), Lance (2010), Schneider, Hlophe, and van Rensburg (2008)

pattern of feminisation is also evident in my field studies, where only 2 out of 15 trainees were males. My casual conversation with a female trainee in the HCBC training session suggests the predominance of women to be the norm, commenting that:

> *"We always have many more women. Maybe one or two men at most in every course. Men don't like to do such things, and they also always don't stay very long. Not many men are interested in nursing, it can be very tiring and we don't get paid a lot". (Zola, Female, 34, caregiver)*

Five empirical studies[32] in my meta-analysis report that HCBC participants consider the programme to be a pathway into healthcare sector jobs, with participants who have made progression into paid employment often joining the healthcare sector either as assistant nurses or as community healthcare workers. The small sample size of these studies however does not allow for a conclusive statement to be made about the market absorption of HCBC participants into health services.

Furthermore, interviewees from my pilot study show employment progression in the HCBC programme itself in terms of greater responsibilities, tasks and role permanency, although advancements of HCBC graduates outside the programme remains unknown. My personal communications with caregivers in the training programme reveal high dropout rates due to familial commitments and deaths, rather than from having found better opportunities. Unfortunately, getting in contact with dropouts proved to be challenging, as such interviews with dropouts were not collected during the pilot study.

SSA's (2015b) QLFS report however shows (1) community and social service sector to be the larger job providers, (2) an expansion of low/semi-skilled jobs in the community and social service sector in the last five years which contributed to increase in market absorption rate of women, and (3) a predominance of women in community and social service and private households (see Appendix E for details). The above pattern demonstrates the availability of low/semi-skilled jobs in the community and social services sector for HCBC graduates, possibly implying that HCBC supports a "persistent pattern of occupational gender segregation" (Folbre and Nelson 2000, 126), discussed by Kabeer (2005) as a situation whereby women continue to work under exploitative working conditions of long working hours, precarious work, low pay, less insurance, unhealthy and unsafe conditions.

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[32] Mdhluli (2006), Swartz (2013), Swartz and Colvin (2015), Thabethe (2006), Schneider, Hlophe, and van Rensburg (2008)

5.5.3 Training and human capabilities

As for training to increase caregivers' human capabilities, my meta-analysis and interviews found a lack of consensus on the effectiveness of HCBC training. This variation is due to (1) the haphazard manner in which HCBC has been implemented which results in unstandardized and inconsistent training methodologies, and (2) inconsistent reporting (see section 5.5.1). Overall though, HCBC offers more substantial training (see Appendix C for elaboration) to its participants than other EPWP sectors, with DPW (2009c) reporting that social sector contributed to 28.97% of total training days achieved, despite only comprising 10.78% of the work opportunities and 21.79% of the person-years of work (see section 5.5.1) (see Figure 9). Similarly, in EPWP phase 2, significant number (42%) of training years were dedicated to the social sector, despite only having created 15.24% of the work opportunities and 25.39% of the FTEs (see Figure 9).
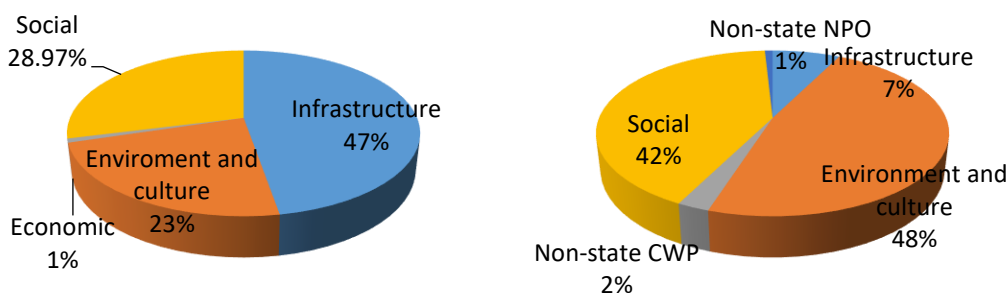
Figure 9: Achieved training days in EPWP phase 1 and 2

Source: Author's own calculations, from data in DPW (2009c) and EPWP quarterly reports

10 of 30 empirical studies[33] in my meta-analysis with a discussion on human capability however show that most of these training days are often assigned to larger, more visible HCBC institutions which are registered and funded by the DoH and DoSD and tend to have stronger administrative functions. Organisations which are more effective in skills development also tend to provide caregivers with training that:

- are longer,
- cover a wider variety of topics including information about HIV/AIDS, Tuberculosis, orphan and vulnerable children counselling and support, palliative care, psychosocial treatment, ancillary home based care,
- have practical sessions or attachments to healthcare facility,

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[33] Akintola (2010), Byenkya, Sebastian, and Oti (2008), Davids et al. (2009b), Dworzanowski-Venter and Smit (2008), Lance (2010), Mdhluli (2006), Morton, Mayekiso and Cunningham (2015, 2013), Samson (2008), Schneider, Hlophe and van Rensburg (2008), Zerden, Zerden and Billinghurst (2006)

- have strong support and professional advice from registered nursing supervisor,
- include continuing sessions,
- offer individual development through funding of courses,
- include opportunities for further training if excellence is demonstrated.

The effectiveness of comprehensive, continuing training in contributing towards caregivers' capability development is demonstrated by two of my interviewees' evaluation of the training programme as such:

> *"Next week I am going to another HIV/AIDS training for three days. Also I can understand new information because HIV is changing. You cannot say I was trained in 1998, then that information is still the same. I have to go for new updates. Living Hope [FBO] provides me with these trainings." (Tariro, Female, 45, Trainer and caregiver)*

> *"I want to apply nursing school, that is where my goal is now. With all this information and certificates and everything, then maybe I can." (Mbali, Female, 25, caregiver)*

Apart from equipping HCBC caregivers with the practical skills to provide care, two studies (Muwaniki 2009, Moetlo, Pengpid and Petltzer 2011) indicate that administrative skills are also necessary considering the rather diverse nature of caregivers' responsibilities. All in all, closer examination of my meta-analysis and pilot interviews reveal difficulties in ascertaining the impact of HCBC on caregivers' employment status either in terms of time availability to seek paid employment or human capability development. The above inconclusiveness is due to significant variations in time commitments, training, and career development opportunities from organisation to organisation. What remains consistent from my research is that HCBC caregivers working for more established, better managed and registered organisations tend to be more privileged than those working for smaller agencies in terms of access to opportunities to increase human capabilities.

5.6 Control over economic resources

Data from the government reports (DPW quarterly reports) demonstrate HCBC participants to be the lowest paid, with the slowest increment and sharpest fluctuations in stipend rates across the ten-year period of 2004-2014 (see Appendix F for details). 30 studies in my meta-analysis discuss caregivers' control over economic resources. Of these, a significant proportion of 25 studies report on the low wages of HCBC participants which reinforce findings in the government reports. Issues identified in these 25 studies

include: (1) the low amount of stipends received[34] (2) irregularity and unreliability of the payment process[35], and (3) lack of stipends with gifts in kind[36] given on rare occasions, such as free treatments [37] , gift vouchers and presents for children on celebrative occasions[38], token gifts from clients' family[39], short holidays[40], handouts[41] and end of year stipends[42]. Caregivers are paid a minimal or non-existent income and tend to be unemployed (refer to section 5.5.2). Limited financial gains from caregiving and its challenges are discussed by one of my respondents as such:

> *"I live with my child and my brother who is still schooling. I support them on my own because my mother is not working, she is at Eastern Cape and my grandmother is getting grant. The one who is putting food on the table is me, if the electricity is finished, I have to go find some money to go and buy it. If my brother need some lunch to carry school, I have to give it. Then for my child I have to pay for the preschool as well, it is 100R, the expenses are 350 R. I cannot afford, it is very expensive because I have a lot of things to do. That is why some other times I do extra job, so that I can afford some food. It is all my responsibility; I don't get anything from anywhere else. It hurt sometimes, because we just look at the wages, and we see, hey this month it is not going to go this far and this far, I just sometimes go to my uncle, but my uncle is married. For them they can't understand because you are working, they thinking how can you come and ask for whatever, so it is difficult to go and ask when they know that you have salary, you get paid every month so some other times I just decide that I have to do on my own." (Kagiso, Female, 27, caregiver)*

14 of the 30 studies[43], find caregiving to place financial burdens on caregivers. These studies identified three key areas where a drain on personal resources may be experienced: (1) travelling to/transportation of clients[44], (2) giving personal resources or incentives

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[34] Byenkya, Sebastian, and Oti (2008), Davids et al. (2009b, 2009a), Lance (2010), Mdhluli (2006), Moetlo, Pengpid, and Petltzer (2011), Sliep and Kezaabu (2011), Thabethe (2006),

[35] Fynn (2011), Lance (2010), Munakamwe (2009), Naidu (2011), Samson (2008), Schneider, Hlophe, and van Rensburg (2008), Sips et al. (2014), Thabethe (2006)

[36] Akintola (2004, 2005, 2006, 2008a, 2010), Campbell, Nair, et al. (2008), Hlengwa (2011), Muwaniki (2009), Naidu and Sliep (2011), Naidu, Sliep, and Dageid (2012), Naidu and Sliep (2012), Qalinge (2011), Singh et al. (2011), Sobuce (2007)

[37] Akintola (2004, 2005), Davids et al. (2009b), Vale (2012a, 2012b)

[38] Akintola (2004, 2005, 2006, 2008a), Akintola, Hlengwa and Dageid (2013)

[39] Akintola (2010), Sobuce (2007)

[40] Davids et al. (2009b)

[41] Akintola (2010), Sobuce (2007)

[42] Akintola (2004, 2005, 2006, 2008a, 2010)

[43] Akintola (2004, 2005), Mdhluli (2006), Muwaniki (2009), Qalinge (2011), Sips et al. (2014), Sobuce (2007), Thabethe (2006)

[44] Akintola (2004), Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell et al. (2010), Davids et al. (2009b), Gibbs et al. (2010), Gibbs et al. (2015), Munakamwe (2009), Naidu and Sliep (2011), Naidu, Sliep, and Dageid (2012), Naidu and Sliep (2012), Sips et al. (2014), Sliep and Kezaabu (2011), Sobuce (2007),

such as medicines, food, soap, blankets to clients[45] and (3) funeral costs[46]. Due to the above circumstances of poverty which HCBC has little managed to alleviate, many caregivers in my meta-analysis expressed the need and hope for stipends[47] to (1) purchase material needs for themselves and for expenditures on transport, food and materials for clients[48], and (2) ensure the survival and reproduction of their families[49]. Apart from being financially burdened by their altruistic intentions of resource sharing with their patients, work etiquette and expectations set by hospitals/healthcare clinics on caregivers also impose additional expenses on them (Davids et al., 2009a; Samson 2008; Munakamwe 2009).

It is possible to conclude from the above findings that low, irregular pay, heavy workloads and the social obligation to share limited resources with clients often place caregivers in a situation of poor economic condition with multiple care burdens. As such, there is consensus in my meta-analysis and pilot study that HCBC is limited in increasing the amount of economic resources caregivers can exert control over. Despite the unique circumstances of caregivers in terms of their geographical locations, living conditions, financial abilities and employment status, caregivers across a majority of the studies in my meta-analysis suggested that they struggle with control over economic resources and time due to the rather taxing but lowly paid nature of HCBC work.

The above is not to discredit the contributions of HCBC to empowerment, as a small number of 5 of 30 studies report instances where caregivers receiving adequate remuneration experience increase in control over economic resources, which translates into improvements in economic and social well-being (further discussed in section 6.1). These five studies reinforce the significance of a decent wage in facilitating caregivers' empowerment through HCBC. This contradictory outcome arising from my meta-analysis, attributable to differential economic gains through the HCBC, draw attention to how HCBC can turn into a case of Marais's (2005, 65) 'poor subsidising the poor', rather than one facilitating poverty alleviation of caregivers. As an intervention which has limited impact on the income and economic well-being of caregivers, one questions the extent to which socio-political gains can be achieved.

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[45] Fynn (2011), Munakamwe (2009), Naidu, Sliep, and Dageid (2012), Naidu and Sliep (2012, 2011), Sliep and Kezaabu (2011), Sobuce (2007)
[46] Akintola (2004, 2006, 2008a)
[47] Naidu and Sliep (2011, 2012), Naidu, Sliep, and Dageid (2012), Swartz (2013), Swartz and Colvin (2015)
[48] Akintola (2004, 2006, 2008a)
[49] Munakamwe (2009), Swartz (2013), Swartz and Colvin (2015), Vale (2012a, 2012b)

Two studies in my meta-analysis demonstrate exceptional cases of how HCBC facilitates the achievement of social gains which improves the economic well-being of caregivers. In particular, Naidu and Sliep (2011, 2012) and Naidu, Sliep and Dageid (2012) report that caregivers use caregiving as a platform to encourage alternative forms of income generating collective activities such as a stokvel (savings club) to supplement their income and achieve economic well-being. Caregiving encouraged the development of group identity and sense of belonging, with mutual trust and interdependence supporting collaborative endeavours in economic activities (Naidu and Sliep, 2012). In the case of Lance (2010), however, while caregiving led to income generating projects such as chicken raising, gardening and beadwork, these activities had limited success in achieving financial gains for caregivers. In view of the limited impact of HCBC on caregivers' economic well-being, there is scope for further analysis as to whether HCBC can instead encourage social gains which can potentially translate into income gains.

5.7   Access to infrastructure/assets/services

My meta-analysis demonstrates caregivers to be overloaded with care provisions for patients, many of whom are home-bound and would not otherwise have received care due to their inability (financial and/or mobility) to travel to healthcare facilities. 32 of 35 studies in my meta-analysis reported service delivery to be an issue influencing the conduct of care, with several of my interviewees affirming the importance of infrastructural delivery in supporting care delivery. Drawing on findings from my meta-analysis and pilot study, I seek to demonstrate that albeit having the potential to upscale care to poor households with sick people, the conduct of care under conditions of infrastructural and material shortage compromises on the socio-economic well-being, and hence empowerment of HCBC caregivers.

5.7.1   Physical infrastructure

Out of 32 studies on service delivery, 7 studies[50] which were conducted in rural provinces reported greater challenges in accessibility to patients due to limited/poor road access. Poor accessibility had a negative impact on caregivers' well-being as physical strain was reported by caregivers in seven studies[51], with Samson (2008) adding on financial burdens for the purchase of footwear. In the case of townships and informal settlements,

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[50] Byenkya, Sebastian, and Oti (2008), Campbell, Nair, et al. (2008), Fynn (2011), Grut et al. (2012), Lance (2010), Moetlo, Pengpid, and Petltzer (2011), Sobuce (2007)

[51] Akintola (2004, 2005, 2006, 2008b), Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell et al. (2010), Davids et al. (2009a, 2009b), Gibbs et al. (2010), Gibbs et al. (2015), Mdhluli (2006), Qalinge (2011), (Sobuce 2007), Vale (2012a, 2012b)

inaccessibility was attributed to inaccurate databases which led to difficulties in locating patients and more tedious journeys for caregivers (Akintola 2004, 2005). There was consensus among all studies that poor accessibility overstretches caregivers, negatively impacting on their social and/or economic well-being. A specific link between the lack of physical infrastructure and empowerment of caregivers was made by Zerden, Zerden, and Billinghurst (2006), reporting that transportation of patients in critical conditions to healthcare institutions is often a source of frustration and disempowerment for caregivers.

5.7.2 Urban services

The lack of urban services subjects caregivers to precarious working conditions. For example, the lack of water contributes to poor infection control (Davids et al., 2009b), while the lack of humane housing compromises care due to inadequate sanitation and water supply (Morton, Mayekiso, and Cunningham, 2013, 2015), both of which place caregivers at greater health risks to contagious diseases. The negative impact of inadequate urban services on the socio-psychological well-being of caregivers were not reflected in my meta-analysis, although the issue was evident in one of my respondent's discussion of her struggles as such:

> *"People who are living next to the stagnant water and it is smelly. Health wise it is risky, to the patient and to me as well. To the patient, wow they using their medication, then also it rains, it is stinky, and also she is using the water that is coming from outside, I think it is not acceptable. And also, the safety, from our patient, you know mostly we work with the HIV/AIDS ones, but now there is these rapes and stuff." (Retha, Female, 30, chaplain)*

Not only is Retha psychologically disturbed by the unsanitary living conditions of her patients, she is also worried about how conducting care under unhygienic conditions may affect her health, coupled with the fear of being raped while conducting care in insecure shacks. Similarly, Tariro (Female, 45, trainer and caregiver) describe how the lack of service delivery negatively influenced her self-esteem, as she migrated from a house in Eastern Cape to a shack in Cape Town and has been unable to move to more decent housing on her caregiver income:

> *"I came to Cape Town and to a shack, and it was something else for me. It can lower your self-esteem because now you have to live in a shack. And also from where I am coming from, shack is something that degrades people, for people who are poor, poor, poor, poor."*

It is evident from Tariro's response that the socio-psychological impact of inadequate urban services is exacerbated in situations where caregivers themselves are subjected to

similar living conditions as their patients. The inability of HCBC to uplift caregivers from their deprived living conditions results in the development of a negative image of themselves as poor, with negative emotional consequences. Social-psychological challenges experienced by HCBC caregivers due to limited access to urban services align with existing literature (Satterthwaite 2011, McIlwaine 2013, Moser and McIlwaine 2004, Chant and McIlwaine 2016) which suggest that women living in slums face various threats to their health, physical and mental well-being which compromise their empowerment. The above findings demonstrate how limitations in HCBC to improve the economic well-being of caregivers can translate into losses in socio-psychological well-being and power within oneself. There is a need to examine how the EPWP infrastructure sector can support HCBC delivery, in particular how the coordination of both types of services can bring about more decent working and living conditions for HCBC caregivers which can facilitate gains in self-esteem and socio-psychological empowerment.

5.7.3 Welfare provisions, medical supplies and educational resources

A lack of essential supplies can compromise care quality which in turn affects caregivers' social and psychological well-being. For example, food shortage places caregivers in a state of distress when caring for patients (Thabethe, 2006), a lack of educational resources compromises knowledge (Moetlo, Pengpid, and Petltzer 2011), while a lack of medical supplies increases caregivers' risks of contracting diseases (Akintola, 2004, 2006, 2008b). All of the above insufficiencies reduce caregivers' ability to provide care, which in turn compromises their self-esteem, power within oneself and empowerment.

5.7.4 Government funding

4 of 32 studies discussing service delivery[52] in my meta-analysis point to the lack of government funding resulting in the loss of hope among caregivers, demotivating and undermining their confidence in providing care. Six other studies[53] report insufficient and erratic material support to be disruptive to caregivers' work, with Mdhluli (2006) elaborating on the disappointment felt by caregivers when government did not deliver on their promises of food parcels and stipends. It is evident from my meta-analysis that government funding for a resource heavy programme such as the HCBC is essential in

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[52] Akintola, Hlengwa, and Dageid (2013), Kezaabu and Sliep (2011), Sliep and Kezaabu (2011), Akintola (2004, 2005), Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Gibbs, Campbell and Maimane et al. (2010)
[53] Naidu and Sliep 2011, 2012, Naidu, Sliep, and Dageid 2012, Thabethe 2006, Swartz 2013, Swartz and Colin 2015, Lance 2010, Samson, 2008, Mdhluli (2006)

providing caregivers with a safe and decent environment to provide effective care, which impacts on caregivers' confidence and self-esteem.

5.8   Self-esteem

Despite limited increases in employment status, control over economic resources and service delivery, caregivers in both my meta-analysis and pilot study experienced a sense of self-efficacy and satisfaction from having the ability to assist patients, albeit also reporting associated feelings which may decrease their sense of self-esteem. These negative feelings are (1) despair and hopelessness from witnessing patients' plight and (2) the vulnerability of being a lone female providing care for male patients.

In total, 29 studies in my meta-analysis discussed the impact of HCBC on caregivers' self-esteem, with 8 of these studies [54] reporting on the sense of satisfaction and achievement felt by caregivers from being able to provide help to others. Caregivers in the above studies also indicated feeling (1) informed, skilled, confident, effective and preparedness due to the training they received, and (2) valued by the community for their expertise, both of which contributed to developments in self-esteem. The importance of HCBC training to self-esteem is further supported by two studies [55] reporting insufficient training to exacerbate the sense of helplessness felt by caregivers placed under stress. Inadequate training lowers caregivers' morale, making them feel unequipped and unconfident about providing care (Morwe, Klu and Tugli 2013, Morwe and Ramaila 2012), and lacking in skills and social recognition to assert themselves in the community (Campbell, Nair, et al. 2008).

The positive contributions of HCBC to caregivers' development in self-esteem ('power within') is further supported by my pilot study. Two of my interviewees describe feelings of fulfilment from caregiving as such:

> *"I am a teacher in support group for HIV/AIDS. There are some people who changed, and some of them even come to me ask certain questions. I feel happy because the people they trust me." (Farai, Female, 33, support group facilitator/caregiver)*

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[54] Akintola (2004, 2005, 2010), Akintola, Hlengwa, and Dageid (2013), Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell, Nair et al. (2010), Campbell, Gibbs and Nair et al. (2009), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010), David et al. (2009a, 2009b), Lance (2010) and Schneider, Hlophe, and van Rensburg (2008), Muwaniki (2009), Sobuce (2008)

[55] Morwe, Klu and Tugli (2013), Morwe and Ramaila (2012), Campbell, Nair, et al. (2008)

"I feel special. [...] I gain nothing, only the lives I have saved, I feel like a God." (Mbali, Female, 25, caregiver)

Apart from developing self-esteem through the ability to exert a positive impact on patients' well-being (health and socioeconomic), caregivers in Akintola (2010) report emotional and psychological self-growth and discovery as they develop virtues of patience, compassion, non-discrimination and love through caring. Similarly, in my pilot study, Retha (Female, 30, chaplain) suggested the development of patience to be essential to carework, discussing her positive emotions when witnessing transformations in her patients as such:

"One of the fruits of the spirit is patience. You need to be patient about people. People, they are not easy. I know even myself, the others they can say I am not easy. [...] but you need to be patient with people, you need to love people, you need to show that love, and the love that is from your heart through Christ. Then for me, seeing people come to know the Lord, seeing people getting better and go back to their homes because it used to be at hospice whereby people know that they come here to die. But now we see a change, whereby people they know that they are not coming to die anymore. I feel like heaven, for myself it is like I feel that I am happy that when I get to work, there is this devotion."

Just as satisfaction is derived from the ability to render help, five studies in my meta-analysis suggest that caregivers experience feelings of inadequacy and grief on occasions that they are unable to meet clients' unrealistic expectations[56].

In addition, the impact of a professional image on caregivers' identity and feelings of self-worth is evident in four studies[57], reporting that the formalisation of caregivers' HCBC status which enables them to dress professionally increases confidence and self-esteem. Female caregivers who value their societally assigned caregiving roles and strongly believe in their efficacy as caregivers also experience an increase in agency as they create opportunities to increase their visibility and voice in the public sphere (Naidu and Sliep 2012, 2011, Naidu, Sliep, and Dageid 2012). The above study describes a unique case in my meta-analysis, as caregivers already have a strong sense of identity and support group to rely on, both of which enabled them to resist against their legitimising role as family

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[56] Akintola (2004, 2005), Vale (2012a, 2012b), Zerden, Zerden, and Billinghurst (2006), Sips et al. (2014), Munakamwe (2009)
[57] Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell, Nair et al. (2010), Campbell, Gibbs and Nair et al. (2009), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010) and Schneider, Hlophe, and van Rensburg (2008), Vale (2012a, 2012b)

caregivers, to construct an alternative, 'resistive identity' as community caregivers through HCBC.

Through my meta-analysis and pilot study, I identified three factors influencing the extent to which HCBC increases self-esteem: (1) the amount of community encouragement received, (2) the level of recognition given to the role of a HCBC caregiver within the community, and (3) the degree of support provided by superiors and caregiving peers. Supportive communities motivate caregivers while HIV/AIDS stigma which discourages disclosure tend to have an isolating impact on caregivers (Kezaabu and Sliep 2011, Sliep and Kezaabu 2011). Four studies reveal that caregivers who are (1) maligned by the community (Akintola 2004, 2005); (2) mocked and frowned upon by community members (Fynn 2011), and (3) downplayed for their caregiving efforts by family members (Thabethe 2006, Fynn 2011) and the professional community (Thabethe 2006, Samson 2008) often feel unappreciated for their work, which impacts their sense of self-esteem. Similarly, one of my respondents (Kagiso, Female, 27, caregiver) add that a lack of recognition and support can become a disappointment and discouragement to caregivers:

> *"it is difficult, sometimes you cry, because when you go to people's house, sometimes you find out they drinking, then they asking what do you come here for. You know that you want to help that person, it is more than a job just giving your time to help this person, and I feel down, sometimes I tell mama I give up now."*

Specific factors which were emotionally exhausting to caregivers were identified in two studies[58] as the death of patients and the prioritisation of work over personal issues. In addition, psychological and emotional burdens of care were raised in five studies[59], with three others[60] adding that witnessing patients' deterioration can remind caregivers of their own fragility and hence cause emotional stress.

Shifting the focus to men, two studies[61] find HCBC to have a negative impact on them, as male caregivers are often teased for being 'deviants' and unmanly. Such taunts also perpetuate gendered labour segregation which disadvantage women by confining them to reproductive roles. Female caregivers also experience other forms of vulnerability which

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[58] Davids et al. (2009a), Hlengwa (2011)
[59] Akintola (2004, 2006, 2008a), Akintola, Hlengwa, and Dageid (2013), Hlengwa (2011), Schneider, Hlophe, and van Rensburg (2008) and Vale (2012a, 2012b),
[60] Akintola (2004, 2006, 2008a), Kezaabu and Sliep (2011) and Sliep and Kezaabu (2011)
[61] Akintola (2004, 2006, 2008a, 2005)

impact negatively on their self-esteem, such as the (1) fear of being raped/sexually assaulted during home visits (Dworzanowski-Venter and Smit 2008, Mdhluli 2006, Vale 2012a, 2012b), (2) insecurity and vulnerability in homes (Vale 2012a, 2012b), (3) fear of theft/contact crime on journeys to clients' houses (Mdhluli 2006, Samson 2008), and (4) embarrassment of exposure to male nakedness (Thabethe 2006). Evident from the above findings is that HCBC can potentially promote emotional and psychological development which increases caregivers' self-esteem ('power within' themselves), especially when conducted within a supportive environment where caregivers can draw on the assistance of community members, superiors and peers to bring about a positive outcome on the well-being of their patients.

5.9 HCBC: Not a route to poverty alleviation but hope yet for employment

This chapter draws on a meta-analysis of 35 selected studies, pilot interviews and quantitative government reports to conclude that HCBC provides women with a small number of job opportunities with possibilities for career progression, albeit 'feminising' labour in terms of increasing women's employment in the lower paid care economy of healthcare, education and domestic services. With regards to the effectiveness of HCBC in poverty reduction, findings suggest that HCBC has had little success in increasing female caregivers' power over economic resources due to the low, irregular stipends provided. There are however rare instances where HCBC facilitated social gains among caregivers which resulted in improvements in economic well-being through income acquired from collective activities outside of carework.

The conduct of HCBC in resource-poor settings can result in HCBC transferring care burdens "into the 'invisible' zones of the home and the neighbourhood", as such making caregivers shoulder the hidden costs of care which are "deflected back into the communities and domestic zones of the poor" (Marais 2005, 67). In so doing, HCBC further limits caregivers' control over economic resources, at the same time perpetuating feelings of inadequacies to provide care among caregivers which compromises on their self-esteem. Where the conduct of HCBC is not hindered by financial constraints and inadequate training, caregivers report experiencing an increase in self-esteem, even in circumstances where they did not experience improvements in economic well-being through carework. A supportive environment can also contribute to further increase in caregivers' morale and motivation to provide care. From the above findings, it is possible to conclude that a well-supported HCBC programme can potentially provide caregivers

with opportunities for career advancements and self-development, having a positive impact on their socio-psychological well-being, which is essential for empowerment.

Chapter Six

The social impact of home community-based care

The purpose of this chapter is to discuss the social aspect of empowerment, in particular to evaluate the impact of women's poverty alleviation brought about by participating in HCBC on their power within the household and community spaces in which they participate, and the extent to which HCBC achieved its key goal of community participation. The chapter will be organised in four sections: the first elaborating on caregivers' decisions over household consumption, the second discussing caregivers' bargaining power within the household and community. The third section examines the contributions of HCBC towards caregivers' accumulation of social capital, with the fourth section discussing community participation in the aspects of involvement, activism and resistances, programme implementation and ability to intervene in policies.

Through my meta-analysis and pilot study, I find that HCBC's limited success in increasing female caregivers' power over economic resources (discussed in Chapter 5, section 5.6) limits women's decision making power over household consumption and their bargaining power within social relationships. In addition, while there is some increase in self-esteem or 'power within' oneself as discussed in the previous chapter, it is unclear that this has translated into 'power with' the community in the sense of active community participation in healthcare and programme implementation and policy design. I also report on the significance of an increase in social capital towards the effectiveness of HCBC programmes in facilitating empowerment.

6.1   Decisions over household consumption

18 out of 35 studies in my meta-analysis discuss the impact of HCBC on caregivers' decisions over household consumption. In six of the studies discussed below whereby caregivers were poorly remunerated, caregivers are unfortunately not in a position to make decisions regarding the distribution of material resources in their households (Fynn 2011), with several (Davids et al. 2009a, 2009b) describing their work as being a burden to their own families. The lack of ability to provide for their families is exacerbated when caregivers are also household heads and breadwinners and receive little assistance from their former partners for emotional, material, financial and caregiving needs (Akintola 2004, 2006, 2008a, Mdhluli 2006). With the inability to provide as a common concern, the ability to decide over material distribution within the household did not surface as a cause for worry among caregivers. On the contrary, despite their rather limited control on

material consumption within the family, caregivers express gratitude for familial support especially from male members, preferring instead to try navigating around their limitations and endure the lack of autonomy than to be subjected to financial inadequacy (Munakamwe 2009, Sips et al. 2014).

Five studies suggest that caregivers' decision making outside of the financial sphere is limited to the amount of time caregivers choose to dedicate to their households versus to their patients (Akintola 2004, Sobuce 2007). Women's choice to prioritise their patients does not imply that they would receive assistance on caring for their own families, with the above often resulting in guilt as caregivers feel that they are neglecting their own families for carework[62]. The inability to negotiate household responsibilities due to the highly feminised nature of carework in South Africa is also expressed by one of my interviewees as such:

> *"Sometimes if he is at home, he helps me. But sometimes I do it myself. Yes, I do most of it, washing and whatever, it is me. Yes, it is tiring, but there is no way out, I have to do it. My husband he is trying to sell some stuff when he has money, like socks and tights for ladies, he goes knocking on houses, tough. Because he is starting now, I don't want to put pressure on him. He used to work, but not all the time, he is not someone like me, I like to work, to go look for a job, but he is not like that, I think it is also his upbringing." (Tariro, Female, 45, trainer and caregiver)*

The patriarchal setting diminished women's ability to negotiate their contributions of reproductive labour to the household, with female caregivers being expected to shoulder the burdens not only within their own families, but also within the communities in which they live. From the response of Tariro, it appears that men's availability due to unemployment does little in terms of being a helping hand to the woman as a sole breadwinner, as men have greater freedom to prioritise job seeking or attempts to find paid work due to the gendered norm which recognises men as the breadwinner. When men contribute time towards household chores, the chores tend to be manual forms of labour, as described by two of my male interviewees:

> *"Yes, I am still useful in the house, that is why my parents still want me around. When things are not working in the house, I am the one they call to fix it. If I am not useful like this, they would have kicked me out, because our religious ideas are different, they are traditional, they think you have to worship your ancestors and Jesus together, but for me, I think the living should not fear and respect the dead." (Bongani, Male, 27, woodworker)*

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[62] Akintola (2004), Naidu and Sliep (2011,2012), Naidu, Sliep, and Dageid (2012), Campbell, Nair, et al. (2008), Swartz (2013), Swartz and Colvin (2015)

"My responsibility is to make sure that everyone is happy and the property is clean, fixing the shacks and all." (Kgosi, Male, 29, woodworker)

As such, despite having the freedom to decide on their participation in HCBC caregiving, women continue to lack decision making power in the distribution of household chores and responsibilities. Apart from not having the power to negotiate household responsibilities, gendered social norms also tend to limit women's decision-making within other aspects of the household, discussed by one of my interviewees who is a single dad as such:

"According to the culture, the father is always the head. You don't find ladies being the head, the one who is doing everything, and making the final decisions, it is always the father. It is our culture, the mother can't make decisions by herself, the father has got to be there, so my dad is still in charge. And when they get older, maybe that will be the time when I will be fully in-charge." (Bongani, Male, 27, woodworker)

Drawing from the above findings, HCBC appears to be reinforcing the feminisation of care through facilitating women's participation in community carework, further limiting women's ability to delegate domestic duties to men. Having little impact on women's economic resources and decisions over household consumption, HCBC subjects women to the double burden of care, relegating them to England's (2005) secondary and devalued role of a caregiver, instead of increasing their decision making power within the household. Furthermore, women's flexibility to decide on their contributions to community caregiving may be derived from the idea that men should not be interfering in the domain of care, since caregiving is a women's job. The distancing of men from care-related matters can perpetuate the normalisation of a gendered role segregation which further limits women's bargaining power over household responsibilities (see section 6.2 for further discussion).

On the other hand, in five other studies[63] where HCBC was reported to have some positive impact over caregivers' control over economic resources as caregivers were either paid a substantial or regular income (Vale 2012a, b), and/or have the financial support of male partners (Thabethe 2006), caregiving increases their sense of autonomy over household expenditures, with women showing greater freedom to spend on themselves. The importance of a regular stipend towards caregivers' increased decisions over household

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[63] Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015) and Gibbs, Campbell and Maimane et al. (2010), Munakamwe (2009), Samson 2008

consumption is reflected in the response of Tariro (Female, 45, trainer and caregiver) who described her paid employment as a care worker making her the key source of income and decision-maker in her household:

"I work, my husband don't. […] If you got job, you can buy a house, it comes together. […] Yes, I am the head of the household, I contribute to household, only me. I live with my husband and younger son. My other son is married, he lives on his own, my daughter is living with her boyfriend. My younger son is 15 and he is still in school."

In short, empirical findings show that while female HCBC participants often have some control over the allocation of their time to the household, their decisions over material consumption is dependent on various other factors such as the amount of money they bring home, their breadwinner status and the extent of male financial support. Given the level of poverty, the areas of contention generally relate to basic goods such as food, soap, toiletries and clothes which make up a significant component of the household budget (see Figure 10) (DPW 2014a). DPW (2014a) reports that among EPWP participants, men are more likely than women to spend money on (1) themselves for food, drinks, clothes, transport and socialising and (2) their families for water and electricity, while women have a greater tendency than men to expend their money on (1) food for the household, and (2) schooling and clothing for themselves and the family (see Figure 10). DPW's (2014a) findings match my meta-analysis which reports spending of women to be more on food for the family, schooling of children and clothes for themselves. As compared to DPW's (2014a) government data, my meta-analysis provide a more thorough understanding of how resources are allocated in households, and also consider the circumstance which influence women's ability to spend on their own needs and desires.
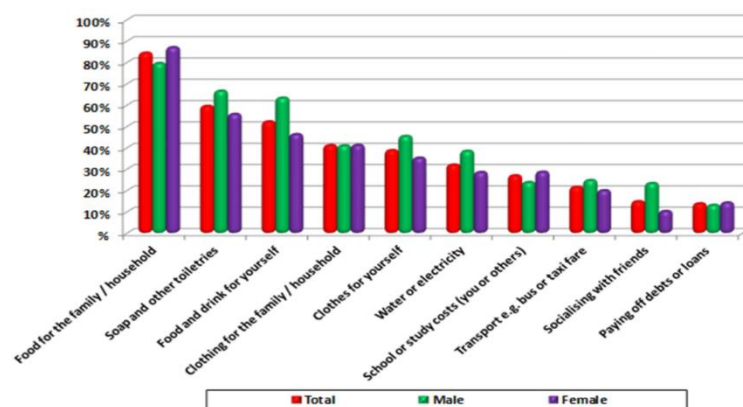

Figure 10: Expenditures of EPWP participants
`Source: DPW (2014a)*

6.2   Bargaining power

15 studies on bargaining power in my meta-analysis discussed the theme across various social dimensions such as the (1) distribution of caring responsibilities, (2) negotiation of safe sexual practices, (3) authority in intimate relationships, and (4) authority in caregiver-client relations. My analysis finds that gendered social norms and power over material resources play a key role in determining the bargaining power of caregivers.

6.2.1   Distribution of caring responsibilities

As discussed in section 6.1, the feminisation of caregiving and domestic responsibilities leaves women with little bargaining power in reallocating such tasks to men, whether it be within or without the household. Outside of the household and within the community space, men remain unwilling to assist in caregiving due to the gendered nature of the work, and where help is desperately sought and required, there tends to be a segregation of caring labour whereby men choose to offer help in the perceptibly more masculine tasks of transporting/lifting patients or providing financial support to cover the costs of care[64]. Not only is physical help for caregiving work (in the community and at home) unavailable to women, they are also expected to perform household chores in a timely manner (Akintola 2006, Munakamwe 2009). The presence of a gendered attitude towards the conduct of caregiving and household chores in South Africa is supported by SATUS (see Appendix D) which shows that women shoulder a disproportionate amount of care-related work within both the household and community.

In particular, despite women's time devoted to community services via the HCBC, this does not have much effect on the domestic division of labour within the home. Both SATUSs 2000 and 2010 (SSA 2001, 2013a) show that women continue to invest more than twice as much time than men in their conduct of household chores, regardless of having less available free time for these activities due to HCBC commitments. An analysis of employment status demonstrates that unemployed women invest more time into reproductive work compared to employed women and to men. Significant gender gaps in time devoted to domestic work has not changed despite six years of HCBC implementation, which suggests that women's bargaining power over the distribution of domestic roles and responsibilities remains limited. For example, one of my interviewees

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[64] Akintola (2004, 2006, 2008a), Muwaniki (2009)

state that she felt empowered only when working in the programme, and this does not transfer to the household:

> *"I feel empowered in my job, even though at home I am not feeling the same way because of what is happening at home, there is oppression. […] I am alone, I not happy of my home, because sometimes my husband just says nothing works, about care and this house, that doesn't make me feel happy. He does not do anything". (Farai, Female, 33, support group facilitator/caregiver)*

Despite HCBC's limitation in disrupting the gendered segregation of household chores, Thabethe (2006) discusses an exceptional case where HCBC gives visibility to the contributions of unemployed women to carework, with their perceived usefulness increasing their legitimacy and bargaining power within the community. A similar phenomenon is discussed by Naidu and Sliep (2011, 2012) and Naidu, Sliep, and Dageid (2012), where caregivers assume the identity of mothers to embrace their (socialised) caregiver role through HCBC, as a result restoring power associated with the traditional status of motherhood back to women. In both cases however, caregivers struggle for bargaining power through the performance of a socialised role, further reinforcing the finding that HCBC is unable to transform gender segregated norms within the household and community.

6.2.2 Authority in caregiver-client relations

5 of the 15 studies with bargaining power as a theme demonstrate power over material resources to be a key determinant of caregivers' bargaining power with patients and their families. In particular, control over and ability to provide material resources such as food parcels regulates caregivers' access to patients (Sobuce 2007, Akintola 2004,2005), while their role as gatekeepers to social grants and medical treatments endows them with authority over patients (Vale 2012a, 2012b). Conversely caregivers lose their power as a consequence of delays in welfare grants and their clients get very frustrated (Muwaniki 2009, Morton, Mayekiso, and Cunningham 2013). One careworker quoted by Morton, Mayekiso, and Cunningham (2013, 364) states that:

> *"There is nothing I can give them, like food and bandages, seems they get fed up".*

6.2.3 Negotiation of safe sex and authority in intimate relationships

Female caregivers' have little bargaining power in personal sexual relations (Dworzanowski-Venter and Smit 2008, Campbell, Nair, et al. 2008). In both studies, caregivers' attribute their limited authority in intimate relations to their lower earning power as compared to men's. Despite having experienced an increase in agency through

their participation in HCBC which preach safe sex to the community, caregivers report that this does not translate into an ability to negotiate condom use within their own relationships (Dworzanowski-Venter and Smit 2008). HCBC provides caregivers with a platform to assume the temporal identity of a confident woman with the power to negotiate safe sex, albeit not having any real impact on their personal relationships.

In three of the studies discussing the impact of gains in control over economic resources on caregivers' authority in intimate relations, findings were mixed. Positive outcomes of independence and tenacity to leave boyfriends and abusive partners to assume the role of a primary breadwinner, self-sufficiency and empowerment were reported in two studies[65], while one other study[66] suggests that caregivers continue to lack autonomy in their personal lives and safe sex. The above lack of consensus is attributable to social norms in the rural community the research is based which deviates from that in the other two studies, whereby caregivers describe men to have paid lobolla (bride-price) for them, obligating them to perform their sex duties with no room for negotiations.

My analysis suggests that being financially self-sufficient may have a role to play in increasing women's bargaining power within the household and the community, although underlying social norms and deep social bonds mean that the exercise of agency is limited, for example the ability to negotiate safe sex in their own relationships. Furthermore, caregivers' power in the community and with clients depends on their ability to provide access to material resources. The above draws attention to the importance of accounting for social dimensions when evaluating the impact of HCBC on caregivers' empowerment.

6.3 Social capital

In this section, I discuss the extent to which HCBC supports the formation of social capital and the impact on carework and caregivers' personal lives. Most of the 33 studies in my meta-analysis on social capital report similar findings that HCBC provides opportunities for the formation of social relations, although these new relationships cannot all be considered as a form of capital. I identify five types of social relations: between caregivers and the (1) community, (2) patients and their families, (3) caregivers' own families, (4) peer caregivers and healthcare professionals, and (5) other influential individuals in the

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[65] Vale (2012a, 2012b), Lance (2010)
[66] Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell et al. (2010), Gibbs et al. (2010) and Gibbs et al. (2015)

community. However, I find these relations in my meta-analysis to have a mixed impact on caregivers' livelihoods.

In particular, I draw on Coleman's (1990, 331) normative approach to social capital but add a gender perspective to illustrate some of the negative consequences deriving from social norms which can constrain actions. I show that social capital can have some negative impacts on the psychosocial health of community caregivers, especially within the context of HIV/AIDS where deaths are inevitable. With regards to the benefits of social capital, I adopt the network-based approach of Bourdieu (1986) and Lin (2001a) to discuss social capital as being embedded in networks of social relations. I focus on the networks created through community caregiving, questioning Lin's (2001b) contact and network resources accrued through caregivers' social relations. Apart from examining the socio-economic attributes of Lin's (2001b) contact resources, I seek to incorporate the psychosocial dimension which is integral to the aspect of caregiving. In so doing, I aim to add to the literature on social capital when applied to healthcare.

6.3.1 The development of social capital and benefits of social support

Community acceptance and support is a major determinant of the effectiveness of caregivers. In particular, support from caregivers' own households though the sharing of tasks by other family members is essential in enabling caregivers to provide high quality care, although this may only be possible in communities where community caregiving is recognised and supported (Davids et al. 2009b). Various forms of support from parents, churches and the community were identified by three studies [67] to be essential in encouraging care provision. The above findings are supported by my pilot study where caregivers receive a substantial amount of community support, especially through the church. Kagiso (female, 27, caregiver) describes how she benefited from the support given by the church community as such:

> *"If I in need of anything at some point, [...] I go to my fellow brothers and sisters in church because that is where I gain hope and everything. So I go to them and ask if I don't have anything, sometimes I go to my uncle, if my uncle refuse so I go to my church."*

This response reinforced findings in the meta-analysis that social capital facilitates carework as it provides emotional and material support, with the increased ability of caregivers to perform care increasing their socio-psychological wellbeing, as such

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[67] Morton, Mayekiso, and Cunningham (2013), Sobuce (2007), Fynn (2011)

enabling the translation of power with the community into power within oneself. In addition, the church community provides a fall-back position for caregivers where familial support is not available.

In many cases however, community support does not present itself in an all or none scenario. In three studies[68], caregivers paint the image of a supportive community whereby members help by making material contributions to patients to facilitate care. Trust among community members also facilitated community caregiving. On the other hand, instances of rejection by family members due to stigmatisation and a lack of support from the community were also reported. Similarly, in my pilot study, Kagiso (female, 27, caregiver) drew attention to the uneven support across the whole community, with the community church intervening to reduce the stigma displayed by some community members. Kagiso suggested that:

> *"because of the stigma, the other people they help the community but some other people in the community, I won't say the whole community, some other people they are just pointing fingers on the people that so and so is having this, and so and so is having that, that is why we find out so and so is working with someone else, that is why so and so is doing this and that, that is why so and so is so slim, because of his ART. That is why sometimes I just ask my pastor, I think it was this weekend, so that we can have someone working in the church but is not from the church, it is from the community but taking the community inside the church because that is where the people they can get hope."*

Apart from providing caregivers with opportunities to develop strong community networks, HCBC also supports the formation of relationships among peer caregivers (Morton 2013). In so doing, caregivers are able to enlist help from their peer networks, an encouraging example being reported by Sobuce (2007) whereby mutual help is observed between caregivers despite their attachment to different NGOs. Strong peer relations also promote learning as caregivers relay information to peers who missed training (Zulliger, Moshabela and Schneider 2014), and supports income generating projects (Lance 2010). HCBC encourages the formation of support groups or personal friendships among caregivers as a coping mechanism against isolation, rejection and seclusion (Qalinge 2011, Naidu, Sliep, and Dageid 2012, Naidu and Sliep 2012, 2011), with the development of strong networks facilitating caregiving. Relationships developed through HCBC are based on trust and commonalities (Fynn 2011), an example being through the shared role of motherhood which enabled a common identity to be created

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[68] Sliep and Kezaabu (2011), Kezaabu and Sliep (2011), Akintola (2004; 2005)

around a metaphor of love and mothering that describes the nature of carework (Naidu and Sliep 2011).

On top of strong friendships between caregivers, having a positive relationship with supervisors is also integral to caregivers' working experience. Caregivers who have better relationships with their supervisors and receive more social support seem to be more adapted to their roles[69], as a strong social network within healthcare settings can potentially overcome the negativity caregivers encounter in their community and increase the successful implementation of HCBC.

Not only are existing social networks helpful towards caregivers' work, caregiving can also encourage new social networks which may become useful to caregivers later. For example, in conducting carework as a cooperative, caregivers forge new social relations with neighbours, extended families of clients and traditional authorities, which may be useful towards facilitating carework or enlisting help in future (Sobuce 2007). HCBC has the potential to encourage (1) community bonding (Qalinge 2011), (2) the development of trusting relationships between caregivers, patients and families for disclosure (Akintola 2010, Ncama and Uys 2006, Ncama 2007), and (3) the formation of more stable intimate relations with fewer sex partners for both caregivers and patients (Ncama and Uys 2006, Ncama 2007). Similarly, my pilot study demonstrates HCBC to encourage the formation of supportive relationships with patients, discussed as such:

> *"I have learnt to be connected, close to people. In my life I have been close to people who are in church because most of the time I have been in church, so now I get close to people in the community, working with people, I just talk to them and be support to them so I just tell them that, 'no you can get through this, I have been there, I have been there, I have been there." (Kagiso, Female, 27, caregiver)*

Caregivers recognise the importance of forming social bonds with patients as a means of facilitating carework, with those in Zulliger, Moshabela, and Schneider (2014) using health talks not as a focal service, but a conduit into households. Through giving health talks, caregivers gain access to and develop friendships with the patients' families in a non-threatening way, thereby enabling them to reach out to sick clients. Caregivers also tend to be selected from the community as their social ties facilitate preventive and promotive work (Zulliger, Moshabela, and Schneider 2014, Lance 2010).

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[69] Munakamwe (2009), Morton, Mayekiso, and Cunningham (2013), Singh et al. (2011), Zerden, Zerden, and Billinghurst (2006), Schneider, Hlophe, and van Rensburg (2008)

The importance of developing trusting relationships in facilitating disclosure is a key concern of the HCBC organisation I conducted my field work, evident in its emphasis during the HCBC training course. Formation of trust as a precursor to successful care through developing relationships and displaying a positive, non-judgemental attitude, are repeated by my interviewees:

> *"I start a relationship with that person not wanting to talk to me or whatever to hear, if I say I am a chaplain or pastor, and then I go the second morning and I greet that person, [...] and then 'oh yes my pastor, I miss your smile or whatever'. You know people are depressed, they need people that are patient." (Retha, Female, 30, chaplain)*

> *"People who are HIV positive are not facing HIV only. Sometimes they don't want to disclose because they know what is happening at home. And if there is domestic violence, then it is not going to be easy for them to disclose. When you say 'you must disclose' then that 'you must' is not proper, because if you say to someone 'you must', then that is a force. Sometimes you can just close your mouth and listen, because people sometimes they don't want you to try and sort their problems. They want to talk, they want someone who is going to listen to them" (Tariro, Female, 45, Trainer and caregiver)*

It is evident from my findings that adopting the role of a caregiver has facilitated the formation of social capital, as caregivers adopt a positionality and personality which allows them to reach out to the community. In so doing, caregivers develop strong ties with patients, with trusting relationships facilitating disclosure and sharing, further strengthening the relationship and creating an enabling environment for providing care, which can in turn impact on the socio-psychological well-being of carers.

New social networks are also created between organisations where HCBC provides opportunities for engagement in quarterly networking meetings which promotes the development of relationships with other service providers and partnerships with member organisations and key community stakeholders (Byenkya, Sebastian, and Oti 2008). For example in Schneider, Hlophe, and van Rensburg (2008), caregiving acts as a base for enabling access to wider community networks of support such as policing forums and municipality committees. It also enables the development of a sense of solidarity amongst grassroots residents and local leaders, with the strengthened partnership enabling the push for more effective HCBC implementation[70]. Apart from enhancing cooperation between member organisations, HCBC also acts as a platform for connections with government

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[70]Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell, Nair, and Maimane (2007), Campbell et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010)

departments, in return benefiting the programme through increased access to government related services (Byenkya, Sebastian, and Oti 2008). The networking functionality of HCBC is also observed in my pilot study, where carework adds legitimacy to the FBO to become part of a connected network (MasiCorp) of NGOs, CBOs and government organisations, working together to provide for the overall well-being of poor residents of Masiphumelele.

In addition to intra-organisational partnerships, findings in five studies[71] show that HCBC facilitates the formation of strong inter-organisational relationships which in turn increases successful implementation. In particular, the development of strong relationships with employees in community healthcare facilities (Fynn 2011, Sips et al. 2014), and well-resourced people with social and professional networks (Swartz 2013, Swartz and Colvin 2015) facilitates access to working materials and provides a 'transient platform for upward social mobility' (Vale 2012a, 75).

6.3.2   Social cost of social capital

Communities with strong social ties are more likely to be familiar with individuals and their personal circumstances, making it difficult to keep secrets and caregivers better known. High visibility and social recognition within the community become drawbacks when caregivers feel a need to fit into the socio-cultural image of caregivers as being stronger. In so doing, caregivers may delay/forgo seeking help, tending to be reluctant to report their physical and health problems and hiding their ailments more so than other less visible members of the community. The above is evident in three studies[72] conducted in close-knit communities, where caregivers reject HIV/AIDS treatment to avoid embarrassment, and maintain silence about their own concerns, not wishing to appear insensitive to sick clients. In my pilot study, Mbali (Female, 25, caregiver) supports the above finding, commenting that female caregivers are strong as they are capable of suppressing their personal struggles to portray an optimistic outlook when facing patients:

> *"Men have power in hands, women have power in mind. A woman can handle a bunch of things that a man couldn't stand. A woman, you cannot see that this woman is in pain, a woman they can smile in front of you, but when they turn their backs they are crying. But when they come to face people, they can pretend everything is okay. But men, you can see that something is wrong with them." (Mbali, Female, 25, caregiver)*

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[71] Fynn (2011), Sips et al. (2014), Swartz (2013), Swartz and Colvin (2015), Lance (2010), Vale (2012a, 2012b)

[72] Grut et al. (2012), Zerden, Zerden, and Billinghurst (2006), Akintola (2004, 2006, 2008a)

In providing care, strong social relations also hinder caregivers from taking necessary precautionary measures to protect themselves, such as the refusal to use gloves which are perceived of as a sign that they do not love the sick (Akintola 2004,2006,2008a). Close personal relations with patients also increase caregivers' anxiety and worry over patients' health (Akintola 2004, 2006, 2008a, Akintola, Hlengwa, and Dageid 2013), an effect which tends to discourage reciprocity in caregiving (Kezaabu and Sliep 2011, Sliep and Kezaabu 2011), or depersonalisation and insensitivity towards patients' plight as a protective mechanism against stress (Akintola, Hlengwa, and Dageid 2013). On the other hand, where caregivers attempt to distance themselves from patients to prevent grief, the patient-caregiver relationship may become tenuous and fragile, thereby hindering the performance of care (Vale 2012a, 2012b). Caregivers' emotional stress of witnessing deaths is also exacerbated by community members who question their competency with frequent patient deaths (Akintola 2004, 2005).

Apart from dealing with patients' decline especially in cases of HIV/AIDS, caregivers working among communities with high network capital facilitating efficient information flows also tend to experience higher stress levels due to increased stigmatisation, as they are recognised by the community as being associated with the disease (Hlengwa 2011). In my pilot study, Tariro (Female, 45, trainer and caregiver) described her decision to quit her community leadership role due to its hindrance to the establishment of trust necessary for carework:

> *"I was working in the community and also working around HIV/AIDS. Then I said no, if I am going to be involved in the community, that is going to cause a lot of problem. People won't trust me when I was going to be around a lot of people. Then people won't want to come and disclose about HIV status."*

In some instances, close-knit communities may adopt particular social norms which hinders care work. For example, gendered lines of care is strongly guarded by the community in Swartz (2013) and Swartz and Colvin (2015), with the pastor being the only individual able to cross the line due to his identity as a pastor. The gender segregation of work hinders female caregivers from exploiting strong community ties to garner assistance from male members of the community for their carework (Swartz 2013, Swartz and Colvin 2015, Muwaniki 2009). Across the three townships I conduced my pilot study, interviewees relate the presence of a traditional male breadwinner norm which discourages men from conducting domestic carework and confines women to reproductive roles. For example, Ntombi (Female, 40, unemployed) describes

expectations from her husband for her to become a stay-home-wife, as a condition for him to migrate to, and settle in Cape Town with her and their child:

> *"Women they stay at home to look after the children. Some of them they go work, some of them they stay at home to look after the children. Their husbands go work. The man, they have to go work, all the man they work. He used to say to me, look I will come here (Cape Town), but you mustn't go work, you must look after the children, send the baby to school, maybe in time we can find a new home, life is a little bit better for me. Most of the man they work outside Cape Town. He and the man are working, most of the man are working. Those who are not working is maybe they don't find a job or they are lazy".*

In Ntombi's narrative, men's expectations for women to conduct carework is also informed by social norms which place the breadwinner role on them, obliging them to engage in productive work or be perceived of as being unemployable or lazy. The guarding of such norms in communities with strong social networks hinders male participation in carework, making it difficult for women to draw on the assistance and availability of men. In addition, social perceptions of men as being naturally inapt in carework can perpetuate a feminisation of care as male involvement is discouraged, discussed by Retha (Female, 30, chaplain) as such:

> *"Men do care as well, but mostly the women are very committed on it. It is not that men they not doing it [care] properly, sometimes they not available, but women always available and they got their responsibilities. [...] the women have experience, it is like when we talk about the word of God, and we are people that they can talk, men they talk less you know. Most of them they like to be in pulpits, they like to preach, to say something, not to spend time doing this. But to us as women, it is our nature to talk to people and to want to listen to their stories and to help, we got that heart of helping each other. With the man they run away to look for the work that they can do it properly according to the attitude they got, because this thing of spending time with patients/clients, talking about them, is not in their nature."*

It is evident from my meta-analysis and pilot study that a traditional male breadwinner notion places the burden on men to earn a regular, substantial income to support their families, a criterion which carework does not satisfy, thereby providing both an explanation and a justification for their lack of participation in care. In addition, social norms tend to naturalise the caring role as one which is suited to women because of their attitudes, nature and experience, a role which men are unable to do as effectively as women, further perpetuating women's role as carers. Strong community networks tend to uphold such gendered social norms, further disadvantaging female caregivers, many of whom are female breadwinners. Community perception of female caregivers as

secondary income earners downplays the importance of their productive roles towards supporting the reproduction of their families, as such perpetuating the exploitation and under-remuneration of HCBC caregivers who are mostly women. On the other hand, in cases whereby caregivers receive just and regular payment for their HCBC work, adherence to gendered norms may exclude men and hence retain more opportunities for women.

In my pilot study, the recognition of women's productive roles did not bring about a decrease in their reproductive work. Retha (Female, 30, chaplain) describes women as the backbone of families and communities, having the ability to conduct both productive and reproductive roles, to

> *"do something out of your own without somebody, […] sharing the knowledge that you have got to others so they can share it to others, in order for us to keep life going on and on."*

Assigning power to women to "keep life going on and on" imposed additional responsibilities on them. The strength of women came to be measured against their abilities to transcend the challenges associated with absent fathers and partners, to procreate a generation of productive individuals. For example, two of my interviewees describe strong women as independent single mothers as such:

> *"Women are very strong, to any kind of situations women are very strong, whether you are illiterate, whether you are highly educated, women are very strong by nature. There are so many households that are leading by women, even if you can go next door and another next door, you can find out, there is a single woman with a kid, no husband, single woman with a kid, no husband, single woman with a kid, no husband. Single women household heads are stronger than women in relationships. If you are alone as a woman, then you know what you want, you can just think your own. […] In our culture, you cannot decide yourself as a woman, you have to wait your husband to tell you what to do. Even you got your own ideas, they always suppress our ideas. For me, relationships didn't work." (Neo, Female, 43, caregiver/social work student)*

> *"Yes women we have power, because women we have kids sometimes, and we grow kids on our own. Like me, I do everything alone, everything is me, if there is meeting in school is me, if there is something they want to do it is me, I feel very great doing things myself." (Nyarai, Female, 58, dressmaker)*

From the above interviews, their image of an empowered woman is one who can manage their productive and reproductive roles, one who has successfully resisted against the male breadwinner normative. Women are expected to fulfil their nurturing roles, and at the same time earn a living wage to nurture their families, with the failure to meet such

expectations often resulting in a negative perception of them as bad mothers. Such gender segregated norms places a triple burden on caregivers who find themselves having to juggle familial responsibilities, community caregiving and productive employment.

Apart from gender biased norms, caregivers are also confronted by sociocultural norms around age which is difficult to transgress especially when they administer care through home visits. Differential treatment of caregivers by patients and their families depends on caregivers' age and can often influence the quality of care provided, as the suggestions and recommendations of younger caregivers tend to be ignored (Vale 2012a, 2012b). Zulliger, Moshabela, and Schneider (2014) provides another example of an age barrier being a hindrance to care as young women who discuss taboo topics such as sex are often subjected to community discrimination, thereby impeding the informational, educational and communication activities of younger female caregivers. In my pilot study, Kagiso (female, 27, caregiver) discuss challenges encountered in administering care by nature of being a woman:

> *"Men, they are very stubborn. You can tell a man that you have to take your medication. And then the next day, he is not taking the medication. Then you meet him in the street drinking. […] The attitudes of males are different in the group, even in the community. […] The females they like to listen […]. That is why I think we also need man facilitators who look after the male side because we don't know what they are dealing with. Because if you interfere about the man, they will just say 'oh you are a woman, I can't tell you everything.' You see it is like that in our culture, I don't know about any other culture, but for us to go and interfere about being a man, it is uncomfortable for them to tell us everything. But for a woman to interfere about being a woman and how is it like, it is free for us to tell you everything that is happening."*

Another sociocultural barrier is on religion, as discussion of preventive topics which involve the use of condoms leads to caregivers' losing social support from church affiliated HCBC organisations (Zulliger, Moshabela, and Schneider 2014). Evident from the meta-analysis and pilot study is that communities with strong social relations tend to uphold social-cultural norms around gender, age and religion, making it more challenging for HCBC caregivers to perform care, and experience improvements in their economic and social well-being through carework.

6.3.3 Impact of an absence of social capital

Stigma, discrimination and social isolation due to their association with HIV/AIDS have been reported by caregivers in six empirical studies[73], resulting in little psychological and physical support from relatives, friends and neighbours (Qalinge 2011, Kezaabu and Sliep 2011, Sliep and Kezaabu 2011) and making the job difficult for caregivers (Thabethe 2006). HIV/AIDS induced social stigma also led to community caregivers being perceived by the community as gossipers and dangerous, since having a personal relationship with caregivers would by association be equivalent to disclosing one's HIV status. As for caregivers, involvement in care associates them with HIV/AIDS and leads to community stigmatisation, discussed by one of my interviewees as such:

> *"it is not easy, to tell the truth, because if you work in this position I am working, people they know that maybe she is positive, no, it is not a maybe, she is positive because she is working as a support group facilitator, so that is a stigma that you get. And at that time I was sharing with them, one of my colleagues they ask me 'why are you working as a facilitator, I just thought maybe you are HIV positive'." (Kagiso, Female, 27, caregiver)*

Stigma hinders the development of strong social ties through carework, as patients and families demonstrate more caution in their interactions with caregivers (Vale 2012a, 2012b). Apart from stigma, a divided and unsupportive community disrupts social capital formation through HCBC (Fynn, 2011), in turn making caregivers' work more challenging due to rejections and negative reactions[74].

While HCBC is reported to facilitate the development of strong relationships between caregivers and supervisors (see section 6.3.1), five studies[75] in my meta-analysis report that such is not often the case. Caregivers experience a lack of support from facilitators and supervisors (Davids et al. 2009a) and disrespectful treatment by professional nurses (Samson 2008, Schneider, Hlophe, and van Rensburg 2008), both of which cause distress and inhibit the practical application of knowledge acquired through training into caregiving (Mdhluli, 2006). These negative consequences of weak supervisor relations negatively impact on caregivers' self-esteem, social well-being and hence empowerment.

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[73]Campbell, Nair, et al. (2008), Moetlo, Pengpid, and Petltzer (2011), Naidu and Sliep (2012, 2011), Naidu, Sliep, and Dageid (2012), Qalinge (2011), Kezaabu and Sliep (2011), Sliep and Kezaabu (2011), Thabethe (2006)

[74]Akintola (2004, 2005), Moetlo, Pengpid, and Petltzer (2011), Sobuce (2007), Vale (2012a, 2012b),

[75] Davids et al. (2009a), Mdhluli (2006), Samson (2008), Schneider, Hlophe, and van Rensburg (2008), Fynn (2011)

Just as strong social relations with colleagues are integral to quality care (see section `6.3.1), the contrary holds. Five empirical studies[76] find that competition for economic rewards and advancement and the guarding of professional knowledge tend to occur in organisations using caregivers with varying status, qualifications and stipends, leading to discouragement, lack of cooperation and relationships laced with distrust, territoriality and indebtedness. Competition disrupts caregivers' social gains in terms of the formation of social relations, the lack of which hinders cooperative partnerships and the provision of quality care, in turn influencing caregivers' self-esteem.

6.4   Community participation

In this section, I draw on a large subset of studies in my meta-analysis which paid attention to community participation in terms of involvement, activism and resistance (N=21), decision-making in programme implementation (N=20), and influence over social and economic policies (N=14). I draw attention to authoritative organisational structures in HCBC organisations and hierarchical practices of healthcare institutions as having a stifling effect on the agency of caregivers to intervene in programme implementation, so undermining their empowerment.

6.4.1   Community involvement

Community participation is limited to engagement by the church, local health facilities, civil based organisations, referral of patients to caregivers and NGO activities[77]. The form and extent of the involvement varies, but it is clear that involvement of the community in the recruitment process increases community support for care workers and ensures that caregivers have local knowledge[78]. This recruitment process increases community acceptance and participation in care-driven activities, in turn increasing the support caregivers' receive in carework (see section 6.3.1) and having a positive impact on caregivers' self-esteem (see section 5.8). The significance of having local knowledge was evident in my pilot study, for example with Retha (Female, 30, chaplain) who emphasised that even though she did not stay within the informal settlement in which work was

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[76] Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair, et al. (2008), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010), Kezaabu and Sliep (2011), Sliep and Kezaabu (2011), Lance (2010), Swartz (2013), Swartz and Colvin (2015) and Byenkya, Sebastian, and Oti (2008)

[77] Davids et al. (2009b), Vale (2012a, 2012b), Sobuce (2007), Morton, Mayekiso, and Cunningham (2013), Schneider, Hlophe, and van Rensburg (2008), Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Zulliger, Moshabela, and Schneider (2014)

[78] Ibid.

conducted, she was asked to serve in the community due to her familiarity. In her own words:

> *"I came here to study theology, it was 2004 and I finished 2007. I went back to the Eastern Cape but this organisation called me to come down to work for them, because when I was still in seminar, I was doing my internship in this settlement".*

Another area of participation is community education which is considered to be effective in terms of increasing community awareness of HIV/AIDS[79], facilitating preparedness of communities to accept the disease and take on preventive measures[80], developing more positive attitudes among the micro-communities (consisting of family/friends, neighbours, church relations, work/school group) of the HIV/AIDS patient, facilitating caregivers' access to patients [81], and encouraging both community members with HIV/AIDS and caregivers to be involved in awareness and advocacy activities[82]. In particular, local leaders consider community caregivers to be the bridge between them and the community, while community support and participation in caregivers' activities further increases caregivers' confidence and recognition in the field of HIV/AIDS[83]. Drawing from the above findings, HCBC is effective in promoting community participation through educational/awareness creation activities, and is especially effective in the case of HIV/AIDS as it promotes acceptance, disclosure and safe sexual practices which are messages that the HCBC programme intends to disseminate. The above suggests that community education can be used to address issues associated with stigmatisation and low social capital due to community rejection of HCBC caregivers (as discussed in section 6.3.3). On the other hand, some studies[84] point to the presence of strong community spirit upholding strict social norms posing as barriers to effective community education. HIV is considered to be a hush topic not to be openly discussed

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[79] Ncama and Uys (2006), Ncama (2007), Smit (2008)
[80] Ncama and Uys (2006), Ncama (2007), Smit (2008), Akintola (2010), Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010)
[81] Ibid.
[82] Ncama and Uys (2006), Ncama (2007), Smit (2008), Campbell, Gibbs, et al. (2008), Campbell et al. (2009), Campbell, Nair, and Maimane (2007), Campbell et al. (2010), Gibbs et al. (2015), Gibbs et al. (2010)
[83] Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell et al. (2010), Gibbs et al. (2015), Gibbs et al. (2010)
[84] Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010), Zerden, Zerden, and Billinghurst (2006)

among the community. In this case, educational resources and activism did not make much difference to the dynamics of secrecy and stigmatisation related to HIV/AIDS.

6.4.2 Caregivers' activism and resistance

Despite the difficult and hazardous working environment and the low and often delayed payment, activism and resistance among HCBC caregivers is rare. There are occasional demonstrations such as in Orange Farm township in Johannesburg but both strike attempts by caregivers were terminated prematurely and did not amount to any significant changes in their power to intervene, but instead reinforced their state of powerlessness (Samson 2008, Munakamwe 2009). There was one case where caregivers successfully went on a two week strike when the training and debriefing sessions which DoH had promised to them was not implemented (Schneider, Hlophe, and van Rensburg 2008). Caregivers expressed resentment towards government officials' lack of delivery, remarking that:

> *"he should bring police officers and body guards the day he decides to visit us, because he might not survive on his own. People are very dissatisfied with the way he does things" (Schneider, Hlophe, and van Rensburg 2008, 184)*

This statement is rather bold in light of most of the evidence which portrayed HCBC caregivers' activism to be difficult and almost impossible to organise. However, it is unclear what the outcome of the strike was or its impact on subsequent programme implementation, which is a significant gap in the literature.

6.4.3 Intervene in programme implementation

Caregivers have little agency in determining how the HCBC should be implemented and their attempts to demonstrate dissatisfaction and voice their opinions are often thwarted by authorities or hierarchical structures. HCBC caregivers feel unable to do anything about the lack of support from HCBC organisation (Davids et al. 2009a, Moetlo, Pengpid, and Petltzer 2011) and have little involvement in decision making processes in the programme (Qalinge 2011). Caregivers who were given little supervision felt that they had no control over supervisors who withheld information from them, as they had no one more senior to turn to (Moetlo, Pengpid and Petltzer 2011). Caregivers also lacked control over the limited psychosocial support they get, feeling that they are unable to communicate everything to their facilitators as they are afraid of being judged (David 2009a, Akintola 2004, 2006, 2008a). Rather, caregivers feel stifled by the hierarchical structure of management and reporting, being expected to be on-site without fail, given

only limited control over the scheduling of their work, unable to raise dissatisfaction over the irregular distribution of stipend, and not given a say over care pedagogy (Vale 2012a, 2012b, David et al. 2009b).

Community participation in HCBC is thus conducted within 'invited spaces' constructed by the implementing organisations and partner healthcare institution, whereby caregivers are expected to play by the rules set for them and to practice silence with respect to their own interests and the way the programmes are run. Drawing from the above studies, it is evident that the lack of clear communication and career progression compromises the agency of caregivers, as they receive inadequate support for their tough caring job, are intimidated by the authoritative structure of HCBC implementing body, have no say over HCBC programme implementation or any power to suggest changes and so they have to suffer in silence. In addition, gender bias also hindered caregivers' attempts to intervene in the running of HCBC, and female caregivers reported a lack of ownership since the project is run by a small group of men who would not permit any female caregivers to take on leadership positions[85]. In being denied management/decision making positions, female caregivers were unable to play an active role in the project, despite having invested time contributing towards the healthcare goals of the organisation.

One NGO, HIVAN was however different as it tried to provide more support for caregivers and resist gender biases imposed by the community and its civil-based organisation. Despite HIVAN's efforts to develop and encourage more democratic working styles among the leadership, little success was evident as the task of challenging community norms as an external organisation proved to be ineffective, and caregivers reported feeling demoralised when their problems remained unaddressed despite being passed on to superiors[86]. A lack of acknowledgement of women's abilities to be leaders provided one explanation for the gender biases above, and discussed by one of my interviewees:

> *"There will be people, especially if you are woman, who can even not understand that you can be a leader as a woman. [...] but there are also people always encouraging me. Even men, they say that "you well done, you are doing it as a man, you don't need a man to do it.' Even to be a pastor*

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[85] Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010)

[86] Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair, and Maimane (2007), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015), Gibbs, Campbell and Maimane et al. (2010), Samson (2008)

as a lady is a challenge. Now I can praise the lord seeing that God can use woman as a leader. In
my culture it is not common for women to be leaders." (Retha, Female, 30, chaplain)

It is clear leadership is still perceived as a male domain, and that women who lead well are considered to be "doing it as a man". On the other hand, two of my interviewees added that women are often the ones upholding gender biased norms impeding women from leadership:

"The other challenge we face as women leaders is that sometimes you can see that you are
undermined by women. You see that people that are giving you hard time are the other women,
instead of challenge with the men. You can see those who undermine you are women. Maybe they
approve the style of the man, they think there can't be a women pastor, they think I can speak to a
man because it is dignified. Women can give you hard time, I don't want to lie. [...] women are
putting us down, it is hurting." (Retha, Female, 30, chaplain)

"I used to be a committee member, like a leader. I feel a lot of pressure being a leader as a woman,
and also women do pressurise other women themselves, we do put down other women. I don't
know whether we don't have confidence or what, but we do trust if it is a man. But if it is a woman,
they talk a lot of stories." (Tariro, Female, 45, trainer and caregiver)

My findings suggest that community caregivers appear to be stuck in the rut, often having to endure the hierarchal oppression of their workplace as they are left out of decision making on programme implementation, and feeling powerless to alter the system despite making efforts to take radical actions for change as discussed in section 6.4.2. Despite the above, caregivers comment that they are unable to walk away from the system as they are bounded by a responsibility towards their patients, which spurs them to endure their disadvantaged positions in their workplaces[87].

Hierarchy and seniority in the healthcare setting is established though task allocations and training/experience, the lack of which often compromises the legitimacy of caregivers[88], and hence their inability to intervene in programme implementation[89]. The powerlessness of caregivers is further exacerbated by the autocratic and hierarchical leadership style adopted by those in control. For example, the community leader reported in Campbell and Nair (2008) thwarted grassroots mobilisation which sought to disrupt gendered socialisation, while younger carers in Swartz (2013) and Swartz and Colvin (2015, 145)

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[87] Ibid.
[88] Zulliger, Moshabela, and Schneider (2014), Qalinge (2011), Sobuce (2007), Naidu and Sliep (2012), Schneider, Holphe, and van Rensburg (2008)
[89] Hlengwa (2011), Naidu and Sliep (2012, 2011), Naidu, Sliep and Dageid (2012), Akintola, Hlengwa, and Dageid (2013), Mdhluli (2006)

were denied control over the HCBC programme implementation as more senior people such as the manager insist on being "the one in control". Nurses also tend to behave like 'bosses', rarely giving HCBC caregivers credit for their contribution to patients' wellbeing', upholding a hierarchical system which makes caregivers feel isolated and unappreciated (Vale 2012a, 2012b, Schneider, Hlophe, and van Rensburg 2008). Likewise, the relationship between donors and NGOs can be hierarchical:

> *"exposing the divide between those at the hem of the purse and the policy, and those who were supposedly meant to be engaged in schemes of improvement."(Lance 2010, 108).*

The strict demarcation in ranks between funder, NGO and caregivers makes it difficult for caregivers to voice their unhappiness. Occasionally, caregivers are free to determine the types of treatments for HCBC patients and refer patients to clinics for treatment as and when they deem necessary. This occurs especially when good working relationships have been established with the nurses at the clinic, further reinforcing the importance of social capital formation in enhancing the effectiveness of HCBC, which has an impact on the socio-psychological well-being of caregivers (see section 6.3.1) (Sobuce 2007).

6.4.4 Influence over polices and legal representation

Turning from the community to the national level, studies show that HCBC caregivers have little influence over the development of HCBC. Rather, the development of HCBC's policy is dominated by politicians and, a political process which neither reflects nor consults the perspective of civil society (Daniels, Clarke, and Ringsberg 2012). Despite this lack of consultation, community members are still expected to take ownership of their role as socially responsible citizens and contribute to the programme with limited government support[90]. Caregivers' contact with the government is limited to the making of referrals and applications for social grants for their clients[91]. Apart from that, caregivers are subjected to distancing governance mechanisms which they have no power to change or use to improve the livelihoods of their clients (Vale2012a, 2012b).

The lack of a formal title for HCBC caregivers often leads to a multitude of different titles being used to describe the role, such as CHW, HBC worker, community-based worker (CBW), community development worker (CDW). The different terminologies cause confusion and downplays some of the titles as newer ones are created (Lance 2010,

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[90] Naidu and Sliep (2012, 2011), Naidu, Sliep, and Dageid (2012), Qalinge (2011), Sobuce (2007), Vale (2012a, 2012b)
[91] Akintola (2010), Sobuce (2007) and Vale (2012a, 2012b)

Mdhluli 2006). Within a hierarchical HCBC environment, the lack of accreditation diminishes caregivers' ability to influence policy. In particular, caregivers are often used as space fillers in meetings and not given opportunities to contribute, making them feel invisible and undervalued (Mdhluli 2006). In addition, as a role which is not professionally recognised, the work of caregivers lacks legislative and regulatory standards and are subjected to little protection rights[92]. Owing to the lack of labour laws governing caregivers' employment, caregivers are often over-extended and over-exploited as they are made to take on heavy workloads and non-care related tasks (Davids et al. 2009b, Samson 2008).

Caregivers would legally fall under the Ministerial Determination for Welfare Sector[93] which grants employee rights and benefits as afforded by labour legislation, or to the Codes of Good Practice for South African Non-Profit Organisations. The complexity of the contracting process and the lack of education of caregivers would however hinder them from understanding the policy objectives, acknowledging their legal rights and mobilising for their employee rights, especially without the support or representation of their contracting agencies (Daniels, Clarke, and Ringsberg 2012, Munamakwe 2009). Furthermore, caregivers' ambiguous employment status compromises the extent to which they would be covered by the above two legislative acts, the first of which is specifically targeted at employees in the welfare sector. As such, HCBC caregivers often lack status and legal representation, and have little say over the terms of their employment[94].

Caregivers' limited negotiating power may also be attributable to a contracting structure (partnership between government and non-government sectors) which avoids the employment of caregivers directly. In cooperating with external agencies (NGOs/NPOs/CBOs/FBOs) to implement HCBC, contracted caregivers "may receive a stipend but not be government employees" (Friedman 2005, 179). HCBC's outsourcing approach involves multiple managing institutions, creating complications in reporting,

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[92] Davids et al. (2009b), Morwe, Klu, and Tugli (2013), Morwe and Ramila (2012), Qalinge (2011), Samson (2008), Schneider, Hlophe, and van Rensburg (2008)

[93] The Minister of Labour has the authority to establish basic conditions of employment for employees in various sector by means of a Ministerial Determination. The Minister is able to make a determination to exclude or replace any basic conditions of employment as listed in the Basic Conditions of Employment Act. In the Ministerial Determination for Welfare Sector, clauses include (1) a limitation of overtime to 15 hours a week with normal wages and a grant of additional leave, (2) average 45 working hours a week, and 10 overtime hours across the contracted period, (3) payment and additional grant of leave for work on Sundays, (4) flexibility of choosing night work and (5) a grant of an additional week's leave for regular standby employees.

[94] Munakamwe (2009), Sliep and Kezaabu (2011), Kezaabu and Sliep (2011)

funding, labour rights, programmatic implementation, monitoring and evaluation. The above complexities make it difficult for (1) implementing organisations to understand policy objectives, (2) government agencies to report and track progress, (3) unions to mobilise for careworkers' rights[95], and (4) caregivers to know to whom they should forward their problems[96]. In addition, implementing agencies also encounter challenges developing strong relationships and working structures with DoH to provide longer-term support to caregivers[97], with small scale and short term organisations often deemed by government to be unworthy of attention, and less predictable 'bottom up' projects being left out of the governments' support structures[98].

Aside from having to play to the likes of government agencies, NGOs/NPOs/CBOs/FBOs also succumb to the preferences of external donors. The receipt of foreign aid can often transform carework into a bureaucratic, professionalised and commoditised system preferred by donors, one which marginalises HCBC caregivers without professional accreditation and formal employment rights (Swartz 2013, Swartz and Colvin 2015). The above is exacerbated for female caregivers as Daniels, Clarke, and Ringsberg (2012) point to gender considerations in the healthcare worker policy as a check box exercise to satisfy legislative requirements, rather than one conducted with intentions to engender HCBC policies.

6.5   HCBC: Last line of defence provided through communities

My research suggests that HCBC has had little success in increasing female caregivers' power over economic resources, which in turn limits its impact on women's decision making power over material household consumption and their bargaining power within intimate relationships. In some instances, where HCBC was more successful in contributing towards poverty alleviation (discussed in Chapter Five), women's power over financial resources did not always translate into their power to make decisions and bargaining power within the household, as social norms interact to hinder such gains. With regards to household bargaining power, while caregivers lack the ability to reallocate household duties, they have some freedom in deciding on their levels of commitment towards voluntary work. It seems plausible to conclude that while HCBC

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[95] Mdhluli (2006), Lance (2010), Samson (2008), Munakamwe (2009)
[96] Daniels, Clarke, and Ringsberg (2012), Munamakwe (2009)
[97] Campbell, Nair, and Maimane (2007), Campbell, Gibbs, et al. (2008), Campbell, Gibbs and Nair et al. (2009), Campbell, Nair et al. (2010), Gibbs, Campbell and Akintola et al. (2015) and Gibbs, Campbell and Maimane et al. (2010)
[98] Ibid.

offers women an opportunity for possible career advancements and self-development, its ability to contribute towards social aspects of women's power to determine intimate relations, household dynamics, and community processes remains rather weak.

My meta-analysis and pilot study reinforces my theoretical framework of empowerment, suggesting that when evaluating HCBC from a social development lens, it is possible to offer a more nuanced perspective on different forms of power across the different spaces of the self, household and community which are attained by caregivers through their carework. By so doing, it draws attention to areas where HCBC has fared well in responding to the government's objectives of empowerment and transformation (discussed in section 4.4) and areas where more work is necessary. HCBC has been observed to encourage the formation of social capital in the community which facilitates collaborative community participation, contributing to the successful implementation of the programme and increased socio-psychological well-being of caregivers. On the other hand, the practice of HCBC without supportive networks, coupled with the lack of government funding, would match Marais' (2005, 66-67) concept of an unethical project whereby:

> *"the well-being of the poor becomes ever more precarious, additional burdens are being shifted onto them. Celebrating this as an expression of hardiness and vim, an affirmation of Ubuntu, seems morally base. […] Expecting the poor to provide the backbone and lifeblood of care – with a minimum of structured support – is unreasonable and unrealistic".*

Despite having the potential to engage 'power with' the community to mobilise participation in care provision, HCBC is limited in enabling caregivers to draw on their 'power with' each other to intervene in project implementation, influence policies and fight for legal representation. My analysis suggests that this lack of power derives from the hierarchical workplace and hierarchal relationship between funders and implementers which limits HCBC caregivers' voice, as they are on the lowest rung of the care ladder. Furthermore, the ambiguity of caregivers' employment status confuses the reporting structure, leaving caregivers without either legislative or civil society representation despite their being contracted to civil-based/non-profit organisations. In view of the above, it is difficult to conclude that HCBC encourages political empowerment, since female caregivers are often excluded from the political processes of the programme and only allowed to participate in 'invited spaces' defined by their provision of care, labour and community education.

Chapter Seven

South Africa's home community-based care: A means to empowerment?

7.1   Contributions of PWPs to women's empowerment

Women's empowerment has been widely adopted in development policy literature in the more recent years. The purpose of my thesis was to examine the extent to which the inclusion of a social dimension into public works programmes (PWPs) contributes to women's empowerment, through a case analysis of South Africa's home community-based care (HCBC) programme. To do this, I first carried out a genealogical examination of how empowerment has been used by international development agencies and found that the focus has been on economic empowerment and so shifted away from the feminist agenda which promotes a more emancipatory approach. In particular, development agencies seek to empower women by ensuring their greater participation in the market economy. In this respect, my findings concur with much of the feminist critique of this conception of empowerment (Batliwala 2007, Cornwall and Brock 2005, Mohan and Stokke 2000, Parpart 2002, Wong 2003)

More specifically I found that women's economic participation is considered to be synonymous with their empowerment, with little questioning of the (1) types of job opportunities available to women, (2) type of work women take on, (3) value women place on their economic participation, (4) redistributive outcomes of women's productive roles within the households, (5) extent to which paid work has contributed towards improvements in women's livelihoods. In particular, notions of women's power and status which accompanied the feminist discourse on empowerment seem to have been omitted, replaced by a focus on investing in women's productivity and employment as a means to empowerment. It is within such a context that PWPs have been promoted as a means of facilitating women's empowerment though increasing access to employment and income.

Academics (Tanzam and Gutierrez 2015, Kabeer 2008, Antonopoulos 2007, Chopra, Kelbert and Iyer 2013) who adopt a socio-economic perspective to examine the concept of women's empowerment have however demonstrated limitations in PWPs' ability to promote women's empowerment, suggesting that more gender responsive programmes are necessary. Yet others (Holmes and Jones 2011, McCord 2005, Antonopoulos 2007) propose the incorporation of social care into PWPs to factor in the impact of carework on

women's participation. The number of PWPs that provide social services is however limited, so few studies have considered how these projects have contributed to women's empowerment, a gap I sought to redress in this research.

My research examined the effectiveness of one of few PWP driven social care programmes, namely the Home Community Based Care (HCBC) in South Africa, on the empowerment of female participants. I first summarise my empirical findings and compare with my conceptual framework of empowerment. I then identify some implications for South Africa's HCBC programme and PWPs in other parts of the Global South, before providing suggestions for future research on empowerment and home community based care in the Global South.

7.2 South Africa's HCBC a means to female caregivers' empowerment?

In this study, I proposed a conceptualisation of empowerment as an interplay of power and agency across the five key spaces in which women act: state, institution, community, household and individual. Drawing on the works of social science and feminist researchers, I proposed an understanding of power which transcends that of power over resources and individual gains, to include power dynamics in social relations. I adopt Rowland's (1996) multidimensional approach to empowerment to examine four different forms of power across the five key spaces which empowerment operates. In so doing, my conceptual framework examines women's empowerment as a holistic experience encompassing the social, political and economic aspects.

Using my conceptual framework of empowerment, I examine the HCBC in terms of the economic impacts of employment, paying attention to wages, skills development and access to infrastructure supporting carework, and then analysed the socio-political impacts of poverty alleviation and community participation on HCBC caregivers. In this section, I summarise the key empirical findings of my research which was based on a meta-analysis of 35 selected empirical studies, and these were supplemented by government documents and 11 semi-structured interviews and 4 personal communications I collected during an initial pilot study. My findings suggest that it is important to revive the feminist agenda for women's empowerment.

7.2.1 Economic empowerment

South Africa's HCBC demonstrated limited capacity in the development of women's capabilities through the provision of employment opportunities. In particular, the number

of employment opportunities provided through the programme is limited, especially when considered against the context of chronic, high unemployment in South Africa. Nonetheless, HCBC's limited opportunities offer a glimmer of hope to female participants who are mostly unemployed or conducting informal work, with several participants commenting that carework provides a route to personal growth and future employment. In terms of training, while haphazard documentation and inconsistent reporting may have contributed to a lack of consensus on the effectiveness of HCBC in increasing caregivers' human capabilities, the general understanding is that HCBC offers more comprehensive, relevant and continuing training than other sectors within South Africa's EPWP.

My findings suggest that HCBC provides opportunities for employment and skills development to a select few. However, female caregivers often increase their employability in feminised care-related jobs but these are generally low paid. Furthermore, the pursuit of new pathways for career advancements through the HCBC often led caregivers to be sandwiched between multiple conflicting commitments of (1) community caregiving, (2) reproductive labour within the household, and (3) productive work outside of community caregiving. The resulting 'triple burden' (Moser 1993) of female caregivers demonstrates the inadequacy of policies which just shifts carework from the home to the community. My findings on the HCBC draw attention to the need for more gender responsive provisions in terms of (1) fair remuneration for the time and financial resources women invest into their carework, (2) reduction of women's household responsibilities through marketization or the provision of care services, (3) equal opportunities for career advancements within the workplace, and (4) opportunities for decent work with fair wages within the care industry. These findings fit feminist demands that emerged during the GAD era and post-2015 agenda to redress the uneven gender division of labour within the household which limit women's productive capacities and institutional regulations which limit women's access to employment and income generation

With regards to poverty alleviation, due to the low, irregular stipends, HCBC demonstrated little potential in increasing female caregivers' power over economic resources. Caregivers often use personal resources to supplement clients' resources so depleting their own, illustrating Marais' (2005, 65) understanding of HCBC as a case of the 'poor subsiding the poor'. HCBC's effectiveness is also compromised by the lack of physical infrastructures, urban services, welfare services, medical supplies, educational

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resources and government funding as discussed in Chapter Five. Not only do these inadequacies limit the scope and scale of HCBC, caregivers often shoulder the burden, not only by using their own resources and enduring the challenge of caring with limited services, but also because they are exposed to increased risks of disease and threats to their physical safety. These material inadequacies and threats to caregivers' health and safety not only hinders caregivers' conduct of care, but also compromise their socio-psychological well-being and has a knock-on effect on women's experience of social empowerment.

In reviewing the contributions of HCBC towards caregivers' employment (economic resources), skills development (human capability) and service delivery, it becomes evident that the impact of HCBC on caregivers' economic empowerment is minimal. Even so, HCBC work enhanced their self-esteem and confidence, as they anticipate further opportunities for personal growth and career advancement, as discussed in Chapter Five. Adopting the identity of a community caregiver, together with respect, appreciation and recognition from the community further increased their self-esteem which leads to the socio-political aspect of empowerment.

7.2.2   Socio-political empowerment

Caregivers with limited economic resources report that they are unable to contribute towards household expenditures and as a consequence have limited say over the distribution of material resources within the household. By contrast, those who are better remunerated or who are the only contributor to household expenses, have increased ability to determine the use of resources as discussed in Chapter Six. Where women have limited control over household expenditure, their use of household resources for caregiving is often done stealthily without the knowledge of their husbands who are likely to disapprove their decisions.

In terms of bargaining power within the household, female caregivers' can negotiate the amount of time they invest in community caregiving but there is little or no change in other aspects such as caring responsibilities and negotiation of safe sexual practices due to the persistence of gendered social norms and power. The only exception appears to be where women achieve independence as primary breadwinners or become major contributors to the household as a consequence of fairer remuneration for their carework. Under such circumstances, female caregivers report an increase in control over the household budget and/or the ability and freedom to leave oppressive intimate

relationships. Having material resources also impacts on female caregivers' authority within the caregiver-client relationship. Caregivers with greater command over material assistance such as food parcels have greater authority over patients who tend to be more compliant, as discussed in Chapter Six. It is evident from my findings that where there have been economic gains, such gains have to varying extents been translated into socio-political gains in power within the household and community spaces in which women act.

The above findings reinforce the feminist perspective of empowerment which emphasises the need to consider not only the economic aspect, but also the socio-cultural and political dimensions of empowerment. Although some of the literature on women's employment and empowerment show that in some cases women's employment in paid, formal protected work can reduce their vulnerability, increase their ability to escape poverty and have spill over effects on their autonomy, agency, social well-being and political participation (Kabeer, Mahmud, and Tasneem 2011), in my study I did not find this to be the case. This could be due to the fact that caregivers in my study were only paid a stipend - and it was considered more as voluntary work rather than formal waged employment. In particular, the lack of protection, remuneration and formality in the caregiving work offered through HCBC has not only deprived caregivers of 'power over' economic resources (economic empowerment), but also negatively impacted on their agency within the household, their bargaining power in intimate and non-intimate relationships, and their ability to acquire autonomy through exiting oppressive relationships.

However, the limitations of HCBC in facilitating economic empowerment has not necessarily compromised on its ability to bring about social empowerment. In particular, HCBC enabled female caregivers to develop strong social capital through their active involvement in the community, networks which are essential towards supporting the performance of care through encouraging community participation, opening up new possibilities for women's future career development and being a source of potential help and support which women can draw upon in future if needed. In increasing women's visibility, social networks and self-esteem ('power within'), HCBC promotes women's 'power with' the community through their assumption of a caregiving role.

Unfortunately, women's increase in 'power within' themselves, and 'power with' the community to conduct care cooperatively seems to be confined to the dimension of care within the space of the community. In particular, HCBC has not expanded women's capabilities beyond their 'power to' care to dimensions such as the 'power to' understand

and transform institutional rules and policies. Furthermore, women's 'power with' the community is limited to their carework, and has not translated into 'power with' each other to participate in activism and resistance for the right to intervene in HCBC programme implementation and influence policies and legislation. The above may in part be attributable to the ambiguous employment status of HCBC caregivers which gives them little status and few labour rights. My findings demonstrate HCBC to promote women's social empowerment, albeit confining it within the care realm, as female caregivers continue to be socially excluded from the political processes governing their participation in interventions and have limited control within the household. In addition, among those who reported gains in income and economic well-being, such gains have not translated into socio-political gains in institutional and legal-politico spaces.

A contradiction in point is that while the inclusion of social care into PWPs was recommended as a means to promote women's economic empowerment through employment and skills development, South Africa's HCBC has demonstrated such intervention to have instead contributed towards women's social empowerment. While it is uncommon for interventions targeting economic empowerment to have instead achieved social empowerment, my case analysis of South Africa's HCBC have nonetheless reinforced the importance of adopting a holistic approach to women's empowerment first promoted by Sen and Grown (1988).

7.3   Policy implications for HCBC phase III and PWPs in the Global South
7.3.1   Incorporate a gendered perspective to HCBC policies

Findings of South Africa's HCBC demonstrated a need for more gender responsive, flexible PWP interventions when targeting poor, vulnerable women. Apart from identifying women and youths as key beneficiaries of HCBC, there is a further need to take into account both gender dynamics and demographics which affect programmatic implementation and outcomes. Three key issues which require further attention in HCBC policy making are: (1) the setting of stipend rates for HCBC caregivers which takes into consideration the gendered structure of carework within South Africa and other parts of the Global South, (2) an analysis of the impact of gendered social norms on women's participation in HCBC, and (3) a questioning of the extent to which HCBC can support a transformation of gender biases which perpetuate women's time and economic poverty. The importance of a gender responsive agenda within PWPs in the Global South is supported by the works of Tanzam and Gutierrez (2015) and Kabeer (2008), drawing attention to the effectiveness of projects which take into consideration women's socio-

economic circumstances and factor in flexible arrangements to cater for women's care-related commitments. PWPs which address the above three issues when incorporating a social care agenda can potentially contribute to women's empowerment in both the economic and socio-political dimensions.

7.3.2 Include qualitative indicators in impact evaluation

Currently, HCBC evaluation is only quantitative, such as the number of jobs created, number of training hours provided, number of 'learnerships' offered and the amount of stipends granted. This assessment facilitates comparison between HCBC and other EPWP sectors, but does not address the power dynamics during implementation. My empirical findings are less optimistic than quantitative data, suggesting that opportunities for economic empowerment are limited and socio-political empowerment has not been achieved within institutional and legal-politico spaces. Rather, HCBC is more effective in promoting social empowerment within the space of community care. There is a need for more comprehensive qualitative analysis to examine the interactive processes underlying caregivers' practice. My study reinforces Cornwall's (2007) proposal that a return to women's everyday lived experiences is necessary to build a comprehensive picture of women's empowerment. Comprehensive impact evaluation of the transformative capacity of HCBC and PWPs in the Global South would need to incorporate qualitative dimensions documenting women's personal accounts of their experience, its impact on their livelihoods, and changes in their agency within household, community, institutional and legislative spaces.

7.3.3 Adopt more standardisation in implementation

The lack of standardisation in implementation, from the capacitating of caregivers, to remuneration practices, to allocated working hours to job titles, not only confounds reporting, monitoring and evaluation, but also disadvantages caregivers' differentially, leading to internal struggles which hinder co-operative team working and hence aspects of social capital formation and self-esteem development which are essential for empowerment. More standardisation in HCBC practice enabled through clear, unambiguous HCBC policies/regulations and professional supervision of implementing agencies from coordinated government bodies is necessary. The above can support more equal opportunities for training/skills development, long-term employment, wages and resources, and a more structured mode of skills transfer which ensures caregivers receive training to a certified level as shown in Chapter Five.

This approach would be similar to that identified by Grosh et al. (2008) in relation to Ethiopia which demonstrates that a transparent and structured means of implementing the social care agenda of PWPs across the Global South is necessary to encourage healthier competition for opportunities. In particular, South Africa's HCBC demonstrated that the presence of hierarchical stratification and intense competition impede the cooperative pursuit of a common goal to improve the quality of care available. The use of a standardised training programme can potentially enable clearer career pathways and provide goals for caregivers to work towards and a motivation for caregiving.

7.3.4   Improve coordination between stakeholders

Having multiple stakeholders both within and outside of government who are engaged in HCBC is encouraging. However, an inadequate overarching framework to inform the implementation of HCBC and the lack of coordination between various stakeholders, especially between government stakeholders, can result in unnecessary duplication, inefficient utilisation of resources and poor targeting. Case analysis of other labour intensive PWP projects in the Global South have supported the finding that strong coordination is necessary for project effectiveness. For example, World Bank (2006b) reported poor coordination among multiple participating institutions to be responsible for highly delayed payments which participants rely on for their daily basic needs, compromising the effectiveness of the programme to provide a form of emergency work.

My analysis of South Africa's HCBC shows that the lack of cooperative partnerships between and among agencies and governments undermine efficiency and the provision of holistic care. This inability to provide quality care in turn impacts on the self-esteem and empowerment of caregivers. On the other hand, the involvement of government agencies as initiators and implementers of wide cooperative networks and partnerships among different stakeholders across communities can increase the effectiveness of HCBC. If social care is to be built into PWPs in the Global South, then more coordinated efforts across different sectors of the PWP would need to be developed to ensure that caregivers from needy communities are provided with physical and social infrastructures and services to conduct carework. Strong networks enable stakeholders to clarify their roles and accountability between each other, reducing the possibility for duplication and resource wastage. Rather than being passive funding allocators, governments play an important role as active collaborators of PWP implementation. Regular dialogue between stakeholders and civil society supported by government agencies facilitate the formulation of effective social care policies and legislation which can make a positive

impact on female caregivers' political empowerment. The inclusion of stakeholders and civil society is also important for encouraging community buy-in, since people tend to be more supportive of initiatives that they are a part of, and community support is necessary for the effective introduction of social care into PWPs in the Global South.

7.3.5 Engage in active community participation

At present, HCBC's implementation of community participation is limited to an invitation of community members to engage within the spaces mapped out by implementing organisations and governments, mainly through a contribution of their labour towards the agencies' work as discussed in Chapter Six. Aligning with Miraftab's (2004) understanding of the limitations of 'invited spaces of participation' in encouraging transformative collective action, I suggest that there is a need to include capacity building programmes which (1) develop female caregivers' organisational experience, and (2) enable them to actively engage with the government on policy planning to incorporate social care into PWPs. Active involvement of caregivers in the design and implementation of the social care arm of PWPs can potentially increase its chances of contributing towards their livelihood improvements and empowerment. The above is since local communities often have rich knowledge to contribute, such as that of (1) their immediate environment, (2) economic circumstances, and (3) complex constraints which may negatively influence initiatives.

The development of active community participation may be supported through strong civil society coordination which brings together diverse partners that can represent female caregivers to effect social change in policies and gender biased norms which disadvantage women. Governments can also support the development of a gender responsive social care agenda within PWPs by funding civil society organisations which represent female caregivers. The availability of funds potentially strengthens the ability of implementing agencies to support caregivers in cooperative projects related to community development outside of caregiving, such as food gardens or other income generating activities. In so doing, social care programmes can potentially empower caregivers to be agents of their own development, to 'invent' their own spaces for participation, rather than being passive renderers of community care services through contracting agencies.

7.3.6 Provide training for management and mentors supporting HCBC

Aside from developing caregivers' capabilities, it is necessary to equip support staff with required skills (mentoring, counselling, management, communications, monitoring) to

perform their roles and responsibilities, as my findings demonstrate the lack of supervisorial support to have a negative impact on caregivers' empowerment. My study finds that contributions of support staff are essential in ensuring that caregivers are able to translate the knowledge acquired through training into practical skills, well adapted to the healthcare settings in which they are attached, and psychologically supported in their emotionally challenging caregiving roles (see also (Al-Baseir 2003, Grosh, et al. 2008)). The above findings reinforce the need to train staff and consultants to ensure the effective implementation of a social care agenda in PWPs across the Global South.

7.4   Suggestions for future research

Studies examining the impact of incorporating social care into PWPs in the Global South on female participants' empowerment are limited perhaps because of the small number of PWPs that include a social dimension in their policies and practice. Existing research[99] report contradictory findings on the impact of social care provision on women's participation in productive work. In my meta-analysis and pilot study of the HCBC, I have added to the limited literature in suggesting that community caregivers in social care interventions experience social empowerment, albeit falling short of achieving economic and political empowerment. While my study offered some insights into the potential for including social care within PWPs to empower female caregivers, the analysis is confined to providing care in the context of South Africa where HIV/AIDS is prevalent. It is unclear whether these findings might relate to other forms of social care, such as Early Childhood Education (ECD), community crèches or community kitchens. More research is needed on the empowerment impact of social care provision in different contexts.

As for HCBC, my case study identified various gaps in the literature requiring further research. First, most of the HCBC literature is focused on patients, with a small proportion (examined in my study) directed at caregivers. Little is known about how community care impacts on patients' family structures and household distribution of responsibilities, and how the local context influence patterns of care, such as traditional beliefs, family structures, extended families and the norms governing community. Additional costs of bringing care from the hospital to the home may be imposed on families through special foods, travel, laundry, heating, buying time to care by purchasing other services such as child care, as well as the direct costs of healthcare expenses (Netten 1993, Desmond, Michael and Gow 2000). Increased burdens of care shouldered by family caregivers draw

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[99] Antonopoulos (2009, 2008), Budlender (2004), Folbre (2006)

attention to the need to evaluate the costs and benefits of HCBC not only to community caregivers, but also households in which care is conducted. In particular, households tend to reallocate labour, change household composition, enlist the help of extended family and community, withdraw children from school, sell assets and withdraw savings as coping strategies for the extra financial costs (Desmond, Michael and Gow 2000). Aside from community caregivers, it is important to examine the extent to which HCBC empowers primary and secondary caregivers who are likely to be women. There is need for research questioning the role played by primary and secondary caregivers, in order to map the shifts in care patterns and responsibilities due to the provision of community care, and the advantages underlying such transitions. Potentially, such an investigation could inform policies and practices on making social services more accessible to women.

As for studies on HCBC participants, my findings highlighted the need for more nuanced understanding of care challenges which takes into consideration factors such as gender, age, socio-economic status, access to social and health services, all of which can influence the extent to which caregivers experience improvements in their socio-economic well-being. Such studies are useful in informing policy and programme planners on how to enable interventions to cater for caregiver needs. In terms of political empowerment, more needs to be known about the power dynamics of the decision making process behind HCBC, for example the extent to which an involvement of female caregivers through civil society representation or activism and resistances influence programmatic outcomes on women's livelihoods.

With regards to social empowerment, my analysis showed HCBC to be effective in facilitating the development of social capital among community and peer caregivers. Less is known about the socio-relational challenges caregivers face when interacting with professional support staff and the contributions of strong social capital towards the resolution of such difficulties, suggesting scope for further research. In the area of economic empowerment, future research quantifying the time and economic commitments of female caregivers is necessary to inform the setting of fair remuneration rates for women's carework. In addition, tackling the issue of inadequate material support would require further studies to explore better coordination of both physical and social infrastructural provisions through PWPs, and the extent to which more coordinated efforts can contribute towards improvements in the quality of care provided/received and livelihoods of beneficiaries and participants.

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List of interviewees

No.	Interviewee	Sex	Age	Occupation	Marital status
1	Retha	F	30	Chaplain, involved in overseeing HCBC	Single, no children
2	Nyarai	F	58	Dressmaker	Single mother of 2 children
3	Ntombi	F	40	Unemployed	Married with 2 children
4	Tariro	F	45	ACT trainer of HIV support facilitators, Caregiver	Single mother of 1 child
5	Bongani	M	27	Woodworker	Single father of 1 child
6	Chikondi	F	37	Sewing teacher	Single mother of 2 children
7	Kgosi	M	29	Woodworker	Single, no children
8	Farai	F	33	Support group facilitator, caregiver	Married with two children
9	Neo	F	43	Caregiver, social work student	Divorced mother with 3 children
10	Kagiso	F	27	Caregiver	Single mother of 1 child
11	Mbali	F	25	Caregiver	Single mother of 2 children

List of personal communications

No.	Interviewee	Sex	Age	Occupation
1	Lesedi	F	28	Unemployed
2	Zola	F	34	Caregiver
3	Becca	F	42	Artist, volunteer in townships
4	Andy	M	78	Retired

Appendix A

Research methodology

Key search terms

The two key search terms of my study are women and South Africa's EPWP HCBC programme. Variations of the key search terms related to each of the above two aspects are as follows:

Women	EPWP HCBC
woman	South Africa
women	public work programmes
young woman	PWP
young women	expanded public work programmes
girl	extended public work programmes
female	EPWP
daughter	community based public work
mother	home based care
youth	community based care
young people	Community work programme
working age population	CWP
participants	community health worker
gender	CHW
men	community based worker
	CBW
	community development worker
	CDW
	community health worker
	caregiver
	secondary caregiver
	community caregiver
	carer
	volunteer
	healthcare volunteer
	care worker
	volunteer caregiver

Search term combinations

Self-esteem/dignity			
woman	EPWP	self esteem	
women	HCBC	dignity	
girl	expanded public work programmes	confidence	
young people	South Africa	self- consciousness	
youth	community based care	self-discovery	
female	home based care	self-respect	
	CWP	awareness	
	extended public work programmes	resilience	

Control over economic resources			
woman	South Africa	income
women	public work programmes	income generation
young woman	expanded public work programmes	economic
young women	EPWP	financial
female	HCBC	access
daughter	community based public work	control
mother	caregiver	productive asset
gender	CWP	decision making
men	care worker	household
	Volunteer caregiver	distribution

Employment and employability			
woman	South Africa	employment
women	public work programmes	job
young woman	PWP	skill
young women	expanded public work programmes	skill training
female	EPWP	vocational
youth	HCBC	vocational training
working age population	community based public work	vocational education
participants	home based care	industry related skills
gender	community based care	managerial skills
	CWP	administrative skills
	extended public work programmes	entrepreneurial skills
	volunteer	financial literacy
	community caregiver	capabilities
	secondary carer	education
	care worker	literacy

Decisions over household consumption			
woman	South Africa	household
women	public work programmes	consumption
female	expanded public work programmes	resource distribution
daughter	EPWP	children
mother	HCBC	expenditure
gender	HBC	spending
	community based public work	power
	home based care	decision making
	community care giver	agency
	CWP	livelihood
	extended public work programmes	assets
	Volunteer caregiver	savings

Bargaining power			
woman	South Africa	power
women	public work programmes	bargain
female	expanded public work programmes	negotiate
daughter	EPWP	education
mother	HCBC	responsibilities
gender	community health worker	roles
men	community based public work	agency
	home based care	caring

	community based care	education
	CWP	children
	community caregiver	household

Access to infrastructure/assets/services		
woman	South Africa	childcare
women	public work programmes	crèche
girl	expanded public work programmes	community care
female	EPWP	nursery
daughter	community based public work	social assistance
mother	home based care	healthcare
youth	community based care	medical service
young people	HCBC	home care
participants	CWP	nursing
gender	community caregiver	AIDS
men	community health worker	water
	volunteer	sanitation
	secondary carer	electricity
	care worker	transport
	volunteer caregiver	roads
		social service
		well-being

Social capital		
woman	South Africa	social capital
women	public work programmes	network
female	expanded public work programmes	connection
daughter	EPWP	community
mother	HCBC	self-help group
participants	community based public work	intangible resources
gender	home based care	non-material
	community based care	non-financial
	CWP	Exchange
	volunteer caregiver	mutuality

Community participation		
woman	South Africa	Community participation
women	public work programmes	institutional
young woman	expanded public work programmes	mobilisation
young women	EPWP	political
female	community based public work	collective action
mother	CWP	agency
participants	extended public work programmes	voice
gender	HCBC	movement
men	volunteer caregiver	unions
		implementation
		clientelism
		policy change
		legislative
		employment law

Hand search combinations

Women	Economic empowerment	EPWP
women	empowerment	South Africa
woman	income	public work programmes
female	financial	expanded public work programmes
gender	assets	HCBC
	decision making	community based public work
	power	home based care
	agency	community
		participation

Appendix B

South Africa's EPWP

Organisation chart of the EPWP

In terms of institutional structure, DPW oversees the overall coordination of the EPWP through a Director-Generals' (DGs') steering committee, and a lead department is assigned to each of the different sectors (see Figure 11).
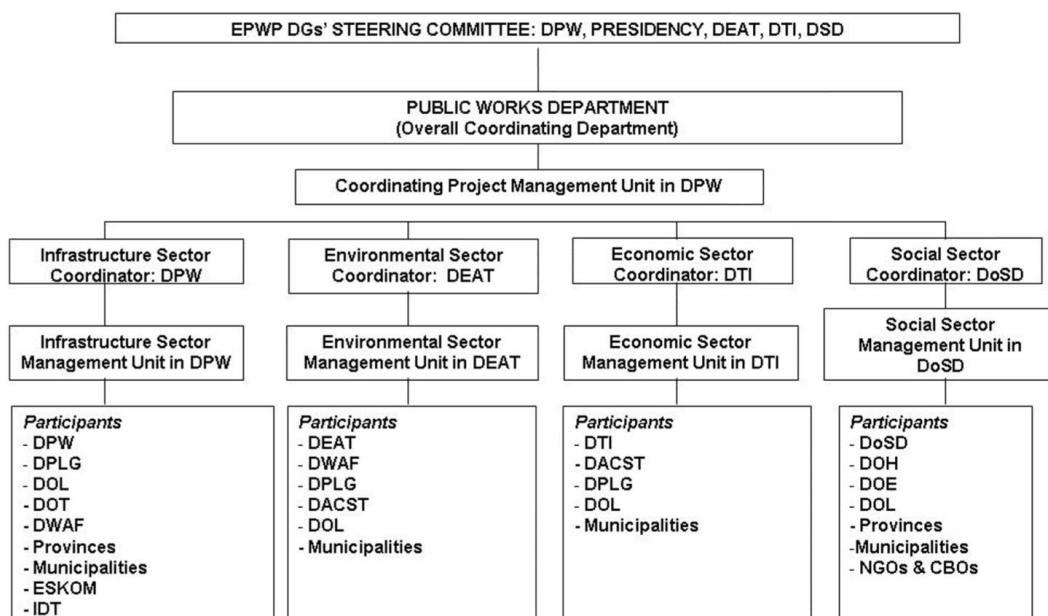

Figure 11: EPWP organisational chart
Source: DPW (2004a)

With training being central to all the sectors, the Department of Labour National Skills Fund and the Sector Education Training Authority (SETA) have been tasked with developing the training programmes. The Department of Labour is responsible for coordinating training and skills development and for gazetting a Code of Good Practice for Special Public Works Programmes to be used as a legislative framework for the employment practices of EPWP. The Code of Good Practice sets out the (1) regulation for wages based on the job and local rate for hiring of unskilled workers, (2) limitations on training and employment duration, (3) conditions for selection of participant to involve CBOs, and (4) targets for the employment of women, youths and people with disabilities. The above conditions are determined by the understanding of EPWP as an instrument to create short-term jobs for the unemployed with a view to enable them to gain work experience, training and short term income.

The three phases of EPWP, 2004/05-2018/19

Phase One: 2004/05-2008/09

According to DoSD, DoE, and DoH (2004), the first phase of the EPWP has its focus on the infrastructure sector which is targeted to provide 900 000 of the proposed 1.3 million job opportunities, as compared to 200 000 for the environment and culture, 150 000 for the social and 12 000 for the economic sectors (see Figure 12). In terms of 'learnerships'[100] which is the main vehicle for providing formal training under the EPWP, the social sector is the biggest provider of an approximate three-quarters of the 41 100 opportunities, with infrastructure only catering for a meagre 1% (see Figure 13).
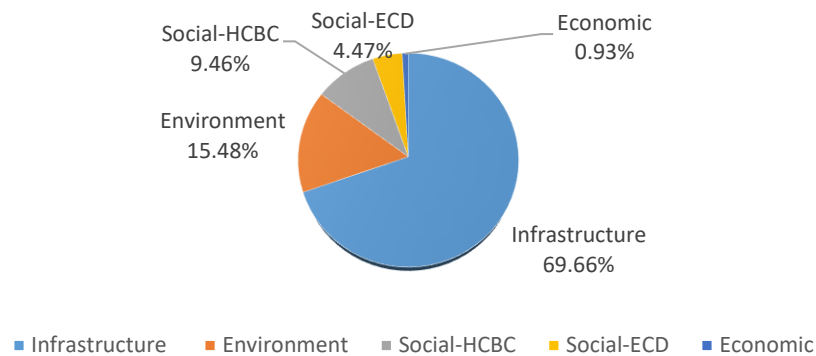

Figure 12: Distribution of employment opportunities across sectors in Phase one

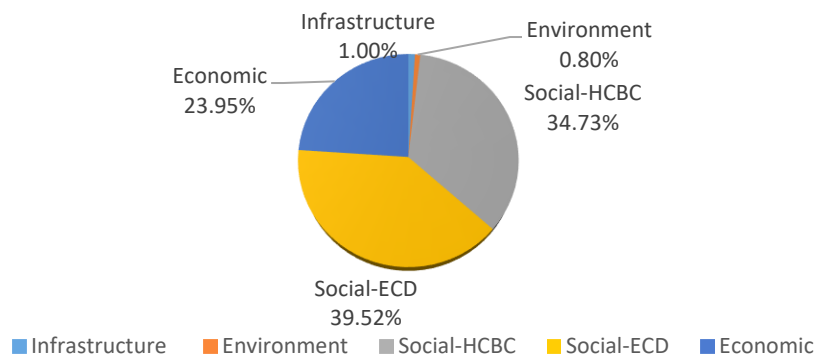*Source: Author's own with data from DoSD, DoE, and DoH (2004)*

Figure 13: Distribution of 'learnership' opportunities across sectors in Phase one

Source: Author's own with data from DoSD, DoE, and DoH (2004)

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[100] According to the DoSD, DoE, and DoH (2004), 'learnerships' bring together structured learning and on the job experience, and is one of the route towards acquiring an accredited qualification registered under the National Qualifications Framework (NQF) by the South African Qualification Authority (SAQA). 'Learnerships' often take at least a year to finish and is made up of a specified number of credits, short courses. Assessment is often by a mentor, coach, trainer or assessor. Graduates of 'learnerships' are presumably able to demonstrate practical competencies within an employment context, making it a programme which is designed specifically to help unemployed individuals access job opportunities.

The above statistics suggests that despite the ability of the infrastructure sector to provide immense number of work opportunities, it appears least able to provide its participants with (1) opportunities for relevant and formal training, (2) on-the-job experience to increase their capabilities, or (3) possibilities for longer term employment/income opportunities. The temporality of infrastructure sector opportunities may be due to the main focus of the sector on increasing the labour intensity of infrastructural projects funded by the government through providing massive job opportunities for a short period of four months. During this work period, workers receive eight days of 'livelihood training', which is in accordance with the regulation for an allocated training of minimum 2 days for every 22 days spent in employment. The scalability of the infrastructure sector may also be attributable to a significant proportion of the EPWP funds being allocated to it in phase one, receiving R15 billion, as compare to R4 billion for the environmental sector and a comparatively meagre R0.6 billion for the social sector (DPW 2004a).

Despite the limited funding and more modest scale of the social sector, it seems to display a higher potential to offer longer term opportunities or more substantial training to an approximate one-quarter of its participants through 'learnerships' (See Figure 14). The social sector's main components are the Home Community Based Care (HCBC) and Early Childhood development (ECD), both of which have more ambitious targets of training a new cadre of intermediate to highly skilled individuals to provide healthcare and childhood education, albeit being the newer and hence least developed of sectors.

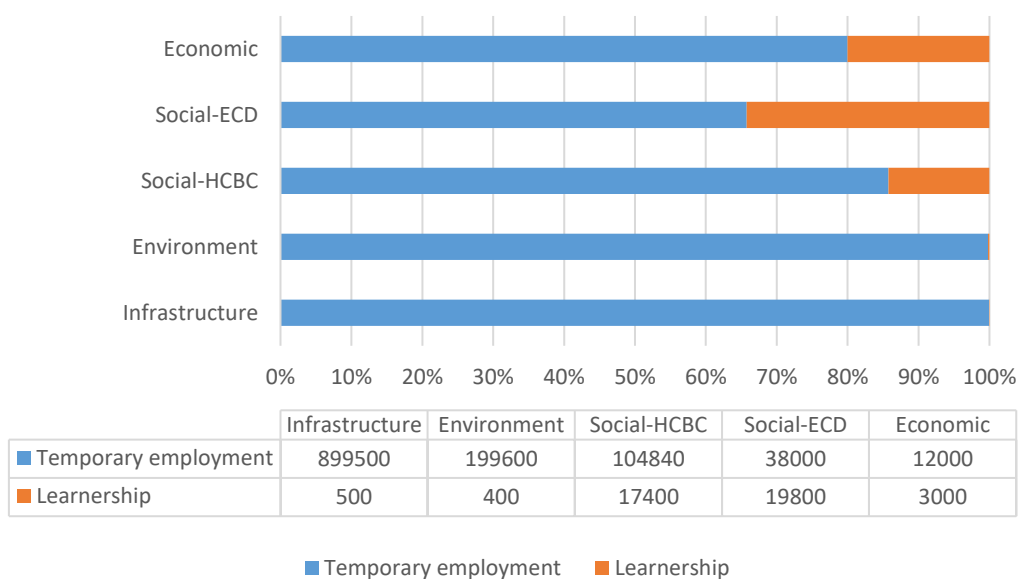|	Infrastructure	Environment	Social-HCBC	Social-ECD	Economic
Temporary employment	899500	199600	104840	38000	12000
Learnership	500	400	17400	19800	3000

Temporary employment   Learnership

Figure 14: Employment and 'learnership' Phase one
Source: Author's own with data from DoSD, DoE, and DoH (2004)

As for the environment and culture sector, workers are offered an opportunity to be involved in public environmental improvement programmes, mostly through working with government public agencies such as Working for Water, Comprehensive Agricultural Support Programme, Working on Coast, LandCare, Working on Fire, Rehabilitation of Wetlands, and Community-based Natural Resource Management. Associated tasks are usually accomplishable with little training, such as the clearing of alien (non-native) vegetation, wetland and land rehabilitation, coastal clearing, supporting fire protection associations and community tourism projects. The economic sector involves income-generating programmes relating to entrepreneurship, cooperatives and microenterprises. The intention of the sector is to create and support small, medium, micro enterprises (SMMEs) across the infrastructure, environment and culture and economic sectors with a view that these new enterprises are potential creators of work opportunities.

Phase Two: 2009/10-2013/14

EPWP expanded its scope in the second phase following success in the first phase and also as a response to the global economic crisis, increasing its targeted opportunities of 100 workdays each by almost four times to that of 4.5 million, with participants to be paid R50 a day. A targeted R25 billion was to be injected into the EPWP, an amount which is 125% that allocated to the first phase. New developments in this phase also include the introduction of the non-state sector with two programmes, namely community work programme (CWP) and non-profit organisation programme (NPO), which seems to have replaced the economic sector (DPW 2009b).

The economic sector with its various SMME development programmes will instead be integrated into the other sectors of the EPWP which will continue to function into phase two (DPW 2009b). The above changes are in recognition of the significant contributions of non-state organisations towards development, and therefore the need to mobilise the non-state capacities of NGOs, CBOs and local communities in order to achieve a massive upscaling of the EPWP programme. Work in the non-state sector will consist of a wide range of activities to be identified by local communities, NGOs and CBOs, and funding will only be provided for wages of participants. Similar to the first phase, the infrastructure and environmental sectors continue to offer a significant proportion of three quarters of the total job opportunities, although the contributions of the social sector have increased to 15.24% (see Figure 15).
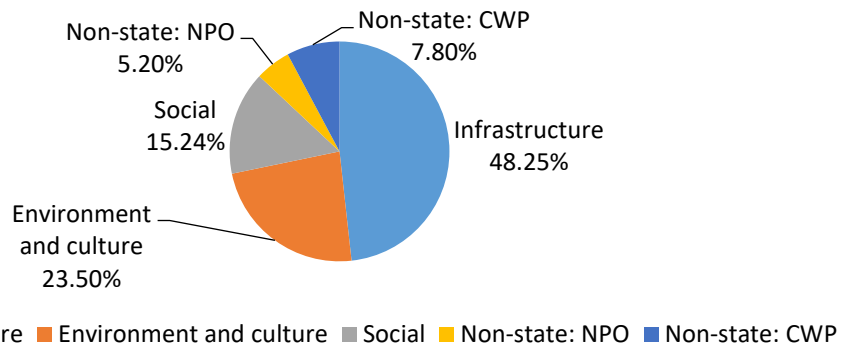
Figure 15: Targeted work opportunities in EPWP phase 2
Source: Author's own, with data from DPW (2014a)

In particular, DPW (2012a) set a target for the social sector to create 750 000 work opportunities and 513,043 full time equivalent[101] (FTE) jobs, a target which is way more ambitious than the first phase. In phase two, the social sector is the only other sector (apart from the non-state CWP sector) to have exceeded its target by 15% (see Figure 16). However, with a target which is about a third of the infrastructure sector (see Figure 15), the opportunities provided by HCBC as a proportion of the total still remains rather low. When looking at the FTE statistics, the social sector commands a significantly larger 25.39% of the overall person years targeted for phase 2 of the EPWP (see Figure 17).

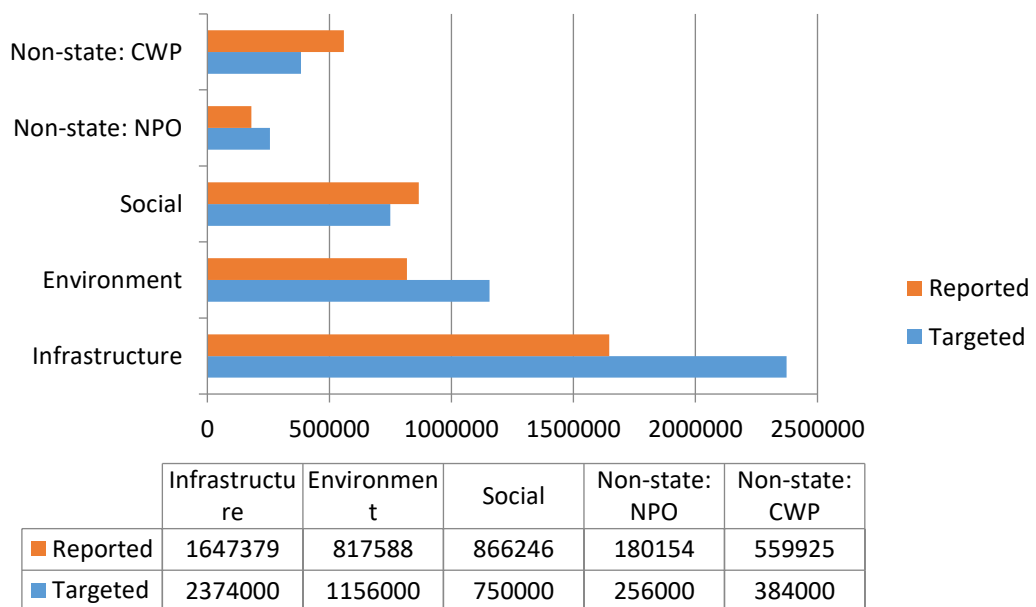|	Infrastructure	Environment	Social	Non-state: NPO	Non-state: CWP
Reported	1647379	817588	866246	180154	559925
Targeted	2374000	1156000	750000	256000	384000

Figure 16: Reported and targeted work opportunities for phase II across sectors
Source: Author's own, with data from DPW (2014a)

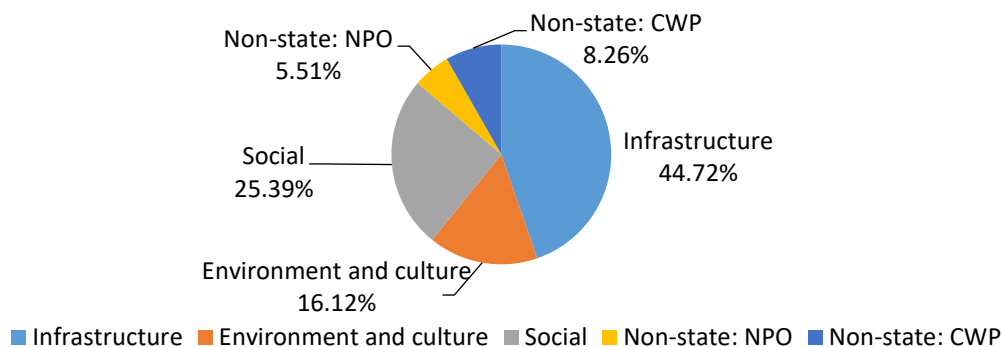[101] A full time equivalent is equals to one person's year of work.

Figure 17: Achieved FTE (person years of work) in EPWP phase 2

Source: Author's own, with data from DPW (2014a)

Phase Three: 2014/15-2018/19

The third phase of the EPWP has a more ambitious target of creating six million employment opportunities by 2019, with a targeted budget of a substantial R150 billions of state funds, which is six times that of phase two, invested into its implementation across a five year period between 2014/15-2018/19 (DPW 2015). The four sectors across which the EPWP's third phase are to be implemented are similar to those in the second, albeit calling for improvements in the strategic and operational aspects in terms of standardization and uniformity across EPWP programmes, monitoring and evaluation of qualitative aspects and collaboration among lead departments and stakeholders and between public work projects and other developmental initiatives. Similar to the first two phases, infrastructure continues to dominate, albeit decreasing to make way for non-state sector which has overtaken the environment and culture sector, while the social sector remains relatively stable (see Figure 18).
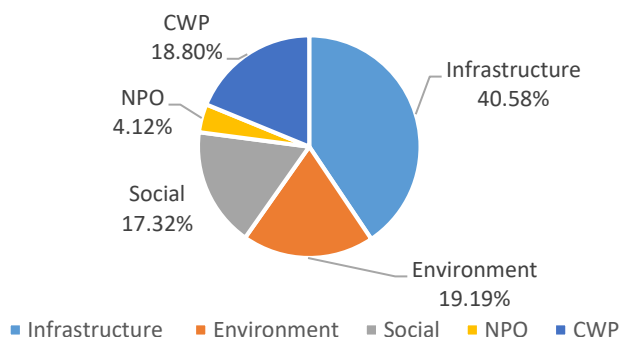
Figure 18: Work opportunities for all sectors across Phase three

Source: Author's own with data from DPW (2015)

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Expenditures on the EPWP

According to the National Treasury (2013), consolidated government expenditure for the financial year 2013/14 is 1,055,044.6 million[102] rand (30.0% of GDP of 3,520,268.2 million rand) to be distributed nationally and provincially across 38 different government sectors, 14 of which are contributors to the EPWP and are allocated 60.97% (643,260.7 million rand) of the total budget (see Figure 19).
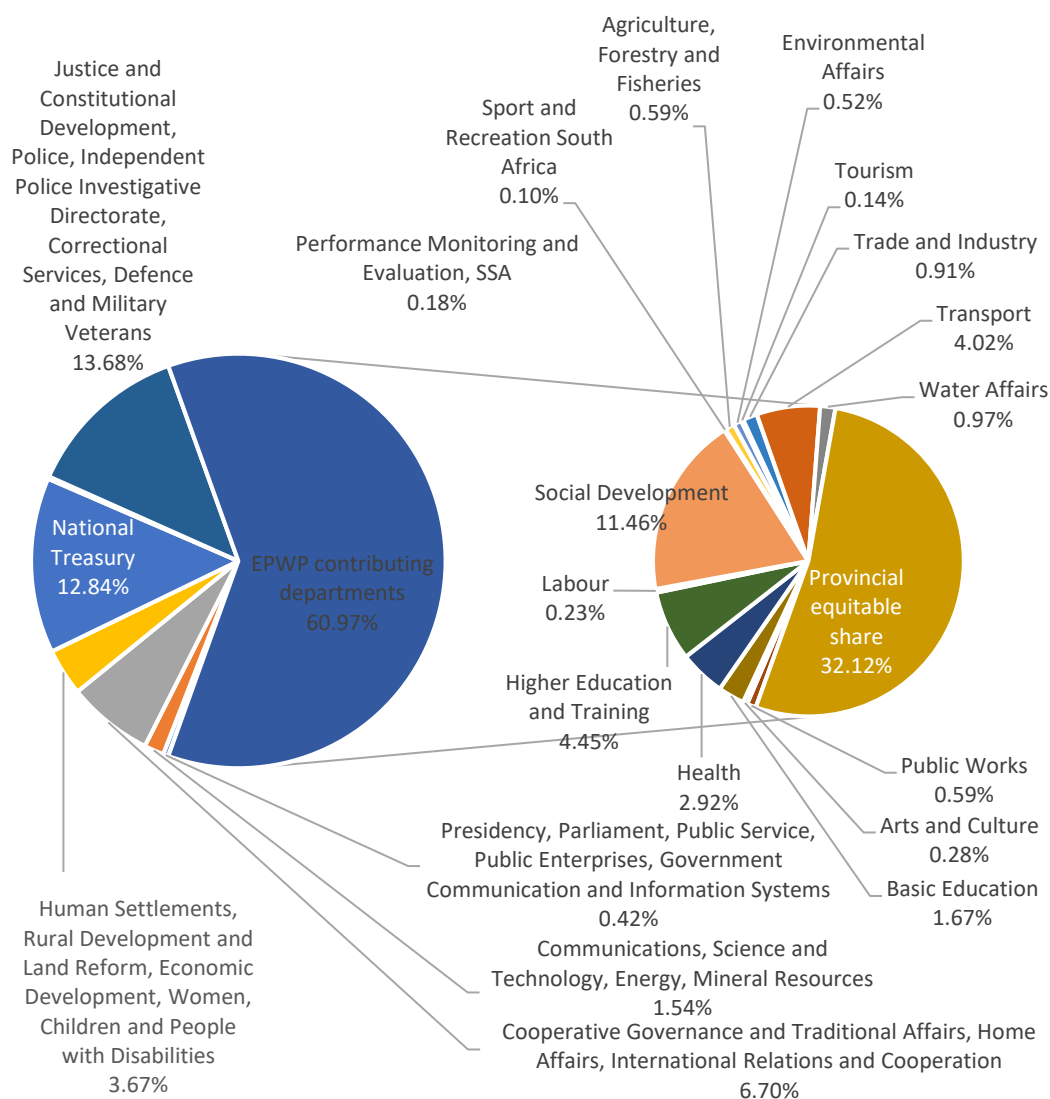
Figure 19: Allocation of consolidated government expenditure
Source: Author's compilation with data from National Treasury (2013)

Despite the large government expenditure, DPW (2014b) only reported an EPWP expenditure (including professional fees) of 17.4 billion rand in the year 2013/14, of

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[102] This amount is inclusive of state debt costs of 99,741.4 million rand and contingency reserve of 4,000 million rand in 2013/14.

which National government departments contributed 2,824.7 million rand and Provincial government departments 6,243.5 million rand, the remaining being attributable to contributions from the 103,963.4 million rand allocated to infrastructure expenditure according to the National Treasury (2013). Funding allocation to infrastructure is however not considered to be additional funding, but rather existing funds which are to be used in a labour intensive manner towards the EPWP. In view of the above, direct contributions from the government towards the EPWP for the financial year 2013/14 would therefore only amount to 9068.2 million rand (USD$ 844.2 million based on the March 2014 rate of 1 ZAR=USD$ 0.093096), constituting 0.86% of total government expenditure and 0.26% of GDP.

In McCord's (2007b) comparative study of PWP programmes (see Figure 20), the expenditure as % GDP of the EPWP in 2006/07 is reported at 0.20%, which is not much of a deviation from that in 2013/14. When comparing the programme cost as % GDP and jobs as % labour force of the EPWP with other PWP programmes though, the EPWP seems to pale in comparison to most of the others such as the PSNP, NREGA or Argentina's JEFES programme. Despite the EPWP's continuously more modest financial investment into phase two as compared to the other PWP programmes, the EPWP seems to have made some gains in terms of % labour force, with the DPW (2014b) reporting a provision of 278,725 person years of work[103] including training in 2013/14, which is 0.80% of the labour force of 35022 million in the fourth quarter of 2013 as reported in SSA (2013b). In spite of the EPWP's doubling of its employment creation impact in the second phase, efforts to reduce unemployment still appear rather inadequate when approached from the perspective of the Quarterly Labour Force Survey by SSA (2015d) which reports unemployment rate at 26.4% (see Figure 21), with both the official unemployment rate[104] and expanded unemployment rate[105] experiencing an increase since 2014, with a year on year rise of 1.2% and 1.0% respectively.

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[103] One person's year of work is equivalent to 230 days of work per year, with eight hours of work per day.
[104] SSA's official definition of unemployment is an individual aged between 15-64 (within the economically active population) who is without a job in the week preceding the interview, but who is job seeking or taking some initiative to start a business four weeks prior to the interview, who wants to work and is available to begin work within a week of the interview. The official unemployment rate is therefore tabulated based on the percentage of the economically active population which is without a job.
[105] The expanded definition of unemployment includes people who have stopped looking for a job, in addition to those who are officially unemployed.

	Total number of PWP jobs/annum	Total number of person years/annum	Total Labour Force	Jobs as % labour force	Person years as % labour force	Programme cost as % GDP
SOUTH AFRICA: EPWP (2006/7)	200,000	70,000	16,000,000	1.3%	0.44%	0.20*
INDONESIA: PK (1998/99)	1,481,481	181,818	92,000,000	1.6%	0.20%	0.20
INDIA: NREGP (2006/7)	21,200,000	4,109,091	427,000,000	5.0%	0.96%	0.30
INDIA: NREGP* (2008/9 estimate)**				15%	3	1.0
IRELAND: CEP (90s)	41,000	n/a	1,400,000	2.9%	n/a	0.18
ETHIOPIA: PSNP (2006/7)	1,500,000	n/a	31,000,000	4.8%	n/a	2.00
SENEGAL: AGETIP (2004)	21,000	n/a	4,500,000	0.5%	n/a	0.80
USA: NEW DEAL PROGRAMMES (1933-1940 average)	n/a	n/a	53,000,000	3.4-8.9%	n/a	3.9
JEFES: ARGENTINA** (2003)**	2,210,000	n/a	17,000,000	13.0%	n/a	0.90

* This figure rises to 0.47% if the funding allocation to infrastructure is included, however, since this is not additional funding, but existing funds which are to be used in a more labour intensive way, this figure has not been used in the table, and the 0.20% represents only social and environmental allocations for direct government employment activity.
** NREGP 2006/7 only operational in 200 out of 600 districts.
*** Indicative figures only based on assumption that programme is taken to scale as anticipated, ie programme is extended to all 600 districts by 2009, total cost anticipated to be approx 1% GDP, and approx 15% of the total labour force is likely to be employed.
**** The Jefes programme has a small companion programme, the Programmea de Emergencie Laboral (PEL), which is similar in terms of benefits but has slightly differing eligibility criteria, and so the data here is not representative of total PWP expenditure or performance in Argentina

Figure 20: Comparative assessment of the scale of EPWP

Source: McCord (2007b)

	Jan-Mar 2014	Oct-Dec 2014	*Jan-Mar 2015	Qtr-to-Qtr change	Year-on-year change	Qtr-to-Qtr change	Year-on-year change
	Thousand					Per cent	
Population aged 15–64 yrs	35 177	35 643	35 799	155	622	0,4	1,8
Labour force	20 122	20 228	20 994	766	872	3,8	4,3
Employed	15 055	15 320	15 459	140	405	0,9	2,7
Formal sector (non-agricultural)	10 780	10 911	10 796	-115	17	-1,1	0,2
Informal sector (non-agricultural)	2 336	2 448	2 483	35	147	1,4	6,3
Agriculture	709	742	891	150	183	20,2	25,8
Private households	1 231	1 219	1 288	69	58	5,7	4,7
Unemployed	5 067	4 909	5 535	626	468	12,8	9,2
Not economically active	15 055	15 415	14 805	-611	-250	-4,0	-1,7
Discouraged job-seekers	2 355	2 403	2 397	-6	42	-0,3	1,8
Other (not economically active)	12 700	13 012	12 408	-605	-292	-4,6	-2,3
Rates (%)							
Unemployment rate	25,2	24,3	26,4	2,1	1,2		
Employment/population ratio (absorption rate)	42,8	43,0	43,2	0,2	0,4		
Labour force participation rate	57,2	56,8	58,6	1,8	1,4		

Due to rounding, numbers do not necessarily add up to totals.
*Note: Q1:2015 estimates (column Jan-Mar 2015) are from the 2013 Master Sample.

Figure 21: Key labour market indicators

Source: SSA (2015d, iv)

Appendix C

EPWP's social sector and HCBC

EPWP social sector: Funding allocation and projects implemented

In the financial year beginning 1ˢᵗ April 2013 and ending 31ˢᵗ March 2014, a total of 2.9 billion rand have been allocated to the EPWP social sector, out of which 34.45% is injected into the health sector, 25.54% in social development and 18.12% in education (see Figure 22) (DPW 2014b). The skewed distribution of funding towards the health, social development and education sectors is observable across almost all nine provinces. With the exception of Gauteng province, the health, social development and education sectors together make up more than 70% of the total funding allocated to each of the other eight provinces (see Figure 23).

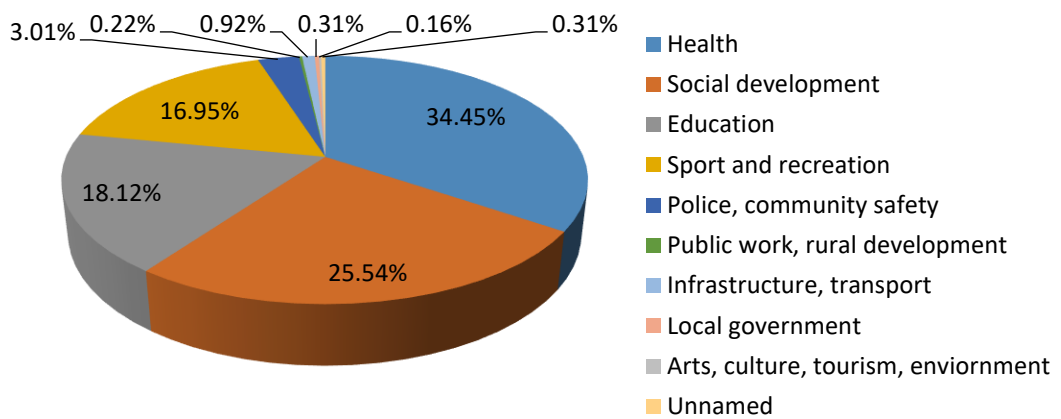*Figure 22: Budget allocation of the EPWP social sector*
Source: Author's own calculations with data from DPW (2014b)
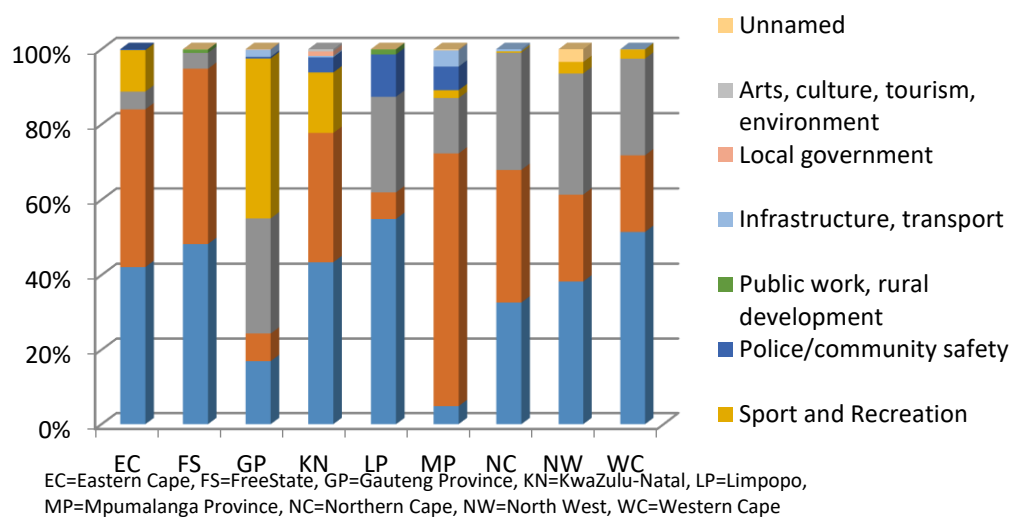

Figure 23: Provincial allocations of the EPWP social sector
Source: Author's own calculations with data from DPW (2014b)

In the health sector, provinces with more than 40% of their funding injected into health interventions include KwaZulu-Natal, Limpopo, Free State, Eastern Cape and Western Cape provinces. Significant concentration in the social development sector were observed in Eastern Cape, Free State and Mpumalanga provinces while education predominated in the Gauteng, Limpopo Northern Cape and North West provinces. When taking into account the number of projects implemented across each of these sectors, health, social development and education continue to predominate across all provinces (see Figure 24). Surprisingly though, the number of health projects recorded seems rather trivial when compared to the proportion of funds allocated to it, with social development and education based projects documenting significantly larger project counts. The large funding versus project ratio of the health sector may possibly be attributable to greater complexity in health programmes and hence the larger cost of each project, although the exact reasons have yet to be ascertained and is beyond the scope of my project.
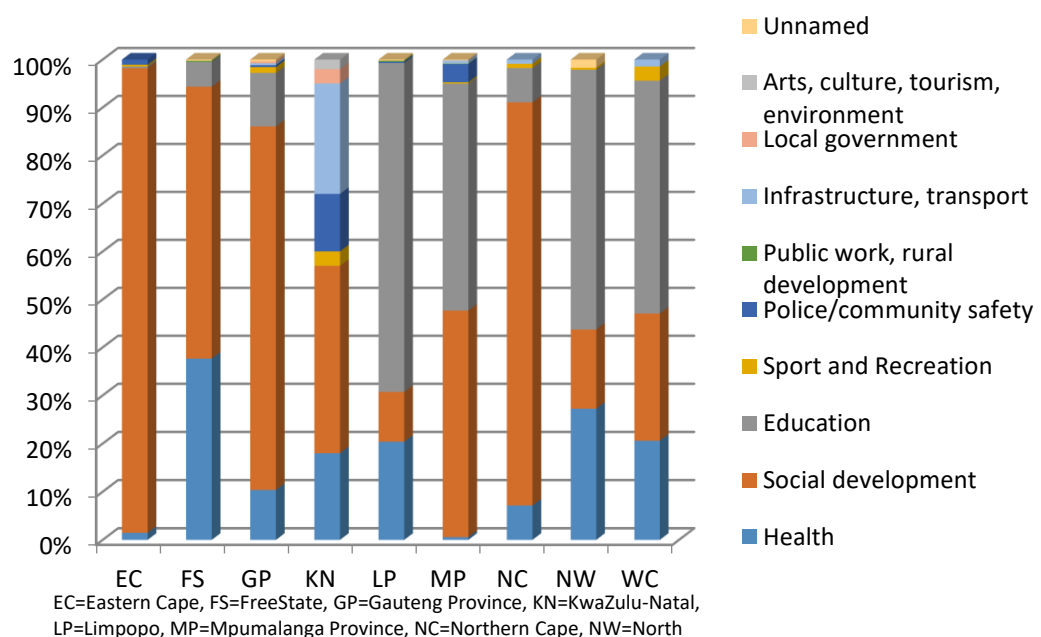
Figure 24: Project counts across sectors
Source: Author's own calculations with data from DPW (2014b)

A three pronged approach to HCBC in EPWP phase one

A three pronged approach to the HCBC has been proposed in the first phase of the EPWP (refer to Appendix B for an elaboration of the different phases in the EPWP). The first phase sets a target of 122 240 work opportunities, out of which 17 400 will be 'learnerships' (DoSD, DoE, and DoH 2004). The above targets are estimated based on a

report conducted by the National Population Unit in 2003, which was used as a guiding framework for the planning of HCBC under the EPWP. According to the report, there is an existing 892 sites already providing some forms of home community-based care services, out of which 87% are operated by CBOs/NGOs and 356 receive government funding (presumably from the DoSD) with further supplementation from international donors and businesses (DoSD, DoE, and DoH 2004).

The 892 sites are serviced by a total of 19 616 volunteers, of which 15 326 do not receive stipends. In view of the significant proportion of caregivers working without a stipend, the first prong of the three pronged HCBC plan (plan A) seeks to stipend and train these existing volunteers to the capacity of an NQF level 1 community care worker, to be implemented by the DoSD (see Table 1). According to the DoSD, DoE, and DoH (2004), volunteers at the NQF level 1 who are training for the Ancillary Health Care worker qualification will receive training in a number of electives.

Work category	2004/5	2005/6	2006/7	2007/8	2008/9	Duration	Jobs	Person years
Plan A: Current plan								
NQF level 1	5 988	-	7 000	-	7 000	18 months	19 988	29 982
NQF level 4								
Plan B: Short-term expansion								
DoSD: NQF level 1 & 3	4 284		4 284		4 284	18 months	12 852	19 278
DoH	9 000	9 000	9 000	9 000	9 000	12 months	45 000	45 000
Umsobomvu	3 000	3 000	3 000	3 000	3 000	12 months	15 000	15 000
QF level 4	500	2 400	3 500	5 000	6 000	24 months	17 400	34 800
Plan C: Medium-term expansion								
NQF Level 1 & 3	0	3 000	3 000	3 000	3 000	24 months	12 000	24 000

Table 1: HCBC work opportunities across a three pronged plan

Source: DoSD, DoE, and DoH (2004, 15)

Apart from the existing home community-based care sites under the purview of the DoSD, DoH also provide stipends for 19 810 community health related volunteers out of an approximate 60 000 across its HIV/AIDS programmes. In the second prong (plan B) of HCBC, the DoH seeks to train these 60 000 volunteers to be community healthcare workers at NQF levels 1 or 3, sharing the load with its partner, Umsobomyu. NQF level 3 Health Care worker positions have a more comprehensive training plan than level 1, consisting of 59 days of training to be offered by the DoH (DoSD, DoE, and DoH 2004). In addition, SETA targets to contribute 17 400 'learnerships', while DoSD aims to absorb an additional 4284 workers every other year as part of plan B. The final prong (plan C) would involve a medium term expansion of 300 HCBC sites a year, providing 3000 work opportunities per annum.

Appendix D
SATUS

South African Time Use Survey

South Africa is one of the first developing countries to measure, analyse and document the time spent daily on paid and unpaid activities by a diverse group of South Africans of all age groups, ethnicities, income levels and geographical locations (rural and urban). Two surveys were conducted across the space of 10 years, one in 2000 and the other in 2010, both with the intentions of providing a gendered perspective to the division of productive and social reproductive labour, offering an insight into the social wellbeing of different groups of individuals. The United Nations System of National Accounts (SNA) classification system which places 10 different forms of labour into 3 broad categories, has been adopted by the South African time use survey. SNA production activities underlie the calculation of GDP and include (1) waged and domestic work in establishments, job seeking, (2) primary production for establishments such as water/fuel collection, subsistence farming, and (3) other productive activities such as street trading, informal services (hairdressing) and home-based production. Non-SNA production activities include (4) household maintenance such as personal/ household shopping and housework, (5) care of persons in the household and (6) community service to non-household members. Non-productive activities pertain to (7) learning, (8) leisure mass media activities such as listening to radio or watching television, (9) personal care such as washing, dressing, sleeping, eating, drinking, and (10) social and cultural activities.

According to Budlender, Chobokoane, and Mpetsheni (2001), unemployed women tend to participate more actively in the non-SNA production activity of caregiving, although equal commitment seemed to be observed in household maintenance and community service (see Figure 25). However, when taking into account time spent in the above activities and not just the participation rates, women spend significantly more time on household maintenance and care of persons than men (see Figure 26). Time spent on community services/volunteer work appear to be the same for both sexes, although the types/forms of services offered by both sexes have not been documented. A gendered analysis of the forms of services provided to non-household members is therefore not possible without an understanding of the labour provided by men and women to the community in which they reside. The male-female gap in terms of time spent on household maintenance and care of persons widens when taking into account marriage

(see Figure 27), age (see Figure 28) presence of young children (see Figure 29), low household monthly expenditure (see Figure 30), and unemployment (see Figure 31).
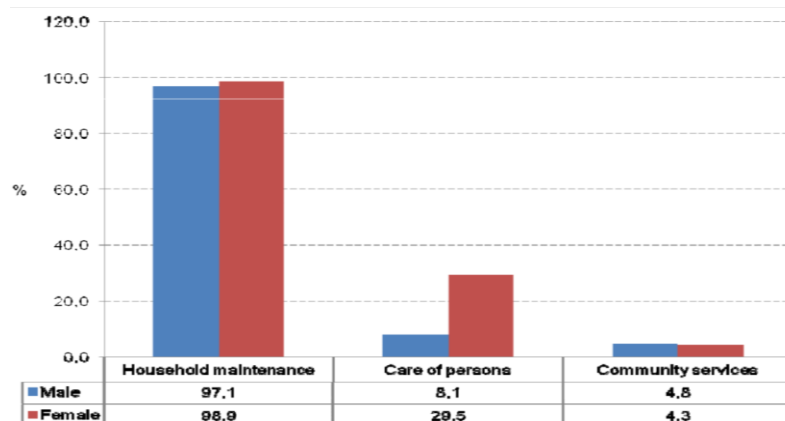

	Household maintenance	Care of persons	Community services
Male	97.1	8.1	4.8
Female	98.9	29.5	4.3

Figure 25: Participation in non-SNA productive activities

Source: Budlender, Chobokoane, and Mpetsheni (2001, 24)

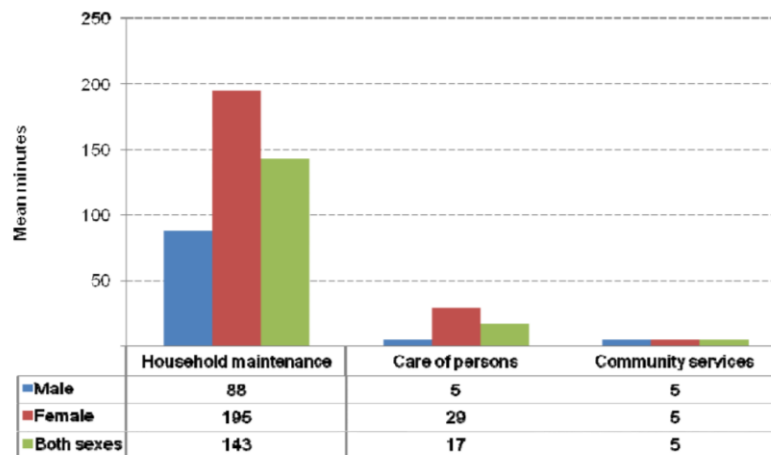|	Household maintenance	Care of persons	Community services
Male	88	5	5
Female	195	29	5
Both sexes	143	17	5

Figure 26: Mean minutes spent on non-SNA productive activities

Source: Budlender, Chobokoane, and Mpetsheni (2001, 29)

	Household maintenance			Care of persons			Community services		
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes
Married*	94.5	98.9	97.2	15.0	38.4	29.2	5.9	5.0	5.3
'Widowed/seperated'**	98.6	98.8	98.8	8.6	22.1	19.2	3.4	5.4	4.9
Never married	98.2	98.9	98.6	5.0	25.4	15.6	4.4	3.6	4.0
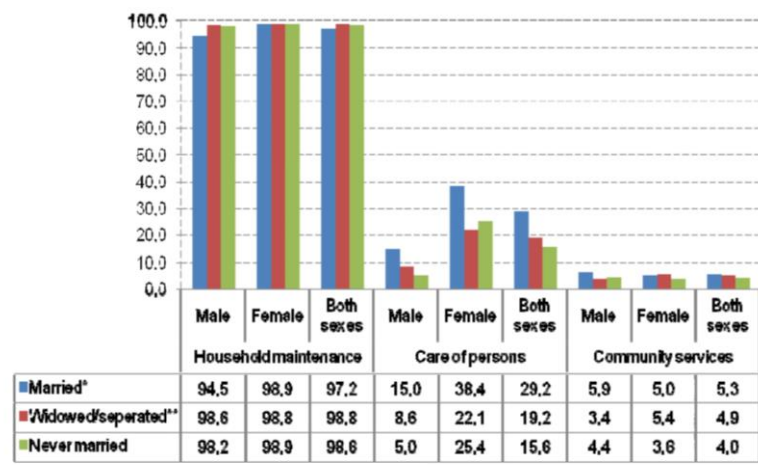
Married includes married and living together like husband and wife
*Widowed/separated includes widow, widower, divorced or separated

Figure 27: Participation rates in non-SNA productive activities by sex and marital status

Source: Budlender, Chobokoane, and Mpetsheni (2001, 25)

	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes
	Household maintenance			Care of persons			Community services		
10-17 years	66	112	89	2	7	4	2	1	1
18-45 years	94	220	158	5	43	24	5	5	5
46 years and above	93	210	157	6	15	11	8	6	7

Figure 28: Participation rates in non-SNA productive activities by sex and age group

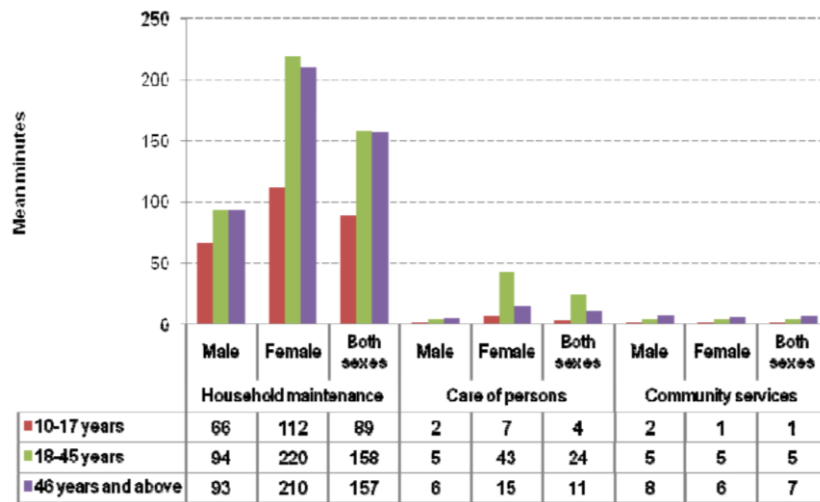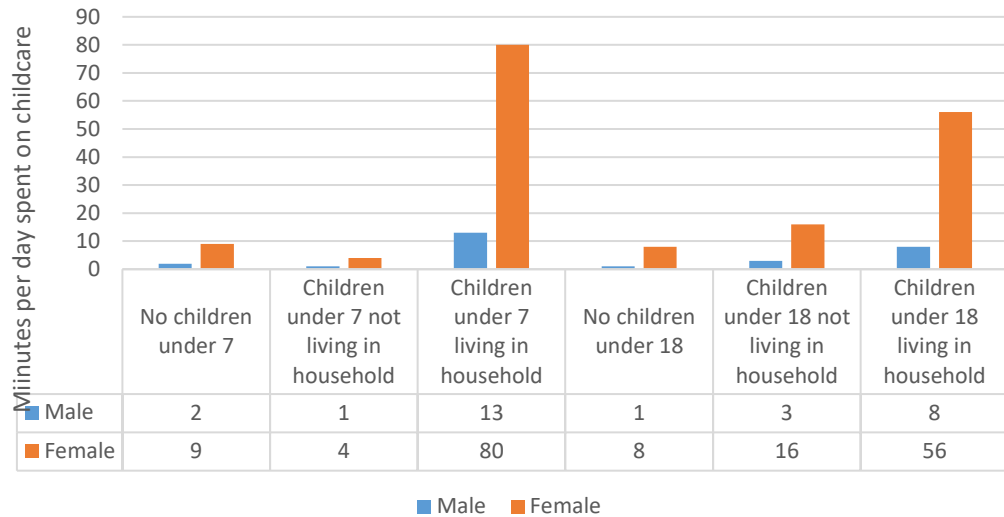*Source: Budlender, Chobokoane, and Mpetsheni (2001, 30)*

	No children under 7	Children under 7 not living in household	Children under 7 living in household	No children under 18	Children under 18 not living in household	Children under 18 living in household
Male	2	1	13	1	3	8
Female	9	4	80	8	16	56

■ Male ■ Female

Figure 29: Time spent on child care by sex and age of children

Source: Author's own, with data from SSA (2013a)

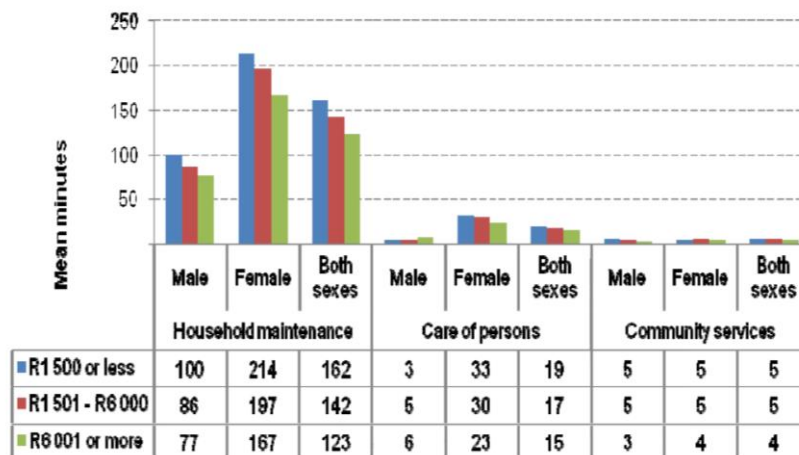|	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes
	Household maintenance			Care of persons			Community services		
R1 500 or less	100	214	162	3	33	19	5	5	5
R1 501 - R6 000	86	197	142	5	30	17	5	5	5
R6 001 or more	77	167	123	6	23	15	3	4	4

Figure 30: Mean minutes spent on non-SNA productive activities according to household expenditures

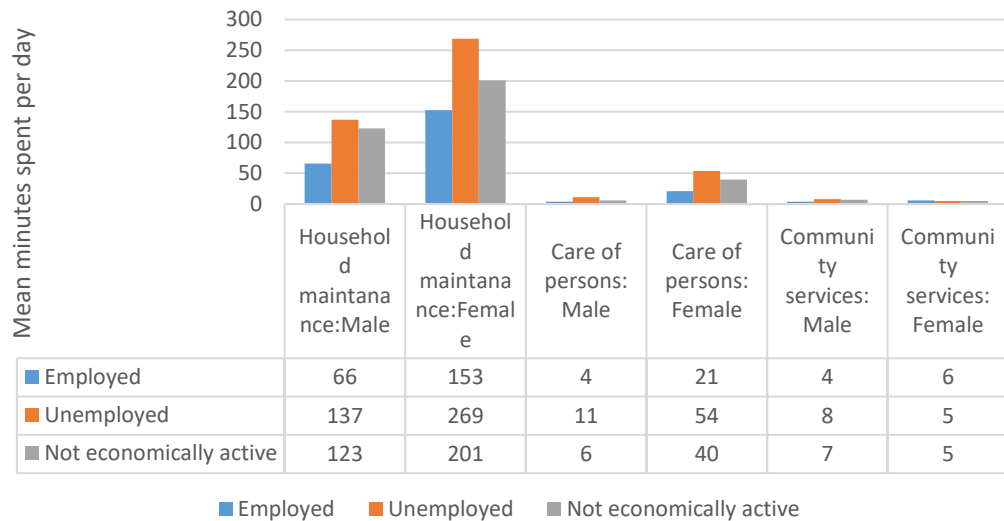*Source: Budlender, Chobokoane, and Mpetsheni (2001, 32)*

Figure 31: Mean minutes spent by respondents above 18 by labour market status and activity types

Source: Author's own, with data from SSA (2013a)

Comparing the 2010 statistics against those in 2000 before the implementation of the EPWP, the gender gap in time dedicated to non-SNA productive labour does not seem to have been closed as women continue to dedicate an average 2.5 times more time to such work than men (see Figure 32). Furthermore, similar to the statistics of 2010, women in their productive age who have a lower household expenditure tend to shoulder more responsibilities in non-SNA productive activities (see Figure 33 and Figure 34). Unemployed women also tend to invest the most time into non-SNA production activities, approximately three times that of unemployed men and one and a half times that of unemployed women and women who are not economically active (see Figure 35).
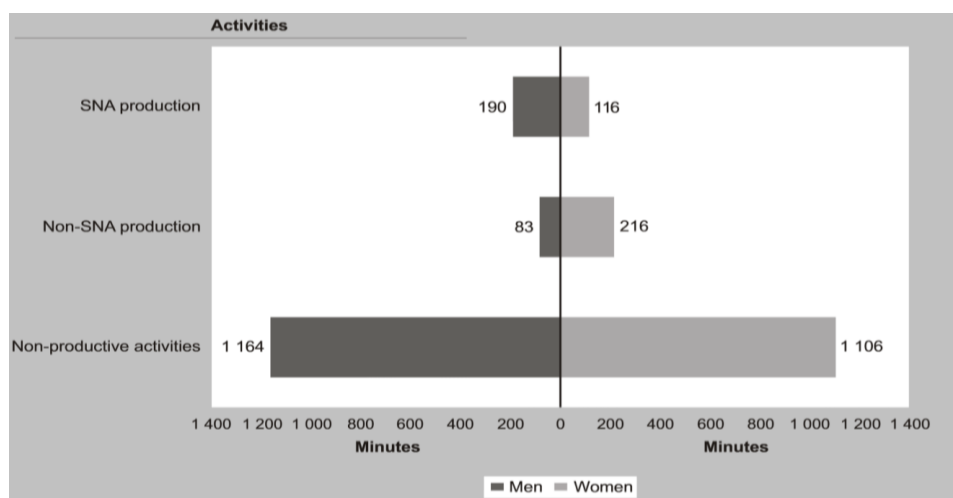

Figure 32: Mean minutes spent on productive and non-SNA productive activities by sex

Source: (Budlender, Chobokoane, and Mpetsheni 2001, 36)

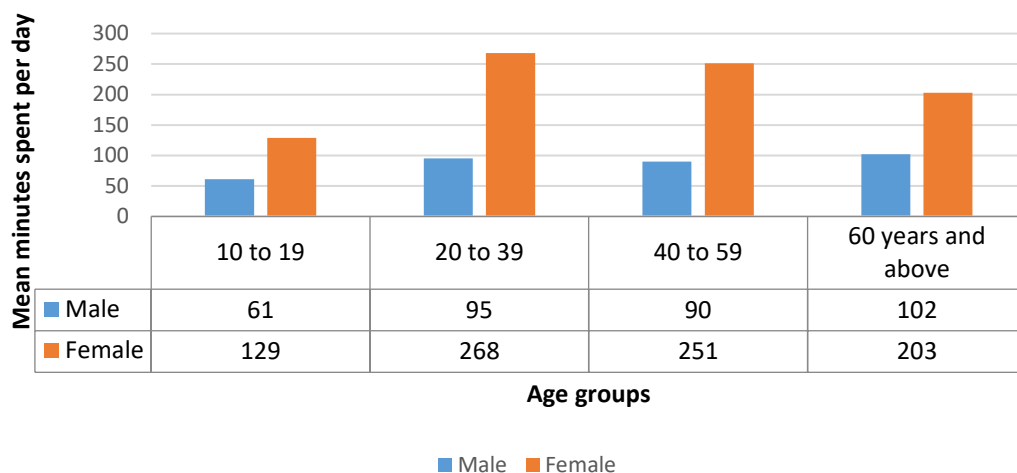| Age groups	10 to 19	20 to 39	40 to 59	60 years and above
Male	61	95	90	102
Female	129	268	251	203

Male   Female

Figure 33: Participation rates in non-SNA productive activities by sex and age group

Source: Author's own, from data in Budlender, Chobokoane, and Mpetsheni (2001)

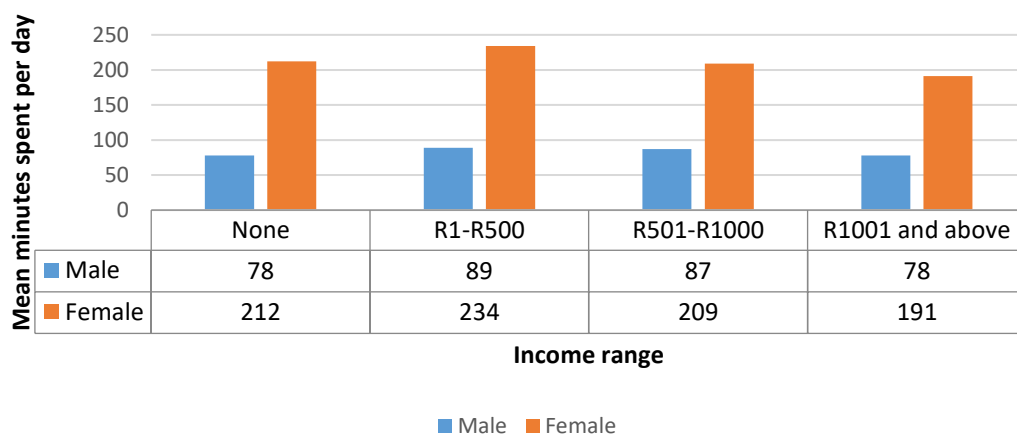| Income range	None	R1-R500	R501-R1000	R1001 and above
Male	78	89	87	78
Female	212	234	209	191

Male   Female

Figure 34: Mean minutes spent on non-SNA productive activities according to household expenditures

Source: Author's own, with data from Budlender, Chobokoane, and Mpetsheni (2001)

	SNA production: Male	SNA production: Female	Non-SNA production: Male	Non-SNA production: Female	Non-productive: Male	Non-productive: Female
Employed	328	260	82	210	1029	969
Unemployed	121	46	119	349	1200	1045
Not economically active	42	28	78	203	1320	1206

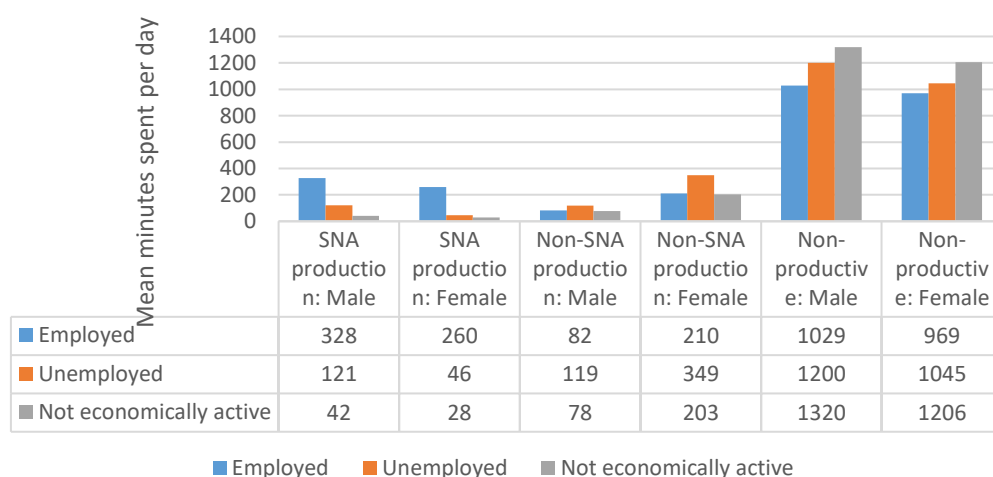Employed   Unemployed   Not economically active

Figure 35: Mean minutes spent by on productive and non-productive activities by labour market status

Source: Author's own, with data from Budlender, Chobokoane, and Mpetsheni (2001)

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Appendix E

Quarterly Labour Force Survey 2015

QLFS 2015: Labour market transitions and occupational gender difference

The 2015 QLFS will be used for an analysis of changes in the formal and informal sector by industry and sex between the periods 2008 to 2015, which covers the second phase of the EPWP. The above analysis may be useful towards substantiating findings from the empirical studies, as it reveals the extent to which changes in market demands across sectors and occupational gender difference affects the employment patterns/ opportunities of women (many of whom would be EPWP participants). In assuming the QLFS employment data to be representative of female EPWP participants, I am aligning with the DPW's (2009c) claim that the LFS is a useful evaluative tool for phase one of the EPWP since 1800 out of its 800 000 participants would be represented.

Along the same line of argument as DPW (2009b), the QLFS 2015 would offer more predictive results for EPWP phase two which has 2.5 times the number of participants in phase one. The above would imply that 4578 EPWP participants may be included in the QLFS, out of which 15.24% (N=698) may be participants from the EPWP social sector, which would provide a sufficiently large sample for an analysis of the HCBC programme. While not being able to profile HCBC participants, a longitudinal analysis of employment market changes from 2008 to 2014 may provide us with an understanding of the types of jobs which are available to HCBC participants, enabling an evaluation of the significance of their training towards their acquisition of employment.

In mapping employment shares by sex and industry across the period 2008-2014, three trends can be identified. First, six key industries, namely (1) community and social services, (2) trade, (3) finance, (4) manufacturing, (5) private households and (6) construction continue to be the largest provider of jobs (see Figure 36 and Figure 37), although community and social services seems to have overtaken trade in having the largest share of employment. In particular, the share of employment in community and social services increased from 19.03% in 2008 to 21.51% in 2011 to 22.67% in 2014, while trade decreased from 22.73% in 2008 to 22.37% in 2011 to 20.78% in 2014 (see Figure 38). Major increases also seem to be observable in the finance and transport industries while manufacturing experienced a decline, with the other sectors remaining somewhat stable.
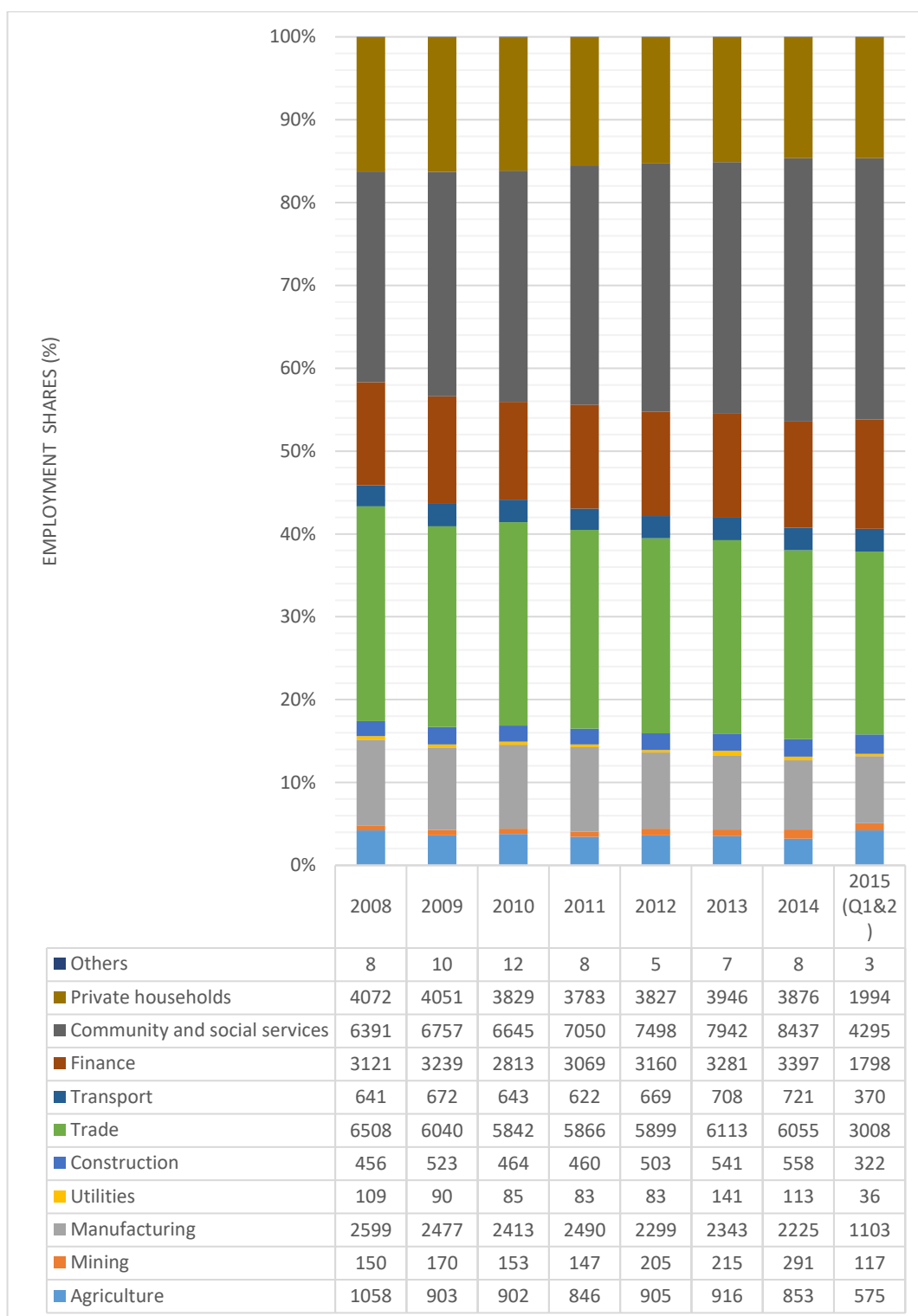
	2008	2009	2010	2011	2012	2013	2014	2015 (Q1&2)
■ Others	8	10	12	8	5	7	8	3
■ Private households	4072	4051	3829	3783	3827	3946	3876	1994
■ Community and social services	6391	6757	6645	7050	7498	7942	8437	4295
■ Finance	3121	3239	2813	3069	3160	3281	3397	1798
■ Transport	641	672	643	622	669	708	721	370
■ Trade	6508	6040	5842	5866	5899	6113	6055	3008
■ Construction	456	523	464	460	503	541	558	322
■ Utilities	109	90	85	83	83	141	113	36
■ Manufacturing	2599	2477	2413	2490	2299	2343	2225	1103
■ Mining	150	170	153	147	205	215	291	117
■ Agriculture	1058	903	902	846	905	916	853	575

Figure 36: Employment shares by industry of women

Source: Author's own calculations from data in SSA (2015c)

	2008	2009	2010	2011	2012	2013	2014	2015
■ Others	6	7	4	12	7	6	8	4
■ Private households	1142	1115	1122	1071	1101	997	1043	585
■ Community and social services	4714	4683	4854	5059	5310	5463	5537	2703
■ Finance	4010	4210	4180	4202	4449	4700	4722	2561
■ Transport	2653	2525	2620	2623	2770	2948	3006	1450
■ Trade	6756	6440	6450	6725	6681	6415	6754	3157
■ Construction	4404	4234	3973	3974	3859	4041	4437	2400
■ Utilities	305	328	294	280	324	372	358	243
■ Manufacturing	5765	5337	4943	4994	4968	4895	4813	2432
■ Mining	1266	1189	1155	1190	1297	1429	1421	772
■ Agriculture	2217	1957	1760	1731	1878	2014	2252	1187

Figure 37: Employment shares by industry of men

Source: Author's own calculations from data in SSA (2015c)
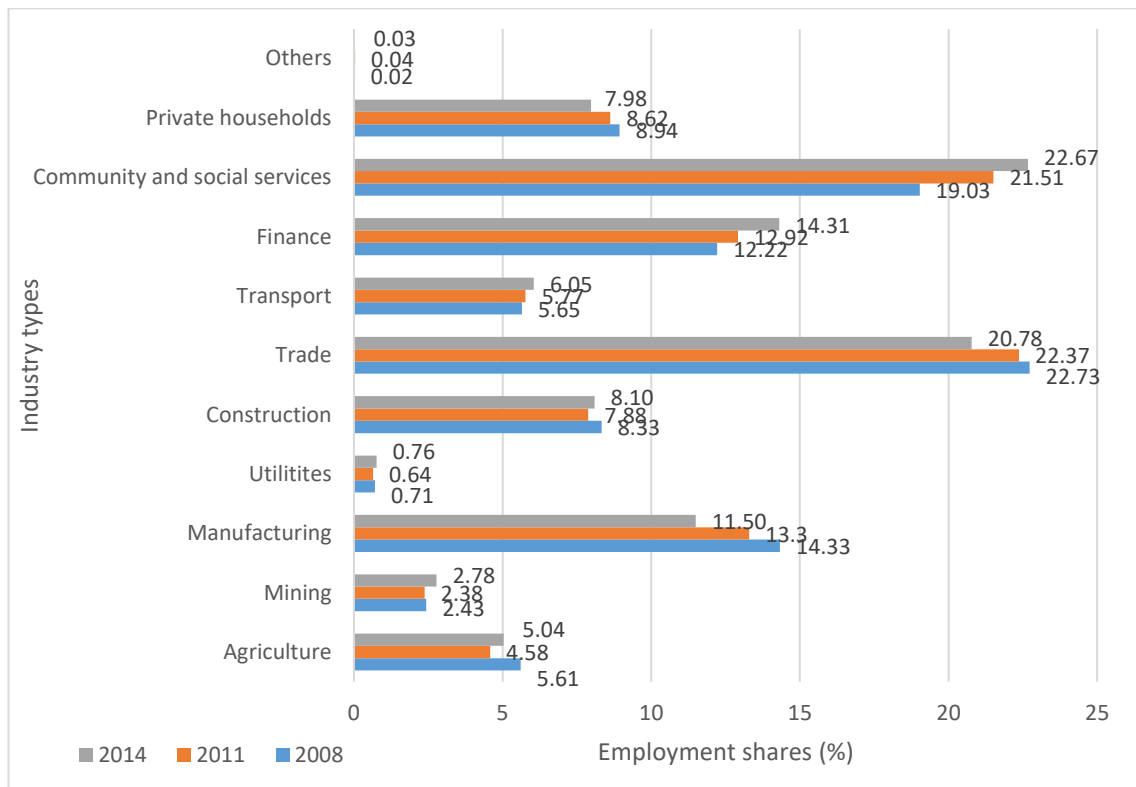
Figure 38: Percentage of employment shares by industry, 2008-2014
Source: Author's own calculations from data in SSA (2015c)

Second, there appears to be occupational segregation as women dominate in community and social services and private households, while a predominance of men is found in the manufacturing, construction and transport industries (see Figure 36 and Figure 37). Industries such as trade and finance appear to be more gender neutral. Third, it seems that an increase in demand in the community and social services industry has contributed towards an increase in market absorption rate of women, as a significant percentage of the opportunities seem to be filled by women. In 2008, women make up 57.55% of employees in the community and social services industry, rising to 60.38% in 2014 (see Figure 39). On the other hand, gains in employment opportunities in the finance industry benefited men more than women, with the percentage of men rising from 56.23% in 2008 to 60.68% in 2014 (see Figure 40). The proportion of men and women in the transport industry remained rather stable, rising very slightly from 80.54% of men in 2008 to 80.65% in 2014 (see Figure 41), demonstrating that growth benefitted both sexes equally. As for manufacturing, it seems that men were harder hit than women by the decline in employment opportunities, with the employment share of men in the industry declining from 68.93% in 2008 to 67.90% in 2014 (see Figure 42). Not only are women over-

represented in the community and social services industry, rising demand in this industry is also likely to benefit women more than any other industries.
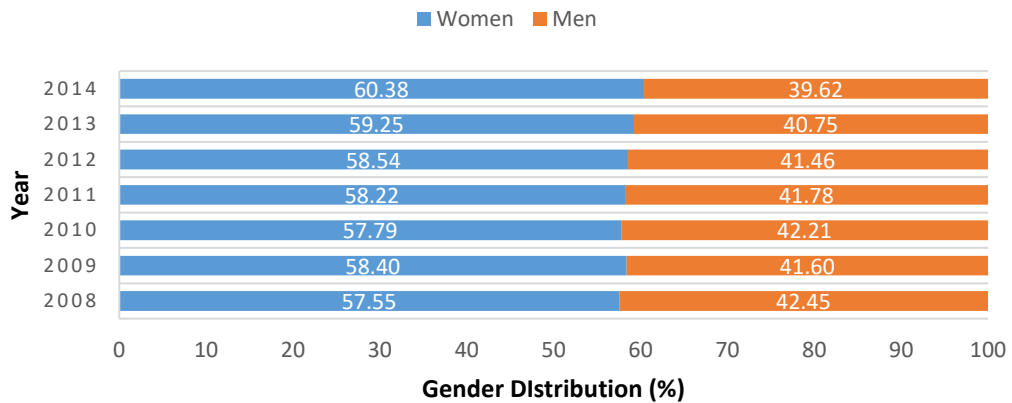

Figure 39: Percentage of men and women in the community and social services industry, 2008-2014

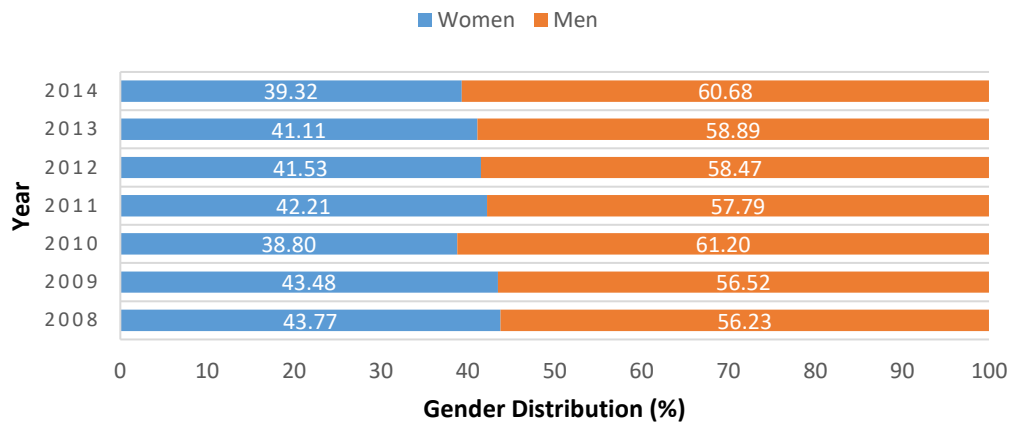*Source: Author's own calculations from data in SSA (2015c)*

Figure 40: Percentage of men and women in the finance industry, 2008-2014
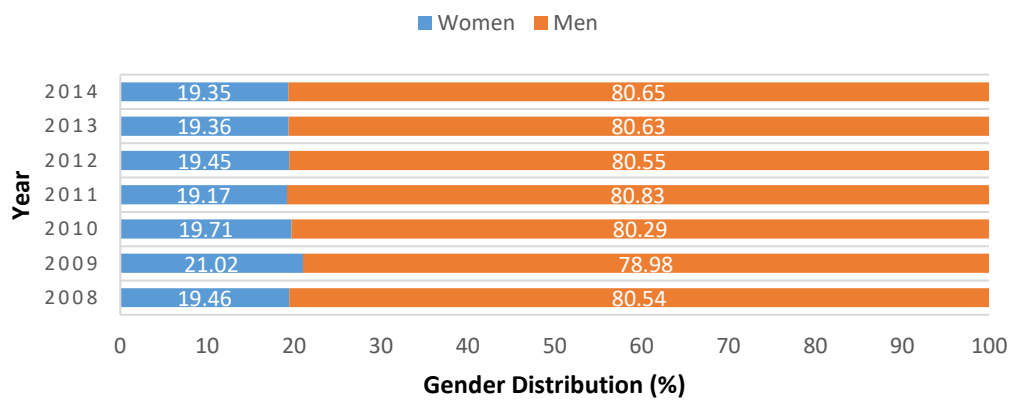
Source: Author's own calculations from data in SSA (2015c)

Figure 41: Percentage of men and women in the transport industry, 2008-2014

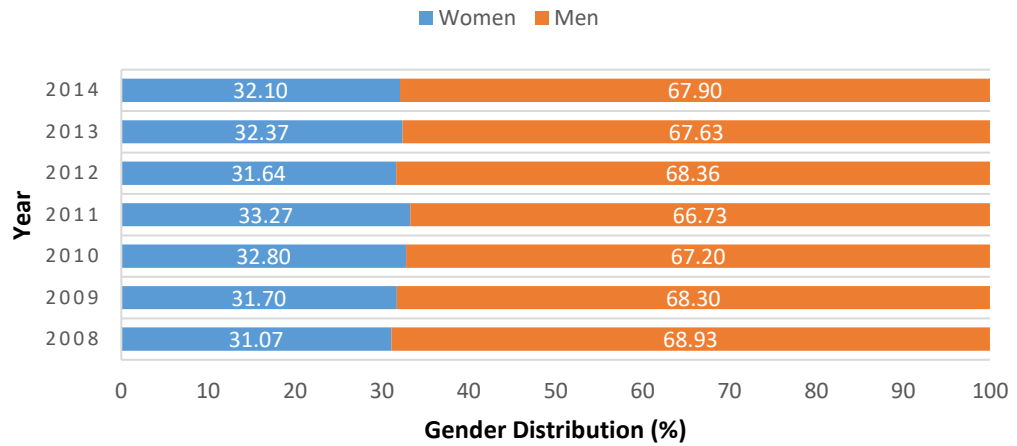*Source: Author's own calculations from data in SSA (2015c)*

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Figure 42: Percentage of men and women in the manufacturing industry, 2008-2014

Source: Author's own calculations from data in SSA (2015c)

Looking at the distribution of skilled labour in 2008 and 2014 (see Figure 43), it would be possible to assume that at least an approximate 75% of the jobs in the community and social services industry would be semi-skilled or low skilled. The above data points to rising market demand, and hence increased low/semi-skilled employment opportunities in the community and social services industry, one which will be more likely to benefit women since the sector is predominantly female.
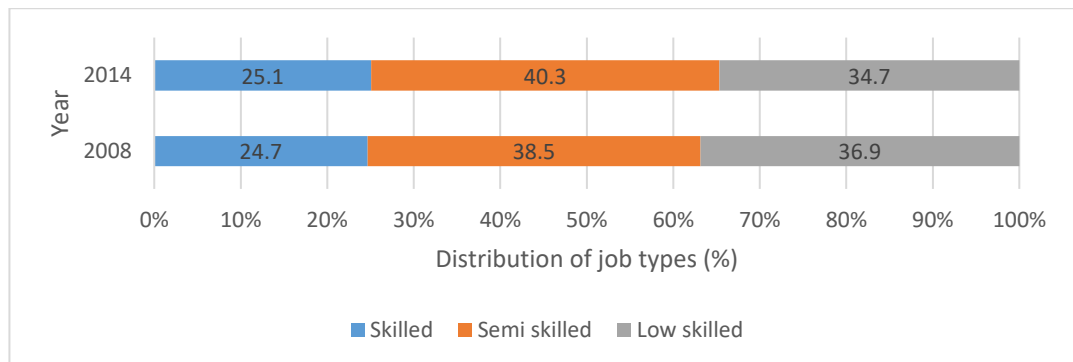

Figure 43: Share of skilled occupation of women in 2008 and 2014

Source: Author's own calculations from data in SSA (2015c)

EPWP stipends

EPWP stipends 2004/05-2014/15

The social sector grant manual of DPW (2012a) states that targeted stipend for HCBC participants is set at R63.18/day, and 80% of HCBC funds are to be directed towards the paying of stipends and training of participants. A comparison of HCBC workers' stipend with other sectors of the EPWP reveals that participants in the HCBC (EPWP social sector) are paid significantly less than the other sectors. For example, DPW's (2014b) most recent report on the first quarter 2014/15 calculated the average minimum daily wage of the infrastructure sector at R128.17, the environmental and culture sector at R106.16, while that of the social sector is at a low of R75.32. Charting the distribution of pay-outs across EPWP's first and second phases, it appears that social sector participants continue to be underpaid compared to other sectors. The rate of pay increment of the social sector across all ten years of the EPWP is also much slower than other sectors. Social sector participants received more than those in environmental and culture sector, and slightly less than the infrastructure sector in the first two years of the EPWP (see Figure 44). However, the pattern of distribution changed rather drastically when the social sector experienced a sharp drop in stipends in 2006/07, making it the lowest paid sector for the subsequent years. The infrastructure and environment and culture sectors experience a steady rise in average daily wages between 2004/05 to 2014/15, while the daily average wages of the social sector demonstrate significant fluctuations. It is evident from DPW's quarterly reports of the EPWP that apart from being rather poorly remunerated, HCBC participants also tend to be succumbed to unpredictable payments which limits their ability to control economic resources.
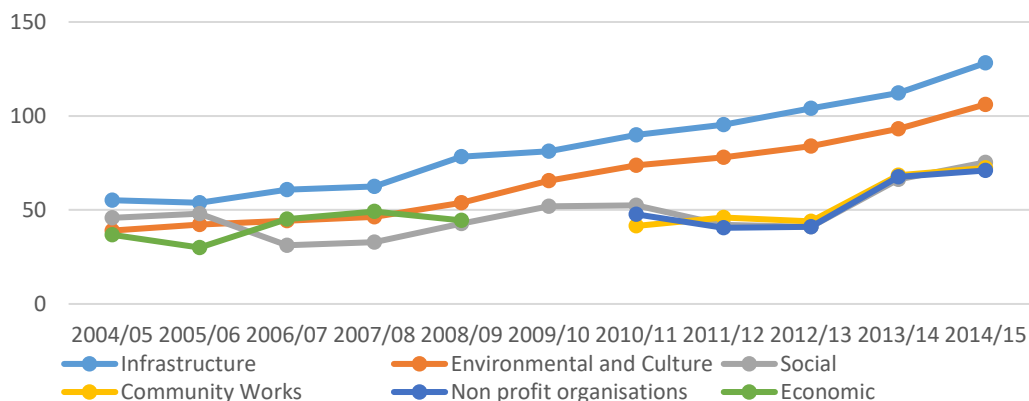

Figure 44: Average daily wages across sectors, 2004/05-2014/15
Source: Author's own, from data in the DPW quarterly reports