Tracing the Normative Framework of South Africa's response to Early Childhood Development and Long-Term Care During the COVID-19 pandemic

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A dissertation submitted in partial fulfilment of the requirements for the award of the degree of Masters of Social Sciences in Industrial Sociology

Faculty of the Humanities

University of Cape Town

2023

COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Abstract

The COVID-19 pandemic has laid bare the crucial role of social care and its fundamental importance in shaping our lives. This research employs a critical political ethics of care approach to evaluate the South African government's response to mandated social care provision during the pandemic. Through a systematic analysis of the state's actions in managing and coordinating Early Childhood Development programs and Long-Term Care facilities for Older Persons throughout the COVID-19 pandemic, this investigation uncovers a pervasive lack of attentiveness, responsibility, competence, and responsiveness. Furthermore, this study delves into the factors contributing to the neglect of these vital care sectors. To do so, it examines the normative approaches to care as delineated in policy documents. Specifically, this research draws upon the White Paper on Social Welfare (1997) and the White Paper on Families (2013) to contextualise the government's response and reveal a predominant familialist approach to care. Within these documents, the study employs the insights of Selma Sevenhuijsen and colleagues (2003) and the Trace method to unearth the conceptualization of welfare and the allocation of caregiving responsibilities. Finally, the research investigates the correlation between the state's response to Early Childhood Development programs and Long-Term Care facilities and the rhetoric, norms, and discourses embedded in the aforementioned policy documents.

Keywords: Early Childhood Development, Long-Term Care, Older Persons, Social Policy, Ethics of Care

Acknowledgement

The research presented in this thesis marks the culmination of almost two years of dedicated effort. Looking back, this journey has been both demanding and incredibly rewarding. I would like to express my sincere appreciation to my supervisor, Prof Elena Moore, for her invaluable guidance and unwavering dedication to upholding an ethics of care in everything she does. I am profoundly grateful for her consistent words of encouragement, her patient nurturing of this research, and her constructive feedback.

This endeavour would not have been possible without the constant care and support from my Mum, masi's and my two dear grannies. Many thanks to my dear friends, Savannah De Matos and Azminah Jhetam, for indulging my spontaneous research insights and lifting my spirits when I needed it most. I am also grateful to Vayda Megannon for the words of affirmation, steadfast support and academic guidance.

Chapter 1: Introduction

"But what does it mean, the plague? It's life, that's all."
— Albert Camus, The Plague

The first case of COVID-19 in South Africa was reported on 5 March 2020. By 23 March, a 'lockdown' was announced to curtail the spread of the novel coronavirus. Through a series of levels, ranging in severity of restriction from level 5 through to level 1, limitations on movement and non-essential activities were imposed. At the height of restrictions i.e. level 5, all educational institutions and businesses deemed non-essential were closed. By April 2020, President Cyril Ramaphosa announced a significant package of social and economic measures to the sum of R50 billion to combat the socio-economic fallout of the rapidly spreading virus and the subsequent lockdown measures (Webb and Vally, 2020). Drawing on South Africa's prolific and far-reaching cash transfer system, the first point of response was to increase the value of existing grants and establish a new Social Relief of Distress (SRD) grant.

Overall, the government reached approximately 30 million South Africans with cash-based relief measures (Center for Global Development, 2020). The positive impact of social cash transfers in the South African context is widely researched (Heinrich et al., 2012; Sagner and Mtati, 1999; Wright et al., 2015). Social grants have contributed significantly towards the reduction of poverty in the country (Satumba et al., 2017). During the pandemic, social grants proved indispensable as the virus and the corresponding lockdown measures disrupted all spheres of life – exacerbating unemployment, hunger, and care demands. However, there remains a dearth of interrogation on how the South African government responded to other realms of social provisioning – particularly state-supported social care.

This thesis examines the South African government's response to Long-Term Care facilities (hereafter referred to as LTC) for older persons and Early Childhood Development (hereafter referred to as ECD) programmes for young children using an ethics of care approach. Specifically, I explore the following research question: How did the South African state respond to LTC facilities and ECDs during the COVID-19 pandemic? And how does this response trace back to

related social policy and the norms held within it? The exploration of this question will be guided by three specific objectives:

1) Critically assess the state's actions towards LTC and ECD facilities during the covid-19 pandemic
2) Explore the relationship between these actions and the normative, ethical, and ideological principles held within social policy documents.
3) Provide brief insight into the implications of retaining a familialist approach to social caregiving.

The care for older persons and young children in South Africa occurs at multiple sites, across a complex regime of care (Button et al., 2018; Moore and Seekings, 2014). Owing to the country's legacy of Apartheid, structural unemployment, profound inequality and established norms of communitarianism, care is largely provided by kin, particularly women (Moore, 2019; Sevenhuijsen et al., 2003). While kinship and community caregiving remain the backbone of life-making in South Africa, factors such as structural unemployment, the turn to austerity in social provisioning, the commodification and marketisation of care and the greater demand for care needs particularly among the ageing population threaten the capacity of families specifically women to adequately perform and provide care (Razavi, 2011; Moore, 2023). Scholars (for example Fraser, 2017; Stevano et al., 2021; Dowling, 2021), albeit predominantly located in the Global North, argue that globally the crisis of care is intensifying, and there is an urgent need to build resilient state-supported and socialised avenues for care. Thus, considering this observation, I have purposely opted to interrogate LTC facilities and ECD programmes–to unveil how the state, presently, features in the 'assignment of care' (Hassim, 2021).

The landscape of social care provision in South Africa is characterised by numerous challenges and has often been overlooked or under-prioritised. In the realm of care for older persons, specifically, 'old age homes', there exist 417 residential facilities officially listed under the Department of Social Development (DSD). Additionally, numerous private facilities operate without official registration. Among these, nine are government managed. Alongside these residential facilities, there are also 1,713 registered community-based care and support services specially dedicated to older individuals. These services predominantly offer home-based care or

organise community activities (Moore, 2023). It's worth noting that the quality and consistency of these services can vary, with NGOs frequently encountering financial challenges (DSD, 2021). However, South Africa's population is ageing and the need for care is rapidly increasing. Projections suggest that in 2040, individuals aged 60 and above will surpass the population of those aged 5 and below, marking the first occurrence of such an age shift (Day and Gray, 2017). Despite projections that care demands will increase among those aged 60 and older, the care of older persons is yet to be adequately prioritised indicating the marginalisation of the demand to improve access to socialised forms of care (Kelly et al., 2019).

Similarly, challenges around access to and the establishment of reliable socialised care are also evident in the ECD sector. ECDs provide a range of important programmatic options to meet the needs of young children. In addition, ECD programmes also provide childcare which often reduces the burden of care placed on women. Even before the pandemic, financial barriers played a massive role in mediating access to ECD facilities (Wills et al., 2021). Despite high rates of poverty and chronic joblessness, fee payments for ECD services remain unaffordable and many unregistered ECD centres are unable to access the allocated subsidies. In 2019, it was recorded that only around 12% of poor children under six years had access to partially subsidised early learning programmes (Ilifa Labantwana et al., 2019). Over and above access, several complex infrastructural, administrative, and bureaucratic challenges persist in the ECD sector. By detailing the state's response to LTC facilities-and ECD programmes and relatedly for two distinct groups i.e., older persons and young children during COVID-19, this thesis aims to demonstrate the common trends and patterns in state-supported care provision.

There is consensus amongst feminist scholars that the COVID-19 pandemic can be read as a watershed moment for making "obvious that the tasks and responsibilities associated with care underpin the economy and shape the relationship between paid work, private relationships and social life" (Hassim, 2021, 53). The closure of schools increased childcare responsibilities among caregivers, highlighting the importance of high-quality, accessible care provision. Above all the pandemic is undoubtedly a moment of unique illumination, particularly in that it "allowed us to deeply feel the vulnerability of life" (Orozco, 2022, iii). The exposure of our vulnerability is not only a means to understand our relationality but represents a moment of profound political significance because our inescapable interdependence is a tenet of life that neoliberalism attempts to suppress (Ghandeharian and FitzGerald, 2022). The COVID-19 pandemic thus represents a

critical opportunity to reinstate the inherent vulnerability of life in all political, economic, and social deliberations particularly at the level of policy.

This thesis contributes to the field of industrial sociology, highlighting the pivotal role that care plays in the broader context of work and societal structures. Amid the COVID-19 pandemic, the study accentuates the interconnectedness of care and challenges the conventional definition of "productive work," underscoring its vital role in discussions on equality and the broader societal impact of labour. By explicitly addressing essential aspects such as long-term care for the elderly, childcare practices, and the intricate gender dynamics within caregiving responsibilities, this research positions care at the forefront of crucial conversations that shape the ever-evolving landscape of work. Through its nuanced examination of these critical dimensions, the thesis enriches the understanding of industrial sociology, shedding light on the transformative implications of care within the dynamics of labour and societal structures.

I use a 'critical political ethics of care' as a theoretical framework and method to undertake the task of assessing the state's response to LTC facilities and ECD programmes during the height of the COVID-19 pandemic. I use the term 'critical' to emphasise a break with the broader tradition of care ethics. A critical political ethics of care exposes the ways in which social policies and care relations are intertwined and co-constitutive. Social policy is frequently portrayed as emerging from an objective process that relies on rational thinking and economic logic, disguising itself as value-free (FitzGerald, 2020). However, contained within policies are carefully crafted norms and discourses that have implications for who is assigned the responsibility to care and how this informs the extent to which social provision is marginalised in the overarching political and economic agenda of the state.

I draw extensively on Sevenhuijsen's et al. (2003) paper titled "South African Social Welfare Policy: An Analysis Using the Ethic of Care", which assesses the 1997 White Paper for Social Welfare and its approach to care. Sevenhuijsen et al (2003, 311) argue that South Africa draws "heavily on a familialist model of social caregiving" without a related consideration of the situation in which families find themselves. This familialist ethos can be traced back to various, intersecting factors such as the legacy of Apartheid, the principle of Ubuntu which emphasises communitarian values and an overarching discourse of self-reliance in the post-Apartheid context (Gouws and Van Zyl, 2015). The net result is the allocation of care to kinship units wherein the responsibility

to provide as well as finance care is placed squarely on the individual (mostly women) (Hatch and Posel, 2018). I revisit the 1997 White Paper for Social Welfare, which remains the most prolific document on social provision in South Africa, and the more recent White Paper on Families (2013) to demonstrate that the norms held within policy are not benign but have material consequences for both caregiving and care-receiving as evidenced by the neglectful response to LTC facilities and ECDs during the COVID-19 pandemic.

The structure of this thesis unfolds as follows: Chapter Two sets the stage by delving into the theoretical framework underpinning this thesis. It offers a concise genealogical overview of the ethics of care, coupled with an exploration of the emergence of the 'critical ethics of care' perspective. Moving to Chapter Three, the research design is outlined, illustrating how the theoretical framework has been operationalised for analysis. In Chapter Four, a comprehensive literature review is presented, covering the landscape of South Africa's social welfare and care regime, the challenges within ECD and LTC provision and the normative paradigms retained in the White Paper for Social Welfare (WPSW) and the White Paper on Families (WPF). The subsequent chapter, chapter five, presents an analysis of the South African government's response to ECD and LTC facilities during the COVID-19 pandemic through the lens of Joan Tronto's four phases of care—attentiveness, responsibility, competence, and responsiveness. Lastly, Chapter Six and Chapter Seven embark on a reflective discussion, critically assessing the influence of social policy documents, particularly the WPSW and WPF, in shaping the state's approach to care provision.

Chapter 2: Theoretical Framework

2.1 Two Strands of Ethics of Care Literature

In this chapter, I establish a theoretical framework that provides the foundational structure for exploring the intricate dynamics of care ethics within South Africa's approach to care. A theoretical framework serves as a guideline, offering a lens through which we can dissect the complexities of care, policy responses, and their underlying ethical foundations. This chapter proceeds as follows. First, I provide an overview of the ethics of care literature as conceptualised by FitzGerald (2020) and Robinson (2011). I then detail how this framework will be used to answer the main research question: How does South Africa's response to Early Childhood Development and Older Person's care during the COVID-19 pandemic trace back to its normative and ideological approach to social care provision?

At the most basic level the ethic of care, more appropriately referred to as the *ethics* of care to assert the diversity of approaches, is a moral framework and perspective that emphasises the importance of caring relationships, empathy, and interdependence in ethical decision-making and social interactions (FitzGerald, 2020). However, while there are conceptual and normative consistencies between approaches to care ethics, FitzGerald (2020) posits that there are two connected but disparate strands of care ethics literature. The first strand explores the *practice* of care itself and the second strand inserts care as a *critical political theory*. The duality of this literature is captured in the definition of care ethics put forward by Sevenhuijsen (2000, 6) as cited by FitzGerald (2020, 251) : "[care ethics can be understood as both a] concrete activity, in the sense of caring about and for daily needs, and as a moral orientation". It must be noted that this representation of ethics of care is by no means a solidified nomenclature as care ethicists have moved within and between this categorisation.

The first strand, care ethics as a "concrete activity", emphasises understanding the dynamics of care practices (Robinson, 2018; Robinson; 2011 FitzGerald, 2020). In other words, this literature

scrutinises “the real world of care provision” (Mahon and Robinson, 2011). An example of this strand of scholarship is the work of Joan Tronto. In Tronto’s seminal book *Moral Boundaries: A Political Argument for an Ethic of Care (1993)*, the ethics of care is based on the dimensions of care as practice and dispenses with the notion that abstract rules can facilitate adequate or good care (FitzGerald, 2020). Tronto (1993) presents four phases and corresponding moral dimensions of care. The elements that constitute an ethic of care, according to Tronto (1993) include caring about and attentiveness, taking care of and responsibility, caregiving and competence, and care-receiving and responsiveness. Tronto’s (1993) phases of care provide a distinct set of criteria by which to determine how practices of caregiving and caring arrangements can be improved or amended. However, Tronto (1993) also emphasises the importance of context and the politicisation of care more broadly. FitzGerald (2020, 251) summarises care as practice as “scholarship that contributes to understandings of everyday practices of care” in varying contexts, across the globe.

The second strand of literature seeks to “reveal the harms caused by absolutist, dualistic categories of all kinds” which are “constitutive of patriarchal-rationalist-universalist approaches to ethics” (Robinson 2018, 3 as cited by FitzGerald, 2020, 252). This scholarship is dubbed a ‘critical political ethics of care’ (Robinson and Mahon, 2011). It is regarded as both a critical and political theory “because it uncovers and critiques binary thinking which currently shapes our governing norms and understandings of morality” (FitzGerald, 2020, 252). A critical political ethics of care takes the perpetual and enduring reality of human and planetary interdependence as its core tenet and point of departure. It emphasises that the claim of this dependence and need is “pressing and is a highly important moral aspect in developing the relations of caring that enable human beings to live and progress” (Held, 2006, 10). Given the interconnectedness of human life, the ethics of care raises a challenge to traditional ethical and moral theories that prioritise abstract principles, individual autonomy, and impartiality. Instead, a critical political ethics of care highlights the significance of nurturing and maintaining relationships, particularly those involving vulnerability and dependency, such as parent-child relationships, caregiving relationships, and relationships within communities. (Held, 2006; FitzGerald, 2020; Mahon and Robinson, 2011).

This strand of literature seeks to extend the ethics of care beyond personal relationships and inserts care within broader social and political contexts (FitzGerald, 2020). It emphasises the importance

of embracing an ethic of care in social policies, institutions, and systems, and calls for contextually sensitive approaches to care. Mahon and Robinson (2011) explain that critical political ethics of care ultimately acknowledge that the concrete care activities of real people are mediated through "webs of social relations" which are informed by "politics and the structure of social policies". A critical political ethic of care thus seeks to interrogate and subsequently transform the norms, structures, and values that shape our political institutions and policies. By situating care as the central normative reference, the prevailing economic-centric values that guide decision-making are brought into question (FitzGerald, 2020).

A significant area where a critical political care ethic has emerged is within social policy (FitzGerald, 2020). Social policy, as defined by Feder Kittay (2017, 569), "is an intervention by governments or other public institutions designed to promote the well-being of its members or intended to rectify social problems". The process of identifying social problems, defining well-being, and making decisions to promote well-being, however, is laden with normative judgments rooted in specific ethical standards (FitzGerald, 2020). AS FitzGerald (2020) notes, when problems are identified and solutions proposed, the act of implementing a particular policy inherently carries normative implications. This means that choosing one policy over another requires asserting its superiority, and such a judgement is also grounded in a specific set of ethical values. Nevertheless, the normative judgements contained within social policy are "often presented as arising from an objective process concealing "hidden ethical principles" (FitzGerald, 2020).

These ethical principles are usually based on a neoliberal paradigm that embraces rationalism and economic reason. Neoliberalism characterises the prevailing ideological framework in the current stage of capitalism's development. It embodies a shift in the role of the state from safeguarding citizens against market uncertainties to safeguarding the market itself (Harvey, 2005). Under neoliberalism, a strong emphasis is placed on valuing autonomy, as well as promoting the ethics of self-interest and individual accountability (Tronto, 2017). While these ethical principles hold significance within our societal framework, neoliberalism elevates them to a dominant and pervasive status. In this context, alternative ethical principles, particularly those that challenge the notion of autonomy, are often deemed as aberrant and abnormal (Tronto, 2017).

In the contemporary era, under neoliberal financialised capitalism principles of personal responsibility, independence and economic self-sufficiency are often contained within social policy discourse, thus informing a specific approach to care (Tronto, 2017). Tronto (2017) that for care, these principles are captured in three distinct. First, care is allocated to the realm of personal responsibility based on the assumption that all persons have the capacity to amass the imperative of 'self-mastery'. Second, care is viewed as a market problem since markets are oriented and expected to fulfil needs. Lastly, the family is situated as the "proper locus of care". Tronto (2017, 32) writes:

"putting these pieces together provides us with a kind of theoretical account of how people should care for themselves and those close to them within a neoliberal society: care for yourself by acting rationally and responsibly; if there are care needs that you cannot meet for yourself, then use market solutions; and finally, if you cannot afford market solutions, or prefer to care on your own, then enlist family to meet your caring need"

However, these normative paradigms are not always made explicit. Yet they retain the capacity to inform the state's approaches to care (FitzGerald, 2020). Thus, critical examination is required to make transparent the values, norms and principles that are really at work, often informing approaches to care sub rosa. Sevenhuijsen's (2004) method called Trace is an example of a type of policy analysis that adopts the ethics of care as a lens or magnifying glass to make visible "normative paradigms". A normative paradigm refers to "a configuration of knowledge which orders the description of social problems, in order to pave the way for regulation" (Sevenhuijsen, 2004, 17). Unlike value statements, normative paradigms are broader in that they capture "modes of defining problems and recurrent ways of speaking and judging" (Sevenhuijsent, 2004, 18). Policy documents are often vehicles of these normative paradigms. Sevenhuijsen et al. (2003) demonstrated the analytical strength of the Trace method through a critical assessment of the White Paper for Social Welfare in South Africa. The paper yielded rich insights and revealed the reliance upon the family, particularly female members as a pathway to welfare and care provision in the country (this will be explored in further detail).

Methods such as Trace have the potential to make evident that our existing social policies, particularly in relation to care, are inadequate. However, FitzGerald (2020, 253) argues that undertaking such an analysis offers deeper, more transformative insight by exposing the "ethical standards which underpin our policies". Consequently, using an ethic of care to assess current policies does not merely amount to reforming the content of specific policies i.e. expand or amend the range of programmes. Instead, "these assessments indicate that a radical transformation of the very ethical systems which are used to develop and assess policies is in order" (FitzGerald, 2020, 253).

The facilitation and delivery of high-quality, equitable care hinge on the acknowledgment of two critical aspects of human life. First and foremost, we exist as interdependent beings, subject to varying degrees of ongoing vulnerability, necessitating care throughout our life journey. Secondly, the dynamics of care and caregiving are deeply influenced by systems of patriarchy, (neo)colonialism, and capitalism. A critical political ethics of care represents a dissenting perspective that not only underscores the interconnectedness of human existence but also recognizes the intricacies of race, class, gender, and caste in the giving and receiving of care (Mahon and Robinson, 2011). Thus, social policy that is grounded in a critical political ethics of care seeks to re-define the conventional neoliberal moral subject. It does so by relinquishing the notion of the independent, self-sufficient moral subject as the basic unit of society and critically analysing how social organisation, power structures and resource distribution influence caring relationships (Mahon and Robinson, 2011; FitzGerald, 2020; Tronto, 2013).

2.2 Merging Care as Practice and Care as a Critical Political Theory

In this thesis, I reconcile these two distinct but interrelated dimensions of care ethics. In doing so I argue that a critical political ethics of care can be operationalised to uncover the connection between the practice of care itself (i.e. the degree of attentiveness, responsibility, competence and responsiveness) and the moral as well as ideological paradigms retained in social policy. I interrogate two distinct but interrelated care sectors: Long-Term Care Facilities for older persons and Early Childhood Development Programmes, otherwise known as social care. Social care, as defined by Daly and Lewis (2000, 286), refers to "the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative,

economic and social frameworks within which these are assigned and carried out" (Daly and Lewis, 2000, 286).

Notably, the term 'social care' is not commonly employed in the South African context. The prevailing body of literature on care, largely generated in the global North, tends to exhibit a distinct separation, with childcare and care for dependent adults often treated as separate domains. Nonetheless, as Daly and Lewis (2002) argue combining the realms of childcare and care for adults, particularly the elderly, can yield valuable insights and lessons concerning the engagement of the welfare state. This research advocates for bridging what may seem like distinct areas of care, specifically care for the elderly and care for young children, by adopting the term 'social care.' Such an approach promises significant benefits, particularly in a context where the overall need for care is on the rise. Moreover, as highlighted by Razavi (2011), the care agenda has, at times, been unduly narrowed to solely focus on childcare.

However, as Razavi (2011) notes, it is important to emphasise that the concept of care emerging from feminist research extends beyond the realm of childcare. While the intensive care required by infants and young children is undeniably linked to women's overall well-being and independence, the scope of the care agenda encompasses a broader spectrum. This includes the care of frail elderly individuals, those grappling with severe illnesses and disabilities, as well as physically capable adults. Advocating for childcare can be bolstered by emphasising the idea of a "social investment state" and the significant societal benefits it can yield (Razavi, 2011). Yet, justifying care for elderly individuals and those with profound disabilities becomes more complex when relying solely on pragmatic justifications.

Therefore, the concept of social care is useful for two reasons, firstly it serves as a pivotal point from which to examine broader transformations within the welfare state and social policy. It prompts a holistic exploration of caregiving responsibilities, transcending conventional boundaries and fostering a more inclusive understanding of care in contemporary society, a fundamental aim of this research. Secondly, Care is perceived as both a connection involving material and relational aspects, as discussed previously in this paper, and as a socially constructed duty. This duty is shaped by societal norms and occurs within specific social and economic settings, which constitute

the institutional framework of care.as Esquivel (2014, 430) notes, “the concept of ‘social care’ allows us to focus on how the gender norms that mean women remain the main care providers interact with the particular ways in which the state regulates and shapes (by action or omission) the provision of care”.

To assess the response to social care provision by the state and to make visible the normative underpinnings of social policy, I connect care as practice and care as a critical political theory in three steps. First, I use Tronto’s (1993) phases of care and corresponding moral dimensions to systematically assess the South African government’s response to LTC facilities for older persons and ECD programmes during the COVID-19 pandemic.

In doing so, I first interrogate how and to what extent the state and related institutions sufficiently enacted the practice of care. Secondly, I then turn to two policy documents: the White Paper for Social Welfare (1997) and the White Paper on Families (2013) to unveil the normative paradigms within these texts. Here I draw extensively on the work of Selma Sevenhuijsen and colleagues (2003) and the Trace method to excavate how the subject of welfare is conceptualised and who is appointed the responsibility to care. Lastly, I explore the relationship between the state’s response to ECDs and LTC facilities and the rhetoric, norms and discourses used in the aforementioned policy documents.

Numerous efforts have been dedicated to reconciling the principles of care ethics with the realm of social policy. The overarching objective of these endeavours is to underscore that care is not merely an individual responsibility but a collective societal duty. Consequently, there is a push to integrate the ethos of care into social policies and governance structures. However, it is crucial to acknowledge that a handful of criticisms of care ethics persist in many works that approach social policy. Specifically, Raghuram (2016) notes that earlier critiques branding care ethics as essentializing and falsely universal continue to resonate within much of the discourse.

Within the framework of feminist care ethics, it is evident that the concept of care has undergone a series of transformations. Care theorists argue that care ethics necessitates disentangling care from associations with femininity, individuality, and the private sphere (Raghuram, 2016)

Nevertheless, Raghuram (2016) points out that care ethics remains predominantly rooted in the geographical context of the global North, failing to transcend or dislocate from geographical specificity.

Most of the scholarly work on care and care ethics is founded on the practices, dynamics, and arrangements of care within the global North (Raghuram, 2016). While these efforts have yielded significant sociological, political, and economic insights from the perspective of care ethics, the geographical bias in the theorization of care ethics has neglected to adequately account for the formative influences on and variations within care that are shaped by different contexts. Using the case of India as an example, Raghuram (2016) highlights how historical contexts, institutional and political arrangements, and the legacy of colonialism have led to various shifts in care dynamics. These shifts encompass questions of financial responsibility, physical location, regulatory oversight (if any), the deserving recipients of care, and the relationships through which care is mediated.

In summary, the historical legacy and intricate configurations of care systems make the term "care" a nuanced and often contentious concept (Raghuram, 2016). Therefore, it is essential to apply the term with sensitivity to both geographical context and historical factors. Considering this caution, this thesis embarks on a historical exploration of EC) and LTC in South Africa. South Africa, like India, has been profoundly impacted by the legacy of violent colonial imposition, which has fundamentally altered family dynamics and, consequently, care arrangements. In chapter #, I provide an overview of South Africa's welfare system, how it has been shaped by Apartheid and further how racial and class inequalities continue to inform care arrangements. However, this thesis uses Tronto's (1993) phases of care despite its development in the global North due to its flexibility and emphasis on contextual sensitivity.

Tronto's (1993) phases of care offer an alternative 'rubric' or 'criteria', grounded in the assertion that care is the root of all sustenance and (re) produces all life. I argue that a care-based criteria is an essential feature in the pursuit of adequately assessing the related care of others i.e. children, women, and older persons. Many care ethicists such as Hankivsky (2004) expand on similar elements of care i.e. contextual sensitivity, responsiveness and consequences of choice. I draw on

Tronto's (1993) four elements as it encapsulates elements used by other care ethicists, for example, Hankivsky's (2004) criterion of contextual sensitivity merges with Tronto's (1993) attentiveness criteria. In addition, central to an ethic of care is the concern with context and relational ontology. Given the extensive use of Tronto's (1993) phases among care ethicists, the framework is not beholden to rigidity allowing for context-rich findings (a central tenet of the ethic of care). Tronto's (1993) four phases of care include attentiveness, responsibility, competence and responsiveness. Below I briefly expand on each of these phases and how I will use each in the context of ECDs and LTC facilities.

2.3 Tronto's Phases of Care

Attentiveness

Attentiveness, according to Tronto (1993), first and foremost involves the identification and recognition of a need or needs. Tronto (1993, 127) notes, "if we are not attentive to the needs of others, then we cannot possibly address those needs". Specifically, this thesis investigates if the state and related government departments that are responsible for administering, managing and providing care to older persons and young children identified and recognised the needs of these two groups. However, this thesis extends the remit of need beyond the care-receiver.

The COVID-19 pandemic and the related efforts to curtail the spread of the virus, such as lockdown strategies, altered the demands of care. For example, due to school closures at the height of South Africa's lockdown female caregivers were tasked with managing greater childcare demands. Due to the gendered nature of caregiving in South Africa, wherein women take on the lion's share of care work, this thesis also looks at the state's acknowledgement of the needs of caregivers. As Tronto (1993) notes, true attentiveness necessitates an enduring commitment to contextual sensitivity and an acknowledgement of the significance of 'others.' This thesis takes the 'other' to mean all those involved in the caring dynamic within a complex web of social, political and economic relations. To assess the level of attentiveness, or lack thereof, I assess if/how specific instruction was delivered to LTC facilities and the role of the government in reopening ECD programmes.

While the recognition of the needs of those around us or those that may be far away may seem without challenges, Tronto (1993, 127) notes that "is a difficult task, and indeed, a moral achievement". However, it is important to note that while Tronto's (1993) care ethics introduces attentiveness as the 'first' criterion, this doesn't imply that attentiveness ceases once a need is acknowledged. On the contrary, attentiveness demands ongoing effort. By examining attentiveness, I argue that we gain insights into the government's grasp of the multifaceted social, political, and economic dimensions inherent in caregiving.

Responsibility

The second phase, responsibility, refers to the process of addressing the needs that have been identified. In other words, assigning the task of caring itself. Thus, responsibility involves both a cognitive awareness of needs and a proactive engagement in actions that promote well-being, support, and nurturing relationships (Tronto, 1993). It involves actively taking steps to meet those needs and provide support or assistance. In the context of LTC facilities and ECD programmes, I assess if the state assumed responsibility for both caregivers and care-receivers. In the absence of state responsibility for care, I trace where the imperative to care goes and how it is assigned. In other words, I assess how care is allocated to various sites such as the family, paid care workers and women. Thus, responsibility serves as a barometer for evaluating the government's proactive engagement in actions that enhance well-being, support, and nurture relationships, and how as well as under what conditions this responsibility is shifted onto other entities.

Competence

The third phase of care, competence, assesses if the care has been carried out effectively. As Tronto notes (1993, 133), "to include competence as part of the moral quality of care, is obviously to align this approach with moral consequentialism" wherein "intending to provide care, even accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met". Central to the ethics of care is the emphasis on real consequences and tangible impacts on individuals' lives (Hankivsky, 2004). Thus, even if one garners the necessary or adequate attention and responsibility to a specific need, it is the outcome that is given the utmost importance. Through the lens of competence, one can ascertain the degree to which an intention or motive to

meet a care need is actualised. As Sevenhuijsen et al. (2003) writes competence refers to the "substance" i.e. "What people need to be able to perform care work in specific situations".

In the context of ECDs and LTC facilities, I frame competence as the necessary allocation of resources, time, money, and expertise by decision-makers i.e., government departments responsible for administering and managing care. Specifically, I interrogate if and how subsidies for these programmes were provided in a timely fashion and what measures (if any) were put in place to combat the challenges of providing care in a time of great economic uncertainty. Thus, the lens of competence underscores the importance of real, measurable impacts.

Responsiveness

The last phase of care, responsiveness, 'recognizes that the object of care will be affected by the care it receives' (Tronto, 1993, 107). The criterion of responsiveness emphasises that those receiving care must be able to articulate, freely if their care need has been met. Thus, responsiveness is concerned with the conditions of vulnerability that are inherent within the caring relationship. In the context of assessing the response to ECDs and LTCs, responsiveness refers to the experience of care or lack thereof by young children and older persons residing in LTC facilities and care homes. I assess how the COVID-19 pandemic, the accompanying lockdown measures and the state's response to ECDs and LTCs affected children and older persons.

Tronto's phases of care allows for an interrogation of how the state responded to LTC facilities and ECD facilities does not sufficiently answer the question of 'why?'. Thus, given the limitations of the 'care as practice' scholarship and the second aim of this thesis: to expose the broader normative approaches in the realm of care, I draw on a 'critical political ethics of care'. I draw on two core policy documents: The White Paper for Social Welfare (WPSW) (1997) and the White Paper on Families (WPF) (2013). I have selected these two documents as they remain among the few documents in South Africa that contain a framework, approach, and mandate to social provision specifically and care more broadly. A White Paper is a "broad statement of government policy" drafted by relevant departments or task teams (PMG, 2023). The WPSW is among the several pieces of legislation that determine the mandate of the Department of Social Development (DSD). Thus, government organs such as the DSD (responsible for managing and providing care)

are required to adhere to the principles set out by the WPSW in all matters of administration as well as budget allocation at a provincial level. Similarly, until 2022 the WPF (2013) was referenced as part of the DSD's mandate (the WPF has since been revised thus explaining its short absence from the DSD mandate).

In addition, these documents have received considerable attention from social policy scholars (for example, Leila Patel and Selma Sevenhuijsen) as carriers of normative paradigms in regard to care. These two policy documents do not contain extensive references to LTC facilities and ECD programmes. The Older Persons Act, 2006 and the National Integrated Early Childhood Development Policy (2015) are examples of legislation and policy that detail the various programmes and initiatives available for older persons and children under the age of 5. However, the purpose of this thesis is not to assess the content of the social policies and care programmes available for these two groups. Instead, the aim is to excavate and provide an approximation of the state's inherent value system and normative underpinnings to social provision.

By uniting care as *practice* and care as a critical *political theory*, this theoretical framework offers a comprehensive approach to assess the South African state's response to the COVID-19 pandemic. It highlights the potential contradictions between policy rhetoric centred on independent, self-reliant individuals and the ethical imperatives of care, which necessitate a more collective and contextually attuned approach to societal care. In adopting this framework, this thesis aims to contribute to a deeper understanding of the interplay between care ethics and policy formation.

Lastly, it is through this theoretical lens that I examine the COVID-19 pandemic as a critical moment to assess the state's response to LTC facilities and ECD. The COVID-19 pandemic is a critical juncture for revitalising and politicising our interdependence and vulnerability. The myth or fiction of independence is perpetuated at various levels which imposes the view that "self-sufficiency is our ontological condition". However, the COVID-19 pandemic has shattered the illusion of our independence, revealing that perpetual and unrelenting vulnerability is a core facet of life. Despite the unprecedented opportunity to critically engage the social, political, and economic structures built on the norms of independence and individualism, Ghandeharian and FitzGerald (2022) caution against situating the COVID-19 pandemic as a unique crisis separate

from the ongoing crisis of care. The ongoing and intensifying crisis of care is defined by a paradoxical dynamic: the state's withdrawal of public support for social well-being on the one hand and the imposition of demanding paid labour on its primary contributors i.e. women. This incongruity between emphasising wage employment and neglecting investment in care leads to a crisis in caregiving and care-receiving. It not only depletes essential social capacities society relies on but also erodes the health, well-being, and autonomy of care providers, both paid and unpaid (Fraser, 2017)

However, the pandemic, as Ghandeharian and FitzGerald (2022, 42) note, is, indeed, "an exceptional opportunity to deliberate on our vulnerable existence" which is generally concealed and obfuscated by political and economic structures. The pandemic, thus, represents an important opportunity to import and politically the fact of our shared vulnerability in ways that are meaningful. This research, which endeavours to illustrate the pitfalls of discourses such as self-reliance and economic self-sufficiency, reiterates the notion that the COVID-19 pandemic is a significant moment for the ethics of care and the creation of a more sustainable, caring society.

This theoretical framework provides a structured approach to scrutinising the multifaceted dimensions of care within the contexts of both ECD and LTC, while simultaneously dissecting the normative foundations of social policies. In doing so, it advances the understanding of how the ethics of care can be a catalyst for transformative change in the realm of social policy.

Chapter 3: Methodology

3.1 Introduction

In this chapter, I present the research methodology used in this thesis, which serves a dual purpose. Firstly, it aims to thoroughly investigate and analyse the actions, or the absence of actions, undertaken by the state in response to the challenges encountered by ECD and LTC facilities during the COVID-19 pandemic. Secondly, it aims to make visible the normative paradigms retained in policy documents that informed the response to both ECD and LTC, and social care provision in the country more broadly.

A qualitative research approach is employed, with a specific focus on documentary analysis. Document analysis is described as "a form of qualitative research that uses a systematic procedure to analyse documentary evidence and answer specific research questions" (Holland Novak, 2017, 296). Document analysis derives from discourse analysis which aims to excavate the ways in which ideas and concepts cohere into determinate ways of seeing the world. Central to the tradition of discourse analysis, is the work of Michel Foucault who argued that "what is written is inextricably locked into what is done" (Holland and Novak, 2017, 295). Thus, there is an "essential connection" between documents, practical action, and sites of action (Holland and Novak, 2017, 295). Drawing on this definition, document analysis is well-suited for this study as it enables a thorough exploration of policy documents, academic literature, and other textual sources. This approach allows for the achievement of two key objectives: firstly, a critical assessment of the state's actions concerning LTC and ECD facilities during the COVID-19 pandemic, and secondly, an exploration of the relationship between these actions and the normative, ethical, and ideological principles governing social care, as elucidated in policy documents.

As discussed in the preceding chapter, the theoretical framework underpinning this research is rooted in a critical political ethic of care. To ensure that this framework's principles are consistently applied throughout the analysis of the state's response and the examination of its normative stance on social care, Joan Tronto's (1993) phases of care (attentiveness, responsibility, competence, and responsiveness) and Selma Sevenhuijsen's (2004) method known as "Trace" are used.

This section is structured as follows: Section 3.2 provides an overview of the data sources used, offering a sample of these sources. Section 3.3 delves into the methodology of data collection. Section 3.4 elucidates the method of analysis, detailing the operationalization of Tronto's (1993) phases of care and Sevenhuijsen's (2004) Trace method. Sections 3.5 and 3.6 address the ethical considerations and limitations inherent in this research.

3.2 Data Sources

To construct a comprehensive 'picture' or overview of the South African government's response to the challenges faced by ECD programs and LTC facilities during the COVID-19 pandemic, a multi-faceted approach involving various sources is adopted. I rely on two main sources of information. Firstly, I extract data from two primary sources: official documents issued by South African government departments and research studies conducted by non-governmental organisations. From official government documents, I gather information found in government gazettes, newsletters, policy briefings, and public addresses.

Additionally, I reference studies conducted by organisations such as Ilifia Labantwana, The Samson Institute for Ageing Research (SIFAR), The National Income Dynamics Study (NIDS) – Coronavirus Rapid Mobile Survey (CRAM), and the World Health Organization (WHO) Regional Office for Africa. The selection of data sources and organizations for this research is carefully justified based on their comprehensive coverage of ECD programs and LTC facilities for older persons during and after the COVID-19 pandemic. The National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) stands out as a nationally-representative panel survey, capturing critical insights into South African individuals' experiences related to income, employment, household welfare, and the impact of COVID-19. Its periodic waves provide a valuable resource for understanding key outcomes such as unemployment, household income, child hunger, and access to government grants.

Ilifa Labantwana, a South African ECD program initiated in 2009, is particularly relevant for its mission to enable one million children aged zero to five to access quality ECD through the Early Learning Subsidy. The organisation's use of data to track ECD program coverage and impact aligns

seamlessly with the study's focus on understanding state-supported social care for young children. The Samson Institute for Ageing Research (SIFAR) is chosen due to its specialized focus on research to improve knowledge about the needs of older persons. This institute, based in Cape Town, contributes valuable insights into LTC facilities and the care of the elderly, both locally and globally. SIFAR's commitment to informing best practice guidelines for elderly care aligns with the study's emphasis on critically assessing the state's response to LTC facilities during the pandemic. These organisations and data sources are pivotal choices as they conduct rapid research on ECDs during the pandemic and prolific work thereafter. NIDS-CRAM offers a comprehensive national perspective, Ilifa Labantwana provides crucial data on ECD programs, and SIFAR brings specialized insights into the care needs of the ageing population, collectively enriching the study's understanding of state-supported social care provision for both young children and older persons.

Complementing these sources, I also utilise 'secondary' documents, namely academic journal articles that cite these studies. These analyses are conducted by various scholars who have examined South Africa's response to care-related issues during the pandemic. Below is a sample of documents used to detail the state's response to ECD and LTC during the pandemic:

Sample of Sources (government gazettes, case material, government regulations, survey data)
Early Childhood Development and Lockdown in South Africa: An update using NIDS-CRAM wave 3.
Cooperative Governance and Traditional Affairs (COGTA Regulations)
Litigation to reopen the sector: Legal challenge was mounted by the SkoleOndersteuningsentrum ('SOS'), Bronkieland Kleuterskool ('BK') and Solidarity (collectively referred to as 'the Applicants') on 09 June 2020
Answering Affidavit (SACA Respondents), 2020, SA Childcare (Pty) Ltd & Others v Minister of Social Development & Others Case Number: 36962/20.
Founding Affidavit [Applicants], 2020, Skole-Onsersteuningsentrum NPC and Others v Minister of Social Development and Others Case number 24258/2020.

In addition, to make visible the normative paradigms I draw on two policy documents: the White Paper for Social Welfare (1997) and the White Paper on Families (2013) which are available on the Department of Social Development's website. The White Paper underwent a revision in 2021 with the objective of addressing past critiques, taking into account contemporary family dynamics, and incorporating feedback from stakeholders (DSD, 2023). However, this thesis predominantly references the 2013 version as it aligns with the timeline of the COVID-19 pandemic during 2020 and early 2021. It is noteworthy that the revised White Paper was officially released on July 2, 2021. Therefore, the study relies on the 2013 version until that date, emphasizing its relevance during the critical period of the pandemic.

3.3 Data Collection

The data collection process for this thesis unfolds in three steps, ensuring an investigation into South Africa's response to ECD and LTC during the COVID-19 pandemic. Each step contributes to gathering and managing relevant documents from various sources.

Firstly, the process begins with document identification (Bowen, 2009). This phase involves identifying crucial documents, including policy reports, academic literature, media articles, and historical records related to ECD, Older Person care, and the COVID-19 response in South Africa. The document identification process employed a systematic approach through a series of keyword searches to capture relevant information. Key search terms included "long-term care," "early childhood development," and "return to school." To further delve into the specifics of long-term care and early childhood development during the pandemic, additional keywords were incorporated. The timeframe for the study spanned from March 2020 to mid-2021, restricting searches to this period for relevance.

Regarding data sources, the extraction process involved searches on various platforms, including Google and news sites. Google Scholar was also utilized to ensure a comprehensive exploration of academic and scholarly materials. This approach aimed to cast a wide net and encompass diverse perspectives on the subject. The systematic process ensured that key documents about the specified topics within the designated timeframe were identified and included in the study.

To streamline data management and analysis, a dedicated database or document repository is created. Within this organised system, collected documents are systematically catalogued along with relevant metadata. This structure ensures that the data remains well-structured and readily accessible for subsequent analytical phases.

Conducting research amid the COVID-19 pandemic added a distinct temporal dimension to the inquiry, necessitating an acknowledgement of the unique circumstances that shaped the study. Given the urgency and dynamic nature of the situation, the research strategically leveraged sources that emerged in real-time, such as reports, newspaper articles, and grey literature, recognising them as invaluable for capturing the rapidly evolving landscape of long-term care facilities and early childhood development during the pandemic. The reliance on these diverse and contemporaneous sources not only enriched the research with real-world insights but also underscored the adaptability and responsiveness required in navigating research within the challenging timeframe of a global crisis. This approach not only enhanced the immediacy and relevance of the findings but also highlighted the pragmatic considerations inherent in conducting research during extraordinary circumstances.

Throughout this process, a critical perspective is maintained. Bowen (2009) notes that there can be no assumption that documents inherently possess precision, accuracy, or comprehensive coverage of past events. Instead, each document's meaning and its contribution to the research problem must be carefully examined. Thus, Bowen (2009) explains that the researcher must become the ‘analyst’ to evaluate factors such as document relevance, alignment with the study's conceptual framework, authenticity, credibility, accuracy, representativeness, and completeness, whether they are comprehensive or selective. This meticulous approach ensures both the rigour of the research and the critical assessment of the collected documents throughout the study.

3.4 Data Analysis

Once the documents have been organised into the relevant folders and categories, the data analysis begins. The data analysis involves a process of skimming (superficial examination), reading (thorough examination), and interpretation (Bowen, 2009). After familiarity with the literature and

sources is established, I draw on Tronto's (1993) four phases of care to critically engage and analyse the state's response to LTC and ECD facilities during the COVID-19 pandemic. Tronto's phases of care include four moral dimensions: attentiveness, responsibility, competence, and attentiveness. Tronto (1993) provides definitions for each phase, however, owing to the nature of the ethics of care approach, there is a space for the criteria to be adapted to the context. Given the remit of this research – exploring the state's response to ECDs and LTC during the COVID-19 pandemic – I operationalise Tronto's phases to facilitate the process of analysis. As Olsen (2012, 3) notes, "to operationalise something usually means to measure it, and more generally to make it easy to examine and discuss". Tronto's four phases of care provide broad directives on what adequate or 'good' care entails. However, the conceptualisation of the phases remains abstract. Thus, as Payne and Payne explain, "general and often abstract 'concepts' have to be converted into separate, clearly specified components that can be studied empirically".

Operationalisation: Tronto's Phases of Care

Phase of Care	Tronto's definition	Definition in the context of ECDs and LTCs	Indicators

Attentiveness	Attentiveness, according to Tronto (1993), first and foremost involves the identification and recognition of a need or needs.	In the context of ECD and LTC, Tronto's concept of attentiveness refers to a careful evaluation and consideration of the manner in which particular directives or guidelines were communicated to LTC facilities and the extent of government involvement in the reopening of ECD programmes	• **Assessment of government communication:** Evaluate the clarity, sensitivity, and responsiveness of government communication in addressing the needs of older persons, young children, and caregivers during the COVID-19 pandemic. • **Recognition of caregiver needs:** Measure the extent to which the government acknowledges and addresses the needs of caregivers, particularly women who bear the majority of care responsibilities. • **Consideration of multifaceted dimensions**: Analyse government policies and responses to caregiving, demonstrating an understanding of the intricate societal, political, and economic factors influencing care provision.

Responsibility	According to Tronto (1993) responsibility involves both a cognitive awareness of needs and a proactive engagement in actions that promote well-being, support, and nurturing relationships.	The concept of responsibility, within the context of ECD and LTC, involves a multifaceted process of addressing identified care needs. It encompasses not only the cognitive awareness of these needs but also active and proactive engagement in actions aimed at promoting well-being, providing support, and nurturing relationships.	● **Government's proactive role:** Assess the extent to which the government assumes responsibility for the well-being and care of older persons, young children, and caregivers within LTC facilities and ECD programs. ● **Allocation of care responsibilities:** Investigate how the responsibility for care is distributed, whether it remains with the state or is shifted onto other entities, such as families or paid care workers.

Competence	According to Tronto (1993) competence refers to the effectiveness of care delivery. Competence underscores the importance of achieving positive outcomes in meeting care needs.	In the context of ECD and LTC, Tronto's concept of attentiveness competence refers to the necessary allocation of resources such as labour, time and finances allocated to ensuring that good or adequate care is realised.	• **Resource allocation:** Examine whether government decision-makers allocate resources, including subsidies, time, money, and expertise, in a timely and efficient manner to support ECD and LTC programs during economic uncertainty. • **Measure of impact:** Assess the measurable impacts of government interventions and support on the quality of care and well-being of care recipients within these facilities.
Responsiveness	According to Tronto (1993) responsiveness involves being attuned to the care receiver's emotional, physical and relational needs and tailoring care accordingly.	In the context of ECDs and LTCs, responsiveness pertains to the lived experiences of care, or the absence thereof, by young children and older individuals residing in LTC facilities and care homes.	• **Care recipient experience:** Evaluate how the COVID-19 pandemic, associated lockdown measures, and government responses have influenced the experiences of young children and older persons residing in ECDs and LTC facilities.

The above framework facilitates an analytical assessment of the state's response to ECDs and LTC during the COVID-19 pandemic. The second aim of this research is to make visible the normative paradigms held within policy documents. Sevenhuijsen's (2004) "trace" method is a systematic approach to analysing policy documents to reveal the underlying normative paradigms and ethical

frameworks shaping them. The method comprises three key steps. However, given the limited scope of this research, I use Sevenhuijsen's (2004) method called Trace to *guide* the process of excavating the norms, ideologies, and paradigms within policy documents. The method includes three broad 'steps': tracing, evaluation, and the renewal with the ethic of care.

The first step, tracing, involves a thorough examination of the policy document, aiming to uncover the underlying normative paradigms. It includes investigating the document's context, identifying value-laden language, recognizing suppositions about human nature, and detecting gender-related discussions. The second step, evaluation, focuses on determining the political philosophy that informs the policy document (Sevenhuijsen, 2004). Various political philosophies, even if not explicitly mentioned, are considered. This step also assesses the adequacy of the problem definition within the policy document, aiming to understand if it adequately addresses the complexities of caring practices. In the final step, the renewal with the ethic of care, the normative framework identified in the policy document is compared to the central principles of the ethic of care. This step explores how the ethic of care perspective can contribute to improving the policy framework, aligning it with caring practices and interdependence among individuals (Sevenhuijsen, 2004).

I use the above steps to inform the process of engaging and analysing the WPSW and the WPF. At the point of familiarisation, the policies' context, language and underlying political philosophy is identified. However, I draw extensively on the existent work of scholars, who have engaged the WPSW and WPF to bring to the surface the norms retained in policy. The renewal with the ethic of care is expanded on in the discussion section. Thus, the Trace method provides guidelines for this thesis but a specific discourse analysis is not undertaken given the limited scope.

3.5 Ethical Considerations

In pursuing this research, I am committed to upholding rigorous ethical standards as guided by the ethical principles outlined in the UCT ethical guidelines. Throughout the research process, paramount attention will be given to ethical considerations. This includes disseminating the research findings, with a strong sense of responsibility, emphasising the need to present and discuss the findings transparently and honestly. An integral part of this ethical commitment

involves clearly articulating the limitations of the analysis while avoiding any unsupported or exaggerated claims, thus ensuring the integrity and credibility of the research.

3.6 Limitations

It's essential to acknowledge some limitations of this research design. This study relies solely on existing documents, which may not provide a complete picture of the decision-making processes and may not capture the perspectives of individuals directly involved in care provision. In addition, the analysis depends on the availability and accessibility of relevant documents, which could be limited in certain cases.

3.7 Conclusion

This research design outlines the methodology for conducting a comprehensive analysis to explore South Africa's response to ECD and LTC during the COVID-19 pandemic and its connection to the normative and ideological approaches to social care provision. The findings from this analysis will contribute to a deeper understanding of the ethical foundations and ideological influences on care policies in South Africa.

Chapter 4: Review of Literature

4.1 Introduction

This thesis embarks on an exploration of how South Africa's response to the COVID-19 pandemic, specifically in the realms of ECD and LTC, is rooted in its historical and ideological foundations within the broader context of social care provision. The structure of this literature review is designed to provide a comprehensive understanding of the intricate interplay between policy, norms, ideology, and the provision of care in South Africa prior to the onset of the COVID-19 pandemic in early 2020.

This literature review is divided into three sections. The first section offers insight into the historical development of welfare in South Africa. This section is subdivided into three critical dimensions which provide an overview of welfare provision in South Africa: social provision, social welfare services, and the familialist approach to care. By delving into the foundations and pathways to the development of the welfare framework in South Africa, this section unearths the norms and ideologies that have deeply influenced the state's approach to social care within the historical context of Apartheid. The policies established and normative paradigms adopted serve as the bedrock upon which to understand South Africa's contemporary policies and subsequent actions during the COVID-19 pandemic.

The second section shifts the focus towards a contemporary analysis of welfare policy in South Africa. Drawing extensively from key policy documents such as the White Paper for Families (2013) and the White Paper for Social Welfare (1997), this section dissects the ideological and normative paradigms held within policy documents. The literature demonstrates that despite the 16-year time span between the WPSW and the WPF, similar policy rhetoric and approaches to care are prevalent. This section closely examines the policy paradigms, including rights-based perspectives, development-focused approaches, the emphasis on family as a site of caregiving as well as the critiques of these frameworks. The norms retained within, and the policy shifts lay the groundwork for comprehending how normative paradigms informed South Africa's response to ECD and LTC facilities during the challenging times of the COVID-19 pandemic.

The final section of the literature review ventures into the practical aspects of care provision in South Africa. This section specifically explores the historical landscape of Long-Term Care facilities and Early Childhood Development centres in the country. Understanding the historical context of these vital components of care infrastructure provides essential background and context for comprehending South Africa's preparedness and response during the COVID-19 crisis. As noted and will be further detailed, the South African landscape of social care provision has remained fraught, facing a myriad of challenges. The COVID-19 merely resurfaced some of these issues and exemplified the consequences.

Throughout this literature review, the central theme that unites these sections is the exploration of how policy is intricately interconnected to the provision of care. The historical, ideological, and policy landscapes outlined in these sections establish the necessary foundation for the subsequent chapter, which delves into the state's response to ECD and LTC during the COVID-19 pandemic. This literature review, therefore, serves as a platform for the forthcoming chapter, ultimately contributing to a more profound comprehension of the complex interplay between policy, ideology, and care provision in South Africa.

4.2 Overview of South Africa's Welfare and Care Regime

Button et al. (2018, 603) describe South Africa's welfare regime as a "hybrid mix of market, state and kin". The current iteration of welfare in South Africa has its roots in a deeply racialised history of Apartheid and colonialism. South Africa's welfare and care regime was forged under the logic of 'differentiation incorporation' which ultimately supplemented the welfare of the white minority while systematically excluding the African population from state support. For the majority of the African/native population, it was believed that their welfare needs were adequately met by family within the traditional or tribal system. On the other hand, as Button et al. (2018) note, a 'familial' approach was used to support the African population, while a more 'liberal' set of policies provided additional assistance to impoverished white individuals, helping them escape poverty and align with the ideals of white supremacy.

However, the “racist dualism of the care regime” soon crumbled as welfare-state builders in the early 20th century “sought to enforce the responsibilities of extended kin within white as well as African families” (Button et al., 2018, 603). The gradual fall of Apartheid brought about the demise of distinctly racialised public provision. The newly elected government inherited a fraught yet notably well-developed social security system for a middle-income country. However, there were strong demands to “transform” rather than simply extend the existing programs for white citizens (Button et al., 2018, 608).

According to Button et al. (2018), three key arguments influenced social welfare policy in post-apartheid South Africa: a rights-based perspective emphasising individual entitlements, a development-focused approach prioritising employment and poverty reduction, and an emphasis on family values. These arguments were reflected in the Reconstruction and Development Programme (RDP) and the new developmental welfare policy known as the 1997 White Paper for Social Welfare (WPSW). In line with these policies, South Africa adopted a distinctly developmentalist approach to social welfare (Patel, 2011). This approach aimed to promote overall well-being and economic growth through social investment, emphasising the importance of macroeconomic policies that prioritise employment. Welfare policies were designed to raise living standards by promoting employment and self-employment among marginalised individuals through human capital development, financial capability, asset building, and social network development (Midgley, 1995). This approach aligned with a 'productivist’ sentiment, emphasising investment in people's productive capacities over sole reliance on social welfare (Patel, 2015).

Drawing on a social development paradigm, the newly elected government established a far-reaching, ambitious mandate for transforming South Africa’s welfare system (Patel, 2015). Faced with a mountain of urgent issues inherited from the racist Apartheid regime, three critical priorities were identified: eliminating bureaucratic barriers to disability grants for African individuals, expanding legal access to grants for supporting impoverished children in African families, and reforming funding for residential institutions, particularly those catering to the elderly (Button et al., 2018). However, due to budget constraints, the list of feasible transformations was further reduced. As a result, reforming social welfare for special target groups and social security (social insurance) became the core goal (Patel, 2008). Despite setbacks in the initial development of a

holistic welfare programme, South Africa's welfare system can be broadly understood as a "social package" composed of social security, social welfare services and universal access to primary health care and mandatory basic education up to the age of 15 (Patel, 2008; Patel, 2015).

4.2.1 Social Security

Social security, often referred to as social protection, refers to "a wide range of public and private measures that provide cash or in-kind benefits" (Patel, 2015, 113). Access to social protection, specifically social grants, was mandated by legislation as per The Social Assistance Act (No. 13) of 2004. The Act defines the eligibility requirements for determining who is eligible to receive social grants and the specific types of benefits they may qualify for. A total of seven grants have been de-racialised and extended, and in some cases established, in the post-Apartheid context, the Child Support Grant (CSG), Old Age Pension (OAP), disability, Foster Care, Grant-In-Aid, War Veterans and the Care Dependency. Since the COVID-19 pandemic a social relief of distress (SRD) grant has been introduced. These social grants are primarily tax-funded, unconditional, and mostly means-tested cash transfers, aimed at providing support to specific groups considered "deserving," such as children, the elderly, and individuals with disabilities (Moore & Seekings, 2019).

According to the South African Security Agency (SASSA, 2023), as of 2023, 47% of the population relies on a monthly grant. In contemporary South Africa, social cash transfers are associated with "positive effects on poverty and inequality" and see to the realisation of "key development outcomes" (Patel et al., 2023, 6). Scholars have extensively studied social grants and social protection in Southern Africa, focusing on their significant role in reducing poverty (Posel and Rogan, 2012), enhancing child educational achievements (Heinrich et al., 2012), promoting dignity among older individuals (Sagner and Mtati, 1999), and improving outcomes for mothers and children (Wright et al., 2015; Zembe-Mkabile et al., 2015). In addition, research suggests that social grants are often used to subsidise and support livelihood activities and other productive activities in the market (Hajdu et al., 2020). However, owing to high levels of unemployment and the absence of benefits for the unemployed in South Africa, social grants are often used as a primary source of income (Patel, 2023).

In the post-Apartheid era, especially during the early years of democracy, social policy scholars such as Patel (2012) explain that the commitment to social grants was not only a result of shifting domestic ideologies but also influenced by changing global attitudes towards social cash transfers. As Von Gliszcynski and Leisering (2000) note, during the late 1990s and early 2000s, social cash transfers began to gain prominence as a new approach to development policy. This approach was firmly rooted in a rights-based perspective, emphasising trust in the ability of the poor to use financial resources wisely. The focus was on empowering individuals to fulfil their existing aspirations, such as sending their children to school, improving their diets, and making small investments to increase their income (Von Gliszcynski and Leisering, 2000, 323).

South Africa was not immune to the global spread of the developmental as well as neoliberal ideas that significantly influenced social policy in the 1990s (Patel, 2012). This was exemplified by the adoption of the Growth, Employment, and Redistribution (GEAR) policy in 1996. The GEAR strategy aimed to attract foreign direct investment and integrate the economy into the global economic system after years of isolation, economic turmoil, and indebtedness. However, GEAR departed from the social objectives outlined in the Reconstruction and Development Programme (RDP), leaning towards neoliberal policies in response to pressures from influential businesses and capital interests (Patel, 2012). While the RDP initially emphasised social development through job creation and improving productive capabilities, this direction was further solidified with the adoption of GEAR and its associated approach to social welfare.

4.2.2 Social welfare services

The adoption of GEAR, a policy aimed at achieving global competitiveness through fiscal restraint and economic liberalisation in the face of slow economic growth and debt (Patel, 2012), had significant repercussions for social welfare, particularly social welfare services. This was due to the emergence of what was seen as an austerity-driven agenda, coupled with substantial budget allocations for social grants, which led to the neglect of welfare service expansion. Consequently, the macroeconomic policies advocated by GEAR created an unfavourable climate for welfare services, essentially pushing spending on them to the back burner or 'crowding it out' (Patel, 2015). In addition, the insufficiency of human resources, knowledge, and skills necessary to implement the new developmental welfare approach hindered the requisite transformation of welfare services.

A notable example is residential care for older individuals wherein the government chose to integrate existing facilities for the elderly without providing additional funds or increasing the overall number of available spaces (Button et al., 2018). Thus, the early years of the transition were characterised by an overarching lack of attention paid to welfare services, which has yielded immense consequences in contemporary South Africa.

Social welfare services cover a wide range of programs, from child and family services to support for the elderly, individuals with disabilities, and those affected by HIV/AIDS, along with crime prevention and restorative justice initiatives (Patel, 2015). These services are provided through a 'welfare mix,' which includes commercial, informal, state, and voluntary services (Patel, 2009, 42). Within this mix, Non-Profit Organisations (NPOs) and Public Service Contractors (PSCs) play a significant role (Patel, 2009). NPOs, authorised by policy and legislation, offer a variety of care services, from formal residential and non-residential provisions to professional social services and informal family, household, and community-based services. Similarly, PSCs provide services on behalf of the state (Patel, 2009).

However, PSCs are concentrated in urban areas, leading to unequal access to care services between urban and rural provinces. NPOs and PSCs have emerged in response to the state's inability to meet people's needs, but their roles in care delivery remain unclear in policy. Access to social welfare services in South Africa is fragmented and uneven, reflecting socio-economic disparities and urban/rural location. Despite a history of informal and community-based social protection, factors like apartheid, migration, and structural unemployment have strained these support mechanisms (Patel, 2015; Patel, 2009, 12).

Given the backdrop of social disintegration and rampant racism during the Apartheid era as well as changing global sentiments, social welfare was imbued with a strong emphasis on fostering resilience within communities (Patel, 2015). Consequently, the care for older persons and other vulnerable populations was encouraged through home-based or family-based care channels. Home-based care aims to provide health and social services, delivered by both formal and informal caregivers, within the individual's own residence. The primary aim of this initiative is to enhance, restore, and maintain the individual's highest level of comfort, functionality, and overall health,

with a particular focus on dignified end-of-life care (Kganakga, 2003). These home-based care services encompass a wide range of care types, including preventive, promotive, therapeutic, rehabilitative, and long-term palliative care (Patel, 2015)

South Africa's welfare system is a complex blend of historical legacies, policy changes, and contemporary challenges. It has evolved through racial inequalities, political shifts, and economic demands. Notably, the country operates a substantial tax-financed grant system, reflecting its commitment to fighting poverty and inequality. However, despite this system, welfare services in South Africa heavily rely on family, the market, and non-governmental organisations. Over time, South Africa has endeavoured to reframe its welfare policies through various lenses, including rights-based perspectives, development agendas, and family-centric ideologies - encompassed within a social development approach.

Critically, the adoption of policies like GEAR and the social development paradigm, with their focus on employment and human capital development for social inclusion, has faced criticism. Scholars like Pons-Vignon and Segatti (2013) argue that these policies have not effectively reduced dependence on wage labour for social inclusion. Bond (2007) contends that in the context of high unemployment, limited welfare service provision, and deepening poverty, the developmental model and emphasis on social grants inadvertently promote private service provision. This highlights the intricate relationship between policy rhetoric, norms, ideologies, and the delivery of welfare services. The following section delves deeper into South Africa's care policy landscape, particularly exploring the state's familial and communitarian approaches to welfare/care provision.

4.2.3 Familalist approach to social care

There is consensus amongst those researching social policy (for example Sevenhuijsen et al., 2003; Patel, 2009; and Bozalek et al., 2007) that South Africa maintains a familialist approach to welfare provision and more specifically social care. As noted in the previous section, the provision of social care in South Africa is largely privatised to the family and/or undertaken by voluntary service providers. This approach to welfare is known as ‘familialist’. According to Razavi (2011, 14) “familialism can be understood as an ideology that promotes family as a way of life and a force

for social integration" and further that "a familialist welfare system is one that relies heavily on the family for the provision of welfare and care". As explored in the previous section, after the demise of Apartheid in 1994, the newly elected dispensation did little to de-familialize care and opted to reinforce the responsibility for care within the family unit. As Sagner and Mtati note (1999, 398) "social policy in the 1990s [saw] the emergence of a new language stressing the involvement of individuals, families, private service providers and the community, apart from the state".

As noted by Razavi (2011), the emphasis on a familialist approach is not necessarily an undesirable framework for social care and welfare broadly. In developing countries, families play a prominent role in the welfare system, just as they do in other parts of the world (Razavi, 2011). In South Africa, a significant proportion of households are complex and extended. In fact, extended family households constitute the largest single category – 36% of all households (Hall and Mokomane, 2018). Many children are raised by adults other than their parents, and these caregivers often share childcare and other care responsibilities, reinforcing the importance of family or kinship networks (Hall and Mokomane, 2018).

Moreover, the family constitutes an important source of social embeddedness often structuring women's entitlements, granting them access to resources such as land, housing and childcare based on conjugal or maternal status. In times of economic crises, as exhibited by the COVID-19 pandemic, these networks are a critical source of support (Razavi, 2011). In such contexts, families and extended kin networks remain crucial for cultural and survival support (Razavi, 2011). However, while households and families play a vital role in social protection and reproduction, they are not isolated or autonomous entities. Instead, they are interwoven with social, political, historical and economic changes on a global and national level. For example, in South Africa the prolonged economic challenges alongside structural transformations linked to migration and HIV/AIDS, have strained the support systems provided by extended family networks and altered kinship dynamics (Moore, 2019).

As Razavi (2012) explains, the underlying problem with familialist policies is that they often assume that the family unit is stable, consistently enacting and embracing principles of reciprocity

and altruism that enable good or adequate care (Razavi, 2012). However, families are sites of contestation, tension, conflict and gendered norms which dictate how care is provided and more importantly by whom (Mosoetsa, 2011). In reality, while familialist approaches endeavour to allocate care to the 'family', women undertake the lion's share of care responsibilities (both practically and financially). In South Africa, care activities constitute approximately 13.3% of women's time spent outside paid work, in contrast to just 7.6% of men's time (Oosthuizen, 2018). The caregiving imbalance is further exacerbated by factors such as race, class and unemployment status. Thus, low-income and unemployed Black women bear the largest share of unpaid care responsibilities. These women grapple with the added challenges of limited access to basic necessities like running water, sanitation, and stable electricity (Valliani, 2023).

The disproportionate caregiving role of Black women in South Africa is intricately influenced by a multifaceted interplay of historical, social, and cultural factors. One pivotal factor is the enduring legacy of Apartheid, particularly the migrant labour system, which enforced the separation of Black men from their families, compelling them into extended periods of labour in urban industries with minimal leave to return home (Gouws and Van Zyl, 2015). Consequently, Black women assumed additional caregiving responsibilities, including traditionally 'male' roles like cattle herding, while many also engaged in domestic work in predominantly white households, further consolidating their caregiving roles (Manicom, 1992, 449).

The Apartheid legacy persists in shaping contemporary South African family dynamics, manifesting in low marriage rates, high rates of extra-marital childbearing, and the prevalence of absent fathers, particularly within the Black population (Moore, 2020). Statistical data underscores the pronounced nature of women's childcare responsibilities, with only 31.7% of Black children being raised with their biological fathers living at home (Statistics South Africa, 2018).

Additionally, the prevalence of female-headed households, a phenomenon originating from the Apartheid era, contributes significantly to the central role of women in caregiving (Hall and Mokomane, 2018). These households, often facing economic challenges, are more likely to have fewer employed residents compared to male-headed households. In 2021, 42.1% of households

were headed by women, with the prevalence reaching 47.7% in rural areas (Statistics South Africa, 2021).

Cultural values, notably Ubuntu, further reinforce the caregiving responsibilities assigned to women. Ubuntu, emphasising interdependence and collective well-being, encourages communal support among relatives (Moore, 2019). While Ubuntu can advocate for equality and human dignity, it can also perpetuate patriarchal values (Ngubane-Mokiwa, 2016). The fluidity of Ubuntu's impact on gender roles implies that individuals' identities are shaped by their relationships with others, thereby amplifying women's caregiving burdens (Chisale, 2018; Razavi, 2013).

In the contemporary South African context, women, who bear a significant burden of unpaid care work, face numerous challenges in supporting it. Firstly, women encounter substantial barriers when trying to enter the workforce, and this is reflected in the alarming representation of women in unemployment statistics (Statistics South Africa, 2020). This disproportionate unemployment rate among women not only affects their economic independence but also places added pressure on them to fulfil their caregiving responsibilities. Moreover, even when women do secure employment, they often contend with unfavourable working conditions and lower wages, earning only 76% of what men earn on average (Statistics South Africa, 2022). This wage disparity not only contributes to economic inequalities but also increases the burden of care by imposing further financial difficulty and uncertainty. In addition, women are more likely to experience poverty than men, with 26.5% of South African women living below the Food Poverty Line in 2015, compared to 23.7% of men (Statistics South Africa, 2017).

In a context where women are primarily responsible for both the financial and the practical dimensions of caregiving and are simultaneously exposed to higher rates of poverty and unemployment, a familialist approach can be likened to 'care extractivism.' Coined by Christa Wichterich (2020, 122), this term describes the intensified commodification and exploitation of labour in social reproduction for the purpose of managing welfare without burdening the state with additional costs and responsibilities. Care extractivism, sustained by familialist or kinship approaches to welfare, “depletes care as a commons in societies in the Global South". Thus,

familisation, as a policy approach, "is a well-calculated form of care extractivism at the intersection of kinship obligation, affection and moral economy" (Wichterich, 2020, 122).

The familialist approach to welfare provision and social care in South Africa has far-reaching implications for the crisis of care within families. Implicitly this approach relies heavily on women and girls, to provide unpaid care work, despite the numerous challenges they face. Historically, the legacy of Apartheid, with its migrant labour system and gendered caregiving norms, has resulted in Black women shouldering the primary responsibility for childcare and household maintenance. This historical burden persists in contemporary South Africa, with Black women facing not only the disproportionate responsibility for caregiving but also the challenges of female-dominated households, often marked by financial strain. While familialist policies may leverage the sense of communalism and social orientation inherent in African kinship systems, they often overlook the fact that unpaid care within families is predominantly undertaken by women. This places immense pressure on women who not only face gender disparities in the workforce and wage gaps but are also expected to fulfil their caregiving roles. Therefore, the familialist approach, while rooted in cultural and historical context, not only fails to adequately address the gendered dynamics of caregiving and the economic challenges faced by women, particularly Black women but creates an environment where care needs go unmet.

4.2.4 The White Paper For Social Welfare

The White Paper For Social Welfare (WPSW) is among the only policy documents in South Africa that elaborates on a framework for social welfare in the post-Apartheid context. Published in 1996 by the Ministry of Social Development and adopted in 1997, the WPSW is a pivotal point of reference for numerous deliberations on social policy formulation and laws in the realm of welfare (Patel, 2014). The aim of the WPSW is to lay out an approach to welfare that breaks with the racialised and undemocratic welfare policies of the Apartheid era. It is widely cited (for example see Patel, 2014) that the WPSW signified an important shift in the landscape of social welfare service delivery in South Africa as it not only sought to address long-standing historical disparities but also redefined the role of social welfare as a contributor to social development within the emerging democracy.

The WPSW is a one-hundred-page document that is structured into two parts. The first part provides the overall framework and the instruments needed to deliver effective and appropriate services. This section deals with issues pertaining to national strategy, institutional arrangements, human resource development, legislation, and finance and budgeting. The second part focuses on the restructuring of the social service delivery system particularly in regard to social security and welfare services. This section lays out the proposed programmes for intervention and details the needs of specific groups such as families, children, youth, persons with disabilities, and older persons. The overview of the WSPW that I present here is by no means exhaustive. Instead, I present some of the overarching discourses that scholars have problematised and their subsequent implications for care specifically.

The formulation of the WPSW coincided with a larger process of policy formulation in the country which informed the content of the Paper. Notably, the ANC's Reconstruction and Development Programme (RDP) and the Constitution played pivotal roles in guiding the policy direction. The RDP was characterised by a commitment to principles such as strengthening public ownership, wealth redistribution, and state regulation of the economy, emphasising the importance of addressing poverty and inequality through initiatives such as job creation, fair wages, democratic practices, housing provision, and land redistribution (Sevenhuijsen et al., 2003). Moreover, the Constitution reinforced these obligations by enshrining a range of socioeconomic rights, encompassing housing, healthcare, education, social security, and more, setting the stage for a comprehensive welfare framework (Bozalek et al., 2007).

However, a significant turning point occurred in 1996 when the ANC government replaced the RDP with the Growth, Employment, and Redistribution (GEAR) strategy. GEAR, framed as a necessity to align South Africa with global economic competition, ushered in a market-driven, neoliberal approach that prioritised macroeconomic growth (Sevenhuijsen et al., 2003). This shift was driven by the need to reconcile left-wing calls for redistribution with neoliberal demands for growth-oriented market forces. GEAR proposed a series of measures, including reducing the size of the public sector, safeguarding property rights through legal means, and addressing the legacy debt inherited from the apartheid era (Bozalek et al., 2007). This transition from the RDP to GEAR was seen as a watershed moment, signifying South Africa's “self-imposed structural adjustment”,

a shift from social justice and wealth redistribution to neoliberal concerns centred on fiscal restraint, control of inflation, interest rates, trade liberalisation, and financial (Parenzee and Budlender, 2015, 19) Consequently, these developments set the ideological tone for subsequent policies, including the WPSW, aligning them with neoliberal principles and significantly influencing their content and approach (Sevenhuijsen et al., 2003).

Owing to the broader shifts in macroeconomic policy, most scholars (Bozalek et al., 2007; Patel, 2014; Bond, 2014) note that the WPSW is grounded in a "social development approach" or "developmental social welfare". In the introductory paragraphs of the WPSW, the primary issues for social welfare are presented as the decline in economic growth, national income, and increasing poverty observed over recent decades (Bozalek et al, 2007). The Paper highlights concerns such as decreasing GDP, diminishing per capita income, declining job opportunities, and the growing inability to meet basic needs, resulting in heightened levels of poverty and significant inequalities among different groups, such as the rich and poor, urban and rural populations, and men and women (Sevenhuijsen et al., 2003,). As Sevenhuijsen et al. (2003) note, given the framing of the 'problem', the Paper eludes to a conundrum: on one hand, faced with a plethora of socio-economic issues individuals are more likely to rely on welfare for income support and social assistance, while on the other hand, the system of social provision lacks the financial resources to meet these needs. Given the challenge of expanding the social safety net to meet demand while simultaneously ensuring 'economic growth', the paper notes that "trade-offs must be made between investment in economic and human resources, and investment in a social safety net" (Department of Welfare, 1997, 4).

To resolve the tensions between the need for economic growth and urgent poverty alleviation, Patel (2014) writes that the WPSW espouses a 'productivist' approach, placing emphasis on, as noted by the WPSW, "employment creation, skills development, access to credit and where possible through facilitating the transition from informal to formal employment" (Department of Welfare, 1997, 13). Bozalek et al. (2007, 33) characterise the "social development approach" to poverty alleviation adopted by the WPSW, as largely premised upon the establishment of a 'work ethic' because it "aspires to create a normative citizen who is self-reliant, independent, autonomous and economically engaged". Drawing from the vision statement which reads:

> *Vision: a welfare system which facilitates the development of human capacity and self-reliance within a caring and enabling socio-economic environment* (Department of Welfare, 1997, 2)

Sevenhuijsen et al. (2003, 304) echo this perspective, noting that the Paper's primary solution to poverty lies in integrating individuals into the labour market and income-generating activities, enhancing economic self-reliance. Bond (2014, 4) explains that "individual self-activation, under the guise of 'empowerment' discourse" combined with the "view of social security and social services as investments which lead to tangible economic gains" is not inherently problematic as it is undeniable that social spending directed to low-income individuals may yield a higher economic multiplier effect. However, the issue with this logic and approach, as Bond (2014, 4) further elaborates is that "welfare becomes oriented to the economy's needs, not the society's leaving no rationale for welfare programmes". Thus, as Sevenhuijsen et al., (2003, 316) the WPSW ultimately embraces the view that self-sufficiency, not welfare dependency, defines "responsible" citizens (Sevenhuijsen et al., 2003, 316).

The White Paper for Social Welfare (WPSW) not only enforces norms of self-sufficiency, independence and economic self-reliance but contains a specific approach to care. As Sevenhuijsen et al., (2003, 301) note, the WPSW does indeed, "display authoritative ways of speaking about care". To unearth the WPSW's approach to care, Sevenhuijsen et al. (2003), examine the text across three interconnected dimensions: care as a social practice (the practical dimensions of care and who is involved in the process), care as a moral practice (the norms that dictate why particular agents are assigned the duty of care), and care as a political practice (how public responsibilities for care are understood).

Within the ambit of care as a social practice, Sevenhuijsen et al. (2003) note that the WPSW acknowledges the diversity in caregiving intensity across households. For example, it contends that social assistance programs empower impoverished families to provide care, particularly for vulnerable members. In addition, the Paper recognizes the potential overburdening of households with elderly, chronically ill, or disabled individuals, highlighting the attendant financial

vulnerability and psychological stress (Department of Welfare, 1997). It also acknowledges that social relief programs can alleviate some of the care burdens. However, Sevenhuijsen et al. (2003) note that acknowledgement of the burden of care and the potential of social relief programmes is eroded as it ultimately succumbs to a "familialist understanding," relegating caregiving predominantly to the private sphere of families (Sevenhuijsen et al., 2003). The Paper notes that:

> *The family is the basic unit of society. Family life will be strengthened and promoted through family-oriented policies and programmes* (Department of Welfare, 1997, 39)

The WPSW's emphasis on the family as the basic unit of society and its role as the primary source of care forms the cornerstone of its care paradigm. The Paper applauds the family's contributions to development, protection, and security, especially for children. The turn to a familialist approach to care is best demonstrated in the context of care for older persons. The Paper problematizes the overreliance, particularly among the white population, on institutional care for older persons and the "inappropriate emphasis on the Government's responsibility for the care of the aged" (Department of Welfare, 1997, 69). The Paper argues that the family should be "the core support system for the elderly" thus shifting away from the notion of "care for the aged" to ageing as a natural life process.

Importantly as Sevenhuijsen et al., (2003, 306) note "family life is described in gender-neutral, functionalist and moral terms". Thus, there is little to no recognition of the gendered division of labour that sustains the unpaid family work that the WPSW relies upon. Women's disproportionate caregiving role is confined to contributions to the *community*, while their pivotal role within the *family* remains obscured (Sevenhuijsen et al., 2003). Sevenhuijsen et al. (2003) explain that the Paper ultimately argues that women should receive support in their caregiving roles without scrutinising the gender divisions in caregiving through the lens of gender justice.

Sevenhuijsen et al., (2003) delve deeper into WPSW's approach to care through the lens of care as a moral practice. As Sevenhuijsen et al (2003) note, the allocation of care to the realm of the family, and ultimately women, is informed by a broader set of moral values. These values encompass securing basic welfare rights equity, non-discrimination, democracy, improved quality of life, human rights, people-centred policies, investment in human capital, sustainability, partnership, intersectoral collaboration, decentralisation of service delivery, quality services,

transparency and accountability, accessibility, appropriateness, and Ubuntu. However, Sevenhuijsen et al., (2003) explain that the emphasis on Ubuntu, among the other values and norms, underscores the presence of a normative contradiction in the text. The WPSW defines Ubuntu as:

> *The principle of caring for each other's well-being will be promoted, and a spirit of mutual support fostered. Each individual's humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual's humanity. Ubuntu means that people are people through other people. It also acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being* (Department of Welfare, 1998

Sevenhuijsen et al. (2003, 305) note that alongside a largely neoliberal framework that emphasises economic self-reliance and the importance of human capital development, the WSPW features "an outspoken communitarian influence" through its emphasis on the 'family' and 'ubuntu'. Given the prevalence of conflicting perspectives, Sevenhuijsen et al. (2003, 305) ultimately conclude that indigenous concepts such as Ubuntu "feature as an afterthought that is not mainstreamed into the vision and mission of the policy framework through the document, and thus also not in its representations of care as a social and political practice". However, Sevenhuijsen et al. (2003, 308) notes that the inclusion of Ubuntu "without further thought" in the document is not without moral or social implications for care. This is made evident in how the WPSW frames care as a political practice.

As a political practice, Sevenhuijsen et al. (2003) note that the WPSW does not sufficiently expand on public or state responsibility for care. The Paper advocates for an intersectoral response and the coordination of social welfare services, however, it falls short of clearly articulating the state's proactive role in care provision. Sevenhuijsen et al. (2003) note that the lack of clarity on the state's role perpetuates ambiguity, hampers comprehensive care provisioning, and restricts the policy's effectiveness in addressing care as a practical, moral, and political endeavour (Sevenhuijsen et al., 2003). Ultimately, the state's role is 'residual' as the market and family are regarded as the primary sites of support. Bozalek et al. (2007, 34) note, "if it is acknowledged that care is not just a private and individual or family responsibility and activity but needs collective and public acknowledgement and responsibility; then care can be seen as a political activity". The WPSW

ultimately fails to see care as a political activity because it emphasises self-reliance, allocates the primary responsibility of care to the family and fails to adequately allocate an active care role to the State.

The White Paper for Social Welfare (WPSW) represents a significant achievement in South Africa's welfare policies. However, the WPSW is influenced by several normative frameworks that shape its stance on care. It arises in a context where South Africa shifted from a focus on social justice and wealth redistribution to a neoliberal emphasis on economic growth, demonstrated in the WPSW's call for self-reliance and economic participation. The policy promotes the family as the primary caregiving unit but fails to recognise the prevalence of traditional gender roles within families. While it includes moral values like equity and human rights, the integration of these values, especially Ubuntu, remains inconsistent. Furthermore, the document lacks clarity regarding the state's active role in caregiving, often viewing the state's responsibility as secondary to that of families and the market. These normative underpinnings significantly influence how care is practised and understood within South Africa's welfare system, influencing the enactment of care and perpetuating gendered caregiving roles.

4.2.5 White Paper on Families

South Africa stands out as one of the few countries in the Global South that has implemented a comprehensive family policy alongside various other social policies that directly or indirectly support families (Hochfeld & Patel, 2018). According to Hochfeld and Patel (2018, 1) “family policy, broadly defined, refers to everything a government does to promote the well-being of families, such as social grants, family services, or social housing The salience of the ‘family’ in achieving a developmental welfare approach is mentioned in significant documents such as the White Paper for Social Welfare and the National Development Plan 2030. These documents also underscore the state’s responsibility to support and maintain the family unit.

In 2012, the Department of Social Development (DSD) released a draft of the first 'White Paper of Families in South Africa,' marking a crucial acknowledgement of the importance of family support and protection. However, it faced strong criticism for its conservative nature, as it appeared to reinforce traditional gender roles and relied on a neoliberal vision of a self-reliant nuclear family

(Rabe, 2017). Furthermore, it assumed that caregiving was primarily the responsibility of families, overlooking the gendered aspects of caregiving, where women often bear the practical and financial burdens. The draft also imposed normative judgments on what constitutes a family, neglecting structural factors such as race, class, and gender, as well as the impacts of neoliberal economic policies on families and social inequalities (Charles, 2013).

However, these criticisms were considered in the development of the White Paper on Families (WPF) which was then approved by Parliament in 2013. The WPF officially launched in October 2014. However, since its publication the document has received considerable backlash as it failed to sufficiently dispense with the prevailing normative approaches to the family and its gendered undertones. A revised version of the White Paper was published in 2021, aiming to address previous criticisms, consider contemporary family dynamics, and integrate feedback from stakeholders (DSD, 2023). However, this thesis primarily refers to the 2013 version due to its timeline aligning with the COVID-19 pandemic.

The WPF (2013) is structured into five sections, beginning with its objectives and aspirations, followed by defining the concept of family and addressing associated challenges. It then examines the existing legal framework on various scales and outlines strategic priorities for families. Finally, it details the coordination and implementation mechanisms necessary to achieve its objectives.

The WPF aims to encourage family life, empower family members to access economic opportunities and enhance their capabilities to establish meaningful social interactions and community bonds (Department of Social Development, 2013). The successful implementation of the WPF is intended to result in well-functioning and resilient families capable of nurturing, supporting, and caring for their members. This thesis primarily explores the normative frameworks within these documents and their implications for the state's role in caregiving coordination, thus this literature review does not detail the programmatic strategies in the WPF.

According to Patel and Knijn (2018), the introductory paragraphs of the WPF reveal a largely ‘structural-functionalist’ approach to families. From this viewpoint, the document underscores the importance of families in society and highlights how promoting family life benefits both

individuals and the overall well-being of society (Patel and Knijn, 2018). The Paper is largely concerned with the 'social ills' that contribute to the creation of 'disorganised' or 'dysfunctional' families which hamper the realisation of societal and individual welfare. However, as Rabe (2017) notes these 'social ills' are premised upon paternalistic, anti-poor and conservative sentiments. Rabe (2017) points to two separate examples where such framing is made apparent. In the section titled "Setting the Context" and the subsection titled *Moral Capacity*, 'poverty' and 'unemployment' are characterised as 'social ills' and a contributor to 'moral degeneration'.

Rabe (2017) argues that this framing is "careless" and provides rich insights into how welfare is perceived by the state. In situating 'poverty' and 'unemployment' as a social ill, the Paper pathologizes the reality of most South Africans and individualised structurally-induced vulnerabilities. As Rabe (2017, 1197) puts it: the Paper implies "that to be poor is to have low moral standards and this can be lumped together or even equated with vandalism and corruption". In another example, Rabe (2017) draws attention to the following excerpt:

> *Financial readiness means that the prospective families are financially capable to dealing [to deal, sic] with the costs associated with a new born child; structural readiness means that the prospective parents have a home within which to raise the child close to clinics or hospitals, care giving facilities and educational facilities.* (DSD, 2012, 40)

As Rabe (2017, 1199) notes, the above excerpt demonstrates how the "specific ideology of the middle-class family is promoted" and further exposes the ideology of the 'deserving poor' The emphasis on 'financial readiness' implies that those without adequate financial resources i.e. poor or low-income individuals should refrain from having children. On the other hand, the emphasis on 'structural readiness' not only excludes those who are poor but also those who do not have access to caregiving facilities owing to factors such as socio-economic status and/or locatedness i.e., urban or rural. Considered together, this logic ultimately implies that without the requisite material and financial resources, certain individuals must take responsibility for their 'choices' and subsequently find other avenues to supplement the demand for care (Rabe, 2017). This moralistic framing thus functions as 1) a mechanism to justify withdrawing support from those who need it and 2) manufactures the grounds on which to push a discourse of 'self-reliance' or 'self-help'.

Despite references to a number of family forms, reflecting the diversity of family composition in South Africa and the reality of poverty, inequality and unemployment, the Paper reflects an implicit bias towards middle-class, heteronormative nuclear family arrangements. As a result, Patel et al. (2018, 8) note that the policies contained in the WPF are thus only "applicable to the rich/middle classes while leaving the poor with self-reliance and kinship support". In other words, the solutions put forward are limited in their capacity to give the majority of families the support they require.

Rabe (2017, 1191) notes that the basic premise of family policy is the assumption that "aspects of care towards individuals will be undertaken by family members". The literature on the framing of care in the WPF is limited. However, much like the WPSW, the family is the primary site at which care occurs and the practice of care is recognised as taking place through "intergenerational solidarity" (DSD, 2013, 3). Under the section titled *Feminisation of Poverty'*, there is an acknowledgement of the disproportionate care burden placed on women. However, reference to the 'gender division of labour' and its implications for women does not feature strongly throughout the paper. The Paper speaks to notions of 'family caregiving' without acknowledgement that women are undertaking the majority of unpaid work. Thus, the family is put forward as a stable 'firm' that is not fraught with issues of gender imbalances and distinct patterns of caregiving.

The Paper also emphasises that by providing care through the mode of kinship or familial relations, public responsibility for care (particularly vulnerable or dependent individuals) is minimised (Patel et al., 2018).

The White Paper on Families (WPF) in South Africa embodies normative paradigms that profoundly influence its family welfare approach, with significant ramifications for social care provision. The WPF's family-centric stance, marked by conservative and neoliberal elements, tends to pathologize poverty, endorse middle-class family ideals, and potentially marginalised vulnerable groups (Rabe, 2017; Patel et al., 2018). Consequently, these policies seem to predominantly favour middle to upper-class families, leaving impoverished individuals reliant on self-sufficiency and kinship support (Patel et al., 2018). Furthermore, the document's focus on family caregiving and intergenerational solidarity often sidesteps the recognition of the gendered

division of labour and women's disproportionate unpaid caregiving burden (DSD, 2013; Patel et al., 2018).

This approach bears significant implications, potentially reinforcing traditional gender roles, deepening social inequalities, and neglecting structural factors such as race and class affecting caregiving capabilities (Charles, 2013). What follows in the subsequent sections is an exploration of how this approach manifests in the state's withdrawal from responsibility, as evidenced by the challenges and deficiencies in the ECD sector and LTC provision.

4.5 Social care provision

This section forms a crucial groundwork for comprehending the systemic neglect and marginalisation of social care provision within the ECD and LTC sectors in South Africa. In uncovering the challenges within the ECD and LTC sectors, this section illustrates that the marginalisation and poor consideration for these sectors preceded the onset of the pandemic. While the pandemic's impact was unparalleled, it merely served to exacerbate and intensify pre-existing structural deficiencies within both ECD and LTC domains.

Moreover, this section delves into the intricate landscape of care itself, shedding light on the pivotal role of the state as both a facilitator and locus of care. This endeavour is undertaken in an effort to start the process of linking the entrenched policy norms discussed earlier and their tangible manifestations in the provision of care services.

4.5.1 Early Childhood Development

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

The historical evolution of ECD in South Africa is characterised by distinct phases influenced by apartheid-era racial policies (Atmore, 2023). ECD programs emerged in response to high infant mortality rates in the early 19th century, initially serving primarily white children with a British-style curriculum (Atmore, 2023). Racial disparities in access to ECD persisted throughout apartheid, with limited options for non-white children (Atmore, 2023). In 1994, however, a commitment to address these disparities emerged, driven by recognition of ECD's critical role in education, health, and social integration (Nel, 2007). In the post-Apartheid era, policies have been developed and transformed to include Grade R as a preparatory year and programs for targeting younger children ages birth to 4 years (Atmore et al., 2012). The most significant change was in the redefinition of ECD, encapsulated in the National Integrated Childhood Development Policy adopted in 2015. This transformation expanded the understanding of ECD to encompass broader aspects such as prenatal care, birth registration, healthcare, nutrition, the initial thousand days, social assistance and parental engagement in children's learning and development.

According to Atmore (2023), while South Africa has made notable strides in its policy development, the implementation of many specified services has shown limited progress, particularly in areas like nutrition, early learning, and caregiver support. This stagnation can be attributed to both financial constraints and the inadequacy of institutional mechanisms needed to effectively coordinate and monitor the complex integration of ECD services. Key shortcomings in the country's approach include the absence of a centralised mechanism to mobilise and coordinate a nationwide program for young children, insufficient capacity to provide quality services at scale, and the lack of established systems for routinely assessing services and measuring progress in various child-related outcomes (Atmore et al., 2012).

The majority of ECD services are informal and often run by private entities, including non-profit organisations, small-scale social enterprises, and self-sustaining entrepreneurs (BRIDGE et al., 2020). These informal childcare facilities, primarily serving disadvantaged communities, are typically small, unregistered, and operate with minimal resources and job security, predominantly employing women (Brooks, 2021). In addition, ECD facilities rely heavily on parent fees as the primary source of funding, with the Department of Social Development (DSD) providing a limited operational subsidy for registered ECD centres (DSD, 2023). However, the criteria for registration

and subsidy eligibility include stringent standards and income thresholds for parents or caregivers, leaving many unregistered centres without financial aid (Metelerkamp, 2022; Wills et al., 2021). The 2021 Early Childhood Development Census revealed that only 40% of ECD programs were registered or conditionally registered, highlighting a substantial gap in formal registration (Metelerkamp, 2022).

Consequently, the ECD sector's sustainability largely depends on student enrolment, making it vulnerable to fluctuations in attendance, especially during crises and economic hardships (Wills et al., 2021). However, it is important to note that subsidised ECD programs maintain lower fees, averaging around R208 per month, while non-subsidized centres charge a significantly higher average of R649 per month (Metelerkamp, 2022). Given South Africa's high poverty and unemployment rates, the financial burden on caregivers, primarily women, is substantial (Early Childhood Development Review, 2019; Wills et al., 2021).

Despite the prevalence of poverty, a high percentage of children attending ECD programs have fees paid for them, indicating the critical role of ECD services for caregivers (Wills et al., 2021). However, there has been a decline in the number of children benefiting from these programs, even before the COVID-19 pandemic (Witten et al., 2021). The situation was further exacerbated by the pandemic, leading to the closure of ECD programs and a further decline in attendance (NIDS-CRAM report, 2020). This reliance on fees and the limited allocation of subsidies and registration in the ECD sector reveals the state's minimal involvement and support, especially for the most vulnerable populations, underscoring the challenges and deficiencies in ECD provision.

State funding remains a major challenge in the ECD sector, where funding allocations barely keep up with inflation, accounting for only about 1.6% of the total education budget (Equal Education Law Centre, 2019). This limited budget allocation reflects a lack of government support and commitment to ECD policy objectives (Dinks, 2022). Furthermore, the ECD sector faces issues of poor interdepartmental collaboration among government bodies like Social Development, Education, and Health, hindering a coordinated approach to ECD initiatives outlined in the Integrated ECD policy (Equal Education Law Centre, 2019). Although multiple entities, including DSD, the Department of Basic Education (DBE), the Department of Health, and the Department

of Home Affairs, are involved, effective cross-sectoral coordination remains a challenge (Equal Education Law Centre, 2019). Non-profit Organisations (NPOs) also encounter limitations in capacity and resources, preventing them from aligning their ECD programs with the Integrated ECD Policy and adequately serving the considerable number of children in need of comprehensive ECD services (Ashley-Cooper et al., 2019).

The challenges within the ECD sector are intricate and multifaceted. These encompass the absence of robust governmental support for policy execution, coupled with a dearth of resolute political commitment to prioritise ECD efforts. The resultant lack of political will has led to inadequate government funding, impeding the attainment of established policy aims. Additionally, the existing institutional structures for implementing ECD initiatives within the government prove ineffective, contributing to a lack of coherence in ECD policies and programs across diverse government departments tasked with ECD responsibilities.

Moreover, the constrained capacity and resources of non-profit organisations engaged in ECD present a significant hurdle. Their current capabilities fall short of delivering ECD programs in alignment with policy mandates and catering comprehensively to the considerable number of children necessitating integrated ECD services. As highlighted by Atmore, despite the absence of racial discrimination in South African laws, substantial disparities in ECD services persist, hindering the realisation of racial integration in ECD centres and programs across the nation. Ashley-Cooper et al. (2019) underscore the imperative of meticulous policy execution for ECD success, as failure to do so relegates the policy to symbolic rather than impactful status, leaving young children without the constitutionally entitled ECD programs.

4.5.2 Long-Term Care for Older Persons

The historical landscape of Long-Term Care (LTC) in South Africa has been shaped by historical events, including the era of apartheid and the HIV/AIDS crisis (Lombard and Kruger, 2009). During apartheid, social services were segregated along racial lines, resulting in superior care for white individuals (Lombard and Kruger, 2009). The transition to democracy in 1994 marked a commitment to a developmental approach to LTC, emphasising holistic ageing and older individuals' contributions to society (Lombard and Kruger, 2009). The Older Persons Act of 2006

is central to South Africa's LTC policy, focusing on community-based care and support for older individuals (Department of Social Development, 2006). It emerged after an inquiry into elder abuse, highlighting the need to improve the quality of life for older persons (Jacobs et al., 2020). This act emphasises the transition from institutional care to community-centred care (Lombard and Kruger, 2009).

Captured in the Older Persons Act of 2006 are two broad programmatic interventions for older persons: community-based care and support for older persons and residential facilities. Community-based care programs provide various services, including economic empowerment, recreational activities, education, and rehabilitation, catering to older individuals' holistic needs (Department of Social Development, 2006). It also includes support for frail older people who require round-the-clock care (Human Rights Watch, 2023). In 2021, it was recorded that there are approximately 1,713 registered providers of Community-Based Support Services (CBSS) which provide essential aid to around 97,923 older individuals, a notable majority of whom (90 percent) benefit from government subsidies (Human Rights Watch, 2023; Department of Social Development, 2021).

However, these figures, though substantial, account for less than 3 percent of the 3.7 million Older Persons Grant recipients (Human Rights Watch, 2023, 28). The accessibility of these services is marked by notable gaps. Significantly, the distribution of services lacks a foundation in need assessment, resulting in inadequate support provision. The Department of Social Development's approach to community-based care and support services is constrained by considerations of "affordability." This strategy is confined to aiding 20 percent of "active vulnerable older persons," referring to independent retirees with mobility and self-sufficiency, as well as 3 percent of "vulnerable frail older persons," characterised by a requirement for round-the-clock care due to physical or mental conditions (Human Rights Watch, 2023; Department of Social Development).

Provincial governments shoulder the responsibility of delivering support services to eligible elderly individuals. Although some provinces acknowledge the necessity to enhance access to essential services for older citizens, the coherence of these regional strategies exhibits notable variance. This divergence translates into inequalities in service and support availability, leading to

a scenario where older individuals in specific provinces enjoy more robust access compared to their counterparts. The inherent incongruity in provincial approaches presents a formidable challenge to establishing a uniform and comprehensive community-based care framework for older individuals throughout South Africa (Human Rights Watch, 2023).

The Older Persons Act of 2006 outlines a comprehensive range of services that residential facilities can provide. These encompass round-the-clock care and support for frail older individuals and those requiring specialised attention, including supervision. Furthermore, services extend to older persons afflicted with dementia and related conditions, offering essential care. Rehabilitation services, public education initiatives addressing ageing issues, particularly dementia, and counselling services for both residents and their family members are integral components. The act emphasises the implementation and monitoring of outreach programs, the provision of temporary accommodation beds for older persons, and respite care services (Department of Social Development, 2006).

In 2021, it was reported that approximately 27,623 older persons, making up 0.5% of the overall elderly population, reside in 417 registered residential facilities under the Department of Social Development. (DSD, 2021). Notably, only nine of these facilities are managed by the government. As with most social provision in South Africa, residential care is largely managed by Non-profit Organisations (NPOs) as well as Faith-based Organisations (FBOs). These facilities are predominantly concentrated in urban areas such as cities and towns, with a scarcity of options in rural locales. This urban bias often necessitates the relocation of individuals seeking long-term care, leading to a potential upheaval in their established living arrangements (Human Rights Watch, 2023). Admission into these facilities is predicated upon a rigorous assessment encompassing various dimensions such as the individual's current living situation, available family support, financial means, and care requirements. Only those satisfying the stipulated criteria gain eligibility for admission (Lombard and Kruger, 2009).

Facilities that are officially registered, amounting to 415 homes, have the option to submit applications on behalf of potential residents who meet specific criteria (Department of Social Development, 2021; Human Rights Watch, 2023). These criteria encompass being 60 years or

older, frail, destitute, and a resident of South Africa in need of full-time care. Currently, the Department of Social Development's (DSD) subsidy covers a notable 51.9% of the costs associated with frail care (Jacobs et al., 2020b; TAFTA, 2019). The remaining expenses are either covered by the individual or by a Non-Profit Organisation (NPO). Typically, the residual cost equates to approximately R3,800 per person per month (Jacobs et al., 2020b). However, an investigation conducted in 2010 unveiled a complex reality where historical racial biases and cultural preferences in admissions impede the transformation and provision of care across all population groups in these facilities (Solanki et al., 2021). The study underscored a stark contrast: among 405 residential homes examined, only 4% of the residents were black, reflecting a racial separation that correlated with the quality of care provided (Solanki et al., 2021). Over time, the value of the monthly subsidy has gradually decreased, thereby becoming an impediment to care provision. According to Jacobs et al. (202b0), this reduction in subsidy amounts by the DSD has led to a situation where facilities struggle to serve impoverished, frail individuals who qualify, while catering to more affluent individuals who can afford the fees. In contrast to this, the private sector boasts over 1000 LTC facilities for the elderly in South Africa (Solanki et al., 2021).

Moreover, operational, and administrative challenges pose significant barriers. Operational inefficiencies are compounded by issues surrounding infrastructure, including subpar hygiene standards, cramped living spaces, and unreliable access to basic amenities like electricity and water. Due to resource limitations, the focus of care within these facilities often tilts toward fulfilling rudimentary necessities, such as aiding with bathing or dressing (Human Rights Watch, 2023). This emphasis comes at the expense of broader objectives like fostering well-being, preserving dignity, and respecting personal choices. As articulated by the World Health Organization (WHO, 2017), the overarching mission of upholding quality of life and individual agency can be inadvertently compromised within these contexts.

Given the poor establishment of and access to LTC or residential care facilities as well as community-based initiatives, the majority of care for older persons is carried out by kin, particularly women (Moore, 2023). While family caregiving remains crucial, numerous factors strain the family's capacity to provide care, including high unemployment rates, evolving societal norms, and women's increased participation in the workforce (Sagner and Mtati, 1999; Moore,

2023). South African women, especially black women, have seen a surge in labour force engagement, including waged employment and self-employment in the informal sector (Mosomi, 2019). However, this transformation has not diminished women's responsibility for caregiving. Despite the growth in women's employment, the division of caregiving responsibilities and financial burden continues to exhibit gender-based patterns (Hatch and Posel, 2018). This is exacerbated by the unequal socio-economic landscape in South Africa, where caregivers in middle- to upper-income households have more resources to manage caregiving demands (Rogan and Reynolds, 2019; Moore, 2023).

4.6 Conclusion

This literature review provides an exploration of the intricate interplay between policy, ideology, and the provision of care in South Africa, drawing on the challenges faced by ECD and LTC facilities. By tracing the development and content of the welfare system in South Africa, analysing contemporary welfare policies, and examining the practical aspects of care provision, it has uncovered the deep-rooted norms and ideologies that underpin the country's approach to social care. This review highlights the persistence of certain policy paradigms over time, despite changes in government and shifting societal dynamics. It has also shed light on the challenges and complexities within the South African landscape of social care provision, which were exacerbated by the COVID-19 pandemic. This literature review serves as a vital foundation for the subsequent chapter, where the analysis of South Africa's response to ECD and older person care during the pandemic takes place.

Chapter 5: Findings

5.1 Introduction

In the previous chapter, I detailed the historical landscape of ECD and LTC. In this chapter, I use Joan Tronto's (1993) four phases of care and corresponding moral values to critically assess the state's response to the unprecedented challenges faced by LTC facilities and ECD centres during the height of the COVID-19 pandemic. For Tronto (1993), good or appropriate care is an ongoing practice that entails four actions and four corresponding moral values: caring about and attentiveness, taking care of and responsibility, caregiving and competence, care-receiving and responsiveness. I use each of these 'phases' to lay bare various dimensions of the state's response. I proceed first by drawing on **attentiveness** which assists in highlighting the extent to which **needs** are **identified** or **recognized**. I then turn to **responsibility** to establish where the imperative to **enact care** goes i.e. who becomes responsible for caring. Thirdly, I use the lens of **competence** to assess the degree to which caring is supported through **financial allocation and resource prioritisation**. Lastly, by drawing on **responsiveness** I shed light on how the **state shapes care relations** which affect the **quality of care-receiving**. In an effort to make visible a pattern of neglect in the realm of state-supported care provision, I assess both the responses to LTCs and ECDs simultaneously.

5.1.1 Attentiveness

During the early months of the COVID-19 pandemic in South Africa, the response to the needs of LTC facilities and ECD programmes was characterised by significant delays and a lack of sector-specific attention, which had critical implications for these vulnerable populations. As Wills and Kika-Mistry (2022) note, it took many months into the 'hard' lockdown before sector-specific relief for ECD programmes was realised. Similarly, while the first intense wave of infections occurred in "old age homes" in the provinces of Western Cape and Gauteng, the government's response to the threat of COVID-19 in LTC was described as "slow, vague and inadequate" (Jacobs

et al, 2020). The nationwide lockdown was implemented on 26 March 2020. With this unprecedented event, the government established a National Coronavirus Command Council, chaired by the President, and composed of 19 cabinet ministers.

In the case of LTC facilities, clear evidence emerged that COVID-19 posed an elevated risk to the elderly and individuals with cognitive and physical disabilities. Globally it was found that COVID-19 presented an increased risk to people with neurocognitive deficits, intellectual and physical disabilities, immunodeficiencies and comorbidities (Jacobs et al., 2020). In a study conducted by the World Health Organisation Regional Office for Africa (2021), it was noted that "persons over 60 [represented] a significant proportion of lives lost in the global pandemic (Comas-Herrera et al., 2020) and over 50% of the deaths in the [African] region". However, no forums representing Older Persons needs were involved in consultations with the government. This 'oversight' meant that the unique vulnerabilities and requirements of LTC facilities went largely unrecognised by government authorities. Consequently, many LTC facilities took it upon themselves to implement voluntary lockdowns even before any official announcement was made, illustrating the urgency of their situation (Jacobs et al., 2020).

The challenges faced by LTC facilities during the pandemic were multifaceted. These facilities had to grapple with issues such as infection control, ensuring the continuous provision of emotional and physical care, and adapting to evolving lockdown protocols. The initial lockdown measures, which heavily restricted the movement of non-essential workers, had unintended consequences. Visitation access was denied to individuals such as loved ones, volunteers, and service providers, resulting in a loss of diversity in the LTC ecosystem and heightened isolation for residents (Jacobs et al., 2020a).

The first reference to Old Age Homes and Frail Care Facilities came more than four days after the announced nationwide lockdown (Jacobs et al., 2020a). This came in the form of a list of four directives in the Government Gazette No. 43182 (Jacobs et al., 2020a, 8). The directives were issued to address and mitigate the spread of the novel coronavirus. These measures included: firstly, a restriction on the release of clients from facilities; secondly, a prohibition on visitations during the lockdown period; thirdly, the suspension of the family reunification and interaction

programme; and fourthly, a temporary halt on new admissions, with the exception being made only for individuals with disabilities in distress. However, by late May 2020 (almost three months into a state of nationwide lockdown), "no obvious information relating to the impact of COVID-19 on the elder care sector" could be found on the National Department of Social Development's official website (Jacobs et al., 2020b, 12). The National Institute for Communicable Disease, however, continued to emphasise, through widespread government and media campaigns, the risk of COVID-19 to older persons. However, the sustained emphasis on the potential threat of COVID-19 on older persons was not accompanied by substantial information on the unique challenges of persons living in LTC facilities and how to address them. In the absence of considered, sector-specific guidelines numerous LTC facilities faced the challenge of developing their own policies and procedures. To address this issue, they relied on global sources such as the World Health Organization (WHO) and the Centres for Disease Control and Prevention (CDC), while also seeking support from their peers in the eldercare sector (Jacobs et al., 2020b)

Crucially, specific guidelines for LTC facilities came considerably later in the pandemic response timeline. It was not until 21 May 2020 that the Western Cape Provincial Department of Health, in collaboration with the Samson Institute for Ageing Research (SIFAR), issued sector-specific guidelines. This delay was partly attributed to the limited communication and engagement with LTC facilities by the Department of Social Development (DSD). The circular provided in-depth guidelines on preventing sector-specific re-infection and brief guidance on the management of residents diagnosed with COVID-19. The impetus for sector-specific relief came through the lobbying of a task team encompassing representatives from various Residential Care Facilities and other organisations that work with the elderly in the Western Cape (Voigt, 2020a). Dr Leon Geffen, a medical doctor and the Executive Director of SIFAR, led this task team "to find ways to deal with COVID-19 among older persons". In an interview with Spotlight, Dr Geffen noted that communication from the DSD had been "extremely limited" especially when considered within the context that the DSD has a "particular responsibility" to state-funded facilities (Voigt, 2020b).

As evidenced by South Africa's campaign against the spread of COVID-19 and subsequent efforts to reduce mortality rates, one can conclude that significant attentiveness to the vulnerability of older persons was present at the height of the pandemic. However, as Dr Geffen lamented in an

interview: the “government’s response [was] very tardy in terms of engaging with *care facilities* and in terms of providing services to care facilities” wherein “measures should have been put in place…months ago” (emphasis added) (Voigt, 2020b). The absence of an immediate, centralised reporting system and rapid response to facilities (wherein among the most vulnerable reside) is indicative of a failure to grant sufficient attention to the unique and particular realities of LTC facilities. Enhanced attentiveness to the specific needs of LTCFs was facilitated through the contribution of independent organisations such as SIFAR and representatives from care facilities across the country. The efforts of these entities ultimately platformed the needs of older persons residing in LTC facilities and led a process to ensure that the unique plight of the sector was made visible.

Similarly, the ECD sector faced its share of confusion and lack of attention by the Department of Social Development. At the end of April 2020, the Minister of Basic Education announced a phased re-opening of primary and secondary schools from 01 June (which was subsequently delayed to 8 June 2020) (Ally et al., 2022). On 28 May 2020, the Minister of Cooperative Governance and Traditional Affairs published regulations (known as the COGTA regulations) that moved South Africa from lockdown level 5 to level 3. This shift signalled a substantial change in the scope and range of permissible activities such as returning to sites of employment (Ally et al., 2022). However, ECD services, which were managed by the Department of Social Development (DSD), remained excluded from the protocols issued by the Department of Basic Education (DBE). This discrepancy meant that ECD centres and partial care facilities lacked clear directives, exacerbating uncertainty within the sector (Ally et al., 2022). At the time, partial care and ECD services were managed and administered by the Department of Social Development (DSD). This meant that while all ECDs fell within the remit of ‘education’ they technically could not follow protocols and mandates set out by the DBE. However, no specific directives were listed by the DSD for ECD centres and partial care facilities (Ally et al., 2022).

Thus, the public was under the assumption that ECDs, along with primary and secondary schools, would reopen under certain health protocols, The Department of Social Development (DSD) issued a circular stating that the ECD sector would remain closed indefinitely (Ally et al., 2022). This decision revealed inconsistencies between the roles and responsibilities of the Department of Basic Education (DBE) and the DSD (Ally et al., 2022). The primary factor that exacerbated the

situation was the lack of coordination and communication between these departments. It was not until late May 2020, more than three months into the pandemic, that the DSD engaged with ECD stakeholders for the first time. During this period, the DBE announced a phased return of ECD and Grade R learners, but the DSD did not commit to reopening the sector (Ally et al., 2022). Between 1 June and 23 June 2020, the DBE clarified its position noting that only children attending grade R and lower in *schools* could return. As Ally et al., (2022) note this excluded ECD programmes under the Children's Act. Amid public confusion and outrage, the DSD finally announced on 4 June 2020 that the ECD sector would remain closed under lockdown level 3 with no further indication of any concrete timeline for return.

Confusion among the public and outrage over the lack of a clear reopening plan led to a legal challenge initiated by various parties, including Skole Ondersteuningsentrum, Bronkieland Kleuterskool, Solidarity, and the SA Childcare Association (SACA). While the case primarily aimed to reopen private pre-schools, SACA emphasised the importance of relief for all ECD and partial care centres in South Africa. They argued that the DSD lacked the authority to limit the reopening of the ECD sector based on the COGTA regulations (Ally et al., 2022).

In a last-minute development, on June 29, 2020, the DBE amended its directions, removing all references to pre-Grade R programs. This amendment effectively restricted the reopening of pre-Grade R ECD programs, both in schools and facilities under the Children's Act. The DSD responded by stating that the legal challenge had become moot. However, the Judge overseeing the case (Judge Fabricius) had already started drafting the judgement, and schools had already begun phasing in pre-Grade R children. This amendment once again highlighted a lack of coordination between the DBE and the DSD. In response, the DSD emphasised that the DBE had no authority to regulate pre-Grade R and declared all communications from the Minister of Basic Education null and void (Ally et al., 2022).

The COVID-19 pandemic laid bare a lack of attentiveness and coordination among government departments, resulting in confusion regarding their roles in Early Childhood Development. This inattention led to unaddressed needs among caregivers and children. Consequently, The Applicants sought to reopen the sector to address these immediate and emerging needs. The DSD's decision to keep ECD closed can be viewed as a failure to adequately recognize and consider these

intersecting needs. ECD facilities serve various roles, including providing meals to millions of children through the NSNP (Seekings, 2020).

The care of young children is undertaken by both paid and unpaid caregivers. Employment in the ECD sector in South Africa is both highly gendered and racialised. Black women from poor and vulnerable communities make up the majority of the ECD workforce. The closures in the ECD sector not only negatively impacted children and unpaid caregivers but threatened the livelihoods of thousands of care workers, "while other parts of the world were supporting at least some level of care for essential workers, the South African Minister of Basic Education, as late as 30 April 2020 (five weeks into hard lockdown), answered a question at a press conference about when ECD centres would reopen by saying that the question had 'come out repeatedly', but that they had 'not given it full consideration'" (Moore and Mbokazi, forthcoming; Vorster, 2020). While many employees were entitled to make use of broader income protection programmes issued by the state, those employed in the care sector, particularly by ECD facilities, were not registered with the Unemployment Insurance Fund (UIF) (Vorster, 2020). This is, in part, due to the nature of feminised labour which is largely without reliable worker protections and often undervalued.

It is, in fact, The Applicants' argument and the subsequent High Court judgement that reflected the importance of ECDs and subsequently the needs of these important groups. First, The Applicants identified the role of ECDs in supporting the holistic well-being and development of children through access to food security, cognitive and sensorimotor stimulation, emotional support, and social interaction (Ally et al., 2022). Secondly, The Applicants sought to make visible the indispensable role of the sector in alleviating the burden of care on parents, particularly female caregivers, as lockdown level 3 signalled a partial return to work (Ally et al., 2022). Lastly, The Applicants also brought light to the economic implications of a prolonged closure on ECD employees and facilities. Thus, the legal action pursued by the Applicants captured the full importance of the ECD sector by recognising the needs of multiple, intersecting groups: caregivers (paid as well as unpaid) and care-receivers (children) (Ally et al., 2022).

5.1.2 Responsibility

The government's lack of adequate recognition of caregivers' and care receivers' needs, encompassing both paid and unpaid sectors, is readily apparent when considering the legal actions pursued by The Applicants in the ECD case. It is crucial to underscore that the reopening of the ECD sector was not instigated by governmental directives from the Department of Social Development (DSD) or the Department of Basic Education (DBE) but rather emerged as a consequence of legal initiatives undertaken by non-profit organisations (NPOs) and representatives from ECD facilities. In the context of LTC for older individuals, the development of sector-specific guidelines resulted from efforts by non-governmental organisations, exemplified by SIFAR.

Poor coordination between government departments must be contemplated beyond the parameters of administrative negligence. This inattention to, and lack of acknowledgement of responsibility for, these vital aspects of care hold significant consequences. Tronto's (1993) second phase of care, responsibility, unveils the state's role, or rather its absence, in the provision of care. While the first phase, "attentiveness," involves the recognition of care needs, the subsequent phase of "responsibility" entails the formulation of a concrete plan of action to address the care needs identified and the determination of the actors involved in its execution.

Within the realm of ECD, both the DBE and the DSD faltered in comprehending fully the sector's paramountcy for caregivers, both paid and unpaid, as well as the significance of ECD programmes for young children. Similarly, the distinct requirements of the LTC workforce and its residents received inadequate attention within the government's response framework. The absence of sufficient attentiveness severely compromises the capacity to enact the subsequent phases of care. As Tronto (1993, 127) notes “If we are not attentive to the needs of others, then we cannot possibly address those needs”. However, the absence of *state* responsibility does not suggest that needs go completely unaddressed and unserved. In fact, the non-assumption of state responsibility often sets in motion the transference of responsibility to alternate entities. This begs the question: if not adequately taken up by the state, where does the responsibility for care go?

In the ECD court case, NPOs, NGOs and ECD institutions played pivotal roles. The court decision ruled against the indefinite closure of ECD programs by the DSD and issued punitive costs to the DSD for its disorderly approach to the sector (Ally et al., 2022). However, the court declared that only private preschool institutions offering ECD services were entitled to open with immediate effect. Nonetheless, this legal intervention substantially mitigated the pandemic's impact on children. Notably, it was through the concerted efforts of civil society, scholars, and the judiciary that the government was prompted to partially re-evaluate its responsibilities. A parallel scenario unfolded in LTC facilities, where entities like SIFAR played an instrumental and indispensable role in advocating for government responsiveness to the specific needs of older persons residing in LTC facilities. As Moore and Mbokazi (forthcoming) note, it was "through the critical engagement of civil society, scholars and the courts, that the government was reminded of its responsibility".

The closure of ECD facilities imposed a caregiving burden, predominantly on women, accentuating how care was repositioned within the domestic sphere. During the early days of the pandemic, the closure of ECD centres led to a significant increase in childcare hours for South African families (Casale and Posel, 2020). By March 18, 2020, as schools officially closed, families, particularly women, found themselves responsible for their children's care for an additional 5 to 9 hours a day. Research indicates that, on average, women in South Africa spend 2.2 hours more per day on unpaid housework and care work than men (Casale and Posel, 2020). This figure escalates to approximately 3.3 hours if a child under the age of seven is present in the household (Casale and Posel, 2020). As the pandemic unfolded, women in South Africa shouldered an even greater childcare burden, with early data from the NIDS-CRAM Wave 1 (2020) showing that, on average, women spent over 4 hours more on childcare than before the lockdown. This underscores the disproportionate responsibility women assumed for childcare during the pandemic (Casale and Shepherd, 2021).

While the closure of ECD demonstrates the ways in which care is often reinscribed to the home and made the sole responsibility of the family, particularly women, the response to LTC facilities during the pandemic illustrates how a lack of state intervention overburdens the paid care workforce. LTC facilities, devoid of government communication and assistance, relied on

internally formulated policies as well as the resourcefulness and creativity of care workers (Jacobs et al., 2020a). The disruption of community-based activities for older persons during the lockdown had the unintended consequence of impeding access to fundamental provisions such as food, income, healthcare, and social connections. Although some carers within LTC facilities displayed ingenuity and compassion in facilitating safe contact between residents and their families, their efforts often extended beyond their designated roles to meet the complex care requirements (Jacobs et al., 2020z). As previously noted, in the absence of government intervention and assistance, the responsibility to care does not go unmet. Instead, confronted with a plethora of unmet needs, care workers become the de facto shock absorbers of the government's neglect.

The non-assumption of responsibility by the government demonstrates the manner in which governmental neglect translates into an augmented burden on care workers (both paid and unpaid). In both the ECD and LTC contexts, the realignment of care responsibilities, stemming from governmental inattention, underscores the critical importance of recognizing and addressing care needs across all phases of the caregiving continuum.

5.1.3 Competence

Tronto's third phase of care, competence, gauges the effectiveness of care delivery and the realisation of care intentions (Sevenhuijsen et al., 2003). It assesses whether the motive (attentiveness) guiding the plan-of-action (responsibility) has been successfully executed. As Sevenhuijsen et al. (2003, 316) write competence refers to the "substance" i.e. "what people need to be able to perform care work in specific situations" Competence, in this context, entails the allocation of necessary resources, including time, finances, and expertise, by decision-makers to ensure the provision of high-quality care.

The SOS judgement, by the end of July, mandated the reopening of the ECD sector. However, numerous stringent conditions, as detailed by the Minister of Social Development, hindered many programs from resuming operations (Ally et al., 2022). These requirements were incongruous with an already resource-constrained sector, exacerbated by a sudden halt in provincial subsidies. Reports emerged that eight out of nine Members of Executive Councils were withholding subsidies paid to registered ECD programs (Ally et al., 2022). Registered ECDs are entitled to a subsidy of

R17 per child per day, divided into three portions: nutrition, stimulation, and administration (Ally et al., 2022). Some subsidies went entirely unpaid, while others received only partial payments. This withholding occurred despite the Minister's assertion that ECD and partial care centres should receive full support during the national state of disaster. Punitive reopening requirements, coupled with a lack of funding, left ECD providers unable to pay employees, comply with COVID-19 health and safety regulations and in most cases unable to re-open (Ally et al., 2022).

The non-payment of subsidies prompted civil society organisations and stakeholders to write to the DSD, expressing concerns about restrictive COVID-19 protocols and non-payment. However, the letter received no response, leading civil society to pursue legal action. In August 2020, SACA and five other applicants initiated legal proceedings, arguing that the Minister and MECs had a constitutional and statutory duty to ensure full subsidies were paid to qualifying ECD programs, regardless of whether they had resumed services (Ally et al., 2022). Extensive evidence was presented, including testimonies from ECD experts and practitioners, to illustrate the crisis' full extent. However, the MECs dismissed these testimonies as "sensational and ill-informed" (SACA para 61 as cited by Ally et al., 2022). The court found that the decision to pay only a portion of the subsidy left ECDs unable to open or receive subsidies, leading to a "condemnatory judgment" ordering the Minister and MECs to pay the full amount of owed subsidies to ECD providers for the entire lockdown duration (Ally et al., 2022).

The consequences of subsidy non-payment threatened the entire ECD sector. Evidence from the NIDS-CRAM longitudinal study showed that despite the sector's reopening, only 13 per cent of children aged zero to six were attending ECD programs by mid-July/mid-August (Wills and Kika-Mistry, 2021). Most practitioners had not reopened their programs by the end of 2020 due to the financial burden of implementing the required health and hygiene measures and a lack of funds (BRIDGE et al., 2020a). Subsidy withholding, coupled with economic challenges as well as COVID-19 related job losses, rendered ECD fees unaffordable for many families (Wills and Kika-Mistry, 2021).

Similarly, the pandemic had a substantial impact on the paid ECD workforce. A rapid survey by Ilifia Labantwana in April 2020 revealed that 20,000 to 30,000 ECD operators were at risk of

closure due to income loss from subsidies and caregiver fees. Tens of thousands of ECD employees, predominantly low-income black women, faced furlough during the closures. At its peak, approximately 175,000 women were at risk of unemployment due to conflicting government policies and a lack of funds (Ilifia Labantwana, 2020). Most of these workers, concentrated in impoverished communities, were not registered with the Unemployment Insurance Fund (UIF), rendering them ineligible for broader income protection programs (Ilifia Labantwana, 2020).

The provision of adequate pay and favourable working conditions, coupled with sufficient funding for ECD programmes, is fundamental to enabling high-quality care for children. A well-remunerated ECD workforce is not only a testament to the value society places on the critical work they perform but also a crucial factor in attracting and retaining skilled and dedicated caregivers. Adequate compensation and supportive working environments empower ECD professionals to offer the nurturing, educational, and developmental experiences that children need during their formative years. Moreover, adequate funding ensures that ECD programs have the necessary resources, materials, and infrastructure to create safe, stimulating, and enriching environments for young learners. In essence, the combination of fair pay, favourable conditions, and sufficient funding forms the cornerstone of effective and compassionate care within the ECD sector.

In response, in mid-August 2020, Minister Lindiwe Zulu allocated R1.3 billion from the economic stimulus package to employ 36,000 youth compliance monitors for ECD programs (Wills et al., 2021). The initial goal was for these monitors to collect data from registered and unregistered centres, aiding in the establishment of a comprehensive database of ECD operators and an ECD management information system to enhance targeted support, expand subsidy reach, and strengthen sector monitoring and evaluation (Wills et al., 2021). However, ECD practitioners protested the Minister's decision, citing neglect of the existing ECD community (Moore and Mbokazi forthcoming). Moore and Mbokazi (forthcoming) argue that the state's response to childcare during the pandemic neglected children's educational, food, and safety needs, while also failing to support professional caregivers and family caregivers, who were predominantly women and considered essential workers.

Furthermore, the Department of Social Development (DSD) earmarked an additional R116.3 million to support the reopening of ECD centres and compliance with COVID-19 regulations (Gontsana, 2022). Despite expectations of full disbursement by the end of the 2020/2021 financial year, only R25 million had been paid out to 1550 sites by May 11, 2022. Ashley-Cooper and Ehrenreich (2021) noted that accessing these funds was marred by complications and technical problems, causing many ECD programs in dire need of relief to abandon the process. While the 2021 Provincial Budget Expenditure Review indicated an annual average growth rate of 5.9 per cent in the ECD budget, reaching R6.3 billion in 2023/24 over the medium term, accountability for the missing COVID-19 relief funds remains lacking. Despite several attempts to financially support the sector, administrative and bureaucratic obstacles hindered the realisation of these efforts and ultimately compromised the competence required to enable good, adequate care.

Similarly, LTC facilities experienced a significant reduction in funds. Empty residential units due to regulations on admitting new patients, job losses among family members unable to pay levies, and decreased donations and fundraising efforts further strained facility finances (Jacobs et al., 2020b). The government's failure to prioritise the distribution of personal protective equipment exacerbated funding issues. Closures of LTC homes, such as those managed by the Cape Peninsula Organisation for the Aged, left residents with no alternatives and caregivers without employment (Human, 2020). The state and related entities, like the DSD, seemed to lack a comprehensive understanding of the resources, labour, and capital required for effective, quality care.

In response to the unprecedented COVID-19 pandemic, the South African government allocated an increased expenditure of R50 billion, primarily directed towards enhancing social grants and introducing the Social Relief of Distress (SRD) Grant (Webb and Vally, 2020). The adjustments made to social grants during this period were pivotal. The Child Support Grant (CSG) witnessed an initial increment of R300 in May 2020, followed by a substantial monthly increase of R500 from June to October. Simultaneously, the Old Age Grant (OAG), designed to support children due to the intergenerational nature of caregiving, received a monthly boost of R250 from May to October 2020. Additionally, a new grant, the SRD grant, was introduced at a rate of R350 per month. While initially received with enthusiasm, closer scrutiny revealed significant coverage gaps (Moore, 2020a).

Of particular note was the intricacy of the CSG increase. Although ostensibly assigned per child, it became evident that this increment was, in reality, designated per caregiver. Consequently, a caregiver with a single child receives the same amount as a caregiver with multiple dependents (Moore, 2020a). This sparked a contentious debate, with some advocating for a distinct Caregivers Grant or an augmentation of the existing CSG. Research conducted during the early stages of this grant's implementation suggested that a 'per child' CSG top-up could have been more responsive to the rising levels of hunger, unemployment, and poverty, even if only marginally (Kohler and Bhorat, 2020). Nonetheless, despite its limitations, the chosen CSG policy proved significantly more cost-effective, resulting in savings of approximately R1.2 billion compared to a proposed six-month R300 per child top-up (Kohler and Bhorat, 2020).

However, underlying these grant adjustments lies a more profound issue. The caregiver grant, with its limitations and exclusions, inadvertently underscores the failure to effectively translate social grants into the necessary resources, encompassing not only financial support but also the substantial emotional and physical labour integral to caregiving (Moore, 2020a). This exclusionary approach, particularly in relation to women caregivers reinforces traditional gender roles within the family structure, overshadowing the individual rights of women. It is worth noting that, during the pandemic, women, particularly low-income black women, experienced a significant increase in their caregiving responsibilities due to the closure of schools and childcare facilities (Casale and Posel, 2020). Consequently, the cost of care during times of food insecurity extends beyond mere financial considerations, encompassing the broader cost of safeguarding children from hunger (Moore, 2020a). The exclusion of women caregivers from the SRD grant indicated a failure to recognize the real cost of care, particularly during crises. Women bore the brunt of caregiving responsibilities due to school and childcare facility closures, amplifying the cost of shielding children from hunger (Moore, 2020a).

These observations highlight a lack of competence in recognizing and addressing the value of care in society and the reliance on family resilience, particularly women, during crises. However, more importantly, it underscores the reality that care is not thought of as an activity that is resource-intensive. Austerity-like agendas seemed to overshadow the importance of care, and a failure to

adequately support care programs not only exacerbated the impact of the pandemic but threatened the landscape of ECD and LTC facilities.

5.1.4 Responsiveness

Responsiveness in care involves the active engagement and response of care recipients, emphasising the mutual nature of care (Tronto, 1993). To illustrate the impact of prolonged ECD closures and inadequate responses in LTC facilities, we provide brief insights.

In South Africa, the COVID-19 pandemic posed significant threats to the progress made in child well-being. Before the pandemic, child hunger affected 2.1 million children or 11% of the child population (Van der Berg et al., 2020). However, the stringent lockdown measures led to a surge in unemployment and a subsequent increase in child hunger. By April 2020, 47% of households lacked the means to purchase food, and 15% reported child hunger (Van der Berg et al., 2020). Families, to shield children from hunger, reduced their food intake or purchased nutrient-deficient foods, potentially worsening issues like childhood stunting, overweight, obesity, and micronutrient deficiencies (King et al., 2021; Department of Health, 2016; Shisana et al., 2007). Although government relief packages provided some relief in mid-2020, child hunger escalated when caregiver and top-up grants were phased out, with one in seven households reporting child hunger by April 2021 (Van der Berg et al., 2021; Shung-King et al., 2021).

The closure of ECDs also impacted the National School Nutrition Programme (NSNP), which ensures daily nutritious meals for 9.6 million schoolchildren. Although the monthly cost of R80 per child may seem modest, it's significant compared to the Child Support Grant (CSG) of R440 per month (Van der Berg et al., 2021). Furthermore, the pandemic disrupted children's educational progress, leading to decreased attendance at Grade R and Educare centres (GHS, 2022; Statistics South Africa, 2022).

For older individuals in LTC facilities during the pandemic, social distancing altered the care dynamics, resulting in feelings of isolation and helplessness (Manderson and Levine, 2020, 134). Residents, including those with dementia, struggled with disrupted routines and the absence of

loved ones, which took a toll on their emotional well-being (Jacobs et al., 2020a, 2020b). Some frail individuals even lost the will to live due to prolonged isolation (Jacobs et al., 2020a).

5.2 Conclusion

The government's response to the COVID-19 pandemic in South Africa, when viewed through the lens of **attentiveness**, reveals a lack of comprehensive understanding of the complex needs of caregivers and care recipients. The prolonged closure of Early Childhood Development centres disproportionately burdened female caregivers and exacerbated child hunger, while in Long-Term Care facilities, the pandemic caused confusion and alienation among residents. This poor recognition of needs underscores a broader deficiency in understanding the critical roles played by ECD centres and LTC facilities in care dynamics. The slow and disjointed response by government departments further demonstrated a lack of attentiveness, leading to confusion and inconsistencies in directives, with adverse consequences for education and livelihoods in the ECD sector and heightened risks for older individuals in LTC facilities. The mounting needs of caregivers and their complex challenges often went unaddressed, indicating a lack of immediate attentiveness in the response.

However, from the perspective of **responsibility**, it is evident that despite the government's lack of attentiveness, care needs were not entirely neglected. Various stakeholders, including NGOs, NPOs, and caregivers themselves, stepped in to shoulder much of the responsibility. In the ECD sector, these groups advocated for reopening and emphasised its importance, while caregivers, predominantly women, took on additional care responsibilities.

When viewed through the lens of **competence**, the findings reveal longstanding shortcomings in resource allocation, administration, and the practical execution of care. Poor attentiveness to resource scarcity within the ECD and LTC sectors resulted in challenges when directives were issued. Stringent PPE regulations and slow subsidy rollouts by government departments made it difficult for ECD centres to reopen, risking permanent closure and financial strain on providers. Similar challenges were encountered in LTC facilities due to inadequate subsidies and restrictive regulations. These shortcomings underscore a significant failure of the government in effectively allocating and delivering the resources and labour required for ‘good’ care. Additionally, the

exclusion of Child-Support Grant recipients from the Social Relief of Distress grant criteria highlights the peripheral status of caregiving in South Africa.

Finally, when considering **responsiveness**, the COVID-19 pandemic disrupted care provision for both young children and older persons in South Africa. Lockdown measures led to increased hunger and food insecurity among young children, reversing progress in their well-being. The closure of ECD centres also impacted the National School Nutrition Programme, affecting children's nutrition. In LTC facilities, older persons experienced emotional and cognitive decline due to social distancing measures, with feelings of alienation and helplessness prevalent. Those with dementia struggled with disruptions to routines and the absence of visits from loved ones. Overall, the pandemic had profound effects on care recipients, affecting their physical, emotional, and cognitive well-being, highlighting the importance of responsive care in times of crisis.

Tronto's (1993) concept of "the Integrity of Care" underscores that good care necessitates the seamless integration of these four phases into a coherent whole. The findings indicate that, due to a lack of attentiveness, responsibility, competence and responsiveness, the state could not see to the actualisation of good, accessible and high quality social care.

Chapter 6: Discussion

In the previous Chapter, I detailed and assessed the government's response to LTC and ECD during the COVID-19 pandemic using the lens of attentiveness, responsibility, competence and responsiveness. The findings demonstrate that the state retains a distinctly residual role, fails to assess the complexity of care needs and ultimately relies on the family, specifically female members to fulfil the duty of care. In this Chapter, I expand on the relationship between the normative paradigms retained in social policy that informed the poor response to ECD programmes and LTC facilities and consequently the overarching marginalisation of socialised care programmes in South Africa.

South Africa adopts a largely familialist approach to social care (Sevenhuijsen et al., 2003, Patel, 2011; Razavi, 2012). As explored in Chapter 4, a familialist welfare system, "is one that relies heavily on the family for the provision of welfare and care" (Razavi, 2011, 14). The reliance on the family as the primary site of care is made evident in various policy documents including the White Paper for Social Welfare (1997). As noted by the WPSW, "the family is the basic unit of society" (Department of Welfare, 1997, 8). The family is thus revered for its contribution to development, protection and security particularly for children. The emphasis on family and communitarian values is justified through a range of normative vocabularies, including reference to Ubuntu. Given the salience of kinship, South Africa's family policy, The White Paper on Families (2013), is tasked with providing a comprehensive framework aimed at creating "well-functioning and resilient families that are able to nurture, support and care for their family members" (Department of Social Development, 2013, 8). However, in both documents family life and subsequently, caregiving is described in gender-neutral, functionalist and moral terms (Sevenhuijsen et al., 2003; Patel, 2011).

In Chapter 4 I outlined a series of other normative paradigms that are prevalent in both the WPSW and the WPF. Situated within a broader politics of policymaking both documents espouse a social development approach (Bond, 2014; Patel, 2012). The WPSW and the WPF emphasise notions of self-reliance, independence and productivism. Thus alongside the 'family' that is regarded as a stable institution, immune to gender imbalances and conflict, social welfare is premised upon the

normative citizen who is self-reliant, independent, autonomous and economically engaged (Bolzalek et al., 2007). The role of the state is vague, often assuming a residual position, which is justified through discourses of individual self-activation, economic empowerment and kinship solidarity.

What does a familialist approach to care that embraces a functionalist and gender-neutral reading of the family, emphasises notions of self-reliance, situates productive economic activity as the primary site of support and assigns the state a residual role amount to? The response to ECD programmes and LTC facilities reveals three primary implications of this paradigm. First, at the level of the state, there is an overarching neglect in adequately identifying and contextualising the complexity of needs among both caregivers (paid and unpaid) and care receivers. Secondly, the responsibility for care is allocated to individuals, particularly women and the state is left with a residual role. Lastly, stemming from an inadequate recognition of need and disavowal of responsibility, the response to care demands by way of policy and programme interventions is often devoid of competency and efficiency. Underscoring all three factors is the assumption that 'care will continue' through the resilience of families and women's resourcefulness. The result is a crisis of care, both practically and financially among families, and an implicit guarantee that the necessary social reproduction of the labour force will continue with little to no material or political investment from the state.

The normative paradigms and principles that underscore social policies are not merely topics of ideological discussion among theorists and academics. Instead, they hold significant implications, shaping the governance of nations and importantly the daily lives of every individual. From a critical political ethics of care perspective, South African social policy does not effectively challenge the prevailing belief that caregiving is solely a private matter; instead, it reinforces this misconception, yielding dire consequences for caregivers and care receivers alike. The state plays a vital and substantial role in shaping the landscape of caregiving activities. Even in its relative absence, as evidenced by the response to ECD and LTC, the state is a core site at which care responsibilities are allocated, however, there is little concern over who in fact carries out these tasks, under what conditions, on whose terms and how they are received. By embracing the notion of the unencumbered, autonomous, self-reliant and economically prosperous individual as the

basic unit of society, there is a failure to reconcile that all persons are enmeshed within a complex web of relations.

Thus, the state, through its adoption of neo-liberal normative paradigms in its social policy, engages in a well-calculated form of care extractivism (Wichterich, 2019). I argue that the state's response to social care during the COVID-19 pandemic exemplifies how care extractivism is enacted and further the consequences of its adoption. The care of children and older persons during the COVID-19 pandemic was steadily sustained through kinship and familialist approaches to welfare. As evidenced by the overburdening of caregivers and care institutions alike, such a policy framework, without the requisite support, resources and attention, yields dire consequences.

A critical ethics of care provides the foundational principles necessary for reshaping and reformulating social policy to better facilitate the provision of care that supports the well-being of all. I propose two distinct pathways through which social policy can incorporate critical ethics of care. Firstly, a social policy grounded in a critical ethics of care necessitates a redefinition of the moral subject. This redefinition centres on acknowledging the inherent vulnerability of human existence and the interconnectedness of individuals, thus discarding norms that pathologize dependence. The COVID-19 pandemic vividly exposed the fallacy of our assumed independence and isolation.

Secondly, at the core of a critical ethics of care lies the imperative to comprehend how social structures, power dynamics, and resource allocation impact caregiving relationships and dynamics. This requires a comprehensive examination of the structural and systemic barriers that impede care provision. In the South African context, such an analysis must engage with the adverse consequences associated with shifting caregiving responsibilities onto families, the deeply gendered nature of caregiving, and the resulting care crisis. As Tronto (1993, 19) aptly observes, "caring requires that one start from the standpoint of the one needing care or attention." Consequently, social policies striving to deliver high-quality and accessible care must prioritise the acquisition of knowledge regarding the needs of not just the care recipients but also all those involved in fulfilling and supporting these care requirements.

Within this context, the policies and programs within South Africa must explicitly accentuate the pivotal role of care within the societal fabric. This emphasis serves a twofold purpose: firstly, it underscores the importance of caring for dependents and vulnerable individuals, and secondly, it advocates for an equitable distribution of care responsibilities across all stakeholders within the care dynamic. This approach underscores the critical significance of acknowledging the centrality of care work, particularly in the realm of policy design.

Chapter 7: Conclusion

In this thesis, my primary focus has been twofold. First, I endeavoured to provide a comprehensive examination and analysis of the government's response to Long-Term Care and Early Childhood Development during the COVID-19 pandemic. Utilising Tronto's (1993) four phases of care, the findings illustrate that the government's response lacked the essential attributes of attentiveness, responsibility, competence, and responsiveness necessary to ensure the delivery of effective, accessible, and high-quality care. Notably, the analysis highlights that the government's response to both LTCs and ECDs reflects a recurring approach to and pattern within social care provision.

The second objective of this research was to excavate the normative paradigms embedded within social policy and explore the relationship between the response to LTCs and ECDs during the COVID-19 pandemic, employing a critical political ethics of care lens. Through a critical analysis of policy documents, such as the White Paper for Social Welfare (1997) and the White Paper on Families (2013), this thesis has illuminated that South Africa's approach to care and social welfare is underpinned by a familialist normative paradigm. This familialist approach to care provision, however, is characterised by a functionalist and gender-neutral interpretation of the family's caregiving role (Patel, 2014). Within this paradigm, caregiving responsibilities and the financial burden associated with care predominantly rest on individual kinship units, disproportionately affecting women. The analysis reveals that the familialist approach to care is also accompanied by a sustained emphasis on self-reliance and the prioritisation of productive economic activity.

By connecting the state's response to ECD and LTC during the COVID-19 pandemic this thesis underscores how these normative paradigms, within the caregiving context, have effectively marginalised state involvement in social care provision. The neglectful and inadequate response during the pandemic underscores the limitations of this care model and the pressing need for a more comprehensive and equitable approach to care provision. In addition, the findings make apparent that the government's approach to both ECD and LTC facilities during the COVID-19 pandemic can be regarded as a microcosm of a larger paradigm firmly entrenched within South African social policy.

Given the inadequacy of the state's approach to social care provision, which embraces the neoliberal, independent and self-reliant moral subject, I argue that social policy must start from the departure point that vulnerability and interdependence is the bedrock of life. I argue that a critical ethics of care offers a foundation for reshaping social policy to enhance care provision that benefits everyone. This proposition involves two key approaches. Firstly, it necessitates redefining the moral subject by recognizing human vulnerability and interconnectedness, challenging norms that stigmatise dependence. Secondly, a critical ethics of care emphasises understanding how social structures, power dynamics, and resource allocation affect caregiving. This entails examining structural barriers hindering care provision, addressing the gendered aspects of caregiving, and acknowledging the care crisis.

Lastly, located within the context of the COVID-19 pandemic, this thesis draws on the political import of the crisis as a mechanism to ensure that vulnerability and interdependence informs social policy. As Ghandeharian and FitzGerald (2022) note, the pandemic presents an exceptional opportunity to confront our shared vulnerability, a reality often obscured by prevailing political and economic structures. It offers a unique moment for us to acknowledge and politicise our interdependence in meaningful ways. This research underscores the limitations of discourses such as self-reliance and economic self-sufficiency, emphasising that the COVID-19 pandemic serves as a pivotal moment for the ethics of care and the creation of a more sustainable and compassionate society.

In the words of Albert Camus, author of the seminal novel The Plague, "But what does it mean, the plague? It's life, that's all." The pandemic has starkly reminded us of the persistent and unrelenting fragility of life, even outside of unprecedented moments such as the pandemic, and subsequently the need for a profound revaluation of our societal priorities. South Africa's response to ECD and LTC during the pandemic serves as a poignant case study, highlighting the imperative of transformative change. To address the growing need for care and to ensure a more equitable and caring society, policymakers and society must urgently embrace a paradigm shift—one that genuinely values and supports the well-being of all individuals, irrespective of age, gender, or socioeconomic status.

It is my hope that this analysis demonstrates the strength of the critical political ethics of care lens. The critical political ethics of care lens employed in this thesis has shed light on the normative paradigms that influence and underpin social policy, with far-reaching implications for various sectors of caregiving. My hope is that this thesis will serve as a valuable foundation for further research into other sectors of care provision and service delivery. I hope the insights through this exploration provide a compelling rationale for continued examination of how normative values shape state-led caregiving and its impact on diverse aspects of state provision The hope is that this work will contribute to a broader conversation on the reconfiguration of caregiving responsibilities within society, ultimately striving for a more inclusive and equitable framework for care. Further research endeavours are crucial in advancing our understanding and facilitating meaningful reforms in this crucial domain of public policy.

References

Ally, N., Parker, R. and Peacock, T.N., 2022. Litigation and social mobilisation for early childhood development during COVID-19 and beyond. *South African Journal of Childhood Education*, *12*(1), pp.1-12.

Ashley-Cooper, M. & Ehrenreich, Y., 2021. The Department of Social Development has Missed the Deadline to Pay Over 80,000 ECD workers from the ECD Employment Stimulus Relief Fund. Where is the outrage?. Available at: https://cecd.org.za/wp-content/uploads/2021/04/op-ed_ecd-stimulus-fund.pdf

Bhorat, H. and Köhler, T., 2020. Social Assistance during South Africa's National Lockdown: Examining the COVID-19 Grant, Changes to the Child Support Grant, and Post-October Policy Options.

Bond, P., 2014. Tokenism in South African social policy. *Transformation: Critical Perspectives on Southern Africa*, *86*(1), pp.48-77.

Bowen, G.A., 2009. Document analysis as a qualitative research method. *Qualitative research journal*, *9*(2), pp.27-40.

Bozalek, J.S., 1995. Presenting 'The Family'-Familist Discourses, Welfare and the State. *Transformation*, (26).

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

BRIDGE, Ilifa Labantwana, National ECD Alliance, Nelson Mandela Foundation, Smart Start, SA Congress for ECD. 2020a. “Second Survey Assessing the Impact of COVID on ECD.” August.

Brown, M. and Neku, R.J., 2005. A historical review of the South African social welfare system and social work practitioners' views on its current status. *International Social Work*, *48*(3), pp.301-312.

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

Button, K. and Ncapai, T., 2019. Conflict and negotiation in intergenerational care: Older women's experiences of caring with the Old Age Grant in South Africa. *Critical Social Policy*, *39*(4), pp.560-581.

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

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

Casale, D. & Posel, D. (2020). *Gender and the early effects of the COVID-19 crisis in the paid and unpaid economies in South Africa*. CRAM report.

Casale, D. and Shepherd, D., 2020. *The gendered effects of the ongoing lockdown and school closures in South Africa: Evidence from NIDS-CRAM waves 1 and 2*. Department of Economics, University of Stellenbosch.

Charles, T., 2013. *'Marriage Above All Else': The Push for Heterosexual, Nuclear Families in the Making of South Africa's White Paper on Families* (No. Evidence Report; 41). Institute of Development Studies (IDS).

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

Cruywagen, V. (2020). Early child development sector faces closures as parents scramble to for fees. *Daily Maverick*, 5 May.

Daly, M. and Lewis, J., 2000. The concept of social care and the analysis of contemporary welfare states. *The British journal of sociology*, *51*(2), pp.281-298.

Day, C. and Gray, A., 2017. Health and related indicators. *South African health review*, *2017*(1), pp.217-339.

Department of Social Development, 2013. White Paper on Families in South Africa. https://www.westerncape.gov.za/assets/departments/social-development/white_paper_on_families_in_south_africa_2013.pdf

Department of Welfare, 1997. White Paper for Social Welfare. https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

Dowling, E., 2022. *The care crisis: What caused it and how can we end it?*. Verso Books.

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

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

Folbre, N., 2018. Developing care: Recent research on the care economy and economic development.

Fraser, N., 2017. Crisis of care? On the social-reproductive contradictions of contemporary capitalism. *Social reproduction theory: Remapping class, recentering oppression*, pp.21-36.

Fraser, N., Honneth, A. and Golb, J., 2003. *Redistribution or recognition?: a political-philosophical exchange*. Verso.

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

Gontsana, M.-A., 2022. Early childhood development: Hundreds of centres are still waiting for their covid money. *GroundUp News*. Available at: https://www.groundup.org.za/article/early-childhood-development-hundreds-centres-are-still-waiting-their-covid-money/

Gouws A and Van Zyl M (2015) 'Towards a Feminist Ethics of Ubuntu: Bridging Rights and Ubuntu', pp. 165–186 in Engster D and Hamington M (eds) Care Ethics and Political Theory. Oxford: Oxford University Press

Gouws, A. and van Zyl, M., 2014. Feminist ethics of care through a Southern lens. *Care in context: Transnational gender perspectives*, pp.99-125.

Gronbach, L., Seekings, J. and Megannon, V., 2022. Social Protection in the COVID-19 Pandemic: Lessons from South Africa.

Hajdu, F., Granlund, S., Neves, D., Hochfeld, T., Amuakwa-Mensah, F. and Sandström, E., 2020. Cash transfers for sustainable rural livelihoods? Examining the long-term productive effects of the Child Support Grant in South Africa. *World Development Perspectives*, *19*, p.100227.

Hall K, Sambu W, Almeleh C, Mabaso K, Giese S and Proudlock P. (2019). South African Early Childhood Review 2019. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana.

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

Hankivsky, O., 2004. *Social policy and the ethic of care*. UBC Press.

Harvey, D., 2005. Neoliberalism.

Hassim, S., 2008. Social justice, care and developmental welfare in South Africa: a capabilities perspective. *Social Dynamics*, *34*(2), pp.104-118.

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

Hatch, M. and Posel, D., 2018. Who cares for children? A quantitative study of childcare in South Africa. *Development Southern Africa*, *35*(2), pp.267-282

Heinrich, C., Hoddinott, J. and Samson, M.J., 2012. The impact of South Africa's child support grant on schooling and learning. *Available at SSRN 2144975*.

Held, V., 2006. *The ethics of care: Personal, political, and global*. Oxford University Press on Demand.

Henau, J.D., 2022. *Costs and benefits of investing in transformative care policy packages a macrosimulation study in 82 countries* (No. 995169793502676). International Labour Organization.

Hochfeld, T. and Patel, L. (2023) *Weighing up South Africa's family policy: What does and doesn't work, University of Cape Town*. Available at: https://ci.uct.ac.za/articles/2018-11-28-weighing-south-africas-family-policy-what-does-and-doesnt-work.

Holland, S., & Novak, D. (Eds.) (2017). . (Vols. 1-4). SAGE Publications, Inc, https://doi.org/10.4135/9781483381411

Human Rights Watch (2023) *South Africa: Older people lack basic care, support*. Available at: https://www.hrw.org/news/2023/06/27/south-africa-older-people-lack-basic-care-support.

Human, L. (2020) *Elderly residents won't be left on the streets, says CPOA, GroundUp News*. Available at: https://www.groundup.org.za/article/elderly-residents-wont-be-left-on-the-streets-says-cpoa/.

Ilifa Labantwana (2020) *The plight of the ECD workforce*. Available at: https://ilifalabantwana.co.za/wp-content/uploads/2020/04/Final-report-The-plight-of-the-ECD-workforce.pdf.

Ilifa Labantwana, National ECD Alliance, Nelson Mandela Foundation, Smartstart & South African Congress for Early Childhood Development. (2020a). *The plight of the ECD workforce: An urgent call for relief in the wake of COVID-19*. Accessed date, 20 May 2022 https://ilifalabantwana.co.za/wp-content/uploads/2020/04/Final-report-The-plight-ofthe-ECD-workforce.pdf.

Jacobs R, Ashwell A, Docrat S and Schneider M (2020b) The Impact of COVID-19 on Long-Term Care in South Africa. LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 31 May 2020.

Jacobs, R., Ashwell, A., Docrat, S. and Schneider, M., 2020a. The Impact of Covid-19 on Long-term Care Facilities in South Africa with a specific focus on Dementia Care. *LTCcovid. org, International Long-Term Care Policy Network, CPEC-LSE*, *10*.

Julian May , C. & Lake , L., 2021. Maverick citizen op-ed: Sona 2021 failed to hear the voices of Hungry Children. *Daily Maverick*. Available at: https://www.dailymaverick.co.za/article/2021-02-15-sona-2021-failed-to-hear-the-voices-of-hungry-children/ [Accessed May 24, 2022].

Justine Burns , Malcolm Keswell & Murray Leibbrandt (2005) Social assistance, gender, and the aged in South Africa, Feminist Economics, 11:2, 103-115, DOI: 10.1080/13545700500115944

Kabeer, N., Razavi, S. and van der Meulen Rodgers, Y., 2021. Feminist economic perspectives on the COVID-19 pandemic. *Feminist Economics*, *27*(1-2), pp.1-29.

Kearabetswe, M.Z. and Grace, K., 2019. Parental absence: Intergenerational tensions and contestations of social grants in South Africa. *Critical Social Policy*, *39*(4), pp.525-540.

Kelly, G., Mrengqwa, L. and Geffen, L., 2019. "They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC geriatrics*, *19*(1), pp.1-14.

Kelly, G., Mrengqwa, L. and Geffen, L., 2019. "They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC geriatrics*, *19*(1), pp.1-14.

Kganakga, M.C., 2003. *Construction of a Model for Home Based Palliative Care: For People Living with HIV/AIDS in the District of Odi* (Doctoral dissertation, Medical University of Southern Africa).

King, M.S., Lake, L., Hendricks, M., Delany, A., Baker, Y., Berry, L., Biersteker, L., Goeiman, H., Mathews, S., Morden, E. and Murray, J., 2021. The impact of COVID-19 on children: Insights from the Western Cape experience. *South African Health Review*, *2021*(1), pp.121-133.

Kittay, E.F., 2001. A feminist public ethic of care meets the new communitarian family policy. *Ethics*, *111*(3), pp.523-547.

Kittay, E.F., 2017. Social policy. *A companion to feminist philosophy*, pp.569-580.

Knijn, T. and Patel, L., 2018. Family life and family policy in South Africa: responding to past legacies, new opportunities and challenges. *Handbook of family policy*, pp.249-260.

Lloyd-Sherlock, P., 2019. Long-term care for older people in South Africa: The enduring legacies of apartheid and HIV/AIDS. *Journal of Social Policy*, *48*(1), pp.147-167.

Lombard, A. and Kruger, E., 2009. Older persons: the case of South Africa. *Ageing International*, *34*(3), pp.119-135.

Mahon, R. and Robinson, F. eds., 2011. *Feminist ethics and social policy: Towards a new global political economy of care*. Ubc Press.

Manderson, L. and Levine, S., 2020. Aging, Care, and Isolation in the Time of COVID-19. *Anthropology and Aging*, *41*(2), p.132.

Manicom, L., 1992. Ruling Relations: Rethinking State and Gender in South African History1. *The Journal of African History*, *33*(3), pp.441-465.

Manona , K. et al., 2022. Through the magnifying glass: Understanding the quality of ECE in South Africa. *World Bank Blogs*. Available at: https://blogs.worldbank.org/education/through-magnifying-glass-understanding-quality-ece-south-africa

Meintjes, H., Budlender, D., Giese, S. and Johnson, L., 2003. Children' in need of care or in need of cash? Questioning social security provisions for orphans in the context of the South African AIDS pandemic.

Metelerkamp, T., 2022. ECD funding crisis: First early childhood development census reveals underfunded and underqualified sector. *Daily Maverick*. Available at: https://www.dailymaverick.co.za/article/2022-05-16-first-early-childhood-development-census-reveals-underfunded-and-underqualified-sector/

Mokomane, Z. (2021) Balancing care and work roles among women working in the informal sector in South Africa, 5(1): 129–147, International Journal of Care and Caring, DOI: 10.1332/239788220X1598463435866

Moore, E. (2020) *Adding insult to injury: When you're a womxn and a caregiver, you're not a citizen*, *Daily Maverick*. Available at: https://www.dailymaverick.co.za/article/2020-08-12-adding-insult-to-injury-when-youre-a-womxn-and-a-caregiver-youre-not-a-citizen/.

Moore, E. and Jeremy Seekings. (2019) "Consequences of Social Protection on Intergenerational Relationships in South Africa: Introduction." *Critical Social Policy* 39, no. 4: 513–24. https://doi.org/10.1177/0261018319867582.

Moore, E. and Mbokazi, N (forthcoming) ''We have not given it full consideration": The South African state's response to care and caring for young children during Covid-19. *Critical Social Policy*

Moore, E., 2019. Who has a duty to support? Care practices and legal responsibilities in South Africa. *Critical Social Policy*, *39*(4), pp.582-598.

Moore, E., 2020. Financing social reproduction. *Revue internationale des études du développement*, (2), pp.37-62.

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

Mosoetsa, S. (2011). Eating from One Pot: The Dynamics of Survival in Poor South African Households. Wits University Press

National Treasury, 2021. 2020 Provincial Budget Expenditure Review. Available at: http://www.treasury.gov.za/publications/igfr/2021/prov/2021%20PBER%20Supplementary%20book.pdf [Accessed May 2022].

Ngubane-Mokiwa, S.A., 2016. Delivering Open Distance eLearning Through Ubuntu Values. *Open Distance Learning (ODL)*, p.147.

Orozco, A.P. and Mason-Deese, L., 2022. *The Feminist Subversion of the Economy: Contributions for a Life Against Capital*. Common Notions.

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

Patel, L., 2011. Child support grants. *Innovative*, p.363.

Patel, L., 2012. Developmental social policy, social welfare services and the non-profit sector in South Africa. *Social Policy & Administration*, *46*(6), pp.603-618.

Patel, L., 2014. Gender and care in the non-profit sector in South Africa: Implications for welfare policy. *Care in context: Transnational gender perspectives*, pp.246-264.

Patel, L., Dikoko, V. and Archer, J., 2023. Social Grants, Livelihoods and Poverty Responses of Social Grant Beneficiaries in South Africa.

Plagerson, S., Patel, L., Hochfeld, T. and Ulriksen, M.S., 2019. Social policy in South Africa: Navigating the route to social development. *World Development*, *113*, pp.1-9.

Pons-Vignon, N. and Segatti, A., 2013. 'The art of neoliberalism': accumulation, institutional change and social order since the end of apartheid. *Review of African Political Economy*, *40*(138), pp.507-518.

Rabe, M. and Naidoo, K., 2015. Families in South africa. *South African Review of Sociology*, *46*(4), pp.1-4.

Rabe, Marlize. "Family policy for all South African families." *International Social Work* 60, no. 5 (2017): 1189-1200.

Raghuram, P., 2016. Locating care ethics beyond the global north. *ACME: An International Journal for Critical Geographies*, *15*(3), pp.511-533.

Ramaphosa, C, 2019. “State of the Nation Address.” Available at: https://www.gov.za/sona2019

Ramaphosa, C. 2018. “State of the Nation Address.” Available at: https://www.parliament.gov.za/state-nation-address-cyril-ramaphosa-president

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

Richardson, B., 2022. Commodification and care: An exploration of workforces’ experiences of care in private and public childcare systems from a feminist political theory of care perspective. *Critical Social Policy*, *42*(1), pp.107-128.

Robinson, F., 2011. Stop talking and listen: Discourse ethics and feminist care ethics in international political theory. *Millennium*, *39*(3), pp.845-860.

Robinson, F., 2018. Care ethics and international relations: Challenging rationalism in global ethics. *International Journal of Care and Caring*, *2*(3), pp.319-332.

Sagner, A. and Mtati, R.Z., 1999. Politics of pension sharing in urban South Africa. *Ageing & Society*, *19*(4), pp.393-416.

Sagner, A., 2000. Ageing and social policy in South Africa: Historical perspectives with particular reference to the Eastern Cape. *Journal of Southern African Studies*, *26*(3), pp.523-553.

Satumba, T., Bayat, A. and Mohamed, S., 2017. The impact of social grants on poverty reduction in South Africa. *Journal of Economics*, *8*(1), pp.33-49.

Sayed, Y. and Sing, M., 2020. Evidence and education policy-making in South Africa during Covid-19: Promises, researchers and policymakers in an age of unpredictability. *Southern African Review of Education with Education with Production*, *26*(1), pp.20-39.

Seekings, J. and Moore, E., 2013. Kin, market and state in the provision of care in South Africa.

Seekings, J., 2020. Failure to feed: State, civil society and feeding schemes in South Africa in the first three months of Covid-19 lockdown, March to June 2020. *CSSR Working Paper*, *455*.

Sevenhuijsen S, Bozalek V, Gouws A and Minnaar-McDonald M (2003) 'South African Social Welfare Policy: An Analysis using the Ethic of Care', Critical Social Policy 23(3): 299–321

Sevenhuijsen, S., 2000. Caring in the third way: the relation between obligation, responsibility and care in Third Way discourse. *Critical Social Policy*, *20*(1), pp.5-37.

Sevenhuijsen, S., 2004. Trace: A method for normative policy analysis from the ethic of care. *The heart of the matter: The contribution of the ethic of care to social policy in some new EU member states*, pp.13-46.

Shaik, N., 2022. Transforming Teaching and Learning in Early Childhood Care and Education During COVID-19 in a Poor Community of the Cape Flats, South Africa. *Early Childhood Education Journal*, pp.1-10.

Solanki, G., Kelly, G., Cornell, J., Geffen, L. and Doherty, T., 2021. The need to incorporate the impact of population ageing into the post-COVID-19 policy and planning reset in Low and Middle Income Countries. *Global health action*, *14*(1),

South African early childhood review 2019 - Children count. Available at: http://www.childrencount.uct.ac.za/uploads/publications/SA%20ECR_2019.pdf (Accessed: 27 August 2023).

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

Stevano, S., Mezzadri, A., Lombardozzi, L. and Bargawi, H., 2021. Hidden Abodes in Plain Sight: the Social Reproduction of Households and Labor in the COVID-19 Pandemic. *Feminist Economics*, *27*(1-2), pp.271-287.

Trafford, Z. and Swartz, L., 2021. The Care Dependency Grant for children with disabilities in South Africa: Perspectives from implementation officials. *Development Southern Africa*, pp.1-14.

Tronto, J., 1993. A political argument for an ethic of care. *Moral boundaries*.

Tronto, J., 2017. There is an alternative: homines curans and the limits of neoliberalism. *International Journal of Care and Caring*, *1*(1), pp.27-43.

Tronto, J.C., 2013. Caring democracy. In *Caring Democracy*. New York University Press.

VALIANI, D.S., 2022. THE AFRICA CARE ECONOMY INDEX.

Van der Berg, S., Zuze, L. and Bridgman, G., 2020. The impact of the Coronavirus and lockdown on children's welfare in South Africa. *Stellenbosch University*.

Vetten, L. and Grobelaar, M., 2020. Rapid assessment on the financial status of non-profit organisations providing social care services.

Voigt, E. (2020a) *As infections surge, how well are older people in SA protected?*, *Daily Maverick*. Available at: https://www.dailymaverick.co.za/article/2020-05-14-as-infections-surge-how-well-are-older-people-in-sa-protected/

Voigt, E. (2020b) *Covid-19: More government support needed for old age facilities - expert*, *Spotlight*. Available at: https://www.spotlightnsp.co.za/2020/07/09/covid-19-more-government-support-needed-for-old-age-facilities-expert/

Voigt, E. (2020c) *Covid-19: As infections surge, how well are older persons in SA protected?* Available at: https://www.spotlightnsp.co.za/2020/05/13/covid-19-as-infections-surge-how-well-are-older-persons-in-sa-protected/

Von Gliszczynski, M. and Leisering, L., 2016. Constructing new global models of social security: How international Organisations Defined the Field of Social Cash Transfers in the 2000s. *Journal of Social Policy*, *45*(2), pp.325-343.

Vorster, R. (2020a). Can South African's early childhood sector be saved? *Daily Maverick*, 23 June. Accessed 10 May 2022,

Vorster, R. (2020b). Government pushes early childhood development centres and welfare organisations to the brink. *Daily Maverick*, 20 August. Accessed 9 May 2022,

Vorster, R.W. (2020) *Can South Africa's Early Childhood Development Sector be saved?*, *Daily Maverick*. Available at: https://www.dailymaverick.co.za/opinionista/2020-06-23-can-south-africas-early-childhood-development-sector-be-saved/

Webb, C. and Vally, N. (2020) *South Africa has raised social grants: Why this shouldn't be stop-gap measure*, *The Conversation*. Available at: https://theconversation.com/south-africa-has-raised-social-grants-why-this-shouldnt-be-a-stop-gap-measure-138023

Wichterich, C., 2019. *Care Extractivism and the Reconfiguration of Social Reproduction in Post-Fordist Economies* (Vol. 25). kassel university press GmbH.

Wills, G. and Kika-Mistry, J., 2022. Early childhood care and education access in South Africa during COVID-19: Evidence from NIDS-CRAM. *Development Southern Africa*, pp.1-19.

Wills, G., Kotze, J. & Kika-Mistry, J. (2020). *A sector hanging in the balance: ECD and lockdown in South Africa*. CRAM survey.

Wills, G., Kotze, J. and Kika-Mistry, J., 2021. Early Childhood Development and lockdown in South Africa: An update using NIDS-CRAM Wave 3. *National Income Dynamics (NIDS)-Coronavirus Rapid Mobile Survey (CRAM) Wave*, *3*.

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

World Health Organization (WHO), 2021. Assessing the impact of Covid-19 on older people in the African Region: a study conducted by the World Health Organisation Regional Office for Africa.

World Health Organization, 2021. Assessing the impact of Covid-19 on older people in the African Region: a study conducted by the World Health Organisation Regional Office for Africa.

Wright, G., Neves, D., Ntshongwana, P. and Noble, M., 2015. Social assistance and dignity: South African women's experiences of the child support grant. *Development Southern Africa*, *32*(4), pp.443-457.

Zembe-Mkabile, W., Surender, R., Sanders, D., Jackson, D. and Doherty, T., 2015. The experience of cash transfers in alleviating childhood poverty in South Africa: mothers' experiences of the Child Support Grant. *Global public health*, *10*(7), pp.834-851.