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To cite this article: Olagoke Akintola, Netsai Bianca Gwelo, Ronald Labonté & Talitha Appadu (2016) The global financial crisis: experiences of and implications for community-based organizations providing health and social services in South Africa, *Critical Public Health*, 26:3, 307-321, DOI: [10.1080/09581596.2015.1085959](https://doi.org/10.1080/09581596.2015.1085959)

To link to this article: <https://doi.org/10.1080/09581596.2015.1085959>



Published online: 15 Sep 2015.



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RESEARCH PAPER

The global financial crisis: experiences of and implications for community-based organizations providing health and social services in South Africa

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(Received 24 December 2014; accepted 12 August 2015)

The global financial crisis that began in 2008 with the collapse of the US real estate bubble is considered the worst economic turmoil since the Great Depression in the 1930s. While the crisis has negatively impacted the global economy and the flow of aid to Sub-Saharan African countries, little is known about the implications of the crisis for community-based organizations (CBOs) providing health-related services in marginalized communities. We conducted qualitative interviews with managers of 14 CBOs providing health and social services to marginalized communities in South Africa about their experiences of the crisis. CBOs reported experiencing a marked decrease in funding received from both international and local donors as a result of the global financial crisis. At the same time, they experienced difficulties in securing new funding. Organizations addressed the funding problems by conducting organizational restructuring and implementing austerity measures that led to the retrenchment of staff, reduction in benefits and incentives for staff and volunteers, reduction in the number of communities served and rationing of services provided to these communities. These measures had negative psychological impacts on paid staff and volunteers and contributed to absenteeism and attrition among volunteers, and some of the organizations eventually closed down. Our findings show that the global financial crisis has far-reaching implications for health, social and developmental services delivery and ravaging impacts on the economy of marginalized communities. Policy-makers should explore mechanisms for protecting CBOs from the effects of economic shocks to guarantee the provision of critical services to marginalized communities.

Keywords: community-based organization; community health worker; global financial crisis; marginalized communities; primary health care; service delivery; South Africa

Introduction

Most economists consider the global financial crisis that began in the USA in 2008 to be the worst economic turmoil since the Great Depression in the 1930s (Musau, 2010). Many advanced economies fell into recession from which several are still recovering, while the rest experienced a sharp decline in economic growth (Edwards, 2010; Purnanandam, 2011). Global trade and financial flows declined and remain sluggish,

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while the integration of global supply chains over the past 30 years meant that, as consumption dropped in high-income countries, production dropped in the low- and middle-income countries that had increasingly become the loci in the manufacture or supply of goods and services. The global financial crisis and subsequent 'Great Recession' led to a decrease in 2009 of about 5% in global economic growth, the first such fall in 60 years (UNAIDS, 2009). Although global economic growth has recovered somewhat (it was 2.2% in 2013), it remains far below pre-crisis levels which, between 2004 and 2008, averaged around 5% (World Bank, 2014).

The Great Recession has led to very high levels of unemployment, underemployment or insecure/informal employment, with workers being retrenched from formal sectors that are directly linked to global markets (Choudhry, Marelli, & Signorelli, 2010). The crisis has also contributed to rising high levels of poverty associated with unemployment in many developing countries (Edwards, 2010; Shahrokhi, 2011). The International Labor Organization estimates that 62 million jobs had been lost as a result of the crisis by the end of 2013, with global unemployment at its highest recorded level (over 200 million in 2013) and concentrated among youth and in the East and South Asian and Sub-Saharan African (SSA) regions (ILO, 2014).

The crisis is also having a significant negative impact on public health and health care systems worldwide (Evans, 2009). This has been most apparent in several countries in the Eurozone, where continuing slow economic growth and the imposition of 'austerity' measures by the European Central Bank, the European Commission and the International Monetary Fund (IMF) has led to reductions in public health and other forms of health-protective social spending (Greer, 2014; Ruckert & Labonté, 2013). These austerity measures closely resemble those of earlier structural adjustment policies imposed by the IMF and World Bank on developing countries in response to their debt crises in the 1980s, which similarly showed negative health and even economic growth outcomes (see Breman & Shelton, 2001; Cornia, Jolly, & Stewart, 1987). Although most critical attention on 'austerity' has focused on the Eurozone and the Anglo-American countries, the bulk of this fiscal retrenchment is actually taking place in developing countries, with one recent estimate placing the global population affected by austerity at over 80% (Ortiz & Cummins, 2013; Ruckert & Labonté, 2014). A growing literature is tracing these health impacts through various channels leading to impoverishment, including increasing unemployment and job insecurity, currency instability and cuts to social and health programs (Mohindra, Labonté, & Spitzer, 2011; Ruckert & Labonté, 2012).

In many SSA countries, the global financial crisis has limited the government's ability to expand social and health sector spending because of the decline in world trade and reduced income from the business sector and taxable formal employment (Espey, Harper, & Jones, 2010; Ortiz & Cummins, 2013). In a survey of African countries, representatives of the Ministries of Health of 36.8% of countries that participated indicated that they had been notified by their Ministries of Finance that the budget for health would be cut (Kirigia, Nganda, Mwikisa, & Cardoso, 2011). The global recession has also affected the flow of foreign aid to many African countries (Kirigia et al., 2011; OECD, 2014). This impact is felt particularly in the health and social sectors where donor spending constitutes a major source of funding (Musau, 2010). In Africa, more than 50% of total public health spending comes from aid commitments (Musau, 2010; OECD, 2014). However, funding has been constrained because most donor countries and donor organizations have been affected severely by the financial crisis, and donor countries have responded in many instances with austerity measures rather than with

progressive tax increases (Global Health Watch 4, 2014). After several years of decline following the financial crisis, development aid to developing countries rose 6.1% in real terms in 2013. However, bilateral aid to SSA countries continued to fall. In 2013, aid to SSA was USD 26.2 billion, 4.0% less than the 2012 figures in real terms (OECD, 2014).

South Africa officially entered recession in May 2009 (Statistics South Africa, 2011; Verick, 2011). Owing to its strong trade and financial links, South Africa was hit hard by the global financial crisis, which has come on top of the longer term structural problems in its economy and labour market (Verick, 2011). In the first quarter of 2009, 959,000 people lost their jobs in South Africa, exacerbating pre-existing high levels of unemployment and poverty (Statistics South Africa, 2009; Verick, 2011). At the same time, aid from development assistance countries and multilateral donors to South Africa declined sharply in 2009 and remained low in 2012 (OECD, 2014).

Non-profit organizations such as non-governmental organizations (NGOs), faith-based organizations and community-based organizations (CBOs) play a critical role in improving access to primary health care as well as social and developmental services and facilitating the well-being of citizens living in marginalized communities in many countries around the world, including South Africa (Akintola, 2011; van Pletzen, Zulliger, Moshabela, & Schneider, 2014). These organizations, however, depend heavily on external funding from international donor and government agencies (Habib, 2005; Pfeiffer, 2003). In South Africa, CBOs typically operate at grass-roots level, led by local community members that work to achieve specific set aims and objectives, while NGOs usually operate at national, provincial and sometimes community levels, often with the help of volunteer members (Akintola, 2008, 2011; DOH, 2001; Habib, 2005; van Pletzen et al., 2014).

While it is well established that the global financial crisis has negatively impacted the global economy and the flow of aid to SSA countries, little is to be found on the specific ways in which CBOs have responded to the impact of the crisis and the implications for these organizations and their beneficiaries. In this paper, we explore the experiences of the global financial crisis among CBOs providing health and social services in South Africa and the implications for policy.

Methods

Participants

This qualitative study was conducted as part of a larger national study exploring the role of CBOs in the delivery of health and social services in South Africa. We elected to use a qualitative research design because it allows participants to construct and interpret their experiences, in this case, about issues related to the financial crisis, in order to produce nuanced data (Ulin, Robinson, Tolley, & McNeill, 2005). We collected qualitative data from 14 CBOs located in the Durban metropolis over a three-year period from January 2010 to December 2012. The CBOs were recruited to reflect a range of CBOs working in various communities in the Durban metropolis (Ulin et al., 2005). Thirteen of the fourteen organizations are located in peri-urban communities, while the remaining one is located in an informal settlement. We conducted qualitative interviews with 14 managers of these CBOs. All the managers were women and their age ranged from 44 to 67 years.

Data collection

We developed interview guides through an extensive review of the literature on non-profit organizations and CBOs providing health and social services and on the general impacts of the financial crisis. The interview guides covered background information about the CBOs and themes developed specifically to explore the impacts of the global financial crisis on their work.

We obtained verbal informed consent as well as permission to record interviews from participants before they were conducted. All the interviews were conducted by two of the authors. Most of the interviews were conducted in English, while some were conducted in isiZulu, depending on the participants' preferences. All interviews were conducted at a time and place chosen by the participants, such as in the offices of the CBOs and community halls. Interviews lasted between 45 and 85 min.

All interviews were transcribed and those conducted in isiZulu were translated into English by the author who conducted the interviews. Analysis of data was done using the principles of thematic analysis. This involved identifying, analysing and reporting of patterns in the form of themes; we developed codes and used these to develop and name themes (Braun & Clarke, 2006). The study was approved by the ethics review board of the University of KwaZulu-Natal, South Africa.

Services provided by CBOs

CBOs in our study help advance the philosophy of comprehensive health care espoused in the Alma Ata declaration by playing a significant role in marginalized communities, not only as providers of health services, but also as providers of social and developmental services that address the social determinants of health in communities that have poor access to government services. The CBOs work in poor communities with high unemployment rates and low skills base, where most people are dependent on government grants for income and constitute the majority of public health facility users in South Africa. All CBOs provided home-based care for people living with HIV/AIDS/TB and other chronic diseases. Other services provided include health promotion and education, HIV counselling and testing, TB treatment adherence support, care and support for orphan and vulnerable children, day care and drop in services, psychosocial support, feeding programs, youth and community development initiatives, paralegal services and support in accessing government health and social services.

The majority of care workers affiliated to the CBOs in this study are volunteers offering their services as community health workers. They do not receive any financial rewards except for incentives such as groceries, sanitary towels, children's school fees and shoes, umbrellas and/or stipends when available. Community health workers receive training from the CBOs or external/government agencies in partnership with these organizations. They are not expected to work every day, but the demands of work often make it an imperative for them to work for extended hours. Community health workers constituted by far the largest number of people working in CBOs (see Table 1). Supervision and training are provided by paid staff working as coordinators or facilitators, who typically rose through the ranks having worked originally as volunteers. Coordinators are paid a salary and report to the managers of the CBOs, while the facilitators who work as volunteers report to supervisors. However, in smaller CBOs, supervision and training are provided by the manager because they cannot afford to employ coordinators.

Table 1. Profile of community-based organizations.

Community-based organizations	Year CBO was founded	Number of communities served	Current number of volunteers	Number of people served	
				Adults	Children
A	2001	2	10	180	100
B	1999	4	10	100	129
C	1999	4	10	65	20
D	2007	4	5	40	100
E	1999	6	10	100	23
F	1999	6	10	100	102
G	2002	4	30	100	40
H	1997	9	205	850	2000
I	2002	4	10	100	50
J	2006	2	5	80	30
K	2002	2	5	50	20
L	2000	1	4	45	25
M	2004	2	8	100	40
N	2003	2	10	80	30

The work of the CBOs is largely supported by funding from international agencies and NGOs, government agencies and local corporate and individual donors. However, there have been long-standing challenges with funding of CBOs working in health and social services sectors in South Africa (Akintola, 2010; van Pletzen et al., 2014), which has negatively impacted on their functioning (van Pletzen et al., 2014). In recent years, there have been shifts in government funding modalities in line with changing policy priorities (see Mosse, 2005). These have led to international agencies channelling funding to governments and to initiatives that address chronic diseases, including the scaling-up of antiretroviral (ARV) treatment. In this new funding environment, CBOs have had to bear the brunt of reduced funding flows (Akintola & Hangulu, 2014; DOH, 2010).

Recently, the government of South Africa introduced wide-ranging health policy reforms at the primary health care level. The primary health care re-engineering strategy is a central element of the national health insurance initiative, which is currently being piloted in South Africa (DOH, 2010, 2011). The goal is to provide comprehensive community-based health services to the citizens and to formalize the role of community health workers within the primary health care system as a state employed cadre working as part of outreach teams headed by nurses (DOH, 2010). However, the current policy does not stipulate specific roles for CBOs. Instead, many of the community health workers affiliated to CBOs have been recruited to work with government, particularly in KwaZulu-Natal, through various government initiatives such as the Expanded Public Works Programme (EPWP) (Akintola, 2015; Akintola & Hangulu, 2014) and the new PHC initiative, leaving CBOs with a shortage of capacity and resources.

Perceived consequences of the financial crisis for CBOs

Our study findings show that the financial crisis exacerbated pre-existing financial challenges already confronting CBOs. The crisis had varied but negative consequences for CBOs depending on their structure, size and funding source. At the start of the crisis,

organizations with medium to long-term (3–5 years) funding contracts were not affected immediately. With the exception of those whose funding cycle came to an end in 2008, the impact on CBOs only became apparent in late 2009 and 2010. Nonetheless, managers of all organizations that depended on funding from overseas donor organizations indicated that they were informed of the impact of the financial crisis on funding decisions and told that their funding would not be renewed at the end of the term. The international funding agencies also cited the dwindling funds from their donors and the difficulty they had in securing new donors, both of which they attributed to the financial crisis. An international Christian funding organization which received regular donations largely from its church members informed a CBO that they were experiencing a considerable reduction in donations and therefore had to review their own funding protocol. The managers indicated that stricter requirements were put in place by international funding agencies that prevented renewal of funding contracts and restricted opportunities for new funding.

They (donors) used to renew our contracts but this year they told us that they will no longer renew them. (Organization G)

It was better before because we were sponsored by the EU (European Union) then we received stipends. It was better because we had money to travel to hospitals and to get to the grant centres but now there is none, it has become worse. (Organization K)

CBOs also reported that they experienced a reduction in donations from individual sponsors. One CBO manager explained that a family reduced their donations considerably, citing the impact of the financial crisis on their family business.

Mr. X's family has been supporting our hospice for the last ten years; his father had started and now he is one of our generous sponsors. They help us with fundraising as well but mostly with donations. They are one of the few families that help us... They have also reduced their donations to us because the crisis is affecting their business. (Organization L)

At certain times of the year, CBOs normally experience an influx of food and essential materials for their patients, for example, around Christmas and Easter holiday periods; but with the recession, corporate donors have been reluctant to donate and/or provide sponsorship. Most of the agencies that raise funds and material support from individual donors as well as private companies such as banks and supermarkets/grocery stores who donate as part of corporate social responsibility reduced their donations to CBOs citing the impact of the global financial crisis. This has had knock-on effects on CBOs' budgets.

The recession has negatively affected our organization because our normal sponsors are even apprehensive about donating to us. We normally get huge piles of clothes, warm things for the patients during winter and money. All these have stopped coming in from one of our major sponsors. The financial crisis has made our sponsors give us less than what they give us so we normally plan to get a certain amount but are falling back, for example, on payments because we have budgeted for this amount but have received less. (Organization K)

Yes we have felt the impact of the crisis. We were turned down by XXX [a corporate organization]. They said that they were going to help and then suddenly they called to tell us that they could no longer assist us financially because of the financial crisis. And there

is another organization that said they will give us so much of an amount and then they called us some time back to tell us that they will only be able to give us half of what they had promised. (Organization M)

Many of the participants recounted how difficult it was to secure new funding from donors in the prevailing environment, stating that their efforts at securing new funding including getting help, from experienced people, to write funding proposals were largely unsuccessful.

The difficulties we are facing have forced us to stand up and search for [new] funders. We look in the newspapers and even on the internet. We have been sending proposals to different possible funders. (Organization A)

We tried to ask for funding from other organizations (donor agencies) but they told us to wait for a year or years and this makes it difficult for us to plan ahead or even draw up a budget. (Organization E)

Some CBOs also made efforts to secure funding from government agencies to ameliorate the funding shortfalls but were unsuccessful. At the same time, CBOs that received funding from government were also hit hard. Participants' narratives showed evidence of reduced spending and reordering of funds on the part of government. Although participants were not sure whether these effects were related to the financial crisis, the changes occurred at the same time that they were experiencing funding shortages from overseas donor agencies that had cited the financial crisis as the reasons for their decreased support.

Organizational responses to the impact of the financial crisis

Organizational restructuring: retrenchment of staff and reduction of benefits

As a consequence of the drastic reduction in funding support, all the organizations embarked on restructuring. The restructuring within these organizations led to heightened job insecurity among all paid employees on yearly contracts working in our sample of CBOs. One organization that had just begun a three-year cycle of funding from one of its major overseas donor agencies when the crisis started in 2008 received a notice from the donor indicating that their contract will not be renewed because of a major dip in the donations received due to the crisis. The CBO immediately put staff members on alert regarding impending restructuring and job cuts. Although the restructuring and job losses did not occur until late 2010 when the funding cycle came to an end, the CBO manager highlighted the atmosphere of insecurity it created. According to the manager, this led to emotional stress, low morale and de-motivation among staff, as they were constantly living in the fear of losing their jobs. Participants indicated that when the three-year cycle finally came to an end and a decision to terminate people's contracts was made by the executive board and communicated to staff, the insecurity was exacerbated.

We had to restructure! We cut down on staff... We had to revisit our goals and mission. So we now want to be more of a facilitator of service provision as opposed to being a provider of services. We are currently looking into changing our mission and vision. (Organization H)

Along with the restructuring and rationalization came retrenchments. Two of the largest CBOs retrenched 20–40% of staff, including nurses and administrative staff and coordinators in charge of the volunteers, as organizations tried to merge roles in order to reduce costs.

We had to restructure our organizations. Since we cut down on the number of communities we serve, we had to evaluate how each staff was performing. Those who were not performing well we had to dismiss them. Also we had to dissolve some positions and merge some roles in order to cut costs. (Organization H)

In six of the CBOs, yearly salary increments for paid staff were stopped and performance bonuses and a '13th' monthly cheque (a standard salary practice) were cut by two of the largest CBOs because they could no longer afford to pay these bonuses.

Rationing of communities served and services provided to communities

Some of the CBOs developed measures to ration the number of communities served in response to the reduced funding streams. Outreach services to some communities were stopped as a consequence of the major restructuring of two of the largest organizations in our sample.

Last year (2009) we were hit badly by the recession, we used to work in 12 communities but now we are working in nine communities. We had to cut down on the communities so as to survive the financial difficulties. (Organization H)

Due to the insufficient resources we are receiving, we found it better to reduce the number of communities we were extending our services to. We have very limited funding so we had to drop two communities and now we are left with four. At first we had six, now we have four. (Organization E)

In addition, all the CBOs took some measures to reduce the cost of running the organizations. Some of the measures employed include rationing of services to beneficiaries' communities in order to reduce overhead costs. Although the CBOs avoided cutting medical and related services, prevention and educational programs, food supplies and material supports were cut. The rationing of food was done in three ways: (1) cancelling feeding programs, (2) reducing the number of items in food parcels and (3) reducing the quantity and quality of food rations in food parcels.

We used to provide a feeding scheme during weekends but we no longer offer it, we now only provide the feeding scheme during the week. We also used to give our beneficiaries some groceries but now we have cut down, you will see that we now divide everything into small quantities so that at least everyone can get [some groceries]. (Organization B)

We used to at least go for home visits on a daily basis during the week, but now with the insufficient funds and materials for home care we no longer go out for home visits on a daily basis. We now go at least three times a week, but this is not good at all for the people we do home visits for. But there is nothing we can do. We had to reduce the days [we offer home visits]. (Organization A)

Some organizations also stopped fee support for orphans attending primary and high schools and instead the CBOs made requests to the principals of schools for exemptions to be granted to these orphans and vulnerable children with limited success.

Reduction in incentives to paid staff and volunteer community health workers

All the organizations reduced the incentives provided to paid staff and volunteers considerably or stopped providing them altogether, until such a time that the organization's financial situation would improve. In addition, all the CBOs found it difficult to pay their volunteers stipends.

You see, due to shortage of funds because of the financial difficulties we are experiencing as an organization, we can no longer afford to pay stipends to our volunteers. We used to give them food parcels and other things we got from our donors like clothes but we stopped. We cannot give them anymore. (Organization E)

All the CBOs reported dissatisfaction among volunteers. Some managers also reported that their volunteers found it difficult to understand why their incentives were reduced and this affected their relationship and led to a breakdown of trust. Managers also reported an increase in the incidence of absenteeism and 12 of the managers reported attrition among volunteers as a consequence of the lack of incentives (see Table 2).

The (financial) crisis has really affected our organization and my relationship with some volunteers has been affected. The volunteers seem not to understand that we are operating with limited funds and we cannot provide them with incentives anymore as we used to. Some who used to get stipends no longer receive them. This has demotivated them because they are also coming from poor backgrounds and the little we used to give them made a difference. (Organization I)

Due to the lack of funding, some volunteers stopped coming to work because they have not received stipends for six months. (Organization B)

Table 2. Attrition rate of volunteers.

CBO	Number of volunteers before financial crisis (2008)	Number of current volunteers (2012)	Attrition rate (%)
A	30	10	66.7
B	30	10	66.7
C	20	10	50.0
D	20	5	75.0
E	20	10	50.0
F	38	10	73.7
G	46	30	35.0
H	240	205	14.6
I	30	10	66.7
J	25	5	80.0
K	5	5	0.0
L	4	4	0.0
M	10	8	20.0
N	12	10	16.0

CBOs also reported difficulties in recruiting new volunteers to replace those that quit.

Now we cannot recruit anyone. Volunteer caregivers are leaving us for better jobs. If a volunteer caregiver leaves us, we do not replace her because already we are struggling with the ones we have. At least those who have been volunteering understand that we do not have funds to pay them. (Organization A)

Closing down

Four of the organizations that participated in the study eventually closed down after struggling to find funding for years without success. Two closed down in 2011, while the other two closed down in 2012. The manager of one of the CBOs, funded mainly by an international NGO, indicated that the management conducted a restructuring in 2009 to reposition itself to be able to respond to the challenges created by the funding shortages. The CBO ceased working in two of the communities it had served, and eventually defined itself as a service organization providing training services to other CBOs and not direct care to community members. But because of the severe shortage of funds and the continued decline in funding from their donors, the repositioned organization could not secure enough income from its training activities and had to close down as a consequence.

[We have] been struggling since the global financial recession began in 2009. Our major funder reduced funding considerably and we had to reposition ourselves to provide training services to raise more funds. However, we are no longer able to raise funds from other funders. We therefore cannot sustain our operations any longer and will be closing. (Organization N)

Discussion and implications for policy and planning

Our study provides nuanced qualitative findings that support previous quantitative data, showing that the global financial crisis has led to a decline in donor funding to the non-profit health sector in Africa that depends heavily on support from foreign and local donors or government agencies (Musau, 2010; OECD, 2014; van Pletzen et al., 2014). The financial crisis exacerbated pre-existing funding problems experienced by CBOs, occasioned by the shifts in funding priorities from HIV funding to ARVs and chronic diseases.

The finding that the majority of CBOs embarked on restructuring and retrenchment of staff highlights the severity of the impact of the financial crisis on their operations. Many of the employees are former volunteers who come from communities with high unemployment rates and few opportunities for employment (Akintola, 2011); therefore, the job losses have implications for their livelihoods and career advancement as well as psychological well-being of the remaining staff. In addition, the rationing of services provided to these communities has implications for the health and well-being of the beneficiaries; for example, the scaling-down of the feeding programs could cause food insecurity and have particularly far-reaching consequences for vulnerable children, while reduced services could negatively affect people living with HIV/AIDS and TB who need to take medication on a daily basis. Similarly, the inability of organizations to provide continued support

for school fees has implications for the education of poor, mostly orphaned children, with knock-on effects on human capital development in the country.

Incentives are a significant factor in the motivation and retention of volunteer community health workers (Akintola, 2011; Nkonki, Cliff, & Sanders, 2011), and their erosion due to reduced funding consequent to the financial crisis contributed to attrition rates. Attrition among community health workers and the retrenchment of supervisors will inevitably increase the workload of those who remain in the CBO, exacerbating stress and burnout. Akintola, Hlengwa, and Dageid (2013) found that work overload was a predictor of stress and that lack of support predicted burnout among community health workers and supervisors working in health-related CBOs in South Africa. Work overload is likely to undermine the effectiveness and sustainability of community-based health programs. It could also have negative rippling effects on support for primary care providers, who are mainly women, increasing their time poverty, i.e. reducing the amount of time available for primary caregivers to engage in social and productive activities that could help develop social capital and generate income (Akintola, 2008, 2010; Mohindra et al., 2011).

While CBOs are recognized for filling gaps created by weak health systems and social service delivery, especially in marginalized communities, it would be a mistake to lose sight of the broader developmental impact that CBOs have in these communities. The provision of skills training and stipends to volunteers and the employment of community members in salaried positions as supervisors in CBOs help to create opportunities for human capacity development and provide livelihoods for otherwise poor and unemployed community members. These have multiplier effects that help stimulate and support the local economy of poor and marginalized communities. The financial crisis thus has more far-reaching consequences that extend beyond the effects on the health systems and health services delivery to potentially ravaging effects on the local economy that these CBOs support.

A number of medium- to long-term measures are being put in place to address the current shortage of health workers that undermines the delivery of health and social services in South Africa (Akintola, 2015; DOH, 2010, 2011). However, in the meantime, the health worker crisis threatens to undermine the current policy reforms on primary health care in South Africa (Akintola, 2015; DOH, 2011), underscoring the need for continued support from CBOs. Yet, there are no specific roles outlined for CBOs in these policy reforms (Akintola, 2015; DOH, 2010; van Pletzen et al., 2014). Instead, the recruitment of community health workers from CBOs into government services has further weakened these CBOs by decreasing their funding and essential supplies (Akintola & Hangulu, 2014). Although the policy document on PHC re-engineering indicates that some health and social services will be delivered by the PHC outreach teams, it is unclear the extent to which the wide range of social and developmental services currently provided by CBOs will be provided to marginalized communities. This suggests that the work of the CBOs will continue to be critical to fill health, social and developmental services' gaps and sustain the health and social welfare essential for addressing social determinants of health for citizens living in poverty in marginalized communities.

It seems prudent, therefore, for policy-makers to explore ways of developing more structured collaborative relationships with CBOs. CBOs could play a major role in supplying critical human resources for health in the form of supervisors and community health workers that could be trained to function in posts created for outreach teams. In addition, the government could help build the capacity of CBOs to serve as trainers for

potential recruits into the outreach teams in the re-engineered primary health care initiative (see Akintola, 2015).

At the same time, there is a need to maintain a separation between CBOs and the state, as the absorption of CBOs into formal health systems might be inimical to the efficient and effective delivery of essential services to marginalized populations (Habib, 2005; Price, 1995). Further, the work of these CBOs in promoting community participation and mobilization will also continue to be essential not only for empowering poor and marginalized communities to improve population health, well-being and socio-economic conditions, but also to provide the latitude for them to continue to provide a platform for the voices of marginalised communities, including resistance to oppressive state policies and social practices (e.g. xenophobia) and promoting democracy (Habib, 2005). CBOs' role in providing a platform for community members to participate in volunteer activities is also critical.

Acknowledging the broad roles that CBOs play in local communities and the society at large, government should explore how to put in place a mechanism for guaranteeing regular funding and other supports for CBOs not only to protect them from the impact of economic shocks such as financial and economic crises, but also to ensure efficiency in their work, even during times of economic prosperity. Research that explores how relevant government agencies responsible for social development, education, agriculture, labour, community development and skills development and job creation could partner with CBOs to promote their important work is urgently needed. At the same time, it is important to understand that CBOs cannot replace weak health systems or the social services' delivery and developmental roles of the state. Therefore, research on how policies can work to strengthen weak health systems, even as they support CBOs, must be of utmost priority. Finally, lessons from this study could be useful for other low- and middle-income countries that depend heavily on CBOs for the delivery of health, social services and developmental services.

Some limitations of the study must be acknowledged. First, we drew a purposive sample of CBOs in the Durban metropolis; the experiences of other CBOs in other regions could differ. Second, we chose to explore the experiences of the global financial crisis among CBOs through the lens of managers of the CBOs, whom we felt were the most knowledgeable about the running of the organization. This approach means that our findings likely reflect the managers' own experiences and may not capture the full impact of the financial crisis on their organizations. Third, we conducted a purposive sampling of CBOs affected by the financial crisis and also focused our questions on CBO experiences that related to the crisis. We also probed to seek clarification whenever it appeared that participants were not sure about the reasons for their funding problems. Despite these efforts, it is possible that some participants may have used the crisis as a catch-all phrase for the financial difficulties experienced; given that our questions were mainly about the implications of the financial crisis for their organizations, it could be that participants attributed most of their financial difficulties and related challenges to the global financial crisis, even though various other problems could be contributing factors. On the other hand, it is also possible that participants under-reported the effect of the financial crisis on their organizations based on lack of adequate knowledge of the reasons for their financial difficulties.

Acknowledgements

The authors would like to thank the management and staff of all the community-based organizations that participated in the study. A different version of this paper was presented at the 20th International Association for Feminist Economics Conference, Hangzhou, China (24 June 2011). We would like to thank the participants at the conference for their feedback and suggestions. We also want to express our sincere appreciation to the Department of Clinical Epidemiology and Biostatistics and the Centre for Health Economics and Policy Analysis at McMaster University, Hamilton, Canada for hosting Olagoke Akintola during the time we were preparing the earlier versions of the manuscript.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the National Research Foundation (NRF) of South Africa [grant number 71101] and the National Research Foundation Incentive Funding for Rated Researchers [grant number 90879]. Netsai Bianca Gwelo's participation in this study was supported by a National Research Foundation funding for postgraduate students linked to OA's NRF [grant number 71101].

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