Community health workers

nothing about us without us

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July 2020

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We hope that this workbook will help CHWs in their political articulation, strengthen their movement and have them reflect critically on the invisible work that they do in building a healthy society!

You are humanity

by Anna Ushamba

SOURCE: ANNA USHAMBA

YOU are Humanity
They call you the Invisible
But YOU are VISIBLE, Your calling is VISIBLE
They call you the Silent
But YOU are SPEAKERS, Your calling SPEAKS

They see you not as a person
But YOU are a PERSON, a COMMUNITY
They say you have no voice
But YOU have a VOICE, Your calling has voices
They say you have no Power
But YOU have the POWER

Yes, YOU are HIGHLY VISIBLE
Yes, YOU have a VOICE
Yes, YOU are a COMMUNITY
Yes, YOU can make a CHANGE
Yes, YOU have the POWER
Above all, YOU are HUMAN, CHANGE, YOU ARE and Doing

July 2020

Foreword

"Going in blind with good intentions"

SOURCE: RURAL WOMEN'S ASSEMBLY

Afrikagrupperna, in 2017, decided to document its journey with Community Health Workers in the Southern Africa Region. The conversation of documenting this journey became a journey in itself. The initial idea was to document the strides made, successes achieved and lessons learnt – we had to ensure that we recorded the impact made. Interestingly, these were similar conceptions to how we entered our journey with Community Health Workers in 2011.

Little did we know that the process would allow us to be shaped and moulded, with Community Health Workers being the potter! Today Afrikagrupperna has a better appreciation of the invaluable contribution of Community Health Workers to a healthier society in South Africa in the context of patriarchal neoliberalism.

The "end" product – *The World of Work of Community Health Workers* produced by the Feminist Research Collective in February 2019! This piece of work, shaped by the voices of black women workers, not only celebrates the role that Community Health Workers play in producing and reproducing society but also brings to the fore the hidden pain and hurt that many times goes with being unheard and unseen.

Afrikagrupperna hopes that these voices will echo and continue to build solidarity beyond the confines of South Africa!

Dean van Rooy

Contents

Acronyms

ABET	Adult Based Education and Training
AHW	Auxiliary Health Worker / Ancillary Health Worker
CHWs	Community Health Workers
CCWs	Community Care Workers
EPWP	Expanded Public Works Programme
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HCBCWs	Home and Community Based Care Workers
HCBC	Home and Community Based Care
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HPCSA	Health Professions Council of South Africa
HTA	High Transmission Areas
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
NQF	National Qualification Framework
NUPSAW	The National Union of Public Service and Allied Workers
PAYE	Pay As You Earn
PERSAL	Personal and Salary System
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
SACWF	South African Care Workers Forum
SAQA	South Africa Qualifications Authority
SPWP	Special Public Works Programmes
TB	Tuberculosis
UIF	Unemployment Insurance Fund
WBOT	Ward-Based Outreach Team
WBPHCOT	Ward-Based Primary Health Care Outreach Team

Chapter 1

Community health workers

SOURCE: COMMUNITY MENTOR MOTHER (M2M)

Community Health Workers (CHWs) are dedicated and passionate about the work they do in their communities. Ensuring that the voice and experience of CHWs is foregrounded is critical to a feminist approach. CHWs' experiences and skills are often not captured and documented. Why is this the case? What does this say about how CHWs are seen and valued within the health system? CHWs are mostly working class black women, living and working in their communities. They take the utmost care with the patients they see each day. They are trained, either as a part of their induction at their sites of work or as part of the training they themselves have paid for, to advance their level of care for the communities in which they work. They are also trained from one generation to another by their mothers, grandmothers and aunts to "take care" of others in ways that are compassionate, empathetic and mindful. Often the work of "taking care" from an early age means that CHWs are shaped and socially trained to enact particular gendered roles. The healthcare system expects the CHW to embody this, yet this care is assumed and not recognised. The value of the work which CHWs bring to the healthcare sector is not acknowledged with adequate remuneration, formalisation of employment, benefits and an equal seat within the healthcare system.

A day in the life of...
Ntebaleng

Ntebaleng Molelekoa
40 years old
Married with two children
Botshabelo, Free State

Ntebaleng Molelekoa is a married 40-year-old-woman with two children. Born and raised in Botshabelo in the Free State, she works there as a CHW. She never wanted to be a CHW, her dream had always been to become a Social Worker. But there was no money for her to go to university. After matriculating in 1999, while looking for work to support her family, an acquaintance told her that the local hospital needed people to help to feed and wash patients. Although a volunteer position, Ntebaleng took it, hoping to earn a salary soon. In 2002, she completed a Home Based Care course offered by an NGO. Since she was a volunteer at the hospital, she did not have to pay for the course. That year, having seen how people suffered in the hospital, she decided to become a Home Based Carer.

Ntebaleng loves working in her community and feels really proud of the work she does here...

Ntebaleng was very happy to have received the training, feeling that she could really help her community with what she had learned. As a Home Based Carer, she earned a stipend of R1 000 per month, working 20 hours a week for four weeks, and was happy to be able to contribute money to her family. A few months later she saw an advertisement for six CHWs to work at an NGO in one of the local clinics. Though skeptical because of her previous experience in the local hospital, she applied, was interviewed and got the job with the NGO, all on the same day. Ntebaleng loves working in the Botshabelo community and feels really proud of the work she does here. She was given a raise and now earns a salary of R3 500 per month. In 2017, she also started studying for a degree in Engineering at the University of the Free State.

A day in the life of Ntebaleng...

Wake up

7.30 am

Ntebaleng wakes up at 5.00 am every morning to get her husband and herself ready for work, and the children ready for school. She starts by boiling water for everyone to use to wash. After washing and brushing her teeth, she makes breakfast, coffee for the adults and packs lunches for her family.

Leaving home

7.15 am

Ntebaleng makes sure her children are ready to leave for school at 7.15 am and tidies her home before she leaves for work at around 7.30 am. It takes 30 minutes to get to work and she walks the approximately two kilometres from home to work.

At the clinic

8.00 am

The first thing Ntebaleng does when she gets to the clinic at 8.00 am is 'clock-in' with her signature. She collects the list of patients she will see for the day and spends time with her fellow CHWs before they start their day. She speaks with her team leader about the challenges of the previous day, particularly those with tracing non-compliant patients. Once her meeting is done, she then starts her day in the community.

Into the community

9.30 am

From approximately 9.30 am to 1.30 pm, Ntebaleng does field work in the community. Here she traces non-compliant patients, and screens and profiles patients who, for different reasons, may not be able to reach the clinic themselves. Some days she also does drug adherence counselling at the clinic and provides patients with their medication should they not be well enough to queue for it themselves. Some patients have no food to take with their medication or soap with which to wash, so Ntebaleng brings food and soap from her own home. These things are not prescribed by her job, but the circumstances of her patients makes drug adherence challenging for them and so she helps when she can. Working in private homes and not in a hospital means she does all her work 'on foot'. She walks from home to home and since she is on the road, she also has her lunch in-between seeing patients. Today, she saw six patients in the community who rely on her to bring their medication and needed to track another four patients, walking 6 000 steps between the clinic and these ten homes.

Daily report

4.00 pm

Before Ntebaleng is able to rush home to cook supper for her family and check on her children's homework, she finishes her daily report for review by her team leader. Her team leader needs this information by the end of the day, but they always discuss it in her morning check-in meeting. Her work day ends at 4.00 pm, but since Ntebaleng is a student she needs to make time to study and do her assignments, as well as tend to her family.

Exercise 1

How do you see yourself?

As a CHW, you may have seen much written about you, but very little written by you. Yet you are the expert on your work, tasks and experiences. How do you see yourself?

SOURCE: CARING IS WORKING (WELLNESS FOUNDATION)

Questions

- What are your skills, both personal and work?
- What are your 'hidden talents', your dreams and beliefs?
- Why did you become a CHW?
- Were you inspired by anyone to follow this path?
- What do you like about being a CHW?

Thando's beloved uniform...

Born in 1972, Thando lives and works as a CHW in the Northern Cape. At age five she lost her father and, at ten, her mother. Having lost her father so young, she grew up living with her grandmother and cousins. Her mother worked out of town as a nurse in an old age home and only came home on alternate weekends, when she had time off work. Thando loved having her mother home on those weekends, and especially could not wait for her mother to remove her uniform so that she could wear it. She particularly loved the hat and every chance she got she pretended to play 'hospital', being determined to always play the nurse. She admired her mom because she was a nurse who cared for people and Thando thought this to be the most important job in the world. The uniform also played a huge role in Thando's desire to become a nurse.

When Thando's mother died in a car accident on her way to Thando's tenth birthday party, she was devastated. She continued living with her grandmother and cousins, most of whom were older and teased her about her fair complexion. This left her feeling very vulnerable and made her conscious of being different, and also that this difference worked to her disadvantage. She felt that she could only relax and forget about the discrimination when her mother was home over the weekends, but since that was no longer possible, she felt isolated and neglected.

She admired her mom because she was a nurse who cared for people...

Having admired her mom so much, Thando longed to become a nurse as a way to honour her. But they were poor and her grandmother could not afford to send her to university. As someone who had 'grown up in the church', Thando became a Sunday School teacher at her local church.

Thando's beloved uniform...

...like her mother, by caring for people, she is doing the most important work in the world.

One day, after the service, a congregant asked her whether she would be interested in working for a local NGO. She agreed and started working there in 2002, spending three years as a volunteer. She did not get a uniform like her mother's, only a t-shirt and a pair of formal slacks. She was willing to work even though, being only a volunteer, providing for her three children was difficult. Her husband's salary as a construction worker was used to sustain the family, but it was a struggle.

In 2005, the Northern Cape provincial Department of Health moved CHWs from the NGO Thando worked at to an agency called Agang. The work was different. She worked at an old age home, was given a uniform and started earning a stipend of R2 500 per month. Now, 12 years later, she earns R4 500 per month. She loves the work she does because, like her mother, by caring for people she is doing the most important work in the world. And though it's not the same, she has a uniform like her mother's.

Exercise 2

What does your uniform say?

A uniform plays an important part in making one visible, especially in public service positions. For example, wearing a uniform helps to distinguish the police or fire services from paramedics. In some instances, not wearing a uniform means your presence is immediately questioned. What does your uniform mean to you?

SOURCE: NURSING WITH NOTHING (WELLNESS FOUNDATION)

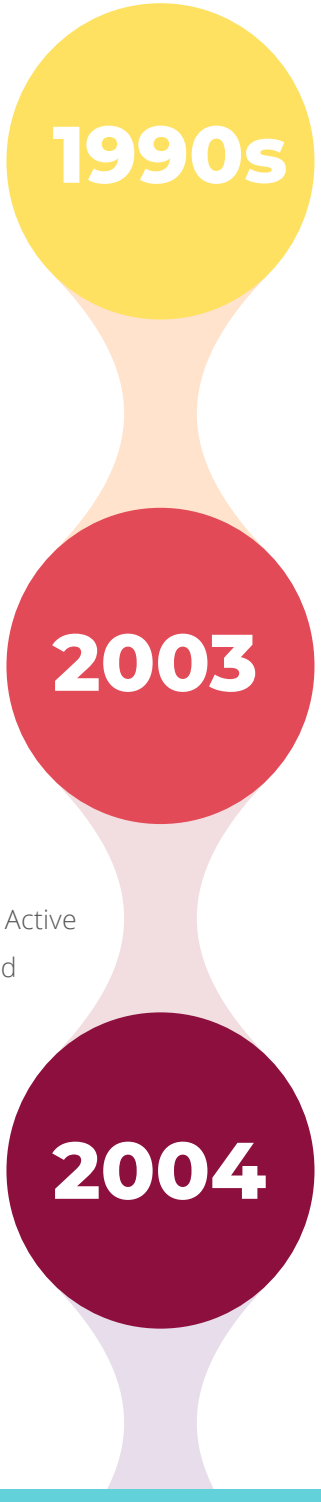
The significance placed on uniforms suggests that CHWs ought to articulate it as a demand. Should you have a standard uniform and who should provide it? Should CHWs buy it, and if so, should CHWs not be consulted about what is looks like? It might be useful to consider creating a standard CHW uniform with badges in different colours, or even lapels, that could represent years of service. Badges could have name tags, with different colours representing volunteers, or years of service from 1 to 3 years, 5 years and more, or 10 years and more. This would demonstrate that the CHWs bring experience and dedicated time to their work, including time spent as a volunteer. Thinking about this could help collectively clarify what an ideal uniform could look like and could be registered as part of demands for uniformity and recognition.

Questions

- Do you have a uniform? Why/why not?
- Describe your uniform?
- What's missing from your uniform?
- What does it mean for you to wear your uniform?
- Did you have to pay for your uniform? How much did it cost?
- How many changes (sets) of uniforms do you own?
- Do you have a medical bag?
- Does the medical bag have surgical gloves, does it have medication?
- What else do you have with you on your home visits?

Policy and the CHW

With the advent of the democratic Republic of South Africa came a non-racial healthcare system that would serve all citizens and residents. To make the service accessible to all it needed to grow and develop. At the same time as this democratic order came into being in South Africa, the HIV epidemic grew rapidly. The post-1994 period saw a boom in policies about CHWs which have shaped how CHWs are perceived and how they experience their work. Below we retrace the policy shifts.



In 1994 the ANC National Health Plan creates a single non-racial healthcare system and introduces local level CHW programmes. Free primary healthcare is also a focus for the healthcare system. Simultaneously, HIV infections are on the rise. With relatively few healthcare workers in the national public health system, and even less in rural areas, the government introduces local level CHW programmes administered by provinces. CHWs support doctors and nurses by giving medication and monitoring patients.

With rising unemployment and rising HIV infections, President Thabo Mbeki announces the Expanded Public Works Programme (EPWP), specifically targeting women. CHWs get a stipend of R500 – R1 000 for Home and Community Based Care Workers (HCBCWs). Provinces are also encouraged to institutionalise the CHW programme.

The Prevention of Mother-to-Child Transmission (PMTCT) and the Highly Active Antiretroviral Therapy (HAART) roll out starts. The National Health Act and National CHW Policy framework is passed. EPWP implementation starts and predicts that 35 000 CHWs are needed nationally. Home and Community Based Carers are recognised as 'volunteers' and their primary focus is around HIV care. As ARVs improve HIV patients' quality of life, CHWs are encouraged to expand their skill set and focus. This is when the EPWP provides basic training over two years with no qualification for Home Based and Community Care Work. Under the EPWP CHWs receive stipends but are not be recognised as government employees.

2006

Accreditation for CHWs under the National Qualification Framework (NQF) is put in place. The Department of Health registers four Community Worker qualifications. The first level is for the Ancillary Health Worker (AHW) which is foundational and qualifies the learner to function as a basic Home and Community Based Caregiver (HCBC). The second and third level provides for the cadre known as the Community Care Worker (CCW), with level four being the "fully-fledged" Community Health Worker (CHW). These standards are all approved by the South African Qualifications Authority (SAQA) and registered on the NQF in January 2005.

2009

The Community Care Worker Policy Management Framework is published. With this, the term Community Care Worker (CCW) is introduced to describe the fact that volunteers in the health care system carry a double burden: they do healthcare work and social development work within clients' homes and at clinics. The definition distinguishing between CCW as a volunteer from CHWs who are members of the primary healthcare outreach teams, is important because it acknowledges the CHWs and their work.

2003

The government launches the primary health care revitalisation process and a Human Resources for Health Strategy to go along with it. Within these frameworks CHWs are envisioned as members of ward based outreach teams and are primarily responsible for healthcare promotion, prevention of illness and health surveillance at community level through weekly visits. The frameworks propose that the government should commit to specifying a standardised scope of work, core competencies, agreement on a training and supervision package, and agreement on terms and conditions of service for CHWs. There is also some discussion of the need for the government to ensure that CHWs are eventually employed by the health department, not NGOs.

2018

Grade 12, alongside relevant training, is required to become a CHW.

Exercise 3

How do others see you?

As a CHWs you know that you are not a homogenous group - you have different ages, backgrounds, skills, languages and come from different provinces and communities. How do you think you are seen by others within the health fraternity as well as by society?

SOURCE: NTOMBUZUKO KRAAI (WELLNESS FOUNDATION)

Questions

How do you think you are seen by

- the doctor?
- the nurse?
- the Department of Health?
- the NGO/labour broker agency?
- the union?
- the community members?
- the ward councillor?
- the church?
- your husband, your family, your children?

A feminist analysis that draws on a grounded approach builds and develops an understanding of the challenges and obstacles in conversation with CHWs. It ensures that the 'herstories', voices and discussions of CHWs inform and locate CHWs struggle for recognition.

Over a period of two years, we assisted with tracing the challenges on this road to recognition and drew on a feminist approach to help shed light on the broader reasons why the work of CHWs is not valued and appears invisible over the preceding two decades. We try to understand why the deep knowledge and experience of CHWs are not drawn upon and consider how this reflects broader perspectives in this society of how black working class women's daily social reproduction work, time, effort and contribution is rendered as non-productive. Importantly, we look at how CHWs are seen. In other words, we consider how CHWs view themselves and how they observe and experience the perceptions others have of them.

We then consider how CHWs' lack of recognition hinges on the historical policy call to volunteer. We ask why so many CHWs work as volunteers for such long periods of time? Here we show that the volunteerism is tied to an implicit patriarchal view which expects women's time to be "free". More so, we see how this call to volunteer potentially dismisses CHWs' work, time and effort as unskilled, hence not valuing the contribution that CHWs make towards the national health system. Key is to re-centre the incredible work that CHWs do and rethink volunteering – it means potentially rejecting the idea of volunteering as a prerequisite for becoming CHWs and considering an embargo on it, or insisting that this volunteering is applied across the board to the entire health fraternity.

Building on this we try to locate and identify where CHWs' work and how their work is regulated. This is important in order to understand the challenges that CHWs face in organising for recognition. It shows fragmentation and the implications for organising given the provincial administration, NGO and private sector variances. Hopefully, it also begins to point to potential demands and new areas to focus on for facilitating a seat at the negotiating table for CHWs. Furthermore, it aims to show areas for greater solidarity and potential areas for alliance building.

By thinking about hierarchies of health care, work and power we draw together many threads of the CHWs work and ask why is it that CHWs take on so many roles and responsibilities, yet there is no recognition in the form of wages, standardised uniforms, formal licencing or registration with the Health Professions Council of South Africa. The hierarchical nature of the health sector positions the CHW at the bottom of the ladder.

We ask how it is that CHWs are at the coalface of the health system bringing primary health care to the doorsteps of millions of South Africans and yet are not recognised in word and deed. We highlight throughout the workbook how CHWs' demand for recognition and a seat at the table is essential and necessary. We hope that this workbook helps to give expression to that.

"When you grow up there are so many children in the house and in my case, I grew up with Basotho (people) and I was the only one who was white (fair of complexion) and the treatment was so bad. My mother was a domestic worker as well and then she was only working away. It was only my cousins and my grandmother. So she had to take care of all of us. And at the end of the day we were struggling a lot. So that's the passion that I had for helping others. I wanted to help somebody because I did not have anybody who could help me. But here I can feel that women are good willed. Thank you."

(Mantona Anna Mariti, Free State)

"It's very sad. I came from a poor family. I was not so good in English because at home we spoke Afrikaans. But once I started as a volunteer from 2002, we did not get any cent. After 2005 they started giving us R500. From R500 they came up to R1 000. I was the only one working. So I had to share my money with my brother and sisters. That's why I couldn't stay at school. My father also drank a lot. And the other thing is in 2006, I married my husband, who took care of me and my family and my children."

(Mary Nokwane, Northern Cape)

Chapter 2

The call to volunteer

PHOTO: THOM PIERCE/SPOTLIGHT

Community health workers often enter the health sector through extensive volunteer work. They do so in the hope of finding employment. Volunteering is an unspoken norm that is a prerequisite for them to find a job. Why is this the case? Why do so many CHWs work as volunteers for long periods? Why is this expected of them?

One reason has to do with how the work of CHWs is viewed by society. CHWs do work that is considered non-productive (e.g. they do not produce dresses or cars for sale on the market) but that is defined as social reproductive work (i.e. work that contributes to producing and reproducing people, specifically the labour force). They do this work in the private homes of their patients, often on a volunteer basis. They make sure that patients take their medicine, go for follow-ups, receive emotional support, and have the information and support they need to advocate for themselves when they seek treatment at the clinic or hospital.

This care work subsidises the health system – CHWs are the foundations on which the health and economic welfare of our society is built. Many employers unfairly see this care work as something that can effectively be done by volunteers – especially in a country with high unemployment amongst women. Employers therefore see the volunteer work they offer CHWs as an "opportunity" to gain skills and training, and do not see volunteering as something that exploits CHWs' time and labour. This is reflected in the career trajectories of most CHWs, who volunteer for some time before they find paid work

PHOTO: THOM PIERCE/SPOTLIGHT

in their field. Some CHWs never find paid work. As worker-volunteers, the experience of CHWs is one of "all work and no pay" (Oxfam 2020, p.13).

Another reason has to do with health sector policies. The government has emphasised the importance of using volunteers to promote service delivery in the health sector since the early 2000s.

"We usually say that a Community Healthcare worker does not stop working, it's like 24 hours a day. You don't want people to suffer. If there is a short staff in the pharmacy you will help them 'cause you care. And you work outside of the clinic." (Bulelwa, 16 November 2018)

This has been especially important in relation to HIV/AIDS and TB treatment services. Government policies such as public works programmes and service delivery agreements with "NGO partners" have a long history of paying CHWs no or low wages. This is justified by arguing that these programmes are mainly supposed to give volunteers work experience and training, not jobs or wages. The problem with this is that many women who participate in these programmes become experienced and highly skilled CHWs, but never find decent jobs.

It is important to critique the idea that CHWs are doing "unskilled" care work that "any woman" can do. This mistaken belief hides their important contribution to the health system and leads to their work being routinely made invisible. This is due to an entrenched patriarchal world view that re-enforces the idea that women's work is unskilled

and comes naturally to them. CHWs often work as volunteers for many years before they are able to find paid work in their field and in this process the value of their work is made invisible.

Volunteering without end: why are so many CHWs worker-volunteers?

In 2002 the ANC launched the Letsema campaign, which named 2002 "the year of the volunteer" in South Africa. It celebrated "voluntary work aimed at building a better life for all South Africans" (Mbeki 2002). In his New Year's speech for 2003, delivered on 30 December 2002, President Mbeki argued "the challenge in the coming year [2003] will be to make Letsema a permanent feature of our society (Mbeki 2002)."

One of the policies that embodied the Letsema campaign's spirit of voluntarism was the Social Sector Expanded Public Works Programme (EPWP), which the government introduced in 2003/2004. This programme identified unemployed women who were not receiving grants, and were HIV-positive or had HIV-positive people in their households, as key beneficiaries. When President Mbeki announced the creation of this programme, he stated that its aim was to function like a training programme which would upskill volunteers for paid work. This programme was described as "a short-to-medium term programme" aiming to "draw significant numbers of unemployed into productive work accompanied by training so that they increase their capacity to earn an income" (Department of Social Development, Department of Education and Department of Health of the Republic of South Africa, date unknown, p.6-7) and "get out of the pool of those who are marginalised" (Mbeki 2003).

According to the EPWP recruitment criteria, community care and health workers could only become EPWP volunteers if they had first "[d]emonstrated community involvement and [worked as] a volunteer for a minimum of 1 year in a HCBC [home and community based care] site funded by the department" (Department of Social Development, Department of Education and Department of Health of the Republic of South Africa, date unknown, p.46 and p.50). Effectively, women had to have a history of unpaid volunteering in the health sector before they were eligible to be an EPWP volunteer and benefit from the training it provided.

Today, many CHWs are still "volunteers" who are not fully recognised as workers and employees.

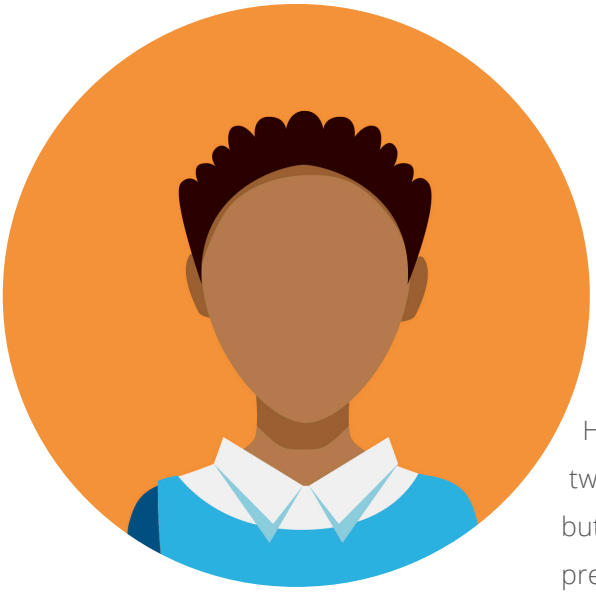
Today, many CHWs are still "volunteers" who are not fully recognised as workers and employees. This means that the EPWP failed to achieve one of its goals: ensuring that home and community based care workers eventually secure decent jobs. Nevertheless, many CHW volunteers continue to complete training programmes provided by NGOs and private colleges in the hope of one day

A Short History of the Volunteer in Search of a Job

When it was first introduced the recommended allowance for entry-level EPWP volunteers was R500 per month (Department of Social Development, Department of Education and Department of Health of the Republic of South Africa, date unknown, p.46). This low level of compensation was legalised through the Code of Good Practice for Special Public Works Programmes (SPWPS). The Code specified that EPWP volunteers would be "entitled to training – from life skills training to ABET in compensation for the lower wages" (Department of Public Works, Republic of South Africa, date unknown, p.12). The home and community based carers enrolled in the EPWP were defined as volunteers. The volunteer was someone who worked in public sector projects or publicly financed projects, but would not be classified as a public sector employee.

The EPWP specified that volunteers were only entitled to on-the-job training, but were not entitled to a job. For example, in the sections on community care workers and community health workers the Expanded Public Works Programme Social Sector Plan 2004/5-2008/9 states that "[i]t is essential that a job opportunity does not become an expectation or entitlement right for volunteers" (Department of Social Development, Department of Education and Department of Health of the Republic of South Africa, date unknown, p.46 and p.49). The policy document notes that the expectation of finding paid work could prove deeply destabilising to service delivery because "the current delivery capacity of social services... is reliant on volunteers" (Department of Social Development, Department of Education and Department of Health of the Republic of South Africa, date unknown, p.33).

finding a paid job (Schneider, Hlope & Van Rensburg 2008). Over time continuous upskilling has become important in surviving in this sector, because recruitment criteria for CHWs increasingly emphasise the need to have formal qualifications (e.g. Grade 12) in addition to having experience working in the field.



Hazel's story

skilled, experienced... and still volunteering

Hazel has been volunteering as a CHW for the past two years. Before that she had a job as a waitress, but she was fired when her boss realised that she was pregnant. During the pregnancy she took part in a peer-counselling programme for young mothers. Through this programme she became involved in an HIV/AIDS organisation and volunteered as a HIV/AIDS educator. She liked the work and decided to find work as a CHW. Her supervisor at the HIV/AIDS organisation referred her to another organisation close by, "The Trust". Hazel was hired sooner than her friend who also applied to work as a CHW because she has Grade 12, and because of her three years of volunteering with the HIV/AIDS organisation.

Even though she already has a lot of community health sector experience, The Trust has employed her as a volunteer.

Even though she already had a lot of community health sector experience, The Trust employed her as a volunteer. They argue that she has not yet completed a training programme to obtain her Further Education and Training Certificate: Community Health Work, so she does not qualify for a permanent post. The Trust only hires CHWs as permanent, paid staff once they have this certificate.

Because she does not earn a stipend, Hazel is still looking for a way to pay for the training course. She has researched the CHW qualification on the South African Qualifications Authority (SAQA) website[1]. She remembers that the certificate claims to teach learners to improve their awareness of themselves and their communities, to develop thinking and problem-solving skills, as well as team work skills. It also claims to teach them how to assist their

Skilled, experienced... and still volunteering

clients and communities to manage their own health more effectively. Hazel and the CHWs that work in her clinic often talk about how unfair it is that they need a certificate to prove they have these skills when their long years of volunteering have made them experts at many of these things. They also think it is funny that a person has to speak at least two languages to earn the certificate. All the CHWs at The Trust speak at least three languages, because that is one of the things that makes them "good" volunteers. However, some of the highly paid and respected doctors that work at their clinic can only speak English and constantly need a CHW or nurse to interpret for them.

Her clients often say she is a good and caring woman, and this is one of the things about her job that makes her feel appreciated.

Even though it is time-consuming and difficult to work as an unpaid volunteer, Hazel stays on at The Trust because she hopes to earn a stipend one day. Right now there is no law or policy that forces The Trust to pay her for the work that she does if she accepts being called a volunteer. Her dream is to qualify as a nurse and she sees volunteering as the first step towards this. She hopes by the time the NHI is implemented she will have completed at least one certificate. This will give her a better chance of being in-sourced as a public sector employee. However, she has also heard from her supervisor that it is not clear how NGOs will be incorporated into the NHI. If the NHI is implemented before she can get her certificate, she is scared that she might have no work at all – not even the volunteer work at The Trust.

Hazel also stays on as a volunteer because it earns her respect in her neighbourhood. Her clients often say she is a good and caring woman, and this is one of the things about her job that makes her feel appreciated.

PHOTO: THOM PIERCE/SPOTLIGHT

CHWs DO CARE WORK THAT SUBSIDISES THE HEALTH SYSTEM, BUT THIS PHYSICAL AND PSYCHOSOCIAL WORK IS NATURALISED AS A "LABOUR OF LOVE"

CHWs are an essential part of the South African health labour force. It is not possible to imagine a public health system without CHWs. Since 2011 the government has spoken about the possibilities of "in-sourcing" CHWs as part of its efforts to improve access to primary health care through ward based outreach teams (Department of Health, Republic of South Africa 2011b, p.66-67). In-sourcing efforts to make CHWs public sector employees have been uneven, as discussed in detail in chapter three, and many CHWs continue to do care work on a volunteer basis, which subsidises the health system.

CHWs are seen as doing "women's work" and this work is seen as a "natural" part of being a good wife, mother, or daughter. Therefore, their important contributions to the health system are routinely ignored or not recognised, and minimised. Their skills and knowledge are taken for granted, and their labour is not seen as "productive" because they are seen as doing the "little things" that make the "real work" that doctors and nurses do possible.

> *"[Working as a] CHW is seen as women's work. It's your responsibility to care for your family, and of the community. And this is essentially where the root of all the issues CHW face today comes from. And it is a feminist issue."*
> *Worker at a CHW support organisation, 1 October 2018*

Andrews et al (2018, p.22) point out that a feminist approach seeks to show that patriarchal capitalism:

> *"reinforces and entrenches the divide between paid and unpaid work, formal and 'informal' employment, productive and social reproductive labour, economic and social spheres, [and the] society and nature dichotomy…[this] makes invisible the work that women perform such that it is not seen as labour, hence making it permissible not to wage it, and therefore … maintains a strict division between the public and private sphere hence relegating the home (where women are the primary carers) as being outside the regulating domain of the market and state and thus not waged, taxed and/or financed while simultaneously 'naturalising women's roles' and 'normalising care' as Fraser (2016) argues."*

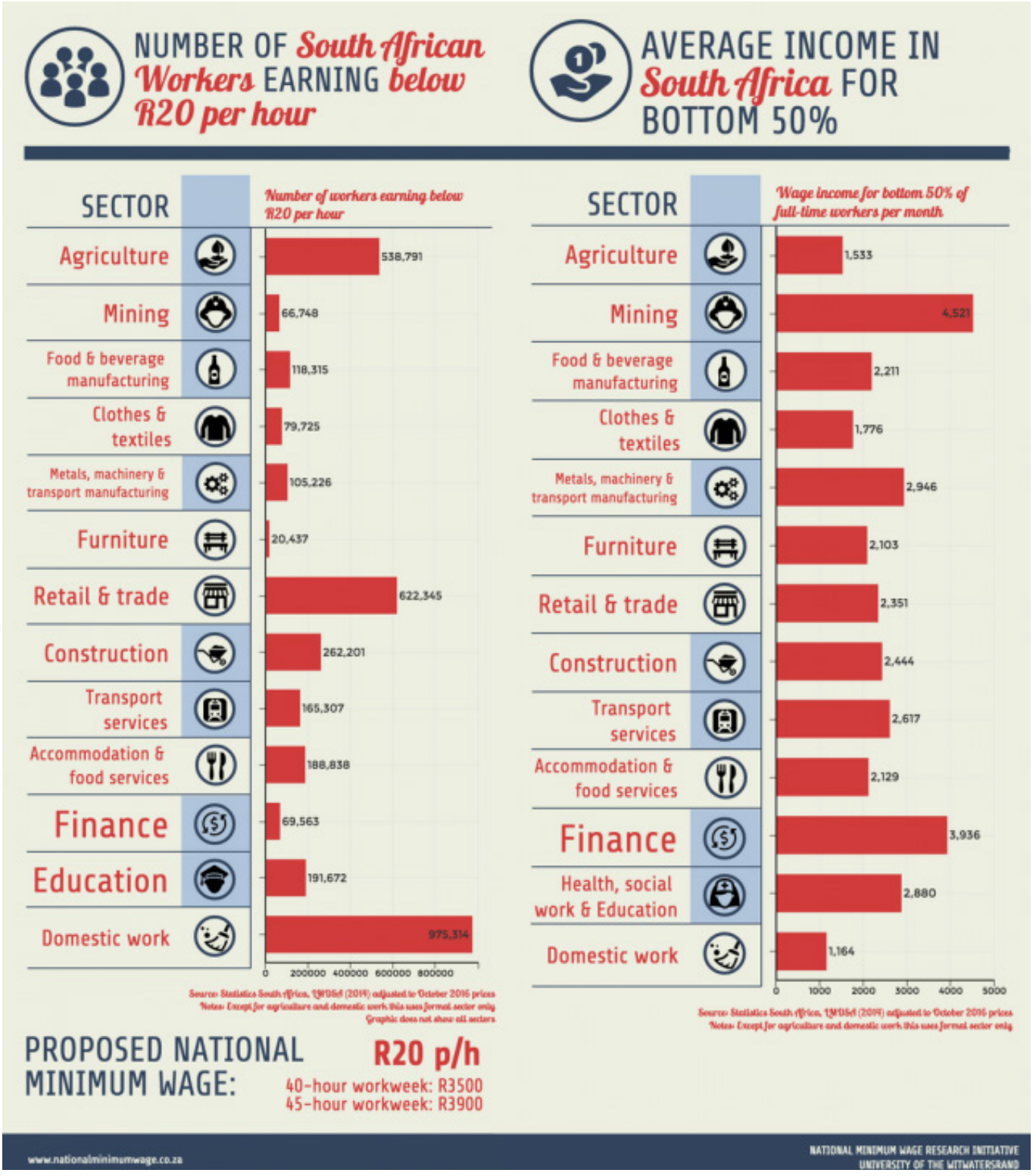
Because the social reproductive work CHWs do is seen in this way its value is made invisible. CHWs often work as volunteers for many years and a lot of CHWs are never able to find stable, well-paid work in their field. History shows that CHWs have taken on the spirit of the Letsema campaign by working for the common good – but with little or no rewards for their efforts. Where do we hear of men needing to volunteer? Do we hear of doctors and nurses having to volunteer and work for free before they can qualify to get a paid job? No, even when new doctors do their community service, they get paid a decent wage. Asking women to volunteer and do unpaid work as well as to marginalise and make invisible the work done by women is a key component of a patriarchal system. It exploits their time, energy and skills without giving them the recognition they deserve.

> *"For them what they see is a tree with red and green parts. They don't see the roots…What they don't see is that care work is a women thing and women in South Africa is still seen as nothing…" (Ntombi, 1 October 2018).*

The Economic Value of CHWs' labour and time

Most women do care work every day: cooking, cleaning, grocery shopping, finding water and cooking fuel, and taking care of children or sick people. This work of reproducing society is done for free within the household and it is the invisible work that ensures children can grow into "productive", employed adults. Social reproduction work is seen as "women's work". Most CHWs are women, and they carry a double burden of social reproduction work. As mothers and wives they do social reproduction work for free in their own households. When they leave home for work, they do this physical and psychosocial labour in their patients' homes. The work CHWs do is extremely valuable and hugely contributes to the national economy. Research by Oxfam shows that women in rural communities and low-income countries spend up to fourteen hours per day on

TABLE 1: The South African minimum wage[2]



unpaid care work. Meanwhile, men spend only about three hours on this work each day (Oxfam 2020). They calculate that the unpaid care work done by women worldwide is worth USD10.8 trillion annually (Oxfam 2020, p.10). This figure only includes the work done by women aged fifteen and over – it would be even bigger if we counted the value of care work done by girls.

In South Africa, researchers did a modelling exercise that wanted to measure the impact of investing more in incorporating CHWs into the public health workforce. This model proposes standardising tasks and training for CHWs, and paying all CHWs at least R3 500 per month. The researchers argue, "A highly performing CHW platform would improve health status and create savings for the country" (Daviaud, Besada, Budlender, Kerber & Sanders 2017, p.10). More specifically, "the better health status of the population and the deaths averted through the [proposed] CHWs interventions, translate into an additional 5 million productive life years added to the workforce over 10 years, or R413 billion added to the GDP" (Daviaud, Besada, Budlender, Kerber & Sanders 2017, p.9

The calculations in this study were based on the 2017 minimum wage. Even with the 3,8% increase introduced to the minimum wage in 2020, CHWs working full time would still earn less than R3 500 per month. This is too low. These calculations above show that CHWs invest in However,there is little investment in their well-being as women and workers. Because care work is done for free within the household – it is not "bought and sold" but is seen as a "labour of love" – its economic contribution is not always acknowledged in the statistics that the government collects. Given the contributions CHWs make to the health system they should earn above the minimum wage, i.e. at least R4 000 per month.

Women in rural communities and low-income countries spend up to fourteen hours per day on unpaid care work (Oxfam 2020).

Working under conditions where their care work is not valued, and where CHWs are forced to volunteer in the hope of getting a job one day, does not make work a source of security for CHWs. Instead, it makes daily life insecure and stressful. A feminist analysis shows that viewing women as "naturally" responsible for care work, and seeing care work as unskilled and without economic value is not natural at all: it is political.

It is political because this view of care work makes it seem like unskilled work that anyone can do when in fact it is highly skilled work. In the case of CHWs this has led to successive policy frameworks stating that CHW should be accredited and trained, without adequately recognising the prior learning and skill they bring to their job after many years of volunteering in this sector.

It is political because it hides the economic

What is Patriarchy?

WOMAN IN PHILIPPI (SUZALL TIMM)

If the labour involved in social reproduction is so valuable, why is it treated as if it is less valuable than productive work? Why is this work invisible, unpaid, and devalued? Why do women do all this social reproduction work without any recognition? Why don't men take on more social reproduction work? When men do take on social reproduction work, e.g. changing nappies or cooking, why is it seen as more special than when women do this work? Why are they seen as "helping" women, who are "lucky to have such a good man"?

Patriarchy is at the heart of why social reproduction work is seen as invisible, unskilled, and strategically devalued. But what is patriarchy? Patriarchy is a political, economic and social system that is based on the belief that men are naturally more dominant and superior to women. Men are always treated with more respect than women in these societies, regardless of their personal characteristics. Because of these beliefs, patriarchal systems systematically give men more control over decision-making, other people (especially over women and children, who are often seen as "their property"), and material resources than women.

Patriarchal societies value men differently to women: men are seen as leaders, providers, and authorities, while women are always seen as inferior to men. Patriarchal systems determine a woman's value based on her relationships with men. For example, historically women with husbands are given more respect by their friends and families than unmarried women; women that give birth to sons have more influence in the family than women who have only daughters; and women that have influential fathers have more influence in the community simply because they are the children of a prominent father.

In patriarchal societies activities that have historically been dominated and controlled by men (e.g. politics, wage work, and intellectual work) are typically done outside of the household and are seen as being important for promoting the wellbeing of everyone in society. In contrast, work that has historically been done by women (e.g. subsistence farming, housework, childcare and caring for the sick) are seen as private matters that have little public significance. This work is typically done within the household and is unpaid.

What are the consequences of these norms and beliefs? Oxfam (2020, p.30) points out that "[p]atriarchal social norms … mean that care is considered a woman's natural role and a woman's duty to provide, rather than it being the state's responsibility to provide. Care is seen as being unskilled, unproductive and not 'work', despite being essential to the functioning of our societies and economy. Most women have been socialized to take on care work in the home" because by doing so they

PHOTO: THOM PIERCE/SPOTLIGHT

are seen as "good women". A patriarchal view of social reproduction work has been central to government policies governing CHWs' conditions of employment. Since the early 2000s, policy guidelines ignore the skills and knowledge CHWs bring to the table and ignore their prior learning and experience. CHWs are seen as "empty vessels" that must be filled with knowledge in a top-down fashion.

Additionally, policy frameworks like those governing the primary health care revitalisation process emphasise that CHWs should be given standardised training that enable them to become better CHWs (Department of Health, Republic of South Africa 2011a). No mention is ever made of offering CHWs training to become nurses or doctors – their career paths are not envisioned beyond the entry-level work they do in the health system.

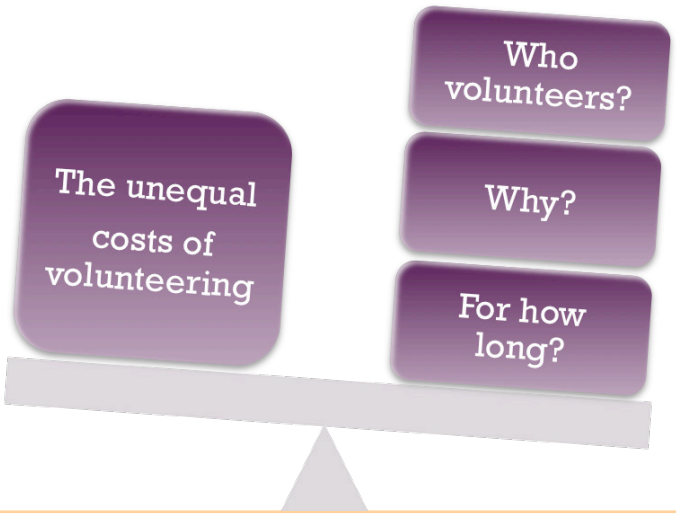
value of this work, meaning that women care workers are not properly recognised in the labour market. In the case of CHWs this has led to them being trapped for many years in the position of worker-volunteers, before they can get access to a paid job. It is also reflected in the fact that the economic value of CHWs' unpaid work is not accounted for in government budgets.

It is political because care work takes up a lot of women's time, and their physical and emotional energy – while men are freed from the burdens of care work. This means that women have less time to engage in other activities they find rewarding, especially activities outside the home. In the case of CHWs this has made organising for better wages and working conditions difficult, because social reproduction work in their own homes and their clients' homes reduces the time and energy they have for political work. The next chapter looks at the difficulties CHWs confront when they try to organise themselves to secure better wages and working conditions.

Exercise 4

Thinking about... who is volunteering and why

Think about these questions. What do your answers to them tell us about who volunteers to work as a CHW? What do they tell us about the socio-economic circumstances and educational opportunities that drive women to volunteer, even when this comes at a great cost to themselves?



Questions

Who volunteers?
- Did you volunteer before becoming a CHW? Why or why not?
- Do you know other people that volunteered before becoming CHWs? Is it common?
- Where do most CHWs volunteer: with NGOs, in the private sector, or in the public sector?
- Do you know any male volunteers? Do you know of nurses and doctors who volunteer?

For how long do CHWs volunteers?
- What are the shortest and longest periods of volunteering that you have heard of?
- How much time during your day do you spend volunteering?

Why did you volunteer?
- Did you have to volunteer in order to be considered for a paid job as a CHW? How was this explained to you?

What is it like to volunteer?
- How does it feel to be a volunteer?
- Is volunteering similar to the work you do at home or not?

"There is a stigma of us being volunteers, that's why they don't understand what we do."
(Mavis Bija, Eastern Cape)

"We are depressed because of our situation, we are mothers at work, at home and also finding out our men cheat!"
(Bulelwa Faltein, Eastern Cape)

"Care work never ends."
(Nozi Diko, Philippi, Cape Town)

"I'm a single parent. I have a home. I have my mother. I am a breadwinner. My mom look at me and my kids look at me so that I can bring something."
(Thembela Flente, Eastern Cape)

" I don't have any children, I take care of my brother's child. So it's much easier for me but for others it's difficult, they are single parents with two or more children, depending on that R2 500 for the whole family."
(Bulelwa Faltein, Eastern Cape)

Chapter 3

Understanding where CHWs work and organise from

SOURCE: NTOMBUZUKO KRAAI (WELLNESS FOUNDATION)

Community Health Workers' contracts, wages and working conditions vary greatly across and within the same sector. Their work is regulated but exactly how and by whom they are regulated, reflect huge variations between provinces and service providers. How do these variations as well as the specific site of work, impact CHWs in their attempts to organise and attain recognition?

THE PATIENT'S HOUSEHOLD: THE HIDDEN SITES OF LABOUR

The patient's household is the site of work for many CHWs. It is the primary site where they conduct their work and engage patients who use the national health system. They are the tentacles of this system and reach patients and communities in the most remote areas of South Africa. Much like domestic workers, whose site of work is in the home of their employer, CHWs also work in the home of the patient. The labouring done by CHWs in the home of the patient is rendered as invisible and often private. Although it is not seen as informal work, being a volunteer is not seen as formal work either. Why does working from a patient's home and often alone make getting a seat at the table to negotiate their wages and conditions of work harder and more difficult?

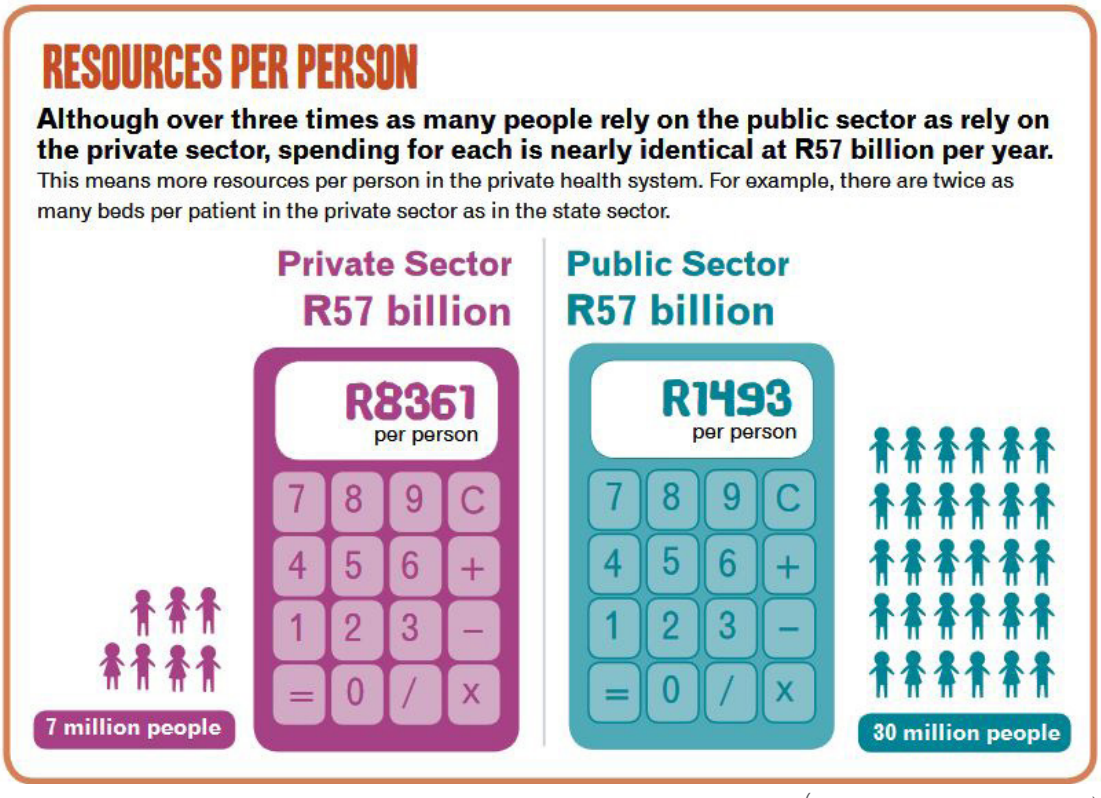
CHWs often work alone in the patient's home, this does not afford them the opportunity to get together to organise like factory workers do. CHWs are not able to "put down their tools" in the same way as workers on a factory floor and therefore impact the profits of capital. They also

invest a lot in their patients which means that boycotting or stayaways will have an impact on their patients.

According to South African labour laws (see Hobden, 2015), the home is not treated as a workplace because it falls in the domain of the personal and so does not reflect the traditional industrial relationship of a workplace, such as a factory, where the relationship between the employer and employee is very clear (Hobden, 2015). CHWs have shared that working in the patient's household is challenging as their work often extends beyond the treatment of terminally ill patients. In almost all instances, CHWs also take on the emotional and physical well-being of their clients, such as taking an interest in how their patients are doing, bathing their patients and sometimes even cleaning their homes. This emotional and care labour is not recognised as productive work. In this way CHWs assume a societally prescribed role of carer, which is relegated to women who are mothers, sisters, daughters and nieces (Andrews, Timm, Paremoer, 2019). This caring is subsumed into being a "caring person" and not as labour – it is thus not work, which in fact it is.

Unlike in the clinic or hospital, which is considered part of the public domain where the boundaries of labouring care are clear, CHWs often find it difficult to negotiate the boundaries of labouring care. They work in impoverished communities and very often deal with patients who do not have the food they need to be able to take their medication. CHWs

FIGURE 1: Resources per person



SOURCE: ALL ABOUT THE NHI, BRIDGING THE DIVIDE (TREATMENT ACTION CAMPAIGN)

have said that they share their food with their patients, taking what little they have to share with them (Andrews et al., 2019).

In some instances, the patients' household is not a safe space and CHWs are endangered when carrying out their daily tasks. CHWs shared that working in households can be risky and reported that some CHWs have been sexually assaulted or held hostage in patients' households (Andrews et al., 2019). The household comes with many occupational health and safety hazards that are not taken into account by the NGOs or provincial departments for which they work. Instead, CHWs are under surveillance and must produce reports on whether they have seen patients and on patients' well-being, yet there is very little concern from those who employ them about the well-being of CHWs after a day's work in the patients' households.

LABOURING CARE IN THE EXTENDED HOME

CHWs who work in the private sector have a different site of work from those working in the public sector. Those in the private sector work in frail care centres, hospices and old age homes (Andrews et al., 2020). The working conditions differ from CHWs in the public sector because the patient to healthcare worker ratio is far lower in the private sector than in the public sector. CHWs who work in public sector ward based outreach teams are responsible for up to 250 households in a community (Andrews et al., 2020). Though the private sector has more resources than the public sector, the working conditions for care workers in

FIGURE 2: Patients per doctor per year in the health sectors

SOURCE: ALL ABOUT THE NHI, BRIDGING THE DIVIDE (TREATMENT ACTION CAMPAIGN)

this sector is often not significantly better than for the CHWs based in the public sector.

Even though private sector based CHWs do not conduct home visits, the private home in which they work can be seen as an extended home. The level of labouring care that CHWs do in private homes mirrors that which happens in the home because of the acute levels of intimacy (Andrews et al., 2020). Care workers often take on additional labouring care of patients whose families have abandoned them and have developed very close bonds with these patients.

CHWs in the private sector are often under surveillance in the nursing homes where they work. They are policed by the staff of these facilities through surveillance cameras. Care workers also experience abuse by their patients but have no platform to report this as the patients' needs always come first.

CHW EMPLOYMENT ARRANGEMENTS ACCORDING TO THE DIFFERENT PROVINCES

There are two types of employment arrangements for CHW programmes under the ward based outreach programme team (WBOT). In the first, CHWs are mainly employed by non-profit organisations (NPOs) or non-governmental organisations (NGOs). This type of arrangement is common among the provinces. NGOs or NPOs take responsibility for human resource management, supervision of CHW responsibilities and the payment of stipends. The NPOs or NGOs play the role of intermediaries[3] contracting the services of CHWs and CHWs are recruited into the ward based outreach teams through them.

In the second type of employment arrangement CHWs are employed by the provincial health department. CHWs sign contracts with the provincial department of health and their stipends are paid through the PERSAL system. In other instances, the payment of stipends is outsourced to external service providers. For example, in Gauteng the CHWs who work for the provincial government are paid by SmartPurse Inc.[4] CHWs in this province have expressed dismay about this service provider as they are not always paid on time.[5]

> *Even the contracts, the EPWP comes from the government, while the NGOs will create a contract to their specifications. They will just put a contract in front of you and if they see you talk too much or they don't like you, you are out of the job at any time. They get contracts month to month. Every month a new contract... (Ntutu, 1 October 2018)*

Another employment arrangement for CHWs is contract work in the private health sector. In this instance, CHWs are not directly employed by the nursing home or facilities but rather are employed through an agency and they are paid an hourly rate

Exercise 5

CHW regulation

SOURCE: PHILIPPI-BASED COMMUNITY HEALTHCARE WORKER CAPTURING HER CLIENTS DATA (TBHIVCARE)

Questions

As a CHW how are your tasks and movements being regulated:

- on a day-to-day basis, on a weekly basis, on a monthly basis, on a yearly basis through your contract?

How do you report your work:

- Do you have a timesheet? Or duty rooster to report on?
- Do you have to write up client folders and reports?
- Do you have to report to anyone - who? How does it work? Please explain.

Do you receive weekly or month reports on what is happening in your area of work and health?

How do patients regulate your work?

TABLE 2: CHW work benefits and stipends according to the different provinces[6]

Province	Who Pays CHWs	Benefits in 2016	Stipends in 2016	Stipends in 2020
Eastern Cape	Some CHWs are on the government payroll (PERSAL), some are paid by NGOs. Others are voluntary workers (meaning that they do not receive income for services provided).	Informal sick leave and maternity leave	R2 000 - R2 500	R3 500
Free State	NGOs are contracted to manage the administration and HR issues of CHWs, incl. stipend payment, monitor and supervise their activities for community based services. NGOs only pay stipends once CHWs have submitted their reports.	Depends on the NPO	R1 850 - R1 900	R3 500
Gauteng	CHWs are employed by provincial government. Claims for CHWs' stipends are received monthly from the districts and paid to individual CHWs. However payments of stipends are outsourced to SmartPurse. CHWs employed by local NGOs.	Sick leave, annual leave, unpaid maternity leave	R2 500	R3 500
Kwazulu - Natal	In 2010 the KZN Department of Health took a decision to terminate contracts with the NGO's and opted to fund the CHWs directly.	Sick leave, annual leave, unpaid maternity leave	CHWs - R1 800 Supervisors - R2 300	R3 500
Limpopo	CHWs are employed by NGOs.	Sick leave, annual leave, unpaid maternity leave	R1 500 - R1 800	R3 500
Mpumalanga	CHWs are employed by NGO's. CHWs employed by provincial government.	Sick leave, annual leave, unpaid maternity leave	R1 000 - R1 200	R3 500
Northern Cape	CHWs are contracted through local NGOs.	Bonus in December	R2 500	R3 500

Province	Who Pays CHWs	Benefits in 2016	Stipends in 2016	Stipends in 2020
North West	CHWs employed by provincial government through EPWP programmes.	Some benefits but it is not clear what they are	R2 000 - R2 500	R3 500
Western Cape	In the Western Cape Province, the government subsidises the payment of CHWs through NGOs who then take the responsibility of supervision.	No benefits	R1 745 - R2 000	R3 500

*Consumer Price Inflation (CPI). 6.2% (CPI + 1%) for salary levels 1-7; 5.7% (CPI + 0.5%) 8-10; 5.2% (CPI) for salary levels 11-12
Source: Table compiled from provincial health department briefings to the National Department of Health on 1-18 August 2016, Spotlight on CHWs (2016), Haynes et al. (2011), Interview with Secretary of South African Care Workers Forum, 8 July 2020.

for a certain amount of days. Similar to NPO/NGOs, nursing agencies also play the role of labour brokers[7] in providing CHWs' services in the private health sector.

Although there are different employment arrangements, there is no difference in how CHWs are contracted. The duration of contracts in both NGOs/NPOs and provincial governments are short term and precarious. For example, some NGOs/ NPOs contracts are so short CHWs must enter into monthly contracts.

The contracts issued by provincial governments are not much different from those of the NGOs. CHWs who are employed by the provincial governments in the different provinces have shared that contracts are temporary and are renewed on an annual basis. Provincial governments do not allow the space for CHWs to negotiate and discuss working conditions, stipends and other terms and conditions of these annual contracts. CHWs are expected to accept these contracts as is and sign without asking questions.

As well as being short term, these contracts do not offer any employment benefits, such as funeral cover, medical aid or any other benefits to CHWs. CHWs are not afforded the same benefits as permanent employees of the National Department of Health. Contracts do not include sick leave and unemployment insurance (Munshi, Christofides, Eyles, 2019). In this way, CHWs are treated as dispensable and easily replaceable.

CHWs and work benefits

It's very painful when a caseworker dies, 'cause the family may expect something from the work, but they get nothing...So if I can die today, my family will not even receive the monthly stipend I would have received for that month. Sometimes you find it difficult to even have a funeral or memorial service. Sometimes we just do a small prayer. There is nothing special other health workers get from the department for the community health workers... (Bulelwa, 16 November 2018).

In 2019, the CHWs came together for the National Community Health Worker Summit in Bloemfontein and made the following demands among others:

3.1 Expedite the Permanent Employment of all CHWs,

3.2 Standardise training and implementation of the WBPHCOT policy across all provinces and the Departments of Health and Social Development,

3.3 Establish a clear scope of practice and work of CHWs and ensure this is implemented by all provinces

"The benefits that we want is payslips. And we also want medical aid. And also we want a danger allowance and a rural allowance. (Bulelwa, 16 November 2018)

KNOCKING ON THE DOOR OF THE UNIONS

CHWs have worked with the unions in their struggle to demand a minimum wage and attain recognition as permanent workers. They indicated that working with unions has not been easy. CHWs belong to five different unions, namely the National Union of Public Service and Allied Workers (NUPSAW), National Union of Care Workers in South Africa (NUCWOSA), Health & Other Services Personnel Trade Union of South Africa (Hospersa), Public Service Association (PSA), Democratic Nursing Organisation of South Africa (DENOSA). The unions recognise that CHWs are a vulnerable category of worker and have fought for a standardised wage and the recognition of CHWs as public servants. The work of NUPSAW and other unions have resulted in the conclusion of the Public Health and Public Social Development Sectoral Bargaining Council Resolution 1 of 2018. This resolution calls for the standardisation of remuneration for CHWs.

"Unions use us for membership so they can go to the bargaining counsel. They give us empty promises..." (CHW, 6 December 2019)

"Our payslips in Free State, R105 is deducted from our salaries..." (CHW, 6 December 2019)

CHWs and Contracts in the Eastern Cape

Bulelwa is a CHW employed by the Eastern Cape Provincial Department of Health. She has worked for the provincial department since 2012 and has been on an annual contract. CHW employment contracts are renewed annually on 31 March. Every year, CHWs are summoned by the provincial department to sign their contracts at the head office. She and other CHWs are expected to travel from their respective areas and the department does not reimburse their transport costs.

Bulelwa shared that very often their contracts are not renewed on time. In some instances, the provincial department may only contact them ten days after the annual contract has expired. When the contracts are issued, CHWs are not given an opportunity to peruse the contracts and think about what they are signing. The approach of the provincial department of health is 'here is your contract, come and sign it because it is already late'. CHWs are rushed to sign the contracts because their monthly salary depends on it.

In other instances, when they have been contacted late, the salary for the following month is delayed because not all contracts were processed in time for payment. Bulelwa shared that if you asked why you were not paid they are told that the department is still processing the contracts because there are too many CHWs - "This happens a lot and we struggle because if we don't pay our funeral policies in time it will lapse".

"They perceive us as an ATM. They came after we signed our contracts to have us join their union..."
(CHW, 6 December 2019)

"We are invisible to them, only when they recruit or need to account..."
(CHW, 6 December 2019)

"[the unions] use us as a Gautrain to get to the bargaining council".
(Ntebaleng, 6 December 2019)

However, it has been two years since this call to standardise remuneration yet nothing has changed. CHW stipends across the provinces remain uneven. In provinces like the Eastern Cape and Gauteng CHWs earn R3 500 and up to R4 000, while others elsewhere earn less than this amount. Even though the unions have been successful in provinces like Gauteng, CHWs in the Western Cape have not reaped any of the benefits. The Department of Health in the Western Cape has refused to comply with Resolution 1 of 2018 and continues to create an enabling environment for NGOs to treat CHWs unfairly.[8] A key question to reflect on is why are unions more successful in some provinces and not others?

Exercise 6

How does your payslip look?

Amatola Nursing Services Salaries

Eastern Cape Nursing Agency cc

Employee Name: [redacted] Calc date: 2020/06/01 to 2020/06/30

EMPLOYEE NO	DATE OF BIRTH	IDENTITY NO	TAX NO	PAYPOINT	START DATE
[redacted]	[redacted]	[redacted]	[redacted]		**2016/04/01**

Basic Run 1	RATE OF PAY	GRADE (S)	COST CENTRE: /Default
	24.10	**/CW**	OCCUPATION: **CARE WORKER**

EARNINGS			**DEDUCTIONS**		**YTD TOTALS**		
192	Night duty	259.20	SALIPSU Union	100	3601	Income taxable	19 175.40
156	Salary	3759.50	UIF	51.03	4141	UIF contribution	191.75
36	Saturday	1084.50			4641	UIF company contribution	191.75
Total earnings:		**5103.30**	**Total deductions**	**151.03**	**Nett pay:**		**4952.27**

Current

Night duty	551.58
Salary	3759.60
Saturday	1084.50

Bank details

Bank Account: [redacted]

Bank branch code: 470010

Bank Name: Capitec

Questions

- When you look at the payslip - what do you think is wrong with it, what is missing?
- When you look at Table 2 on work benefits and stipends on page 44, what do you think should change and why?

FIGURE 3: Resolution 1 of 2018: Agreement on the standardisation of remuneration for community health workers in the Department of Health

PHSDSBC

PUBLIC HEALTH AND SOCIAL DEVELOPMENT SECTORAL BARGAINING COUNCIL

RESOLUTION 1 OF 2018

AGREEMENT ON THE STANDARDISATION OF REMUNERATION FOR COMMUNITY HEALTH WORKERS IN THE DEPARTMENT OF HEALTH

Agreement on the Standardisation of Remuneration for Community Health Workers in the Department of Health

1. NOTING THAT:

1.1. Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams (WBPHOTs) states that:

"Primary health care … relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

1.2. The health service as well as the health output and outcome benefits could be derived from a Community Health Workers (CHWs) programme in South Africa.

1.3. The Head of Departments (HODs) must ensure consideration,investigation and disposal of grievince relating to non compliance within the prescribed contract of employment in a procedurally fair,economical and expeditious manner with due consideration of fair return of work.

1.4. The National Department of Health (NDoH) has set aside funds for conditional grants to provinces for the implementation of standardisation of CHWs remuneration as an interim measure.

1.5. The Department of Health (DoH) data base is the source of integrity management of CHWs and requires finalisation with relevent provinces and such information will be used to give effect to this agreement.

1.6. That CHWs on the database will receive refresher training commencing in the last week of June 2018.

2. PRINCIPLES

2.1. The parties recognize the importance of ensuring fair recruitment of CHWs in the DoH as required and guaranteed by good employment practices.

3. PURPOSE

3.1. To ensure the standardisation of payment of remuneration for CHWs in the DoH.

3.2. To ensure adequate protection for the remuneration payment of the CHWs into Personnel and Salary (PERSAL) system.

3.3. Ensure appropriate implementation and management of recruitment, selection, appointment, placement, remuneration, skills development, dispute resolution and occupational health and safety processes for all members of WBPHCOTs.

4. SCOPE OF APPLICATION

This Agreement binds –

4.1. The National Department of Health;
4.2. The provincial departments of health;
4.3. The Trade Unions and their members who fall within the registered scope the PHSDSBC; and
4.4. The Community Health Workers who are not members of any of the Trac Unions and who fall within the registered scope of the PHSDSBC.

5. AGREEMENT

The parties agree as follows:

5.1. A non-service remuneration payment of three thousand and five hundred rar (R3500.00) should be for those CHWs that have matric or either experience ar those that can benefit from Recognition of Prior Learning (RPL) will be processe through the persal payment system.

5.2. Provincial HODs are accountable for the recruitment of CHWs and provide them with tools needed to do their work in line with the policy.

5.3. The professional nurse remains accountable for oversight for CHWs but can also be supported by trained enrolled nurses.

5.4. The provisions of this agreement shall apply to CHWs for duration of twelv (12) months upon signing the agreement.

5.5. To ensure the development of Standard Operational Procedure for the recruitment,selection,appointment,placement,renumeration,skills development, dispute resolution, occupational health and safety processes, and absorption in the health system for CHWs and subsequent process tha may follow in line with policy framework and strategy for wardbased outreac teams.

6. IMPLEMENTATON OF THIS AGREEMENT

6.1. The provisions of this agreement shall take effect at time and date it attains the majority signature.

7. DISPUTE RESOLUTION PROCEDURES

7.1. Any dispute about the intepretation and application of this agreement may be referred to the PHSDSBC and shall be dealt with in terms of the dispute resolution procedure of the PHSDSBC.

SOURCE: PUBLIC HEALTH AND SOCIAL DEVELOPMENT SECTORAL BARGAINING COUNCIL, 2018

CHWs have also expressed their discontent with unions and felt that unions had a few shortcomings in relation to CHWs. One is that unions were more effective for permanent workers than for those who work for NGOs and private nursing agencies with contract stipend arrangements (Andrews et al., 2019). Another is that CHWs are treated as invisible and are only used for membership fees.

CHW MODES OF ORGANISING[9]

CHWs are also organising outside of unions. The South African Care Workers Forum (SACWF) is one of these places. It is also a space for the politicisation of labouring care and unearthing and bringing to the fore feminist understandings of social reproduction. Unlike the unions, which are mainly concerned with wages and recognition of CHWs, the Forum is a space of consciousness raising where CHWs engage in solidarity with each other and recognise the burden of social reproduction is unduly shifted to them (Andrews et al., 2019).

Using the Forum to organise has made CHWs' issues visible. It plays an important role in keeping their issues on the agenda. In 2019, the SACWF organised a summit in Bloemfontein that brought together CHWs from the nine provinces to discuss the challenges and celebrate the successes of CHW advocacy work.[10] This was an important platform for CHWs to come together to find common ground on their issues. The Forum used the summit as a platform to engage the National Department of Health, Department of Social Development, unions and NGOs and to exchange ideas. It also set out

FIGURE 4: Modes of organising[11]

Exercise 7

How do you organise?

SOURCE: COMMUNITY CARE WORKERS SPEAK OUT (WELLNESS FOUNDATION)

Questions

- Are you encouraged to join a union? If so, why and by whom?
- If not, by whom and what reasons are presented to discourage you?
- How and where do you take up grievances with regards to working conditions; about the patients; about your health and safety conditions?
- How often and where do you talk about your experiences as CHWs?
- Are these informal or formal spaces created by your employer?

Exercise 8

CHWs organising[12]

SOURCE: COMMUNITY CARE WORKERS SPEAK OUT (WELLNESS FOUNDATION)

Questions

- What modes of organising would meet the most urgent needs?
- What needs and goals do CHWs want to address through organising?
- Is there a need to have different modes of organising for achieving different needs and goals?
- What modes of organising would address CHWs needs and goals in a way that put them in control of decision-making about demands, strategies etc?
- What can you learn from other movements, e.g. domestic workers, rural women's movement, that could help you with your modes of organising?

CHWs' demands for permanent employment, appropriate remuneration, acknowledgement, respect and proper working conditions.[13] While this made the CHWs' demands visible, it is not clear whether their demands have been taken forward by any of the stakeholders who attended the summit.

A feminist approach to organising allows for CHWs to carefully consider how they will make their issues visible. It highlights the importance of maintaining a space that is for CHWs only and the power in this to strategise and build their movement.

Key in this case is for CHWs to:

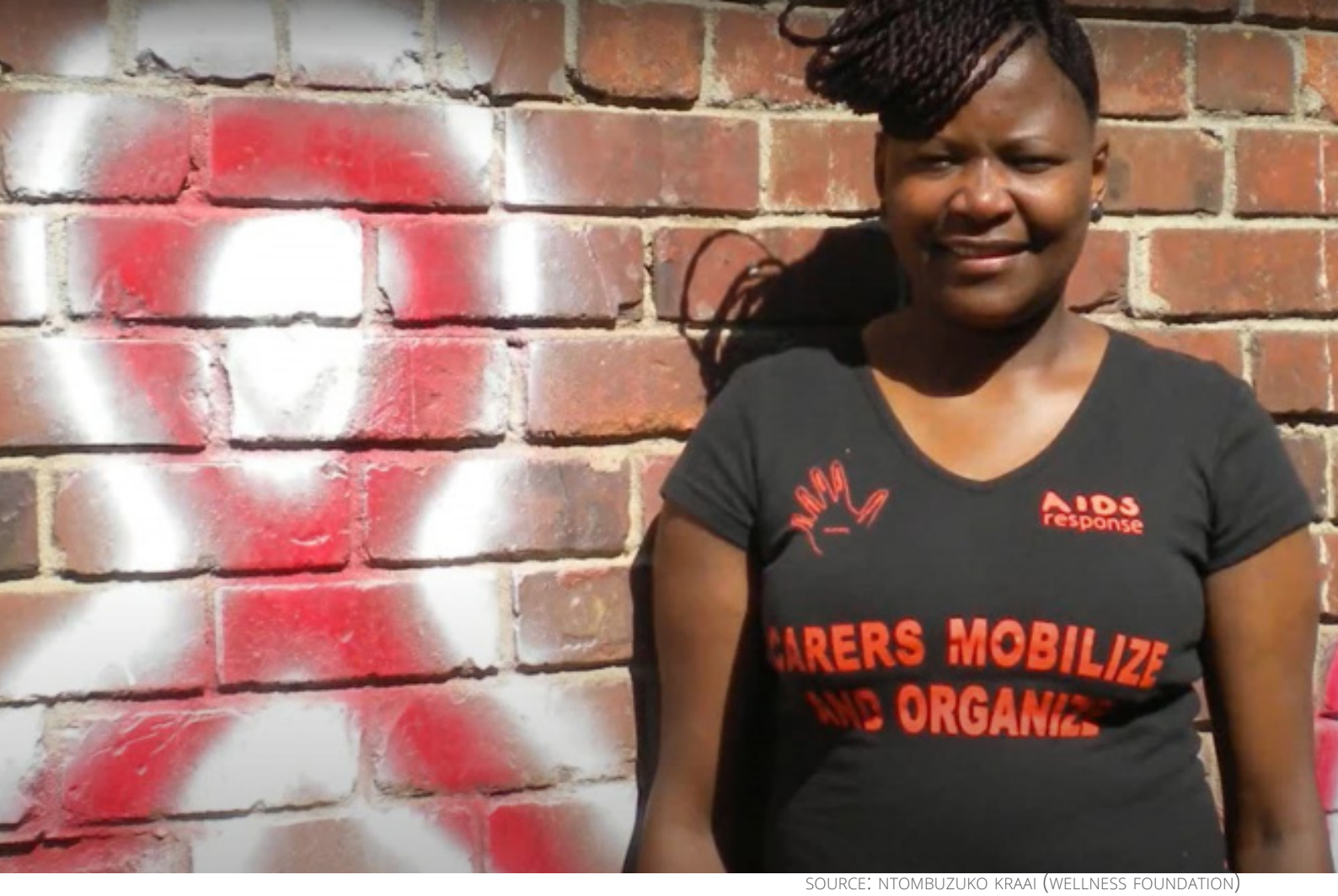
- Rebuild and strengthen internal solidarity among provinces so as to ensure that CHWs' demands stay on the table.
- Build alliances with other sectors such as domestic workers, rural women's movements, etc. to build solidarity.

"Life is hard now because we are not getting paid. But it's not easy to give up, especially when people are coming and crying on us. So we end up doing the things people need. Even today we called the social worker for a pensioner that came to my home for help. I can't give up, I think until I die. The houses are different. There are houses that have no bread no nothing. No soap, no bread, no nothing. You will cry. Some cases are hectic. You need strength. I can't give up, I think until I die."
(Nozi Diko, Western Cape)

"We have continued contracts. If I want to open an account, they say I can't get an account cos you are not a permanent staff member."
(Thembela Flente, Eastern Cape)

Chapter 4

Hierarchies of health care, skills and power



SOURCE: NTOMBUZUKO KRAAI (WELLNESS FOUNDATION)

CHWs are predominantly black women, often heads of households and many lack formal education (Hlathswayo, 2018). Their fight for recognition within the health care system hierarchy is not easy and they face structural resistance to being integrated and waged accordingly. In many instances it is clear that CHWs are referred to as an essential part of the health care labour system, yet CHWs find themselves at the bottom of the national health care system despite numerous talks about mainstreaming CHWs. Why is this?

Since 2011, South Africa adopted Community Ward Health Care aimed at "mainstreaming" CHW programmes into the broader health care system. In 2010, the National Department of Health rolled out the Public Health Care (PHC) re-engineering strategy through the Ward-Based Primary Health Care Outreach Teams (WBPHCOT) strategy which involves the reorganisation and integration of the existing community-based services into outreach teams organised according to wards. These teams consist of CHWs, a nurse, environmental officers and health promoters. A key component entailed re-engineering primary health care so as to ensure health protection and promotion as "everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security and the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights" (South African Bill of Rights, Section 27).

According to the health department "[a] Community Health Worker is a health worker who performs a set of essential health services, receives standardised training outside the formal nursing or medical curricula and has a defined role within the community and the larger health system. [They] play a pivotal role in Primary Health Care Re-engineering especially as part of the Ward Based Primary Health Care Outreach Teams (WBPHCOT's)." (Department of Health: Mpumalanga, 2016)

In the realisation of these rights CHWs play a critical role as certain health service tasks are shifted and deployed to them so as to relieve an overburdened system. CHWs act as the interface between the community and health system and are central to ensuring health promotion, prevention and adherence at a client, household and community level. In many ways they are the hearts, hands and boots on the ground in order for poor communities to access some semblance of primary health care from the state. In many instances, depending on the type of CHW they are, if they are in an urban or rural setting, they are assigned to service between 50 to 250 households per month.

The work performed by CHWs is undoubtedly necessary especially in a context of huge inequalities and unemployment, systemic violence, coupled with a growing burden of non-communicable diseases, a HIV/AIDS epidemic and coalface of this but also within a "critically ill health system" that is under-resourced and has been bludgeoned over many years (Reynolds and Sanders, 2019).

Chapter one and two give insights both into the amount (time and effort) as well as levels (types) of work that a CHW embarks upon in her community. These chapters highlight the social reproductive work that is being performed by CHWs and how it is the axis upon which task-shifting is embodied.

The invisible, unrecognised and unpaid work is a critical part of the system upon which CHW is built. The very emphasis in chapter two, on drumming up the volunteer and motto "of serving your nation" is reliant on women's social reproductive labour which underpins much of the patriarchal capitalist society we live in. The health system is reliant on "good" mothers, daughters, sisters, women volunteers, girlfriends and wives to ensure the health of families and communities. .

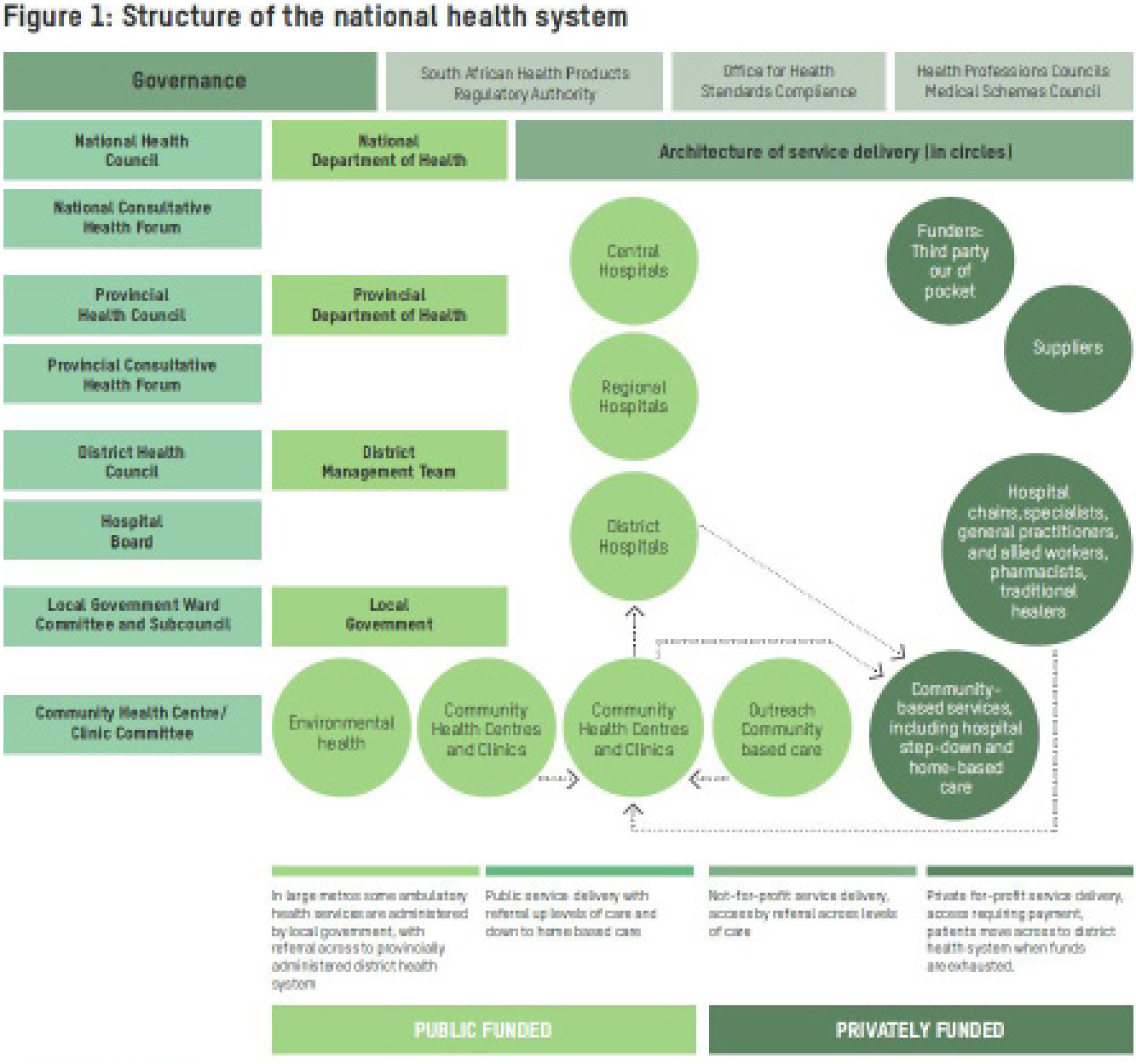
CHWs take on multiple roles and tasks within a context of under resourced and often impoverished households and communities with

According to CHWs "doctors see us as their helper and servant. Someone who they can refer clients to. Nurses undermine us and see us as a tool to be sent all over to do the things they don't want to do." (Feminist Research Collective, 2019)

compassion and dedication at the behest of the health system. They do so with no or little recognition in the form of wages, standardised uniforms, formal licence or registration with the Health Professions Council or representation within the health system. Why is this?

There are many reasons for why there is little or no recognition of the invaluable work performed by CHWs. One of it might be due to the history of CHWs and how this work is perceived (see chapter one) and situated and valued with the world of work and health policy (see chapter two). Another is the

FIGURE 5: Organogram of health system[14]

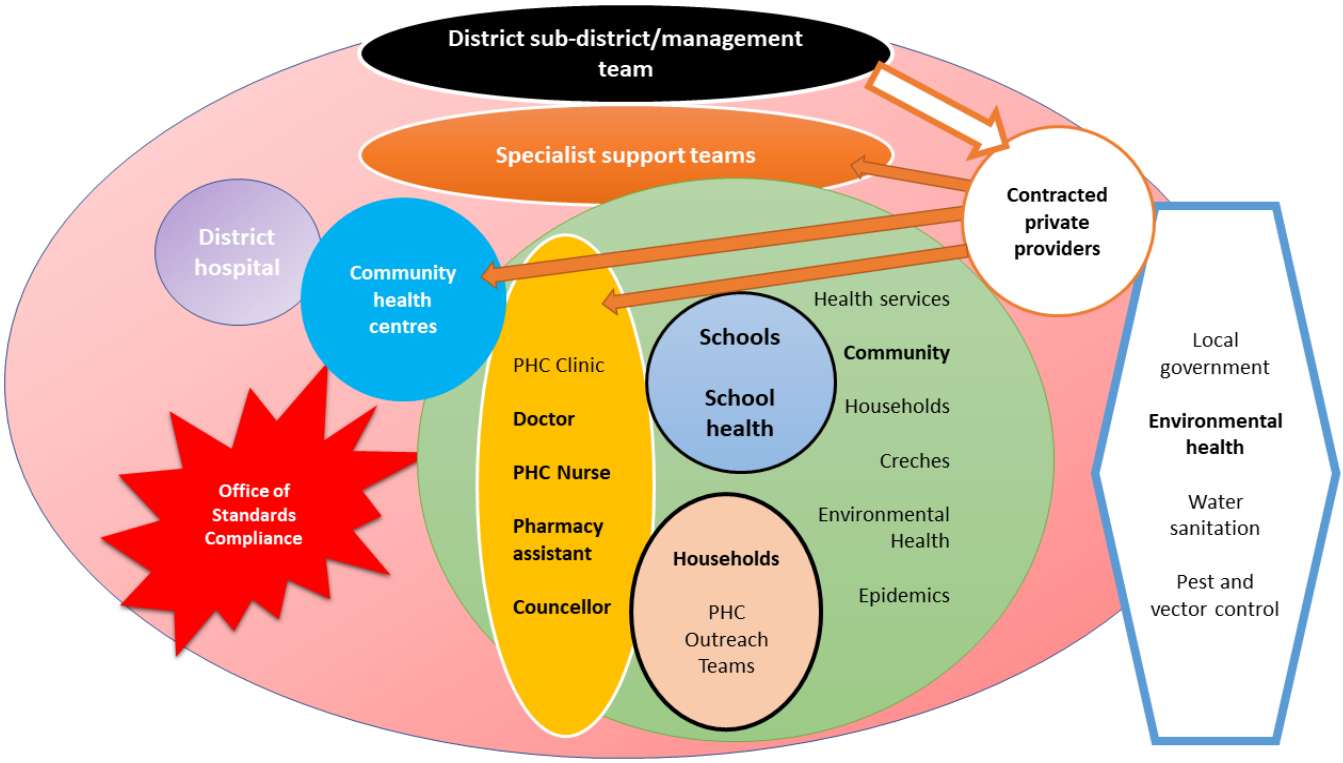


Source: McKenzie et al.[15]

various interfaces of where CHWs are located: public sector, NGOs, CBOs and private sector and how they are regulated (see chapter three). Another is about prioritising financing and resources, specifically how women's social reproductive work subsidises "productive" work and is rendered invisible within the health system (Andrews et al., 2019). And, as discussed below, another reason concerns how structural hierarchies of power impede and operate through formal education, gender, race, wage and, other divides.

CHWs take on multiple roles and tasks within a context of under-resourced and often impoverished households and communities with compassion and dedication at the behest of the health system.

FIGURE 6: Proposed public healthcare model[15]



Exercise 9

Comparing our loads

TABLE 3: Table of salary scales and qualifications.[16]

Occupation	Wages 2018	Wages 2019*	Years	Licenced	UIF	Medical Aid	Contracts	Uniform
Professional nurse	R198 462 - R459 294	R210 768 – R485 475	5	yes	yes	yes	yes	yes
Staff nurse	R161 376 - R280 437	R171 381 – R297 825	4	yes	yes	yes	yes	yes
Assistant nurse	R124 788- R216 861	R132 525 – R230 307	2	yes	yes	yes	yes	yes
Medical								
Paramedic	R239 532 - R492 309	R254 382 – R520 371	1-3	yes	yes	yes	yes	yes
Medical officer	R780 612 - R1 295 025	R821 205 – R1 362 366	5	yes	yes	yes	yes	yes
Pharmacist	R436 359 - R828 507	R693 372 – R871 590	4	yes	yes	yes	yes	yes
Dentist	R 630 171 - R840 942	R797 109 – R1 362 366	4	yes	yes	yes	yes	yes
Medical specialist	R797 109 – R1 362 366	R1 106 040 – R1 834 890	6-10	yes	yes	yes	yes	yes

* Consumer Price Inflation (CPI). 6.2% (CPI + 1%) for salary levels 1-7; 5.7% (CPI + 0.5%) for salary levels 8-10; 5.2% (CPI) for salary levels 11-12

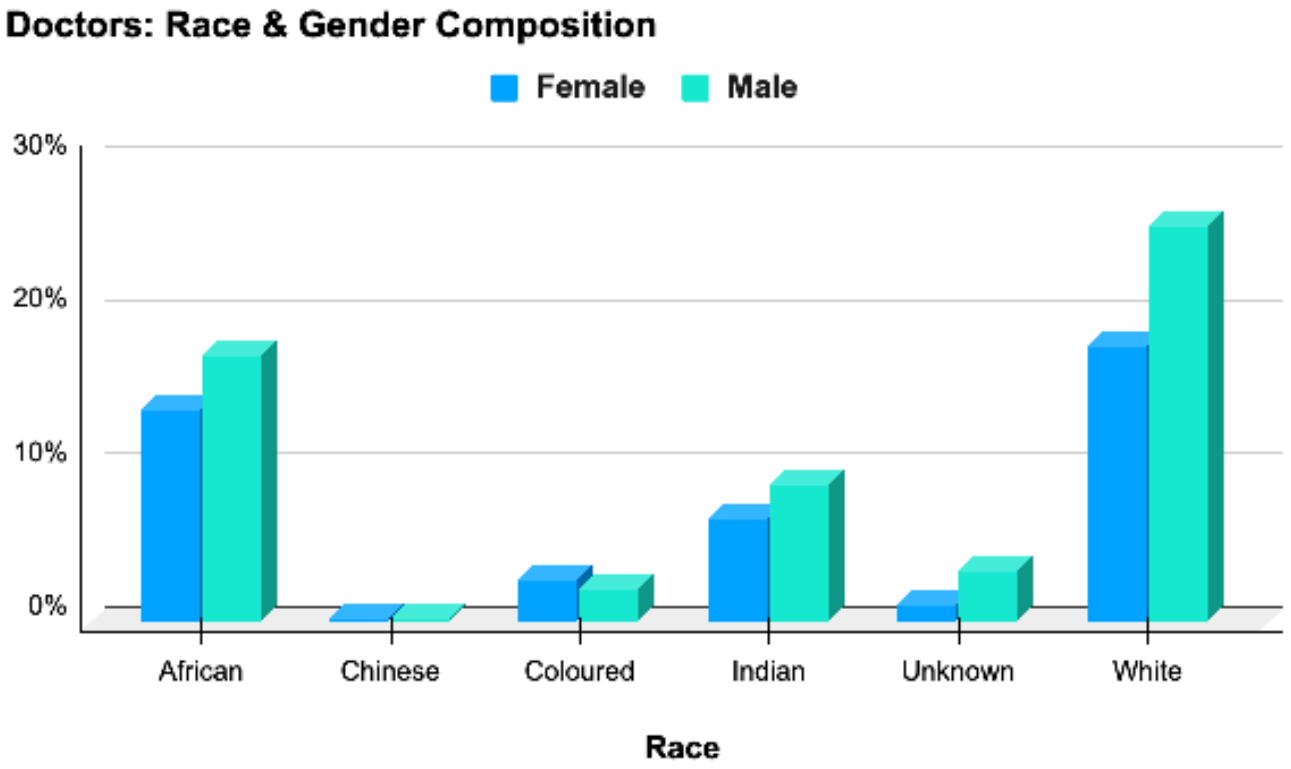
Questions

Have a look at Table 3: Salary scales and qualifications.

Make a list of the things that you have questions about. Who is missing from the table and why?
Make a list of the things that strike you as unfair? Discuss this with other CHWs. Consider doing this exercise at your next CHW forum meeting.
Now think about your work as a CHW and answer the following questions:

- Do you think you work considerably less hours and do less work than the others listed in the table based on your observation in your health setting?
- Do you think you see fewer clients that the others listed in the table?
- Do you think you spend more or less quality time with your clients?
- Do you think the others in the list work with their clients in the same way as you do - what is different and unique about what you offer?
- What is different from the environment that you work in with your clients - is it easier, different, harder? Why do you think so?
- Did you ever consider/dream of becoming a doctor, nurse, pharmacist or paramedic? What stood in your way? Could you do it today? What are the challenges and obstacles?

FIGURE 7: Race and gender composition of doctors

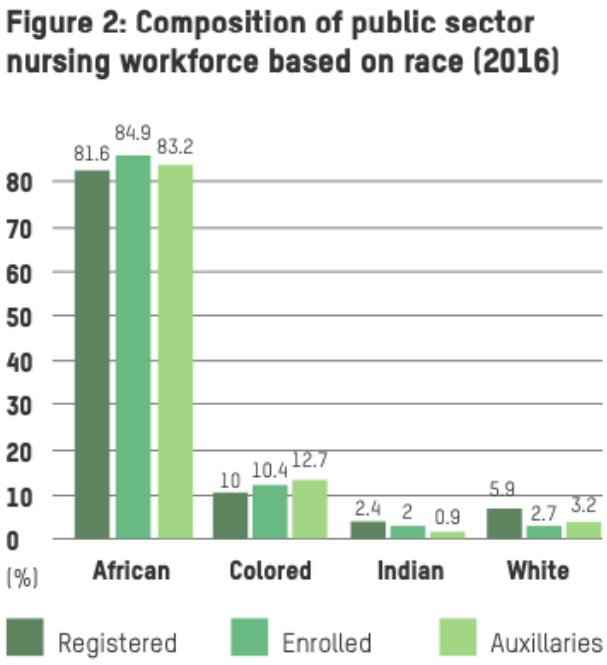


SOURCE: HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

WAGES AND QUALIFICATIONS IN THE MEDICAL SECTOR

Often we are led to understand that skills, training and formal education that are reflected within the health system pyramid are neutral. We take them for granted and assume they are correct. The skills and experience of CHWs are pitted within a framework which places higher value and recognition and power on qualifications and specialised training. This often leads us to believe that CHWs therefore have less to offer and therefore receive less recognition. Is this an adequate assessment, given the critical role CHWs play at the coalface of the health system?

FIGURE 8: Composition of the medical practitioners and nursing sector

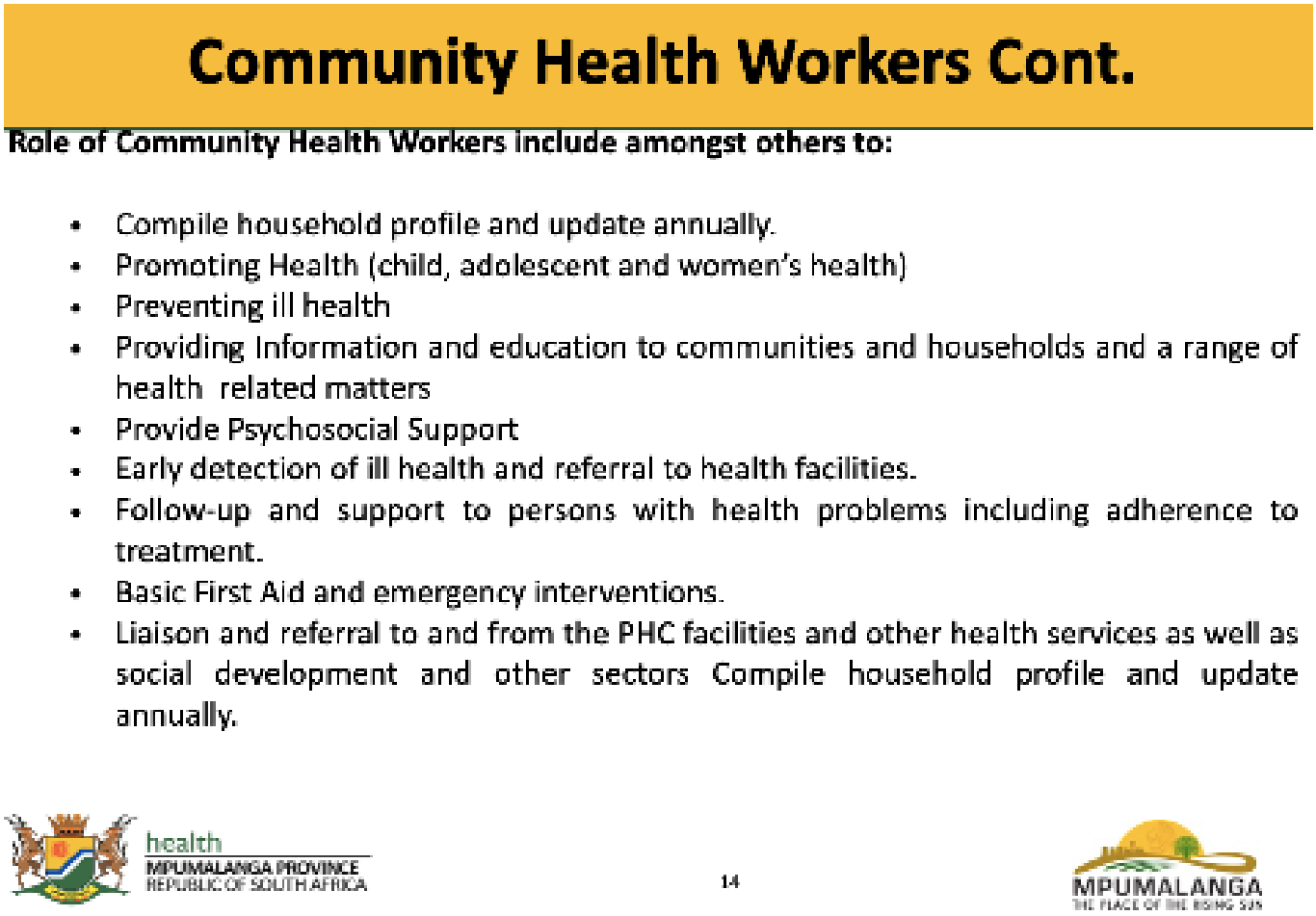


Source : Breier M, Wildschut A, and Mgqolozana T. Nursing in a new era: the profession and education of nurses in South Africa. *Cape Town: HSRC Press (2009).*

TABLE 4: Observations about the skills CHWs employ in their work

Our observations from the interviews, workshop and fieldwork conducted with CHWs suggested that the skills that are being employed are:	Briefing National Portfolio Committee on Health Parliament Committee Room V475, Old Assembly Wing, 16 August 2016, 13).
♦ A deep knowledge of the community as well as the socio-economic and environmental factors that come to bear upon her patients ♦ An extensive grasp of her patients; their support systems or lack thereof. This requires building a relationship with patients premised on trust ♦ An ability to navigate complex situations all the while prioritising the well-being of her patient ♦ Acting as the ears and eyes of the community health system and at the forefront of the community health programmes servicing community clients which is the rubric for a successful measure . ♦ Their work focuses on implementing mother-to-child health, adherence for antiretroviral treatment, HIV counselling, TB DOTS, mental health, care for terminal patients and vulnerable orphaned children ♦ Screening, assessment and referral, information and education, psychosocial support, supporting community campaigns, schools (in rural areas) ♦ Active listening skills to ensure health care and emotional support ♦ A nurturing but firm bedside manner ♦ The vernacular of the community ♦ Data collectors, researchers, mappers, writing up of patient reports ♦ Implementers and monitors of primary health care system ♦ Innovation, adaptability	Role of Community Health Workers include amongst others to: ♦ Compile household profile and update annually. ♦ Promoting health (child, adolescent and women's health) ♦ Preventing ill health ♦ Providing information and education to communities and households and a range of health related matters ♦ Provide psychosocial support ♦ Early detection of ill health and referral to health facilities ♦ Follow-up and support to persons with health problems including adherence to treatment ♦ Basic First Aid and emergency interventions ♦ Liaison and referral to and from the PHC facilities and other health services as well as social development and other sectors How do they work, and what are CHW tasks: ♦ Operate from health facilities by providing counselling to patients ♦ Responsible for the uptake of HIV Testing Services (HTS) ♦ Treatment adherence counselling ♦ General counselling for other issues excluding HIV and AIDS ♦ HIV pre and post test counselling ♦ Couple counselling for HIV and AIDS CHWs responsibilities: Caregivers: Categorised into two groups: ♦ Ward Based Outreach Teams which are responsible for PHC Re-engineering functions ♦ Home Based Caregivers responsible for providing care to patients confined bed at home CHWs responsibilities ♦ Peer Educators ♦ Operate at the High Transmission Areas (HTA) ♦ Providing health services at truck-in areas and also to Commercial Sex Workers (CSWs) ♦ Hot spots, informal settlements, shebeens and neighbouring communities to high transmission areas.

FIGURE 9: Role of CHWs[17]



The PHC system draws numerous skills from CHWs in order to execute the level of health care work in communities. Of great importance from a feminist perspective is to rethink how value is ascribed to particular types of work and specifically why productive work is seen as more valuable than reproductive work. But there is another component to this as doctors who also perform "care work" are seemingly not placed in the same position and their work is valued differently. Historically doctors are white middle-class educated men who are seen as making great sacrifices for the good of society when they work in the public sector - why is this "care work" rewarded differently?

How do we make sense of both the lack of recognition of CHWs with regards to not being part of any health professional council (HPCSA) or the South Africa Nursing Council? Could CHWs not be registered as auxiliary health workers?

CHWs provide health services. Even if one argued that it was not the same type of health service as a nurse or an ambulance assistant who are both registered and licenced and in a professional council, they most certainly compliment and conduct necessary auxiliary health services. The South African Medical Research Council argues that "[o]ne of the primary challenges with CHW programmes is that the role of CHWs has never

Martha's Story
re-engineering PHC outreach teams in the North West

Martha is a 47-year-old single mother from Rustenburg in the North West province. She is a CHW in the Bojanala district. She received her Community Health Worker qualification in 2008. She decided to embark on this training programme because she volunteered at a local community-based organisation as a home based carer. Martha volunteered for one year before she was employed by a local NGO which offers home based care services. Even though Martha worked for an NGO who offered home based care services, she also had knowledge and skills of health promotion.

The training was not very comprehensive ...many...felt that it did not adequately prepare them for what they would experience in the field.

Martha and a few other CHWs in the NGO she worked for were recruited to work as part of the PHC re-engineering outreach teams. Before starting their work in the outreach teams, Martha and the CHWs in her district had to participate in a 10-day training programme that was offered by another local NPO. This training programme was not very comprehensive and many of the CHWs, especially the new recruits, felt that it did not adequately prepare them for what they would experience in the field.[18]

Once Martha and the other CHWs completed this training programme they were allocated to the district in which they lived. Martha formed part of a team of ten CHWs who was supervised by a team leader, a retired nurse. Due to her skill level and years of experience as a home based care giver, Martha took on a leading role in her CHW programme. She was very eager and learned a lot from the team leader.

Martha's Story
re-engineering PHC outreach teams in the North West

There was no meeting place for CHWs at the PHC facility... CHWs are made to feel that they are not part of the PHC facility.

She worked closely with the retired nurse for three years until a new team leader was sent to their CHW programme. The new team leader was an enrolled nurse and did not have a lot of experience of CHW programmes. After a week-long training course the enrolled nurse returned to the clinic. At first she struggled a lot with the administrative and clinical issues, even though she received support from the facility manager.[19] At the time while the team leader was settling in, Martha assisted her a lot in guiding the new CHW recruits to write their reports and also advising them on how to deal with a situation while in the field.

Even though Martha was doing all this work at the facility and in the field, there was no meeting place for CHWs at the PHC facility. When they had team meetings it had to take place behind the facility, under a tree. There was no place for them to store their documents and they had to store them in boxes in the passage way.[20] There was no place for them to have tea. This is very frustrating as CHWs are made to feel that they are not part of the PHC facility even though they are the ones who do the foot work of the facility on a daily basis.

been fully articulated in National or Provincial health policy. In most contexts, there is no policy that guides qualification requirements, training, employment conditions, and scope of practice or primary role within the health system" (Daviaud and Besada, 2017).

TABLE 5: Professions registered with the HPCSA[21]

The following professions are registered under the auspices of the Professional Board for Emergency Care, namely:

- Basic Ambulance Assistants (BAA)
- Ambulance Emergency Assistants (ANA)
- Operational Emergency Care Orderly (OECO)
- Emergency Care Assistant (ECA)
- Paramedics
- Emergency Care Technicians (ECT)
- Emergency Care Practitioners (ECP)

Why is this the case? One key obstacle we want to suggest amidst the many on offer and despite the literature discussion on issues pertaining to supervision and management, financing, standardised training, the disparate and decentralised locations through which CHWs are contracted etc., is to situate the CHW within hierarchies of power. By this we mean to say: who is the CHW on the axis of power? What is the positionality of the CHW? For many she is described as a "low-level" worker with "entry-level" training. She is mainly someone who has not attained a high school certificate and if so not attained higher education, a working class or rural woman, who is black and seemingly has very low economic, social and political buying power. She in many ways carries the markers and legacy of economic and racial and gender apartheid of the past. She is not a daughter of a social worker, nurse or teacher she is more than likely the daughter of a domestic worker, a community health worker, a factory worker.

Yet, she is at the coalface of the primary health care system and in many ways the bedrock for access to health in rural communities and poor urban communities.

Who is the CHW on the axis of power? What is the positionality of the CHW? For many she is described as a "low-level" worker with "entry-level" training.

As a bare minimum all CHWs should be earning R4 000 (at 2020) plus inflation to align with the basic minimum wage without jeopardising any one who is currently earning above that amount. This needs to be accompanied by UIF, PAYE and medical aid. All contracts, service agreements and employment needs to be registered in a central database so as to ensure national and provincial overview. Contracts need to be a minimum of two years and all basic service laws and regulations need to be applied. In addition inspections of CHWs' sites of work need to be enforced regularly and guidelines for health and safety are needed. A standard charter of the rights of CHWs similar to that of nurses are important to develop. This minimum wage must be augmented

SOURCE: DYING TO CARE: A STORY OF SOUTH AFRICA'S COMMUNITY HEALTH WORKERS (SECTION 27)

with access to other grants as the CHWs will earn within the threshold to access state grants. An important issue for CHWs to take up is their licencing and registration and a council to articulate their concerns and to protect the nature of their work. Ideally the council should have a spread of members who appreciate and situate the knowledge of CHWs and who pay close attention to the work that they do and give full recognition to their role within the health system.

A feminist approach to the work of CHWs must ensure that the gendered nature of the work is highlighted and not simply reinforced. We also need to recognise that through particular work gendered roles are being constructed and reinforced. Feminist perspectives point out the oppressive and exploitative power structures in which CHWs operate and aim to change it. Key in the case of CHWs is to change:

- the precarious nature of their work
- ensure health and safety measures are in place
- develop mechanisms to ensure their physical security and acknowledge the dangers and risks they confront in communities and patients' homes.

"It was my dream to be a nurse, but I didn't go to school, I was taking care of cattle. But through God's work I am close to a nurse though I did not study."
(Nozi Diko, Western Cape)

"The benefits that we want is pay slips. And we also want medical aid. And also we want a danger allowance and a rural allowance. We want housing. Most of us are staying in shacks and then most of us want to be permanent cos you can't get benefits if you are not permanent. So I think the way that our government who could show us that he recognised us... is by paying us permanently... employing us permanently and then put us in the organogram. Put us there, we want to be there as the cadres that are working. Even general assistants are in the organogram why can't we be. Then we want to be given accredited training, not to lose money on trainings that is not accredited. I want to take my certificate to the Western Cape and work there. I want to move."
(Bulelwa Faltein, Tanzania, Eastern Cape)

"Doctors come in to work already done, by ME. He doesn't have to do much cos I have collected all the information he is reading."
(Thembela Flente, Eastern Cape)

Chapter 5

Nothing about us without us

Source: Tinashe Njanji (People's Health Movement)

Nothing about us without us

"I want to be involved with the community and fight the health struggles of the Community Health Workers."*

Source: Tinashe Njanji (People's Health Movement)

"I have a feeling that I built a house only to realise the foundation was not strong, now I need to rebuild it."**

Source: Tinashe Njanji (People's Health Movement)

"The dreams that we had when the forum was started is that we pictured ourselves as women being recognized…that care work is taken serious and we are seen as workers…We see ourselves leading our struggle and we were inspired by the domestic workers… we pictured ourselves in 3 years to come having our own forum as CHWs and our own union, the first union of its kind…"*

Source: Tinashe Njanji (People's Health Movement)

"We asked what we can do as the CHWs…we must do a forum. There were some who said we must do a union…then we said no we are not organized to organize a union… we can do a forum. The forum that will be a platform for us to raise our views…a place where it will be like home for the CHWs…in 2015 the forum was formed."*


Source: Tinashe Njanji (People's Health Movement)

Source: Tinashe Njanji (People's Health Movement)

"We changed our name from community health workers forum to care workers forum because we believe if we call ourselves CHWs it will exclude those care givers who are working in the private hospitals and private based homes because they are facility based, they are not community based..."*

"Our dream was that we will reach all 9 provinces of South Africa and it will be the forum for community health workers around South Africa… Now we are only in 4 provinces…Our vision is still now we can be a forum but later when are organized in all 9 provinces we will change to a union."*

Source: Tinashe Njanji (People's Health Movement)

Source: Tinashe Njanji (People's Health Movement)

Source: Tinashe Njanji (People's Health Movement)

"We created a Charter of Demands. We listed our demands. We demanded to be employed permanently, we demanded the right to be organised. We wanted to be recognised as workers. We are not saying we are caregivers, we are workers! We want to earn wages, not a stipend. We are Community Care Workers, not Care Givers. Cos if we say we are caregivers, we are saying we are volunteering. But we are giving for the fact that we did the same job, earning peanuts, it's a passion to us."*

We resolve...

National Community Health Workers Summit Resolutions, Bloemfontein, 1 March 2019

3. We call on, and demand of the National Department of Health to:

3.1 Expedite the Permanent Employment of all CHWs,

3.2 Standardize training and implementation of the WBPHCOT policy across all Provinces and the Departments of Health and Social Development,

3.3 Address with immediate effect the stock-out problems currently experienced by some facilities across the country,

3.4 Prioritize the safety and security of CHWs during their field work,

3.5 Only provide or recommend Accredited Training (phase i, ii, iii) for CHWs with clear career paths within the Health System,

3.6 Establish a clear scope of practice and work of CHWs and ensure this is implemented by all provinces,

3.7 Ensure that there are clear Local, District, Provincial and National DoH Platforms to engage with the Department on their issues affecting the workers.

3.8 Ensure that CHWs have:

3.8.1 Access to psycho-social support (trauma counselling),
3.8.2 Access to transportation,
3.8.3 Access to vaccination and prophylaxis treatment for HIV, TB, Hepatitis B,
3.8.4 Access to working equipment and protective aides, and are
3.8.5 Covered by the Occupational Health and Safety Act and this is enforced across the country, and are
3.8.6 Included in the infection control plan.

Source: Tinashe Njanji (People's Health Movement)

Community Health Work

by Ongezwa Mbele

They call it a Women thing
A thing
But you the workers know it as a service that only women have come to know as their, urgency burden and salvation
Do they even know your language the depth of it?
It is silent waters running deep
It is a radical love of imagining, reimaging and disrupting the social order of the day
A community of women burdened with the term community that does not serve them.
An endless serving with no arrival point
A life calling that is beyond their choices
But is a linage of women putting their bodies and being on the margins for the marginalized
A movement of survival
A network of hands holding each other together tightly, a force through the injustices of it all
An embodied love for humanity caught between a rock and a hard place

To care is to come alive time and time again
To care is to know that the possibilities of lives being lived is the life lines of your palms
For women to have wombs and give birth comes with the frills
Of expectations of sacrificial care
For even the ones that you did not birth
If this is not magic and power I don't know what it is
So here we stand
To call our community workers by their names
A single parent
A breadwinner
A woman
A migrant labourer
A revolutionary
So here we stand asking you to show us your hands
So we gently touch the softness of your palms and trace the stories of care that you have endured and delivered

Lift your hands up so we can worship your spiritual awakening of care not from moral high ground
There is no contract signed for this work of yours
No equipment for this job
But with your hearts and hands open
Depleted to the bone you come with hope and care actioned
We bearer witness to you
as you carry each generation to the future.
We are here to write you into the history books
To marvel at you at humanity and humanness

Source: *Bulelwa Faltein, Eastern Cape; **Ann Genu, Western Cape.

Endnotes

1 http://allqs.saqa.org.za/showQualification.php?id=64697
2 Staff Writer. 2017. It's official: national minimum wage set at R3,500 per month. BusinessTech. 8 February 2017. Available online at https://businesstech.co.za/news/finance/156159/its-official-national-minimum-wage-set-at-r3500-per-month/ [Accessed on 25 June 2020].
3 Schneider, H. 2017. The Emergence of a National Community Health Worker Programme in South Africa: Dimensions of Governance and Leadership (Doctoral dissertation, University of Cape Town).
4 SmartPurse Ltd is a payment management service provider who was appointed by the provincial government to pay the stipends of CHWs.
5 Provincial government pays SmartPurse Solutions (Pty) Ltd which was appointed following a competitive bidding process in (https://content.voteda.org/gauteng/tag/smart-purse-solutions-pty-ltd/
6 Table compiled from provincial health department briefings to the National Department of Health on 1-18 August 2016, Spotlight on CHWs (2016), Haynes et al. (2011), (Interview with Secretary of South African Care Workers Forum, 8 July 2020)
7 South African Revenue Services (SARS). no date. Labour Brokers. Available at https://www.sars.gov.za/ClientSegments/Businesses/Pages/Labour-Brokers.aspx [Accessed 25 June 2020].
8 NUPSAW Western Cape Community Health Workers Memorandum of Grievances and Demands (26 March 2019)
9 Feminist Research Collective. 2019. Modes of Organising. Presented at the AfrikaGrupperna CHW Workshop, 5-6 December 2019. Wits University, Johannesburg. Compiled from Andrews, D., Timm, S., and Paremoer, L. 2019. The World of Work of Community Health Workers: A Research Report for AfrikaGrupperna. Johannesburg: Afrika Grupperna. Produced in collaboration with Fiona Wilson and Ronel Stevens.
10 https://www.phm-sa.org/national-community-health-workers-chws-summit-resolutions-bloemfontein-1-march-2019/
11 Feminist Research Collective (2019), slide 2.
12 Feminist Research Collective (2019)
13 https://www.phm-sa.org/national-community-health-workers-chws-summit-resolutions-bloemfontein-1-march-2019/
14 McKenzie A., Schneider, H., Schaay, N., Scott, V. and Sanders, D. 2017. Primary Healthcare Systems [PRIMASYS]: Case Study from South Africa. Geneva: World Health Organisation. Page 9. Available on https://www.who.int/alliance-hpsr/projects/alliancehpsr_southafricaprimasys.pdf?ua=1 (Accessed on 6 July 2020). Also found in Oxfam Research Report. 2019. The Right to Dignified Healthcare Work. Page 16. Available on https://www.oxfam.org.za/research-report/ (Accessed on 6 July 2020).
15 Department of Health. 2011. Provincial Guidelines for Implementation of the Three Streams of Public Health Care Re-engineering. 4 September 2011. Page 4.
16 Staff Writer. 2018. How much Doctors, Engineers, Lawyers and Scientists get Paid in South Africa. BusinessTech, July 2, 2018. Available at https://businesstech.co.za/news/finance/255775/how-much-doctors-engineers-lawyers-and-scientists-get-paid-in-south-africa/ [Accessed 21 June 2020].
17 Andrews et al. (2019), Department of Health: Mpumalanga (2016), slide 13
18 Munshi et al., (2019), pg. 5
19 Munshi et al., (2019), pg. 4
20 Munshi et al., (2019), pg. 3

Suggested further readings

Psychosocial and Emotional Labour of CHWs in Clinics and Households

Assegaai, T. and Schneider, H., 2019. The supervisory relationships of community health workers in primary health care: social network analysis of ward-based outreach teams in Ngaka Modiri Molema District, South Africa. BMJ global health, 4(6).

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Suggested videos/documentaries/seminars and discussions

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https://www.facebook.com/881997168595080/videos/688678215041534/

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Interview: Bulelwa Faltein, Secretary of the South African Care Workers Forum. 6 July 2020.

Video recordings

Video recordings: Malaki Rabotolo, Northern Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Dorah "kaOne" Gaethusi, Northern Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Gertrude Molekwa, Free State. 6 December 2019. Johannesburg, South Africa.
Video recordings: Maria Pete, Free State. 6 December 2019. Johannesburg, South Africa.
Video recordings: Mary Nokwane, Northern Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Nomfundo Ndumndum, Western Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Nomsebenzi Nombewu, Western Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Ntombethemba Maduna, Western Cape. 6 December 2019. Johannesburg, South Africa.
Video recordings: Pumla Ngishe, Western Cape. 6 December 2019. Johannesburg, South Africa.
Video recording: Xolisa Victoria Rolo, Eastern Cape. 6 December 2019. Johannesburg. South Africa.
Video recording: Suzan Mpharoane, Free State. 6 December 2019. Johannesburg. South Africa.
Video recording: Thembela Flente, East London, Eastern Cape. 6 December 2019. Johannesburg. South Africa.
Video recording: Pumla Ngishe, Western Cape. 6 December 2019. Johannesburg. South Africa.
Video recording: Ntombethemba Maduna, Western Cape. 6 December 2019. Johannesburg. South Africa.
Video recording: Nomsebenzi Nombewu, Western Cape.6 December 2019. Johannesburg. South Africa.
Video recording: Mary Nokwane, Northern Cape. 6 December 2019. Johannesburg. South Africa.

CHW participants in workshop hosted by AfrikaGrupperna on 5-6 December 2019

Nonthando Felicia Andries	Eastern Cape
Sindiswa Beshe	Eastern Cape
Mavis Bija	Eastern Cape
Bulelwa Faltein	Eastern Cape
Thembela Nongenisile Flente	Eastern Cape
Xolisa Victoria Rolo	Eastern Cape
Mantona Anna Mariti	Free State
Suzan Mpharoane	Free State
Getrude Molekwa	Free State
Ntebaleng Molelekoa	Free State
Maria Pete	Free State
Mohau Tshabalala	Free State
Sennanye Elizabeth De-Huis	Northern Cape
Dorah Gaethusi	Northern Cape
Mary Nokwane	Northern Cape
Boniwe Plaatjie	Northern Cape
Malaki Rabotolo	Northern Cape