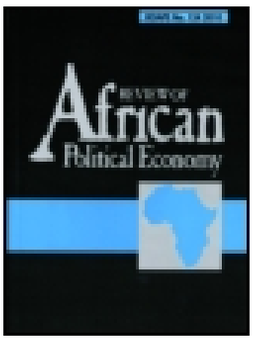

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The new struggles of precarious workers in South Africa: nascent organisational responses of community health workers

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ABSTRACT

Based on in-depth interviews largely with women working as community health workers (CHWs) and documents, the article shines the spotlight on CHWs, who remain a blind spot in the literature on South African labour studies. Abandoned by mainstream unions and often ignored by labour scholars, the article reveals that CHW workers are crafting their own nascent organisational responses as women and as precarious workers to their conditions. New organisational responses led by women who carry most of the social and economic burden are beginning to contest their conditions of precariousness by using tools such as strikes.

KEYWORDS

Women; community health workers; organising; precarious workers

MOTS-CLÉS

Femmes ; agents de santé communautaires ; organiser ; travailleurs précaires

Les nouvelles luttes des travailleurs précaires en Afrique du Sud : l'émergence de réponses organisationnelles de la part des agents de santé communautaires

RÉSUMÉ

Basé sur des interviews approfondies réalisées en grande partie avec des femmes travaillant comme agents de santé communautaires, ainsi que sur des documents, cet article met en lumière ces agents de santé qui demeurent absentes de la littérature des études sur le travail en Afrique du Sud. Abandonnées par les syndicats dominants et souvent ignorées des chercheurs dans le domaine du travail, l'article révèle que ces agents de santé communautaires, en tant que femmes et en tant que travailleuses précaires, sont en train d'élaborer leurs propres réponses organisationnelles adaptées à leurs conditions. De nouvelles réponses organisationnelles menées par des femmes, qui portent la plus grande partie du fardeau social et économique, commencent à contester leur condition précaire à travers l'utilisation de moyens tels que les grèves.

Introduction

Scholarship on labour or power relations in the workplace in the South African context tends to focus on labour histories, profiles of trade unions, strikes led by trade unions,

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wages, work reorganisation, changing social composition of workers who are members of unions, and unions and politics (Forrest 2005, 2011; Buhlungu 2010). Buhlungu (2010), whilst focusing on formal trade unions and the Congress of South African Trade Unions (COSATU) – a trade union federation aligned to the ruling African National Congress (ANC), reveals two related critical processes which he characterises as the 'paradox of victory' or what I would regard as a double-edged sword. On one hand, trade unions and workers won democratisation which meant a formal dismantlement of apartheid laws, and this process, among other things, granted trade unions organisational rights. On the other hand, economic liberalisation or neoliberalism, which led to massive retrenchments, the cataclysmic decline of industries, the rise of labour flexibility and precarious forms of work, and generalised pauperisation of workers and marginalised communities, was a second result of the transition to democracy. Buhlungu (*Ibid.*) further observes that in general unions were unable to respond adequately to massive retrenchments, work reorganisation and the rise of precarious forms of work such as labour brokerage, casual labour and outsourcing.

In the 2000s, several studies demonstrated structural changes in the composition of COSATU, as the public sector workers with permanent employment and benefits had numerical strength within the federation and dominated it as professionals, as opposed to blue-collar workers who were previously the backbone of COSATU. The bureaucratisation of the unions, the use of position as an avenue for upward social mobility for the union leaders, fixation by the union leadership on national politics at the expense of shopfloor issues, and poor servicing of union membership were noted by some of the studies as the main reasons for the failure of the unions to defend and advance interests of workers (*Ibid.*; Masondo 2012; Buhlungu and Tshoaedi 2013). In 2012 the Marikana massacre, which saw the killing of 34 workers near Rustenburg – a platinum mining area 100 kilometres from Johannesburg – showed that the unions who used to champion workers' rights and interests had been co-opted, leading to workers forming their own 'informal' workers' committee which initially led the strike in the platinum area in 2012 (Alexander et al. 2012). Subsequently, and in the context of the Marikana massacre, the National Union of Metalworkers of South Africa (NUMSA) – the biggest union in South Africa – was expelled from COSATU in 2014 owing to organisational and political differences (Satgar and Southall 2015; Bezuidenhout, Tshoaedi, and Bischoff 2017).

The above-mentioned scholarship is valuable in the sense it helps to explain the impact of economic liberalism on unions and the inability of the unions to mount an organisational defence against the attacks on workers – and precarious workers in particular. However, under conditions of generalised precariousness, which also affected workers with permanent jobs and benefits such as pensions and medical aid, the general inability of formalised unions to respond to economic liberalism, and varied responses from workers, mean it becomes necessary to also study informal workers' structures.

In line with what I have just stated, Sinwell (2016) tries to move out of the mainstream studies of labour by examining the workers' committee struggles among platinum workers in Rustenburg since 2012. Sinwell correctly argues, 'The tendency of social scientists to focus on formalised structures in the workplace and elsewhere has meant that they pay little attention to informal workers' organisations – in this case the workers' committee' (3). Sinwell (2011) views workers' committees and militant struggles they led as part of 'insurgent unionism' or a militant form of unionism driven by accountability, militancy

and workers' control. However, workers' committees which came out of internal struggles within the National Union of Mineworkers (NUM), a mining union with strong ties to the ANC, ended up becoming part of another mainstream union called the Association of Mineworkers and Construction Union (AMCU), which is an offspring of NUM. Like other formal trade unions, AMCU, despite having led some important struggles, has tendencies towards bureaucratisation which stifled localised organisational initiatives such as the workers' committees. In fact, according to Sinwell (2016), it was the AMCU leadership which dissolved the dynamic and democratic workers' committee in 2013; the life span of workers' committees was less than one year.

Like the work of Sinwell (*Ibid.*), this article moves away from the mainstream, looking for workers who are marginalised by mainstream unions and who are searching for organisational responses to precariousness. It discusses community health workers (CHWs) who have come to terms with the fact that they must organise themselves as workers operating outside mainstream unions. Unlike the case studied by Sinwell, the CHWs who are a subject of this research have not yet been absorbed by mainstream unions. Without the help of mainstream unions who have resources, relatively speaking, the nascent organisations of CHWs built collaborations with left-wing non-governmental organisations (NGOs), initiated court cases, won legal victories, engaged in strikes and built structures that sought to respond directly to their needs. Workers' committees and mainstream unions all have male leadership, but in this case, women are leading the organisational responses to precarious work. Women are in the majority in this sector and there is a conscious attempt to build a cadre of women since they carry most of the social and economic burden.

This article on nascent organisational responses to conditions of precariousness among CHWs is also a contribution to the South African literature on precarious work which is becoming a general phenomenon in both the private and the public sectors, leading to casualisation of labour, lack of benefits such as medical aid and provident funds, low wages and bad working conditions (Kenny 2015; Paret 2016). Like Kenny (2015), who examined the conditions of precarious workers in the retail sector, this article also looks at the working conditions, wages, benefits and relationships of employment. However, this contribution examines the conditions of precarious workers in the context of the public sector and discovers visible struggles waged by these workers outside of the normal labour avenues such as bargaining councils. Scully's (2016) contribution to the debate on precarious work has helped other scholars to understand that precarious workers also have to wage not only the workplace-based hidden and overt struggles, but also struggles for survival in the context of households. Scully (*Ibid.*, 308) argues, 'While the traditional politics of labour arises from the workplace – the key site of production – the politics of precarity arises from the home – the key site of reproduction.' Unlike Scully (2016), who focuses on survival and household issues of precarious workers, this contribution takes the debate of precarious work back to the workplace and reveals nascent organising for better working and wage increases in the context where traditional unions have tended to ignore struggles and issues of precarious workers.

There is a growing literature examining the conditions of precarious workers employed by the state in Africa and South Africa. Based on this scholarship, it can be deduced that workers employed in public works programmes, for example, earn low wages and do not

have benefits such as medical aid and provident fund (Samson 2007; Theron 2014). Unlike precarious workers employed in public works programmes and as cleaners at universities, community health care workers provide a service in the form of looking after those who are sick, whose right to health is guaranteed by the South African Constitution and certain international instruments. In executing their duties, health workers are likely to be exposed to infections, placing a huge burden on them (Coovadia et al. 2009).

Based on 30 interviews with community health care workers and two representatives of NGOs facilitating the organisation of community health care workers in South Africa's Gauteng province, court documents, newspaper articles, a radio interview, an observation of a health care workers' meeting in Port Elizabeth and Internet sources, the article will show that these precarious health workers working for the state under vexatious working conditions are beginning to assert their social agency by demanding to be employed by the state as they provide crucial health services. The article also reveals that there are various nascent organisational initiatives seeking to advance the economic and social interest of CHWs, who are not part of traditional unions operating under the banner of COSATU and other mainstream unions in South Africa.

Neoliberalism, precarious work and community health workers

According to Lehmann and Sanders (2007), the use of CHWs in public health systems is not a new development. They contend that the concept has existed for the past 50 years, and that a number of local, provincial and national health initiatives have used the services of CHWs, largely in Africa, Asia and Latin America. Lehmann and Sanders advise that the functions and roles of CHWs have to be contextualised as in some instances in the 1950s and 1960s in China, Pakistan and Sri Lanka, CHWs were used to advance a progressive agenda which entailed delivering health services to the urban poor and rural villagers in the immediate post-liberation period (Ceras 2005).

Under conditions of neoliberalism, community health work tends to shift the burden of care from the state to women who are already burdened by patriarchy, which relegates women to carers at home as mothers and as parents who look after children and families. Sanders et al. (2011, 663) clarify the concept of neoliberalism and its implication on public health by saying,

> Neoliberalism has its roots in the theories of classical economic liberalism, which promotes the freedom of markets to operate with minimal regulatory interference, including in respect of rules that may govern wage and price controls or protect the environment and public health.

Neoliberalism has also led the promotion of private health which serves the elite and middle classes, health budget cuts, an increase on donor dependency to provide public health care services, the shortage of equipment and technology in public health institutions, reduction of the workforce and the wage bill, and shortages of medicine.

In the South African context, the rise of neoliberalism, initiated by the apartheid state in the 1980s and consolidated by the democratically elected government in the 1990s, fundamentally transformed the public health system, especially from the perspective of the workforce. Workers in the public sector were employed on a full-time basis and had job security and benefits such as housing and other allowances, and this could be described

by the International Labour Organization as 'standard employment' (Theron 2014). In other sectors, with some exceptions in retail and hospitality, workers had standard employment with elements of permanent employment and benefits. In the 1980s, precarious work was only associated with the retail and hospitality sectors, and was regarded as an atypical form of work. However, these days it can be argued that atypical work has become the norm. Precarious work in the public health sector is associated with neoliberalism, which was formally embraced by the Growth, Employment, and Redistribution (GEAR) policy of the post-apartheid government in 1996. Among other things, GEAR called for the reduction of expenditure on social services such as health (Bond, Pillay, and Sanders 1997).

The lack of investment in public health, the crisis caused by HIV (human immunodeficiency virus), which began in the 1990s, the downgrading of public health facilities which were fully fledged hospitals to community health centres (which are basically clinics), and the closure of nursing colleges which used to supply the public health system with highly qualified nurses are some of the indicators of a chronic crisis in the public health system. With the South African government in 2016 promising to adhere to reducing expenditure on social services, the lowering of the public sector wage bill and declining donor funding, it looks as though standardisation of the working conditions of CHWs will require renewed efforts by the CHWs who are campaigning for decent work (Sanders et al. 2011; Blecher et al. 2016).

The problem is compounded by a shortage of professional nurses who supervise CHWs, and this is largely a result of austerity measures implemented by the state. In 2016, it was reported in parliament that South Africa's public health system employed 270,437 nurses and the system needed 44,780 professional nurses. One of the biggest challenges was that only 3595 were studying towards a nursing qualification. In addition, CHWs are most likely to struggle to pursue studying for a nursing qualification, as nursing diplomas and degrees are offered by the expensive university system and the private sector.

It has been argued by Leur (as quoted in Theron 2014) that globally precarious work in the public sector is becoming a noticeable trend. Leur elaborates, 'As a result of the most recent developments in budget constraints due to public service reform and changes in human resource management in public administrations, a growing number of tasks have been performed by workers in non-standard employment arrangements.'

CHWs are generally women who have to take care of their own families and also the sick and the frail in the public health system. This double burden is made worse by the fact that they tend to have a complicated employment relationship. However, the relevance and the increasing presence of CHWs in public health have compelled the Department of Health to include these workers in its human resource policy. The department notes that the size of this workforce is increasing, with some of the CHWs being employed by the state and some by the NGOs funded by donors and the department. In their article on CHWs, Schneider, Hlophe, and van Rensburg (2008) view the use of NGOs to provide health care in communities as another form of 'externalisation' as costs are shifted to NGOs who pay CHWs low wages and provide them with no benefits or job security.

CHWs cannot be reduced to volunteers working for NGOs as their work in the public health system is of a consistent, permanent and crucial nature. Initially, the state may have wanted this work to be of a voluntary nature which tends to be episodic and not defined by employment relations, but this changed as the work became part of the public health

system, requiring some regulation and guidance. The increase in the intake of community workers and CHWs in particular was driven by a government programme in 2002 called the 'year of the volunteer'. The notion of volunteerism was important for the government to get what could be regarded as cheap labour where workers with no labour rights, benefits and pensions could be engaged to deal with challenges of staff shortages in the public health sector. The policy suggests that CHWs will not be paid a wage with benefits but a stipend. In 2004, the stipend was set at 'R1,000 (US$143) per month' (*Ibid.*, 184). The wages earned by CHWs are extremely low in relation to the duties and functions performed by them. In the context of the HIV pandemic, diabetes and other chronic diseases, CHWs visit patients at their home and make sure that they take their medication; they conduct regular check-ups on patients, save lives and support nurses and other health care professionals (Naidoo 2017).

Like other workers, CHWs are also trained by state institutions to perform their duties within public health. Some aspects of training are delivered by health training institutions hired by the state, nurses and the NGOs who hire CHWs. According to Schneider, Hlophe, and van Rensburg (2008, 181):

> Steps have been taken to standardize and accredit CHW training; by 2006 the Department of Health had registered four community worker qualifications in terms of the National Qualifications Framework, creating the possibility of career pathways for CHWs as mid-level health workers.

Training of CHWs include HIV counselling and testing, management of antiretroviral viral drugs for HIV-positive patients, supporting diabetic patients at their homes, visiting and monitoring patients at their place of residence, and awareness campaigns on HIV and AIDS (its prevention and management). CHWs are trained to conduct home visits and also to work in health facilities such as clinics. Training is accredited, through appropriate learnerships, and the process is supposed to lead to upward mobility of CHWs, but the government's strategy to reduce its wage bill has often hampered the career advancement of CHWs.

Having shown that CHWs emerged as a result of neoliberal health policies of the South African state and the crisis of HIV and AIDS, and are, in fact, a crucial part of the public health system, the article moves to present findings which critically examine how CHWs have tried to resist precariousness in the workplace by building alternative organisations which define them as workers with the rights to standard forms of employment.

Findings

A basic profile and size of the CHW

Based on observations and interviews conducted, health workers tend to be women and in many instances single mothers looking after community members, their children and family members. I attended a meeting of CHWs organised by Workers' World Media Productions (WWMP). There were about 200 participants and the majority of them were women (Hlatshwayo 2016, observation). The Department of Health has also noted that the overwhelming majority of CHWs are 'women without employment or a matric qualification' (Kotze 2016). There are about 70,000 CHWs in South Africa and most are employed by NGOs, with a very limited presence of some employed by private companies delivering a service to the state (Maregele 2014).

Reflecting on the profile of CHWs, Oupa Lehulere, who leads Khanya College – an NGO providing organisational support to CHWs in Gauteng and other provinces – had this to say: 'A lot of them are single mothers. They are actually heads of households' (Lehulere 2016, interview). Enoch Mwari, a leader of the Treatment Action Campaign, which also organises CHWs in Bloemfontein, concurs but adds that males were recruited to support circumcision projects: 'Well, the majority are females, but it is in our era from 2007 upwards they were recruiting males because of the national circumcision programme. They wanted men to convince other men about the importance of circumcision' (Mwari 2016, interview).

Mwari also exclaimed, 'Too much! Yes! Because we as males … some of us are scared. Even those who we recruited with me are no longer doing the issue of caring. They are now in mines or elsewhere … ' (*Ibid.*) The overwhelming presence of women in community health care means that issues and struggles of CHWs have to be understood in the context of broader struggles for the advancement of women socially and economically. Patriarchy and the sexual division of labour have tended to locate women within the spheres of caring and health care.

Employment relationships

There are different employment relationships among CHWs, and these range from being employed by the NGOs that provide a health service to the state to those employed by the state. Mama Tsubani (pseudonym) was born in 1964 and has been working as a CHW since 2001. Tsubani indicated that the prevalence of HIV infections in the Botshabelo area in the Mangaung Metropolitan Council led to a rise in the demand for home-based care workers. Mama Tsubani said:

> We worked for an NGO which was paid by government to provide medical support to people living with HIV and AIDS. We were regarded as volunteers, meaning that we did not have labour rights like other health workers. We visited patients at their houses, washed them, fed them and ensure that they take their medication. (Tsubani 2016, interview)

Numunde Funa (pseudonym), a female CHW working in the Nelson Mandela Bay Metropolitan Municipality, reflected on the complications of her relationship of employment:

> It is because I undertook a one-year Home Base Care training at Siphamandla Home Base Care Training Centre in 2007. After my training I got a two year learnership from the Department of Health and I was promised that at the end of the learnership we would be trained for nursing but that promise was not fulfilled. Instead we were provided another two year contract which [has been] renewed yearly up until now. I have nine years working here now but I am still a contractor and there are people who have been here since 1992. (Funa 2016, interview)

In this instance, the state is a direct employer. Like nurses and doctors employed by the state, Funa is directly accountable to a state facility and its management. Unlike nurses and doctors, Funa's employment status is precarious in the sense that she is working on a two-year contract with a very low wage, with no benefits such as medical aid or guarantee of a permanent post. Funa realises her precariousness and argues, 'The contracts we are signing are not for full time jobs and that is why we decided to fight this now' (*Ibid.*)

In Gauteng, CHWs demanded that they be employed by the state as permanent workers with better wages and benefits. In 2016, these health workers took their case to court and won a legal victory stating that they were employees of the health department, not the NGOs which hired them. Subsequent to that, the response of the Gauteng Department of Health (GDoH) was pragmatic. According to Oupa Lehulere, ' the Department decided to outsource [the CHWs]' (Lehulere 2016, interview). As a negative response to the court ruling, Smart Purse, a service provider, was hired by the GDoH to pay CHWs. Various tactics were used by the department to coerce workers to sign up with Smart Purse, and according to the WWMP, this was achieved by locking out workers and intimidating them (Wa Ramatamo 2016).

This complicated employment relationship raises a number of contradictions and conflicts in the workplace. According to Theron (2008, 5), 'A working definition of the triangular employment relationship is where there are workers employed by an enterprise who perform work for another.' Unlike ordinary nurses and doctors who are directly accountable to the state in the form of being directly accountable to health care centre managers and supervisors, and precarious workers employed in the private sector who have a 'triangular' relationship (Kenny 2015), many CHWs have a complicated quadruple relationship of employment and service. First, they are directly employed by an NGO or a private service provider contracted by the state to provide a public service. Second, these workers work in a state health facility and use instruments or tools of the state. Third, the state's health facility is managed and supervised by the nurses and doctors or facility managers. And fourth, they also have to serve their communities by providing health care services to fellow community members.

In some instances there is a delay in payment of stipends caused by this complicated employment relationship. A 'blame game' between NGOs and the state ensues in these cases, while CHWs are compelled to use their own resources such as money for transport to continue doing their work (Kodisang 2012).

Wages, working conditions and benefits

Consistent with the findings of this research, a World Health Organization study examining the conditions of CHWs globally notes that low pay is one major concern and problem facing CHWs (Lehmann and Sanders 2007). Mama Tsubani complained about her low wages and lack of benefits such as a provident fund and medical aid:

> There are problems. Payment is a problem. In 2001 we were earning R75 per month. There were no benefits. We were regarded as volunteers. Now we get R1,000 per month. We only started getting that amount in April 2016. They say we are volunteers. This job is difficult. I am supposed to be paid well. (Tsubani 2016, interview)

Dibuseng Phaloane of the National Union of Care Workers of South Africa (NUCWOSA), a national union of carers founded in 2016, commented about the demands of CHWs, 'We also need UIF [Unemployment Insurance Fund]. We need a lot of things, we need to also be recognised. … We need a minimum salary or wages, we don't need stipends' (SAFM 2016).

Enoch Mwari argued that they should be permanent workers of the state earning better wages, with benefits and good working conditions. Mwari says,

> Our demand is that we want to be employed full time or permanently because even inside the clinic we are the ones who are doing a lot of work. Nurses prescribe medication or assess a patient, but we are responsible for [the] screening of patients, measuring their blood pressure, and other things. We are responsible for doing a lot of things. It is just unfortunate that we don't have qualifications. Now, we want the department to absorb us and offer us R3,500 a month. We want medical aid. We also want to be covered by occupation health and safety laws. (Mwari 2016, interview)

In 2012, CHWs in the Gauteng area went on a strike for three months in support of their demand for higher wages, better working conditions, and to be employed by the state. According to Bunyonyo,

> At a meeting in Germiston on 12th of April 2012, the representatives of the Clinic Counsellors put their demands to the Health Department as follows: Workers want to be absorbed into the Health Department permanently. Workers want a living wage instead of stipends. Workers want to be trained for recognised qualifications. (Bunyono 2012)

Health workers working for the state are regarded as 'volunteers' and are paid a stipend. The status of being a 'volunteer' implies, of course, that the state has no obligation towards CHWs. Many of these CHWs have been serving working-class and poor communities for more than 10 years with no living wage and benefits, meaning that they are most likely to retire with no pension pay-outs. A health worker in Gauteng who is also part of the campaign for the rights of CHWs said, 'I have been working for over ten years as a health worker. Every year the government says there is no more money for us and we have to wait for six months to be paid' (as quoted in Kodisang 2012).

Struggles to transform employment relations

Not all CHWs are involved in a struggle seeking to change their working conditions into some form of direct employment by the state. Nkulu Kude (pseudonym), a young female CHW looking after orphans and the elderly in her community in Ekurhuleni near Johannesburg, earns a stipend and has no benefits. Kude sees her positions as being 'normal' and 'logical'. In other words, she has internalised her conditions of work. When asked about benefits, Kude said, 'No. It's okay, because we are volunteers, doing what we love' (Kude 2016, interview). With the help from human rights NGOs, CHWs have organised themselves in various ways. It would be a grave error to exaggerate the power of these organisations as they are still nascent forms of organising, requiring further observation and in-depth analysis. Other social movement scholars in the South African context tend to overstate the organisational strengths of embryonic forms of community-based organisation and social movements. As is always the case, history and developments expose this form of 'romanticism' when these organisations collapse and when they face deep divisions based on internal strategic and tactical differences (Runciman 2015).

There are three main organisational responses of CHWs to their working conditions, namely forming a trade union, joining an existing health and human rights organisation, and building a forum. NUCWOSA held its launching congress in Johannesburg from 23 to 25 November 2016. A statement announcing the launch of the union argues, 'Care Workers have long been neglected producers in the economy for reasons that belittle their

work in maintaining the health of patients in our communities. … The formation of NUCWOSA aims to unify the struggle for recognition of care workers' (Wa Matamong 2016, 1).

In a radio interview and speaking on behalf of NUCWOSA, Dibuseng Phaloane said:

> There are different trade unions that do not consider community care workers as workers. NUCWOSA managed to recruit workers from nine provinces. We are in a process of getting registered as a trade union so that we can engage various employers. They [CHWs] do not enjoy labour rights. (Cited in SAFM 2016)

The inability of COSATU unions such as the National Health Education & Allied Workers Union (NEHAWU) and other unions led CHWs to search for their own organisational alternatives. Mwari, who is involved in organising CHWs in the Free State under the banner of the Treatment Action Campaign (TAC), a national organisation comprising people affected by HIV and AIDS, said:

> We did approach them, and we even went to the Premier's office [Free State Premier]. We sought advice. We even went to the unions like NEHAWU, DENOSA [Democratic Nursing Organisation of South Africa] and others but they rejected us. That is why we mostly joined TAC because it was the only organisation that helped us with their resources and finances. (Mwari interview, 2016)

Mwari is one of those CHWs who in November 2013 were part of the 'Stop Stockouts Project', of which TAC was a member. Basically, in 2014 the project, among other things, revealed that the Free State was hard hit by shortages of essential medicines and essential equipment such as surgical gloves, which are also used by CHWs. The TAC started supporting CHWs who had been dismissed by the Provincial Department of Health for demanding better wages and employment by the state. Night vigils were held, leading to 130 CHWs and TAC members being detained for 36 hours. The support that the protesting CHWs received from the TAC convinced them to join that organisation. Mwari concurs:

> Well, I joined TAC the same night when I got arrested, because to be honest I didn't know anything about TAC in Free State, and I always read or watch it at TV about HIV/AIDS related issues. I joined TAC on the 14 June 2014 during that struggle. (*Ibid*.)

CHWs in Gauteng formed the Gauteng Health Workers' Forum (GHWF), a provincial-based forum with a flat leadership structure that avoids having union-like bureaucratic structures. CHWs from a number of working-class areas in Gauteng were convinced that establishing a forum that is controlled by them would help guide and shape their campaigns for full employment with benefits and a living wage provided by the state. The forum is composed of health care workers working for different NGOs who have service contracts with the state (Karibu staff 2013).

The forum, among other things, used the law and the courts to improve the conditions of CHWs in Gauteng. In January 2016, the GDoH decided to advertise the jobs of CHWs who had been working for the department for many years. Four CHWs took the matter to the Labour Court, Gauteng High Court (Molelekwa 2016).

The Labour Court had to address the two contending arguments summarised as follows:

> The Applicants [CHWs] contend that they are employees of the Respondent [GDHE], as contemplated by the Labour Relations Act, 66 of 1995 ('the LRA'). The Respondent, on the other hand, disputes this characterisation of the relationship. It argues that they are independent service providers who provide services as volunteers who, consequently, fall outside the statutory definition of an employee. (Mokoena and Others v MEC Gauteng Department of Health, 2)

The court ruled that the applicants be declared to be employees of the respondent, as contemplated by the Labour Relations Act, 1995 (*Ibid.*, 14). According to Molelekekwa (2016, 1), the Labour Court found in the community health workers' favour, ruling that, despite their status as contract workers, community health workers are effectively department employees and should have received notice prior to their jobs being advertised.

After the court victory, the GDoH changed tack and hired Smart Purse to manage remuneration of CHWs. After protest action and fearing that they would not get even the very low wages offered, the health workers ended up signing with Smart Purse. According to Wa Matamong (2016, 1), 'After protesting for three months against their employment being outsourced by GDoH, community health care workers including those in Alexandra said they have given up the fight.' Lehulere reflected on this complicated relationship of employment, where a clinic was served by CHWs who denied its authority to command or discipline them since they 'belong[ed] to another employer', i.e. Smart Purse (Lehulere 2016, interview). In some instances, and as part of demanding that they be employed by the state as permanent workers, CHWs tactically argued that nurses in clinics were not supposed to give them instructions because the GDoH had stated that they were not its employees. This tactical approach did not undermine the provision of care to poor and working-class communities, because the CHWs understand that their responsibility is to serve the poor and the marginalised.

Reconceptualising the role of CHWs

Lehulere also talked about the need to reconceptualise the role of CHW, not just as workers earning income from the state but also as agents for social change, working for and caring for poor communities. Lehulere draws on an inspiration from the Cuban health system, which views health workers not just as workers with rights and benefits, but also as health militants who put the interests of the poor and the marginalised at the centre of their activities. Lehule said, 'The community health worker is the advance guard of health … the primary angle we want is of a political economy of health' (*Ibid.*).

Lehulere continued,

> An organisation [of CHWs] must undertake health campaigns of its own to promote health within the working class so that their commitment is defined as health militants and not as what has happened to the guys from NEHAWU and SAMWU [South African Municipal Workers' Union]: they are completely alienated from the control of their work. The unions are not interested in the content of their work. The unions are interested in the juridical relations with the employer. So they can in a way block ambulances during a strike … but these are health workers! Why do they endanger the health of others, trash the hospitals? (*Ibid.*)

Unlike the current approach of the health unions in the South African context which see their role narrowly as workers having an employment relationship with the state,

GHWF is debating how to ensure that CHWs view themselves as 'servants of the masses' with workers' rights and responsibilities. This means that protests and campaigns have to make sure that the interests of patients, their safety and health are sacrosanct. This is important in the sense that when campaigning and lobbying for CHWs, they have to win the support of marginalised communities who are served by these CHWs.

The GHWF is studying the Cuban health care system, a 'community-based practice' whose foundations are prevention and early detection of diseases. Community participation and involvement in the health system can help democratise health provision (Spiegel and Yassi 2004). Giving local communities the right to identify health problems, electing their own CHWs, and strengthening the accountability and cooperation between the state, a community health worker and a community, is the model that is being investigated by the GHWF (Rosato et al. 2008).

Discussion and conclusion

A health commission chaired by, and named after, Dr Henry Gluckman, called for a coherent National Health Service and access to health for all, among other things, in 1942. In showing dissatisfaction with the under-resourced health system of post-apartheid South Africa, Zweigenthal, London, and Pick (2016, 55) lament:

> Over 70 years later, in post-apartheid South Africa, the four health system challenges identified by the 1942 Gluckman Commission persist. Poor health service co-ordination also prevails – between national, provincial, and local health departments, and between government departments with responsibilities relating to the social determinants of health. Policies, particularly those affecting the health workforce, are also often not congruent. Maldistribution and shortages of human resources and facilities remain, together with inappropriate emphases on curative and institutional care, as well.

While the conclusions made above are correct, it can be argued that the CHWs discussed in this study are a social force that seeks to redefine, in part, the public health system, characterised by shortage of financial and human resources. In a difficult and slippery terrain, CHWs have defined themselves as workers with social agency, and are involved in a protracted struggle of defending their dignity as women and as workers in the context of being abandoned by the mainstream trade unions.

In debating the workers' agency in the context of vulnerable work, Scully (2016) views trade unions as campaigners for improving access to health and improved living conditions of precarious workers. Scully (*Ibid.*, 309) further asserts that the COSATU unions, NUMSA and the Food and Allied Workers Union are involved in a number of organising initiatives seeking to advance the health and economic interests of the 'poorer' majority of South Africa. For example, COSATU is calling for an 'increased expenditure in public health' to deal with the health conditions of precarious workers in poor communities (*Ibid.*).

Contrary to Scully's (*Ibid.*) optimism about the unions being a force that defends the interests of precarious workers and poor communities at the level of the household, in examining the conditions of CHWs this article concludes that those trade unions and organised labour in general have not acted as an organising force that defends and

advances the rights and interests of CHWs, the very same people who work at the site of reproduction where working-class community members receive health care services.

The data have shown that CHWs working with labour-supporting NGOs and other organisations have developed several responses to their conditions of vulnerability. Some have formed a trade union, the task of which will be to represent the workers in cases of labour disputes and collective bargaining. Others have constituted themselves as a forum, fearing the bureaucratisation process that tends to creep into unions which end up serving the interests of union leaders, instead of workers and the general membership. Another organisational response is the TAC taking up issues and demands of CHWs in the Free State province in particular. A relatively established organisation, the TAC was able to view CHWs as being critical in the struggles against HIV and AIDS and access to treatment as 'foot soldiers' looking after those who are affected by HIV and AIDS (who also tend to be TAC members).

Buhlungu (2010) argued that COSATU unions such as NEHAWU represent the upper strata of the South African labour force. Many interviewees would agree with him, seeing NEHAWU as a union representing the permanent and professionalised constituency in the state's health and welfare sectors. The overriding factor from the interview responses is that these trade unions are not part of crafting organisational solutions to problems facing CHWs, necessitating that the CHWs look to other organisational responses which we have explored above. Instead it is the TAC and left-wing NGOs that are working with CHWs to build alternative organisations and campaigns that aim to define CHWs as workers entitled to decent wages, benefits and better working conditions. These nascent organisational initiatives of CHWs are gendered in the sense that it is the women who earn low wages, have no job security and carry most of the social burden at home and at the workplace, who are beginning to challenge patriarchy and neoliberalism.

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References

Alexander, P., T. Lekgowa, B. Mmope, L. Sinwell, and B. Xezwi. 2012. *Marikana: A View from the Mountain and a Case to Answer*. Johannesburg: Jacana Media.

Bezuidenhout, A., M. Tshoaedi, and C. Bischoff, eds. 2017. *Labour beyond Cosatu: Mapping the Rupture in South Africa's Labour Landscape*. New York: NYU Press.

Blecher, M. S., A. Kollipara, J. Daven, G. Meyer-Rath, C. Chiu, Y. Pillay, F. Abdullah, M. Borowitz, and N. Tavanxi. 2016. "HIV and AIDS Financing in South Africa: Sustainability and Fiscal Space." *South African Health Review* 2016 (1): 203–219.

Bond, P., Y. G. Pillay, and D. Sanders. 1997. "The State of Neoliberalism in South Africa: Economic, Social, and Health Transformation in Question." *International Journal of Health Services* 27 (1): 25–40.

Buhlungu, S. 2010. "South Africa: The Decline of Labor Studies and the Democratic Transition." *Work and Occupations* 36 (2): 145–161.

Buhlungu, S., and M. Tshoaedi, eds. 2013. *COSATU'S Contested Legacy: South African Trade Unions in the Second Decade of Democracy*. Brill: Leiden.

Bunyono, B. 2012. "Community Health Workers Continue Strike." *Karibu!* http://karibu.org.za/Karibu/?p=1409.

Cesar, J. A. 2005. "Community Health Workers in Sergipe, Brazil: Implications for Their Future Role in Maternal and Child Health." *Unpublished doctoral dissertation*. London School of Hygiene & Tropical Medicine.

Coovadia, H., R. Jewkes, P. Barron, D. Sanders, and D. McIntyre. 2009. "The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges." *The Lancet* 374 (9692): 817–834.

Forrest, K. 2005. *Asijiki: A History of the South African Commercial Catering and Allied Workers' Union (SACCAWU)*. Johannesburg: STE Publishers.

Forrest, K. 2011. *Metal That Will not Bend: National Union Metalworkers of South Africa 1980–1995*. Johannesburg: Wits University Press.

Karibu staff. 2013. "HBC Priganise Forum." *Karibu!* http://karibu.org.za/Karibu/?p=1179.

Kenny, B. 2015. "Retail, the Service Worker and the Polity: Attaching Labour and Consumption." *Critical Arts* 29 (2): 199–217.

Kodisang, E. 2012. "Community Health Workers Organise Themselves." *Karibu!* http://karibu.org.za/Karibu/?p=513.

Kotze, K. 2016. "The Ups and Downs of Community Healthcare." *Bhekisisa Centre for Health Journalism*. http://bhekisisa.org/article/2016-10-18-mothers-trained-to-turn-downstream-healthcare-into-an-upstream-success.

Lehmann, U., and D. Sanders. 2007. *Community Health Workers: What do we Know About Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers*. Geneva: World Health Organization. http://www.who.int/hrh/documents/community_health_workers.pdf.

Maregele, B. 2014. "Where's the Care for Community Health Workers?" GroundUp, July 10. Accessed August 8, 2018. https://www.dailymaverick.co.za/article/2014-07-10-groundup-wheres-the-care-for-community-health-workers/.

Masondo, T. 2012. "The Sociology of Upward Social Mobility among COSATU Shop-stewards." In *COSATU's Contested Legacy*, edited by S. Buhlungu and M. Tshoaedi, 110–131. Cape Town: HSRC Press.

Mokoena and Others v MEC Gauteng Department of Health: Mahlangu N.O (J 352/16) [2016] ZALCJHB 98; (2016) 37 ILJ 1445 (LC) (18 March 2016). http://www.saflii.org/za/cases/ZALCJHB/2016/98.html.

Molelekwa, T. 2016. "Community Workers' Jobs Saved for Now [Updated]." *Health24*, March 18. http://www.health24.com/News/Public-Health/community-workers-jobs-saved-for-now-20160318.

Naidoo, N. 2017. "Community Health Workers Play A Vital Role in Healthcare System." Anova Health Institute, April 12. Accessed August 8, 2018. http://www.anovahealth.co.za/community-health-workers-play-vital-role-healthcare-system/.

Paret, M. 2016. "Towards a Precarity Agenda." *Global Labour Journal* 7 (2): 111–122.

Rosato, M., G. Laverack, L. H. Grabman, P. Tripathy, N. Nair, C. Mwansambo, K. Azad, et al. 2008. "Community Participation: Lessons for Maternal, Newborn, and Child Health." *The Lancet* 372 (9642): 962–971.

Runciman, C. 2015. "The Decline of the Anti-privatisation Forum in the Midst of South Africa's "Rebellion of the Poor'." *Current Sociology* 63 (7): 961–979. http://journals.sagepub.com/doi/abs/10.1177/0011392115574784.
SAFM. 2016. "Community Care Workers: Towards their Own Union." *SABC SAfm*, November 23. http://www.wwmp.org.za/index.php/audio-features/workers-on-wednesday/293-community-careworkers-towards-their-own-union.
Samson, M. 2007. "When Public Works Programmes Create "Second Economy" Conditions: Part two: Policy and Political Choices." *Africanus* 37 (2): 244–256.
Sanders, D., F. E. Baum, A. Benos, and D. Legge. 2011. "Revitalising Primary Healthcare Requires an Equitable Global Economic System – Now More Than Ever." *Journal of Epidemiology & Community Health* 65 (8): 661–665.
Satgar, V., and R. Southall, eds. 2015. *Cosatu in Crisis: The Fragmentation of an African Trade Union Federation*. Johannesburg: KMMR Publishing.
Schneider, H., H. Hlophe, and D. van Rensburg. 2008. "Community Health Workers and the Response to HIV/AIDS in South Africa: Tensions and Prospects." *Health Policy and Planning* 23 (3): 179–187.
Scully, B. 2016. "From the Shop Floor to the Kitchen Table: The Shifting Centre of Precarious Workers' Politics in South Africa." *Review of African Political Economy* 43 (148): 295–311.
Sinwell, L. 2011. "Is 'Another World' Really Possible? Re-examining Counter-hegemonic Forces in Post-apartheid South Africa." *Review of African Political Economy* 38 (127): 61–76.
Sinwell, L. 2016. *The Spirit of Marikana: The Rise of Insurgent Trade Unionism in South Africa*. London: Pluto Press.
Spiegel, J. M., and A. Yassi. 2004. "Lessons From the Margins of Globalization: Appreciating the Cuban Health Paradox." *Journal of Public Health Policy* 25 (1): 85–110.
Theron, J. 2008. *The Shift to Services and Triangular Employment: Implications for Labour Market Reform*. http://www.idll.uct.ac.za/usr/idll/resources/papers/jtheron(2008)shift_to_services_and_triangular_employment.pdf.
Theron, J. 2014. "Non-standard Work Arrangements in the Public Sector: The Case of South Africa." *Working Paper No. 302*. Geneva: International Labour Organization. http://www.ilo.org/sector/Resources/publications/WCMS_310221/lang--en/index.htm.
Wa Matamong, R. 2016. "Forced to Sign with Smart Purse: An Outsourced Company Has Been Failing Careworkers in Gauteng." *Workers World Media Productions*, November 14. http://www.wwmp.org.za/index.php/publications/elitsha/287-forced-to-sign-with-smart-purse.
Zweigenthal, V., L. London, and W. Pick. 2016. "The Contribution of Specialist Training Programmes to the Development of a Public Health Workforce in South Africa." *South African Health Review* 2016 (1): 45–59.

Interviews

Funa, N. 2016. Port Elizabeth, 21 May.
Kude, N. 2016. Ekurhuleni, 12 October.
Lehulere, O. 2016. Johannesburg, 10 October.
Mwari, E. 2016. Bloemfomtein, 3 June.
Tsubani, M. 2016. Botshabelo, 9 June.

Observations

Hlatshwayo, M. 2016. Meeting, Port Elizabeth, 18 May.