



Impact of COVID-19 on Precarious Work for Community Health Workers in the Alfred Ndzo District

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DECLARATION

I, Andisiwe Tutula Zinzi Mthatyana (student number 0709525T), declare that this write-up is my own unaided work. This work is a build-up and updated version of the work presented during the Proposal Development and Research Panel modules as requested by the university. In this research, I have acknowledged and referenced to the best of my ability all the resources used.

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This journey began in May 2020. It was a difficult period for all South Africans. Death was the order of the day and to make it out alive was a privilege. This period presented changes and challenges.

In the academic space, one had to adjust from traditional ways of learning to a new environment (virtual). For me, it was a very difficult period, I was battling with depression, and I lost family and friends to COVID-19. The completion of the course work in 2021 was a huge milestone for me, as at some point, the journey seemed blurry and impossible.

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*Dikeledi dia oma. Pelo ya fola. Mathata a fela. Modimo wa araba. uThixo ka Tata
namanyange asekhaya.*

CHAPTER 1: INTRODUCTION

BACKGROUND

This study examines the impact of COVID-19 on precarious working conditions for community health workers (CHWs) in Alfred Nzo District in the Eastern Cape Province. CHWs play an important role in the delivery of healthcare services. The outbreak of COVID-19 arguably revealed and exacerbated deep pre-existing social inequalities and poor working conditions for many. Many industries had their work interrupted and conditions worsened, with the health sector no exception. Over the years, there has been an interest in CHWs in countries crippled with constraints on the availability of professional health staff and heavy burdens of disease (Schneider, Hlophe & van Rensburg, 2008). The limited access to professional health staff and the HIV and AIDS burden in South Africa also necessitated consideration of an expanded use of CHWs (Coovadia et al., 2009).

According to Kok et al. (2016) and Nyalunga et al. (2019), CHWs support and help communities, families, and individuals with preventative health measures and gaining access to suitable curative health and social services. They form a link between populations that might find it challenging to receive these services and organisations that offer social, health, and community services (International Labour Organization, 2012). CHWs play an important role in the health system and in their communities. They are female and predominantly sourced from marginalized communities who provide care to households under general conditions of minimal support and remuneration (Akintola, Hlengwa & Dageid, 2013; Thabethe, 2011).

Thabethe's (2011, p. 789) study provided a socio-economic context of care and women's perspectives on care giving. The study highlighted that the context of care has not changed as the "notion of care remains a burden of black women in the NGO sector". The research subjects in the study were black women (Zulu), poor, unemployed and between the ages of 20 to 46 years.

Current literature on CHWs focuses largely on the role of remuneration as a source of motivation for community healthcare work (Schneider et al., 2008; Wringe, Cataldo, Stevenson & Fakoya, 2010). Further work also highlights issues of gender and the exploitation of CHWs (Akintola, 2011; Maes, 2012; Swartz & Colvin, 2014). Another body of literature addresses the emotional stress faced by CHWs because of interfacing with illness and poverty regularly (Akintola, 2011; Kasimbazi & Sliep, 2011).

Despite the crucial role played by CHWs during the pandemic, research on COVID-19 has focused principally on hospital-based health professionals looking into the impact of the pandemic on the mental health of health professionals (Chen et al., 2020; Hennein & Lowe, 2020; Kang et al., 2020; Nyashanu, Pfende & Ekpenyong, 2020; Pearman et al., 2020; Robertson *et al.*, 2020); experiences of healthcare workers in combating COVID-19 in the workplace (Liu et al., 2020) and personal protective equipment shortages (Cohen & van der Meulen Rodgers, 2020; Emmanuel et al., 2020; Livingston et al., 2020; Saba & Jika, 2020; Singh, 2020).

Some studies conducted in Southern Africa show that CHWs have several motivations for taking up this work, including religious and moral obligations, altruism, and the possibility of future paid employment (Akintola, 2011; Thabethe, 2011). In the paper by Akintola (2011), the research subjects indicated that they were motivated by their passion for community work, avoiding being idle at home, equipping themselves with new skills on community care work with a few citing career-related benefits. In South Africa, CHWs have been part of the health system since 1978 (Walt, 1988), operating as part of the system of primary health care.

Over the years, staff shortages and the disease burden have increased the pressure on government to improve healthcare through strengthening the primary healthcare system (Akintola & Chikoko, 2016). CHWs were therefore incorporated to a greater extent from the 1990s into the formal health care system as part of the ward-based outreach teams that facilitate access to healthcare services in marginalised communities (Akintola, 2016). This included an important role for home-based caregivers (Akintola, 2011; Schneider & Lehmann, 2010).

In 2003, all nine provinces' "community workers (i.e., community development workers, community development practitioners, mid-level workers, community caregivers, community health workers, child and youth care workers, youth workers, probation officers/community service officers and early childhood development practitioners) were brought under the banner of the Extended Public Works Programme (EPWP), one of the government's programmes for poverty alleviation" (Schneider et al., 2008, p. 181).

Steps were therefore taken to "standardise and accredit CHW training. In 2004, the National Department of Health (NDoH) registered four community worker qualifications with the National Qualifications Framework with the aim of establishing a possible career pathway for CHWs" (NDoH, 2004a).

During the launch of the CHW programme in 2004, the Minister of Health stated that the aims of the Community Health Workers Policy Framework (of 2004), was to fight poverty, improve service delivery, develop skills, promote health activities, and address the complexity of the disease burden (NDoH, 2004a). The further policy feature is that, while the programme is a result of government investment in health, CHWs are not directly employed by government (Schneider et al., 2008). The policy framework that guides CHW utilisation in South Africa states that "the employment of CHWs would be through NGOs funded by government" (NDoH, 2004b, p.6). During this period, CHWs fell outside the frameworks that guide employment in the public service. CHWs were then employed directly by government and through non-profits and community-based organisations (Schneider & Lehmann, 2010).

Several "initiatives to support the use of CHWs included the development of a policy guide and policy framework on community care in 2009 and 2011" (Department of Health, 2009; 2011). At the time the policy framework was launched, "the funding of NGOs and the involvement of community workers across the country was established" (Schneider, 2008). While the policy advocated for standardisation at national and provincial level, it left room for ambiguity and interpretation regarding recruitment (Schneider, 2008).

The overarching goal of the policy was the "efficient management of ward-based Primary Health Care Outreach Teams (WBPHCOTs)" to support primary care. In relation to

CHWs, the policy puts emphasis on their link between the community and health facilities (Schneider et al., 2018). Whilst there are frameworks in place, the nature of CHW working conditions and their integration into the health system as workers with employee benefits remains largely incomplete (van Dyk, 2020; Brandt, 2020; Isaac & Damba-Hendrik, 2021). Languza, Lushaba, Magingxa, Masuku and Ngubo (2011, p.4) further add that there is an “uneven development of CHW programmes across provinces” in South Africa in terms of supervision and payment. For instance, in some provinces, CHWs report directly to the health facility manager and in some places, they are under the supervision of non-profit organisations (Languza et al., 2011).

In terms of remuneration, in the Eastern Cape Province, CHWs are paid by the provincial department of health. Others are paid by non-profits, while some are unpaid voluntary workers (Languza et al., 2011).

In the Western Cape, the provincial department of health subsidises non-profit organisations that are given the responsibility of managing the supervision of CHWs (Languza et al., 2011).

While there is a national policy that governs CHWs, provincial health departments are given the mandate to oversee the management of CHWs, hence the differences across provinces. For instance, in Gauteng, CHWs took the provincial government to court, demanding permanent employment, better working conditions and benefits (Hlatshwayo, 2018). Despite succeeding with this application, the Gauteng Department of Health (GDoH) responded by outsourcing CHWs (Hlatshwayo, 2018).

CHWs have continued to argue that their main challenge is “the lack of formalization and standardization” (Health-E News, 2020). Arising from the lack of standardization are remuneration disparities and inconsistencies. Some CHWs are reported to earn R3 500, while others earn as little as R800 per month in 2020 (Health-E News, 2020). In addition to the unequal wage pay, not all CHWs are employed by provincial departments of health, with some employed by non-profit organisations.

Due to the lack of formal employment, CHWs lack job protection, are unorganised, and have no access to a formal pension scheme or other worker benefits typically afforded to formally employed workers. In addition, CHWs are argued to be exploited, working beyond their allocated working hours (Health-E News, 2020).

Before the COVID-19 pandemic, CHWs provided integrated health and social care services to marginalised communities and were also seen as a link between government and communities (Colvin & Swart, 2015; Schneider & Lehmann, 2010). With the COVID-19 pandemic, CHWs continued to provide limited services in their communities, mainly assisting health facilities with the screening of community members as well as (during COVID) contact tracing of suspected COVID-19 cases (van Dyk, 2020).

Currently, there are few studies on CHW working conditions before and during the COVID-19 pandemic. They nevertheless played a major role during the pandemic in assisting health facilities by providing education in communities, screening patients, as well as contact tracing people who tested positive for COVID-19 (van Dyk, 2020).

This study therefore examines the impact of COVID-19 on the precarious working conditions of CHWs.

Given that the COVID 19 pandemic is a new phenomenon, little is known about its impact on precarious working conditions for CHWs and how such workers confront these challenges in the context of the pandemic. Work on COVID-19 in the health sector has focused on hospital-based health professionals looking into the impact of the pandemic on the mental health of health professionals (Chen et al., 2020; Hennein & Lowe, 2020; Kang et al., 2020; Nyashanu, Pfende & Ekpenyong, 2020; Pearman et al., 2020; Robertson et al., 2020); experiences of healthcare workers in combating COVID-19 in the workplace (Liu et al., 2020) and personal protective equipment shortages (Cohen & van der Meulen Rodgers, 2020; Emmanuel et al., 2020; Livingston et al., 2020; Saba & Jika, 2020; Singh, 2020).

The literature on working conditions for CHWs is noticeably scanty, despite the growing significance of CHWs in closing healthcare gaps and enhancing health outcomes in

underserved communities. Most of the research (Perry et al., 2014; Scott et al., 2018) has been conducted on CHWs' training, responsibilities within healthcare systems, and effects on health outcomes. However, little attention has been paid to the difficulties and circumstances that CHWs face while working. This research, therefore, fills this noticeable gap by studying difficulties in CHWs' precarious working conditions, such as low pay, inadequate training, limited job stability, and emotional burnout. Koon et al. (2019) and Balcazar et al. (2011) both recognised gender, socioeconomic status, and cultural competency as significant influences on CHWs' working experiences. The creation of targeted treatments and policies to improve CHWs' well-being, retention rates, and overall efficacy in providing community-based healthcare is hampered by the need for more thorough studies into this crucial component of CHW employment. To create evidence-based solutions to enhance the working conditions of CHWs, which can therefore improve healthcare access and outcomes in marginalised communities, it is imperative to close this research gap. Policymakers, healthcare providers, and other stakeholders can better assist CHWs and their essential role in promoting public health by utilising the knowledge produced in this research.

PROBLEM STATEMENT

The COVID-19 pandemic has had a profound and lasting effect on the already precarious working conditions of Community Health Workers (CHWs) in such a way that before the pandemic, CHWs already faced challenges in their working conditions, such as low pay, lack of job security, and inadequate resources. However, the outbreak of COVID-19 exacerbated these challenges, making their working conditions even more uncertain and difficult. These individuals play a vital role in preventing illness, providing health education, and connecting vulnerable people with essential healthcare services, often operating on the frontline of healthcare delivery in disadvantaged areas. However, the pandemic has exacerbated their existing challenges in several ways. Firstly, their close interaction with the community, combined with insufficient personal protective equipment (PPE) and inadequate training, has significantly increased their risk of contracting infections. As CHWs managed the rise in COVID-19 cases and performed their regular tasks, they also dealt with higher workloads and emotional stress. Thirdly, lockdowns and

its limitations impeded their capacity to reach communities, making it more difficult for those requiring healthcare services. The issues CHWs faced during the pandemic included their physical and emotional health, availability of resources, and the requirement for policy changes to ensure their safety and support, and these are highlighted in this research. As CHWs are crucial in the fight against COVID-19 and in creating resilient healthcare systems for the future, it calls for immediate attention and action to solve these challenges.

While there is growing literature on precarious work prior to the COVID-19 pandemic (see for instance Sefalafala, 2012; Malinga, 2015; Murahwa, 2016; Lenka, 2018; Hlatshwayo, 2018, 2019; Fobosi, 2020, 2021), the focus has been on the private security industry, the socio-psychological impact of precarious work, minibus taxi industry and the public sector (public works programmes and CHWs).

Little work has been done on precarious work during the COVID-19 pandemic. Instead, academic work during the pandemic has focused on hospital-based health professionals, looking into the impact of the pandemic on the mental health of health professionals (Chen et al., 2020; Hennein & Lowe, 2020; Kang et al., 2020; Nyashanu, Pfende & Ekpenyong, 2020; Pearman et al., 2020; Robertson et al., 2020). Research has also assessed the experiences of healthcare workers in combating COVID-19 in the workplace (Liu et al., 2020) and personal protective equipment shortages which have been covered elsewhere and in the media (Cohen & van der Meulen Rodgers, 2020; Emmanuel et al., 2020; Livingston et al., 2020; Saba & Jika, 2020; Singh, 2020).

The aim of this research is to understand the impact that COVID-19 has had on precarious working conditions for CHWs. In other words, this research investigates the extent to which the pandemic impacted on the working conditions for CHWs. The objectives of the study are to:

- Understand the working conditions of CHWs before COVID-19;
- Explore the effect of COVID-19 on the working conditions of CHWs; and
- Provide measures on how to improve the working conditions of CHWs.

RESEARCH PURPOSE

Therefore, the purpose of this study is to investigate the effects of the COVID-19 pandemic on the insecure working conditions of CHWs. CHWs play an important role in healthcare delivery, especially in impoverished communities where they bridge access gaps and provide crucial treatments. The epidemic, on the other hand, exposed and worsened the vulnerabilities and obstacles that CHWs confront, such as job insecurity, insufficient protective measures, increased workload, and limited access to resources. This study intends to analyse the multiple effects of COVID-19 on the working conditions of CHWs, considering the potential repercussions for both the healthcare workforce and the communities they serve.

RESEARCH QUESTION

What are the working conditions of CHWs and how have these been affected by COVID-19?

The following sub-questions will also be addressed in relation to the AND:

- What were the working conditions of CHWs prior to the pandemic?
- How did COVID affect the working conditions of CHWs?
- What measures would improve the working conditions of CHWs?

OUTLINE OF CHAPTERS

This research is divided into six chapters as described below:

Chapter one: This is the introductory section of the research that provides motivation for the study. It outlines the research problem, knowledge gap, purpose of the study, objective, research question and sub-questions.

Chapter two: This chapter outlines existing research on precarity. This chapter further outlines the theoretical framework as well as the debates on precarity. Work on community health workers is also explored in this chapter.

Chapter three: This chapter describes how the research was conducted and the methods of data collection used. These methods of data collection include in-depth interviews and document analysis. The method of data analysis is also referenced in this chapter.

Chapter four: Chapter four present results from data collection.

Chapter five: This chapter discusses the results of the collected data.

Chapter six: This chapter concludes the study and offers recommendations based on the analysis of the data.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION

This research seeks to examine the impact of COVID-19 on the working conditions for CHWs in the AND. The theory of precarious working conditions for community health workers highlights the difficulties and vulnerabilities that this critical part of the healthcare profession faces. Precarious employment refers to settings in which workers lack job stability, security, and proper benefits, and this notion relates well to community health workers who provide important healthcare services in local communities. Community health professionals frequently face a complicated web of obstacles, such as inconsistent work schedules, low income, insufficient job benefits, and a lack of job security. They are typically employed on a contract or part-time basis, which deprives them of the safety nets that full-time employees frequently enjoy. These unstable conditions have a substantial impact on their health as well as their financial well-being.

This chapter provides the theoretical framework that guides this study as well as the literature on precarity in the Global South. It further shows research on precarity in South Africa and existing body of work on CHWs which does not address precarity in CHWs. Lastly it highlights the existing research on CHWs and the gap which the research seeks to address.

Research on the experiences of precariously employed workers, with the exceptions of a few scholars (see Sefalafala, 2012; Murahwu, 2016; Fobosi, 2021), is lacking. This study is the subjective experiences is guided by Guy Standing's broad concept of the precariat (which refers to precariously employed workers) to understand the working conditions of community healthcare workers during the COVID-19 pandemic (see Standing, 2011; 2014; 2015) and other work on precarity in post-apartheid South Africa.

In addition, this is supplemented with Barchiesi's (2011) work which goes beyond employment, and explores precariousness as constituted by the interaction between workplace and household. His work on precariousness argues that precarity is not just

insecure employment. Instead, precarity is a *social condition* which people experience in their lives (Barchiesi, 2011).

THEORETICAL FRAMEWORK

The neo-liberal agenda of the 1970s emphasised the importance of free markets, economic growth, and development depending on market competitiveness (Webster, 2006). The adoption of this economic framework not only had an effect on the structuring of the economy, but it also affected the labour market and introduced labour insecurity experienced by workers and the household (Barchiesi, 2011).

Moreover, due to the flexibility emphasised by the neo-liberal agenda, work has also undergone changes. This includes the erosion of the standard employment relation (SER) (Webster, 2006, p. 22), coupled with the rise of contingent forms of employment (Buhlungu, 2010). This resulted in, what Standing (2011, p. 1) refers to as the “precariat”, which consists of “millions around the world without an anchor of stability”. In the same way, precariat community health workers represent a crucial, yet often overlooked segment of the healthcare workforce. They operate on the frontlines, providing essential care to underserved and marginalised communities (Webster, 2006).

However, their employment status is often characterised by instability, low wages, and limited job security. This precariousness not only affects their own well-being but also impacts the quality of care they can offer. These individuals (CHWs) bridge gaps in healthcare access, addressing social determinants of health and promoting community well-being. Their work includes health education, outreach, and advocacy. To improve both their livelihoods and the quality of care they provide, it is imperative to recognise and address the unique challenges faced by precariat community health workers, such as inadequate training, insufficient benefits, and a lack of career advancement opportunities (Barchiesi, 2011). Supporting and empowering these essential workers is essential for building healthier and more equitable communities.

Standing (2011) conceptualises the precariat in two ways. Firstly, as a “distinctive socio-economic group” i.e., a person is either in it or not. Secondly, he draws from a Marxian perspective and refers to it as “*class-in-the-making*” (Standing, 2011, p. 7). In his analysis on the broader impact that globalisation has had on labour and the labour market at large, Standing (2011) argues that globalisation has resulted in a “fragmentation of national class structures”. For him, this means that as inequalities grew and the world shifted towards a flexible open labour market, class did not vanish, but rather, a more fragmented global structure emerged (Standing, 2011) i.e., the precariat.

For Standing (2015, p. 6), the precariat is a class whose labour is “insecure and unstable, so that it is associated with casualization, informalisation, agency labour, part-time labour, phoney self-employment”. This particular form of labour is growing around the world due to “global transformation which is producing a new class structure” (Standing, 2015, p. 3). This new class structure is exploited, lacks income and labour security and is extremely dependent on wages. In addition, these workers experience working conditions which go beyond the scope of ‘normal’ individuals in the labour force (Standing, 2015). Furthermore, “the precariat lacks seven forms of labour related security which fall under industrial citizenship”, see **Table 1** below:

Table 1: Forms of labour security under industrial citizenship

<i>Labour market security</i> – Adequate income-earning opportunities; at the macro-level, this is epitomised by a government commitment to ‘full employment’. <i>Employment security</i> – Protection against arbitrary dismissal, regulations on hiring and firing, imposition of costs on employers for failing to adhere to rules and so on. <i>Job security</i> – Ability and opportunity to retain a niche in employment, plus barriers to skill dilution, and opportunities for ‘upward’ mobility in terms of status and income. <i>Work security</i> – Protection against accidents and illness at work, through for example, safety and health regulations, limits on working time, unsociable hours, night work for women, as well as compensation for mishaps.

Skill reproduction security – Opportunity to gain skills, through apprenticeships, employment training and so on, as well as opportunities to make use of competencies.

Income security – Assurance of an adequate stable income, protected through, for example, minimum wage machinery, wage indexation, comprehensive social security, progressive taxation to reduce inequality and to supplement low incomes.

Representation security – Possessing a collective voice in the labour market, through for example, independent trade unions, with a right to strike (Standing, 2011 p. 10).

Critical to the discussion on industrial citizenship, the focus has been on “employment security” i.e., “lack of long-term contracts and absence of protection against loss of employment” (Standing, 2011, p. 11). Drawing from these features highlighted by Standing (2011), this study explores how CHWs interpret and respond to these insecurities. Standing (2011) provides invaluable insights into the challenges and dynamics of precarious employment, shedding light on a growing group of workers who lack job security, stable income, and access to social protections. Building upon Standing's analysis, the concept of precariat community health workers (Webster, 2006) emerges as a critical aspect of modern healthcare systems, as these individuals navigate the intricate intersection of healthcare and economic instability. Precariat community health workers embody the very essence of precarity described by Standing (2011). They often hail from marginalised communities themselves and find themselves in roles characterised by fluctuating job security, low wages, and limited benefits as highlighted in chapter four. These frontline workers play a pivotal role in addressing health disparities and promoting well-being within vulnerable populations.

Standing's analysis of the precariat's economic insecurity is particularly relevant in the context of community health workers (2011). These individuals often work on temporary contracts or without formal job security, which can undermine the consistency and quality of care they provide. The precarious nature of their employment also affects their own

well-being, adding to the challenges they face while trying to improve the health outcomes of their communities (Fobosi, 2021).

By addressing the social determinants of health, such as poverty, inadequate housing, and food insecurity, precariat community health workers act as agents of change, mirroring Standing's call for greater societal support (Barchiesi, 2011). They bridge the gap between healthcare systems and marginalised populations, providing essential services like health education, preventive care, and assistance in navigating healthcare resources. In this way, they empower communities to make informed health decisions and reduce health disparities. Therefore, Standing's exploration of the precariat has profound implications for understanding the role of precariat community health workers in addressing health inequalities (Fobosi, 2021).

CHWs operate at the nexus of economic instability and healthcare disparities, making their work indispensable for building healthier, more equitable societies. Recognising the importance of their contributions and advocating for their economic stability is essential for the betterment of both their lives and the communities they serve.

PRECARITY, STATE POLICIES AND CITIZENSHIP

While Standing's work (2011, 2014, 2015) has primarily focused on employment security, Barchiesi's (2011) work goes beyond employment security and explores precarity as constituted by the interaction between work and life. Barchiesi (2011) examines precarious employment in relation to state policies on citizenship and social inclusion in the post-apartheid South African context. He argues that the post-apartheid policies of social inclusion and citizenship emphasised the importance of meaningful and decent work, i.e., economic participation has been central to governments' definition of citizenship (Barchiesi, 2011). Despite the emphasis on decent work, for most workers, particularly the black working class, employment for them remains unstable and insecure, thus departing from the idea of work with dignity and citizen rights, which inspired labour movements that were in opposition to apartheid government.

Barchiesi's (2011) work on precarious employment in relation to state policies on citizenship and social inclusion and his emphasis on decent work becomes central to this research. While government's definition of citizenship has been tied to meaningful and decent work, this is not the case for CHWs. Barchiesi (2011) views precariousness as not just insecure employment, but also as a social condition which people experience in their lives. For him, precariousness can be defined

by the contrast between social policies and governmental discourses that imposes the search for a job, any job, at any condition, as the "virtuous" way to gain social inclusion (also due to privatization, fiscal austerity); and on the other hand, the reality of jobs that are mainly insecure, which hardly provide adequate incomes even to meet basic need (Barchiesi, 2011).

Therefore, for Barchiesi (2011) it is not enough to understand precariousness in terms of working conditions, but to understand precariousness as a condition that transcends the workplace to social life. For him, precariousness is a process that is prevalent in one's life and social existence. This concept of precarity transcending the workplace to the social life is taken up in chapter five of the study where the researcher shows how emphasis on decent work which has been tied to citizenship in South Africa is not the case for CHWs. Instead, their work for CHWs is not a vehicle for social progress.

PRECARITY IN THE GLOBAL SOUTH

While Standing's (2011, 2014, 2015) theoretical exploration of precarity is notable, it's crucial to recognise its foundation in European economic frameworks. Precarity has long been ingrained in the Global South, predating Standing's work, and cannot be homogenized as a singular phenomenon. This study extends the discourse to encompass precarity in the Global South, drawing insights from various scholars (Bremar, 2013; Munck, 2013; Ferguson, 2015; Scully, 2016; Clarke, 2016; Lazar & Sanchaz, 2019; Fobosi, 2021). It aims to elucidate the Southern perspective on precarity, particularly pertaining to South Africa and the context of CHWs.

Scholars writing from the Global South disagree with Standing's (2011) idea that the precariat is a social class (Breman 2013; Munck, 2013). Secondly, they argue that the concept of precarity, as per Standing's (2015) definition, cannot be applied globally, as it is based on European models of labour. This is because the Global South experiences precarity in its own way, as explained by Fobosi (2021) in his study of precarious working conditions in the minibus taxi industry. Fobosi (2021) agrees with Munck (2013) that work in the Global South has always been precarious. The precariat discourse projects the longing for a Keynesian/Fordist/welfare state from the North.

On the other hand, the Southern experience of precarity is marked by the postcolonial state as well as the developmental state which emerged at a later stage (Munck, 2013). In other words, the change in the nature of work in the North is argued to be the end of a welfare state, whereas in the South, the long history of struggle between workers, the state and limited forms of citizenship are the defining features of precariousness (Munck, 2013). This is also echoed by Barchiesi (2011) on his analysis of how work in post-apartheid South Africa has failed to fulfill its promise of work being a signifier of social progress. This is evident in the unstable and insecure work of the CHWs in the study.

Moreover, Standing's concept lacks the understanding of contemporary labour and labour strategies (Munck, 2013). This can be illustrated through the new Global Union called IndustriALL that brought three former global federation unions that cover 140 countries and 50 million members together in 2012 (Munck, 2013). These members came from various sectors but were united under the banner of 'fighting precarious work' (Munck, 2013). The organisation of these former global federation unions resulted in the signing of an agreement with one of the biggest automobile companies (Volksvagen), which stated that temporary work should only consist of 5% of the entire workforce (Munck, 2013). Therefore, Munck (2010) highlights that it is important to acknowledge the role of trade unions in making a difference to those in precarious work positions.

Breman (2013) also argues that work in the South has always been precarious. Since the 1970s, there has been an increase in the number of people in the South moving into urban areas with the idea that "urban life itself would help them in their search for

employment” (Breman, 2013, p. 130). In the urban areas, they had to earn a living through low paid work or through self-employment while living on the outskirts of the city. With the rise of industrialisation, “upward mobility turned out to be a rare occurrence” as many of them remained in the informal economy (Breman, 2013, p. 130). This shows how precarious work is nothing new in the South, rather as Breman puts it, the West has always had to catch up with the rest of the world when it comes to the “growing insecurity of work conditions (2013, p. 130). This has been evident since the 1970’s recession, which weakened labour in the North with “prolonged episodes of high unemployment, privatization, and public-sector cutbacks” (Breman, 2013, p.130 – 131).

For Breman (2013, p. 135), “capitalist societies have always been characterized by a vast repertoire of different employment modalities”. Therefore, by purely focusing on the post–1945 period, Standing’s (2011) account lacks the “historical depth that informs the investigations of global labour precarity” (Breman, 2013, p. 135). Moreover, by assuming that manual workers in Northern countries had labour security distorts the working conditions of the working class (Breman, 2013).

Breman (2013) does not believe that the precariat can be based on the experiences and understanding from the West and then generalised to the rest of the world. The dangers of generalising results in a distortion in Standing’s (2011) claims of the precariat being a new ‘global’ class. This account fails to take into account the majority of the world’s workforce that has been trapped under precarious working conditions for the longest time (Breman, 2013). In addition to the above, Breman (2013) argues that there is not one but a variety of precarious labour. From this, it is important not to rank the precariat into a sequence from greater to less vulnerable, rather to “develop strategies that underline their commonalities” to form alliance (Breman, 2013, p. 137). Alliances are very important, as flexibility in the labour force has weakened the capacity of collective action (Breman, 2013).

Both Breman and Munck argue that “life in the Global South has “always-already” been precarious” (Breman, 2013; Munck, 2013). This is also echoed in the 1970s analysis of informal economies (see Hart, 1973; Peattie, 1987), as well as Denning (2010) in his

concept of “*wageless life*” in describing cities in postcolonial states. In his work, Denning (2010) puts forward the idea that “capitalism begins not with the offer of work but the imperative to earn a living” and this happens in different ways. This implies that their lives are not entirely wage free and not “characterised by the model of a male wage” that supports the family (Denning, 2010). Denning’s (2010) call to “decentre wage labor in our conception of life under capitalism” echoes feminist arguments made in the 1970s. These feminist scholars highlight “the role of housework in the reproduction of life and labour power” (Federici, 2008). They argue that “female housework is necessary to produce and service workers’ factories, streets and other workplaces” (Federici, 2008).

In similar vein to Munck (2013) and Breman (2013), Lazar and Sanchez (2019, p. 3) in their scholarly work on precarity, operate from the premise that “precarity is experienced differently in the North and in the South among waged workers and informal workers. In their paper titled *Understanding labour politics in an age of precarity*, they argue that workers are not “anomic and lacking in work-based political identity, but nor are they straightforwardly a ‘class in the making’” (Lazar & Sanchez, 2019, p. 4). Rather, there are many ways in which people can work as a collective to challenge as well as improve their lives through trade unions, associations and cooperations (Lazar & Sanchez, 2019). These different forms of labour organisation by the precariat have different implications for politics, how we understand “class compositions and of how informal and precarious economies are likely to develop in the future” (Lazar & Sanchez, 2019, p. 3). Using ethnographic analysis of topics, Lazar and Sanchez (2019, p. 4) contribute to a “nuanced understanding of how precarity is constituted in different social contexts”.

In their analysis, Lazar and Sanchez (2019) point out that precarity requires an analytical response that takes into account the contradictions around this term. This implies that “a class modelling of precarity faces a number of challenges” (Lazar & Sanchez, 2019, p. 9). First, the approach must factor in persons that are “poor and vulnerable” and those whose “experience is less novel” (Lazar & Sanchez, 2019). Therefore, if social classes are to become “political actors through their recognition of shared history”, then “the very notion of a precariat has more discursive saliences for communities of people who define their insecurity in temporal terms” (Lazar & Sanchez, 2019, p. 10). For example, areas

marked with a decline in Fordist labour practices, precarity is a new phenomenon that has disrupted identity, family structures, as well as ways of life compared to those in the South where precarity is not something new (Lazar & Sanchez, 2019). Therefore, this difference between the North and the South, according to Lazar and Sanchez (2019), suggests that class modelling of the concept of the precariat does not “engage with the complex political life of the insecure labour in modern workplaces” (Lazar & Sanchez, 2019, p. 10).

Secondly, Lazar and Sanchez (2019) argue that it is important to focus on “domestic lives, kinships and affinal networks of workers” in order to understand how precarity functions and is experienced by different workers who experience precarity differently. In doing so, we begin to understand that precarious workers, regardless of whether they are permanently or temporarily employed, share homes and workplaces with other similar employees. They “participate in the same household economy and share critical perspectives and the idea that they constitute distinct classes” doesn’t hold because of their “economic position and political consciousness” (Lazar & Sanchez, 2019, p. 10).

PRECARITY FROM A SOUTH AFRICAN PERSPECTIVE

Focusing on precarity from a South African perspective, Scully (2016, p. 295) argues that waged work has become more precarious and “the importance of the household in the livelihood strategies of precarious South African workers has increased”. This shift from the household to the workplace has political implications on the strategies that workers adopt. Drawing on data from the national household survey as well as field work and insights across urban and rural areas in South Africa, his research examines common experiences among precarious workers which may point towards some general politics of precarity in South Africa. The findings in his study reveal that precarious workers have complex economic lives, and they rely on a variety of incomes to make ends meet (Scully, 2016, p. 289).

Moreover, “the primary site through which incomes are combined and livelihoods are produced is the precarious workers’ households” and this results in material interests being centered on the household (Scully, 2016 p.289). The primary identity for most of

these workers is not precarious workers, rather a household member. In this context, class struggles and identities are not constructed in the workplace, but rather around the household table (Scully, 2016). For Scully (2016), this has implications for attempts to build organised work.

Scully (2016) further points out that our traditional understanding of labour politics has been rooted in the workplace. Workers' thoughts and interests were shaped by their experiences in their workplace. The rise of precarious work eroded formal waged work and workers ties to the workplace. Their ties to their workplace "have been loosened and they have increasingly begun to rely on social and kinship networks in order to gain a livelihood" (Scully, 2016, p. 298). This makes the household the "the hidden abode of reproduction" which has been key to shaping precarious workers material wellbeing (Martin, 1987 as cited in Scully, 2016, p. 298). The importance of the household to workers is not something new, however, precarity has "increased the centrality of the household" (Scully, 2016).

The findings of his study reveal that while the household has its own conflict and power dynamics, it remains the "site through which workers' livelihood strategies are carried out" (Scully, 2016, p. 299). In addition to the above, precarious workers can be divided into two groups. The first being the workers who are a result of informalisation (precaritisation), they have a "*regular wage*" but lack labour protection as per South African law (Scully, 2016). This group can be further divided into two, i.e., the "*unregulated wage workers*" who are the largest group of workers.

However, the survey data used made it impossible for the researcher to measure their legal work arrangements (Scully, 2016). It is important to note that their scope of work falls out of South African labour law. The second group is called the "*part-time/contract workers*" (Scully, 2016). This group of workers fall under "*regular wage jobs*"; they adhere to labour laws, but the employers find legal means of removing themselves from providing certain legal protections (Scully, 2016, p. 301). Scully's work is useful as it provides an understanding of the nature of CHWs work i.e. the nature of their work i.e. contractual with limited protections and rights compared to permanently employed health workers,

has enabled their employers to use legal means of removing themselves from providing certain legal protections to CHWs.

According to the author, these types of precarious workers reflect Theron's (2010) definition of informalisation, which "consist of those workers who have regular employment and instead rely on low-income survivalist activities" (Scully, 2016, p. 301). Scully (2016, p. 308) concludes by pointing out that precarious workers work in different contexts with diverse working conditions and the defining feature amongst these workers is "not their experience of work but the experience of insecurity".

The majority of precarious workers cannot therefore depend on precarious work for a livelihood. Instead, they have to develop "livelihood strategies" that combine different streams of income (Scully, 2016). These livelihood strategies are "centred on the household and draw heavily on the unpaid labour and social support of the workers and their kin. This broadly diversified household-centred livelihood is the central 'common experience of precarious work' (Scully, 2016, p. 308).

Other scholars have also added on the debate in a South African context and the focus has been on precarity in domestic work as well as the academic space. In her paper titled *Negotiated Precarity in the Global South: A Case Study of Migration and Domestic Work in South Africa*, Jinnah (2020) uses a case study of cross border immigrants to explore what precarity in the global south looks like under the conditions of migration and low waged work. Domestic work comprises 11% of the South African workforce (Statistics South Africa, 2013 cited in Jinnah, 2020, p. 211). Domestic workers are mostly black South African women with low levels of education and the sector has challenges of enforcement which results in workers experiencing limited labour protection, low wages, exploitation and job insecurity (Jinnah, 2020). The author also notes that the sector is also comprised of women from neighbouring countries even though they are disproportionately represented in the South African domestic workforce.

This ethnographic graph study was carried out over four months in three cities (Johannesburg, Pretoria and eMalahleni). 59 semi-structured interviews were conducted in 2014 and 2015 which included three managers working for companies responsible for

placing domestic workers, 25 employers of domestic workers and 34 domestic workers (16 from Zimbabwe, 10 from South Africa and eight from Lesotho). Participant observations, focus groups and informal discussions were also employed as methods of data collection.

The findings of the study revealed that weak citizenship contributed to precarity. In the context of migrant domestic workers lack rights because of their status in the country. They experience legal insecurity which stems from restrictive immigration policies, and this is coupled by corrupt institutions and social marginality (Jinnah, 2020). This means that migrant domestic works constantly live in a state of navigating their safety and security because of their citizenship and lack of documentation to work in South Africa.

In addition to legal insecurity, the study findings revealed a second form of negotiated precarity which is ‘informal employment patterns and relations’ (Jinnah, 2020). The research participants in this study stated that they worked long hours, no employment contracts, job insecurity and no clear description of their work and for the author, the informality of work suggested more than a lack of awareness among employers and employees on rights and obligations (Jinnah, 2020). The data revealed that the employers were aware of their obligations, however, they expressed vague responses on non-compliance. Also, employers expressed that the differences in compliance was based on their understanding of compliance which was flexible and their perceptions of what constituted as fairness.

Furthermore, the study revealed that workers preferred this form of work compared to other low paid forms of employment because it allowed them “to migrate, to work and to survive” while some employers expressed racialized comments such as “the honest, hardworking or happy foreign worker” (Jinnah, 2020, p.223 – 224). For the author, these racialized and gendered narratives exist in the midst of progressive legislation and also show how migrant domestic workers negotiate precarity suggesting a form of agency (Jinnah, 2020).

Jinnah (2020) concludes the study by bringing us back to precarity as a conceptual framework. She argues that in order to understand the lived realities of migrant domestic

workers in South Africa, a form of precarity rooted of the global south is a conceptual lense that will hep us make sense of how formality and legality intersect to produce informal negotiated conditions (Jinnah, 2020).

Walters, Bam and Tumubweinee (2022) join the conversation on precarity by focusing on the experiences of women's academic work and careers during the COVID-19 pandemic. The starting point for these authors is that gender inequalities in the academy existed before COVID-19 (Walters et al. 2022) however, our understanding of precarity in the academic context enables us to become acute to it in the pandemic. For them, these gendered inequalities (recognition, compensation, leadership and women's recruitment) are in terms of are well researched (see Huang, Gates, Sinatra, Barabási, 2020) and they have rendered women's work in the academy precarious (Coe, Wiley and Bekker, 2019; Walters, Mehl, Piraino, Jansen and Kriger, 2022).

In the context of the pandemic, the aim of this study is to highlight the social relations of precarity in post-Apartheid South African universities and to show how precarity is worsened during the pandemic. Using a qualitative approach, the study draws on experiences of 2029 women from 26 institutions of higher learning. The data was collected over a period of three months in 2020 including narratives reflecting on the experiences of enforced lockdown and how that impacted on their lives. The data was analysed using a qualitative content analysis.

The findings of the study revealed that the instability that existed prior the pandemic worsened. The female academics interviewed indicated they experienced loss of income because there were no scripts to mark and those who worked as academic performing artists were unable to perform due to lockdown restrictions. Furthermore, those whose work was depended on data collection were unable to collect data and access laboratories and that had an impact on their research outputs (Walters et al, 2022). The study also revealed that promotion prospects were impossible as most women felt overwhelmed by the amount of work they had to perform i.e. research outputs, teaching, administrative work, adjusting to online teaching and household responsibilities such as

child rearing and teaching. This impacted their work especially their research outputs which is considered during promotion (Walters et al., 2022).

Furthermore, the study also revealed sabbatical applications were compromised for some academics that had scheduled sabbatical which coincided with the lockdown period. This period was crucial for them because of their ability to focus a lot on research publications and attending conferences however heavy academic workloads and household duties impacted the quality of their research outputs thus impacting their career advancement (Walters et al., 2022).

Moreover, academics that were employed on soft funding, i.e. paid through external funding, were severely affected as some donors were pulling out funds and some were not paid because of no research output. These challenges that were exacerbated by the pandemic made some academics consider resignation or consider other opportunities outside the academy (Walters et al., 2022).

The significance of these findings shows us the precarity is experienced by academic women during the pandemic within “the structural conditions of precarity” (Walters et al., 2022, p. 7). It is also important to note that the study also show the intersectionality of their academic work and household lives reveals the conflicts, compromises, contradictions and constraints under they operate in. In addition to the above, these findings also reveal the existing unflexible institutional arrangements and their consequences with regards to appointments, probation and even continued postgraduate studies (Walters et al., 2022). Lastly, this study is significant in that it shows how most academic women who are employed as junior staff members remain precarious by the nature of the work they must perform and how their work affects their career advancement (Walters et al., 2022).

The study concludes by arguing that while post-Apartheid South Africa has improved the socio-economic experiences of women, academic institutions have been slow in the advancement of women and the pandemic has deepened the systematic and institutionalized inequalities.

Solomon and du Plessis (2023) joins the above conversation by exploring precarity in South Africa in the academic space. Unlike Walters et al (2022), they focus on both male and female academics. Their paper focuses on the lived experiences of academics that are employed temporary in South African higher education institutions. The researchers highlight that the institutional demands in the South African higher education require temporary or casual employees. These employees are aware that they are disposable to these institutions of higher learning and for Solomon and du Plessis (2023), they have precarious employment. This employment is constituted by contract work characterized by “uncertainty, instability, and insecurity, leaving workers in a state of vulnerability” (Edgell et al., 2015 as cited in Solomon and du Plessis, 2023, p. 522). Using a phenomenological approach to qualitative research, enabled the researchers to get an in-depth understanding of the lived realities of temporary academics. Twenty-six temporary academic staff were interviewed using semi-structured interviews and the data was analysed thematically following Braun and Clarke (2006). The study revealed that most of these academics are passionate about their work however, the uncertainty and instability have an impact on their mental health and career advancement. This uncertainty and instability have an impact on their social lives (Solomon and du Plessis, 2023). This affects their financial planning, ability to provide for their families and security. Furthermore, institutional policies hampered their academic development of which 76% of the participants indicated that they were not aware of them (Solomon and du Plessis, 2023). These included limited access to funding to attend conferences and exposure to career pathing. They further cited that they are overburdened with work and the remuneration is less for the work they are expected to execute. In addition to the above, 86% of the research participants confirmed that precarious employment and job insecurity positioned them as an outsider living them in a constant state of depression and anxiety (Solomon and du Plessis, 2023).

The authors concluded by highlighting the implications of these practices by institutions of higher learning. Solomon and du Plessis (2023) point out that academics in precarious employment positions grappled the choice of staying in academic positions or finding alternative employment opportunities. For them, this implies that university institutions and their human resources divisions need to review their policies and practices. These

policies and practices must be aligned with the United Nations declaration and definition of decent work for all (Solomon and du Plessis, 2023).

The abovementioned research reinforces the position of scholars from the Global South (Munck, 2013; Breman, 2013, Lazar and Sanchez, 2019) who argue that precarity has always existed and different contexts have shaped the experiences of the precarious workers. This also links to this research, that the nature of the work of CHWs has been precarious and the pandemic exacerbated the existing working conditions for CHWs.

UNDERSTANDING WORKING CONDITIONS IN SOUTH AFRICA

In addition to the above body of work by scholars from the Global South, research on work and working conditions in South Africa is important as it helps us understand the nature of CHWs work. Studies on working conditions in work settings in South Africa have also focused on the histories of trade unions, wages and workplace reorganisation (see Forrest, 2005, 2011; Buhlungu, 2010). In this field of study, Buhlungu (2010) highlights that while the post-Apartheid era was not only marked with democratisation in the workplace and the end of apartheid laws, it also marked a period of neoliberalism which was characterised by retrenchments, casualisation, labour flexibility and precarious forms of work.

He further points out that during this period of neoliberal policies, trade unions were unable to effectively respond to the challenges of the workforce because of the rise of labour flexibility (Buhlungu, 2010). As a result, a new pattern emerged in the early 2000s where COSATU, which was previously dominated by blue collar workers, was now dominated by permanently employed public sector employees (Buhlungu, 2010).

Moreover, some labour scholars noted that the inability of trade unions to respond effectively to worker demands was a result of trade unions aligning themselves in national politics (Masondo, 2012; Buhlungu & Tshoaedi, 2013). The 2012 Marikana Massacre suggests weaknesses in the ability of unions to champion workers' rights and interests. The union of mine workers in Marikana was argued to be co-opted, resulting in workers forming their own collective, which led the miners' strike (Satgar and Southall, 2015;

Bezuidenhout, Tshoaedi and Bischoff, 2017). This shows how unions have been unable to organise and defend workers, especially precarious workers including CHWs that are not unionised.

Existing literature in South Africa on workers employed by the state examines the conditions of precarious work (Samson, 2007; Theron, 2014). These workers are employed through the Extended Public Works Programme (EPWP). This programme sought to bridge the gap between the first and second economies (see Mbeki, 2004; 2006). Samson's (2007) analysis of the EPWP reveals that such initiatives undermine the creation of new jobs. Instead, they create inferior jobs which bear characteristics associated with the 'second economy' (Samson, 2007). Therefore, they contribute to the same problem of two economies separated by the structural divide which the policy claims to help bridge.

On the other hand, Theron's (2014) paper focuses on non-standard forms of work in the public sector. The author defines non-standard forms of work in two ways: first, as casualisation; and second, as the outsourcing of contractors to employ the workers required (Theron, 2014). In his study, the author points out the implications of non-standard forms of work on service delivery and concludes by identifying appropriate policy responses (Theron, 2014). In the context of CHWs, their nature of employment is casual and this has implications in the execution of service delivery.

Based on this body of literature, workers employed in the EPWP earn low wages and do not have benefits such as pension and medical aid (Samson, 2007; Theron, 2014). In the private security sector, the concept of precarity has been employed to capture the lived experiences of security guards (see for instance Sefalafala, 2012; Murahwa, 2016).

Drawing on Standing (2011), Barchiesi (2011) and Candeias's (2004) conceptions of precariousness, Sefalafala's (2012) thesis explores the working conditions and lived experiences of security guards in Johannesburg. Using the nine themes of decent work in the International Labour Organization (ILO), the findings of this thesis reveal that the ILO themes do not capture the meaning of being a security guard (Sefalafala, 2012). Furthermore, the findings reveal that security guards are vulnerable and oppressed

(Sefalafala, 2012). Lastly, the findings concur with Barchiesi's (2011) rejection of the notion that wage employment acts as security to decent work and life (Sefalafala, 2012). Similarly to the work of Sefalafala (2012), the data in this study shows that the nature of work of CHWs concurs with Barchiesi's (2011) work, that waged work is not a vehicle for changing the social realities of CHWs.

Building on the work of Sefalafala (2012), Murahwa's (2016) ethnographic work analyses precarity as experienced by Zimbabwean migrant security guards in the South African Private Security Industry. In his dissertation, he argues that precarity can be embraced from a perspective that explores the subjective views of those grounded in precarious backgrounds (Murahwa, 2016). Pursuant to his argument, he explores the perceptions that migrant security guards have on precarity and how they respond to precarity. This "allows him to explore the views of the workers about their work and lives and how they organise, as well as their treatment in wage employment" (Murahwa, 2016).

His work highlights the disconnection between academic understanding of precarity and the understanding of Zimbabwean migrant security guards who experience it directly.

In his work on Zimbabwean migrant workers in South Africa, Hlatshwayo (2019) examines how Zimbabwean women navigate moving from Zimbabwe to South Africa to find work through the lens of 'precarious work and precarious resistance'. The findings reveal that Zimbabwean migrant workers face a dual risk by virtue of being women. First, they must deal with violence against women and the 'generalized lack of basic services and goods' such as female hygiene (Hlatshwayo, 2019). Second, arriving in Johannesburg places them in a position of finding precarious work and their response to precariousness, and thus, they find strategies and tactics which are defined as precarious resistance (Hlatshwayo, 2019). These strategies and tactics are a response to them being isolated by virtue of being migrant workers. Hlatshwayo (2019) concludes his study by highlighting that migrant workers are in a difficult situation when engaging on workers' rights as they face the risk of deportation. By virtue of being women, they are also subjected to gender-based violence and harassment as well as poor working conditions.

In addition to his work on Zimbabwean migrant workers, Hlatshwayo (2018) further explores precarious work among healthcare workers. His paper focuses on 'nascent organisational' responses to conditions of precariousness among community health workers. Using qualitative methods of data collection, Hlatshwayo (2018) shows how community healthcare workers who are employed by the state are organising themselves outside mainstream unions as a response to precarious work.

The research indicates that women are the majority in the sector and there is a "conscious attempt to build a cadre of women since they carry most of the social and economic burden" (Hlatshwayo, 2018). His paper also looks at working conditions, wages, benefits and relationships of employment by examining the conditions of precarious workers in the context of the public sector. His findings show the wage struggle by community healthcare workers outside their normal labour avenues such as bargaining councils (Hlatshwayo, 2018).

In the informal economy, with specific reference to the minibus taxi industry, Fobosi (2021) uses the concept of precarity to explain the various forms of precarious work within the industry. Drawing on Guy Standing (2011) and Clarke's (2016) work, Fobosi (2021) examines the Taxi Recapitalisation Programme on precarious conditions of work within Johannesburg's minibus taxi industry. He uses precariousness to describe the way that employment practices in the industry as well as legislation (labour legislation from the Department of Labour and Employment) and public transport policies from the Department of Transport) define the nature of the industry.

His study contributes to the field of Industrial Sociology in "how precarious conditions of work develop" (Fobosi, 2021). The analysis makes a theoretical contribution to the literature by theorizing from the Global South. This therefore addresses a gap in the empirical evidence in the minibus taxi industry.

This study focuses on precarity and community healthcare workers. There is existing theoretical work on precarity (see for instance Standing, 2011; Barchiesi, 2011, Butler, 2009). According to Suliman and Weber (2019, p. 525), precarity is defined as a "way of expressing livelihood insecurities associated with labour (working) conditions including

the implications of diminishing protections”. This concept has been used to describe “a specific condition of insecurity that emerges from the spatial and temporal restructuring of the relationship between production, politics, and life” (Suliman & Weber, 2019, p. 528). Such understanding of spatial and temporal restructuring is associated with neo-liberal globalisation. However, this scholarly work on precarity does not consider the subjectivities of community healthcare workers. Instead, it focuses on what they lack in terms of our understanding of employment. According to Standing (2011, p. 17), the precariat lacks seven forms of “labour related security” i.e., labour market security, employment security, job security, work security, skill reproduction security, income security and representation security.

STUDIES ON CHWS

Most studies in the field of community health workers have focused on the motivations for becoming community health workers. Dageid, Akintola and Saberg’s (2016) research explores the motivation for becoming AIDS care volunteers and the challenges confronted in the work. This qualitative study was conducted in two peri-urban areas in KwaZulu-Natal, South Africa using interviews as a method of data collection. The participants were black women ranging from 18 to 44 years with an educational attainment ranging from grade six to 12 (Dageid et al., 2016). The results revealed that they ventured into this work because of the need to care for others, and this for these women is integral to Ubuntu (Dageid et al., 2016). The results also showed that most of the women ventured into care work because they were either affected by HIV or infected with HIV.

Having experienced family members dying from the virus, as well for some being infected by the virus, they were driven to participate in care work (Dageid et al., 2016). Only one research participant indicated that she was driven by financial gain in the form of food parcels (Dageid et al., 2016). The study also revealed that CHWs experience challenges in their work, such as lack of support from government. This includes lack of working tools like home care kits, protective clothing and places for care for the terminally ill (Dageid et al., 2016).

In addition to lack of support from government, these women indicated that when they ventured into care work, they did not expect financial gains. However, having done the work for some time, they noted that the stipend was not sufficient to cover the costs related to care work and their time they spend volunteering (Dageid et al., 2016). The study concluded that to sustain work of CHWs, there is a need for policy makers to create career paths for CHWs as well as regular remuneration. Some studies have focused on the gendered aspect of CHWs or care work. For instance, the paper titled *Community home-based care – a cost-effective model of care: who benefits?* argues that while the National HIV and AIDS Strategic Plan 2007 – 2011 has made progressive strides, the implementation remains a challenge as the plan remains “gender-blind to women’s social, political and economic imperatives” (Thabethe 2011, p. 787).

This qualitative study was conducted in KwaZulu-Natal, South Africa using interviews, observation and documentary review as methods of data collection. The findings reveal that the notion of care in the NGO sector remains the burden of black women (Thabethe, 2011). Furthermore, the study revealed that most women entered the space of care work with the hope of acquiring experience as well as opportunities of formal employment (Thabethe, 2011). Lastly, the study revealed the exploitative nature of community care work (Thabethe, 2011). Thabethe (2011) concludes her paper by proposing a model of care that considers the interests of women.

Some scholars have diverged and focused on the role of CHWs with specific reference to their role and response to HIV/AIDS. Schneider, Hlophe and van Rensburg (2008) analysed the policy context and reported on the reality of CHWs in the primary health care system in the Free State province. This study was part of a longitudinal project which documented and evaluated the implementation of ART rollouts in the Free State Province. To collect data, the study leaned towards the use of qualitative methodology, with in-depth interviews of CHWs and nurses from 16 different health facilities used, as well as document review of policy documents, ministerial speeches and existing literature.

In their analysis, Schneider et al (2008) noted that the CHW programme in the Free State “has its origins in contracts signed in 2001” with two non-governmental organisations. In

2002, the Free State Policy on Volunteer Work outlined the roles and responsibilities of volunteers, and in 2003, the Health Strategic Plan of the Free State Department of Health outlined the strategies to be used in the deployment of CHWs in HIV/AIDS intervention programmes (Hlophe, 2006). The findings revealed that the CHWs were dissatisfied, and this stemmed from the lack of recognition from the healthcare system in the role they play (Schneider et al., 2008).

CHWs also highlighted that they do not recognise themselves as workers but as volunteers, as the system did not afford them the same benefits as other health workers (Schneider et al., 2008). Moreover, the CHWs stated that they remained motivated, with the hope of securing permanent employment with benefits. The paper by Munshi, Christofides and Eyles (2019) looked at perspectives on the CHW programme in Gauteng Province, South Africa. This explorative qualitative study analysed the implementation of the Ward Based Primary Health Care Outreach Teams (WBPHCOT) programme in a large peri-urban area using the National Implementation Research Network's Implementation Stages Framework.

The focus was on one district which was made up of three urban, peri-urban and semi-rural sub-districts (Munshi et al., 2019). Data was collected using in-depth interviews and focus groups with CHWs, team leaders and managers.

In addition to the above observation, Murphy, Moolla, Kgowedi, Mongwenyana, Mngadi, Ngcobo, Miot, Evans and Pascoe (2021) also looked at the CHW policy implementation across six provinces in South Africa but failed to study the impact of COVID-19 on precarious work for CHWs. The provinces include Gauteng, KwaZulu-Natal, Western Cape, Mpumalanga, North West and Limpopo. Unlike Murphy et al. (2019) who analysed the implementation of the WBPHCOT programme, the aim of this study was to explore the reasons for local adaptation of CHW models and to “identify potential barriers and facilitators to implementation of the revised framework” to guide with future planning (Murphy et al., 2021). This qualitative study employed interviews as a method of data collection. A total of 65 in-depth interviews and five focus groups with healthcare

providers, implementing partners, non-governmental organisations and CHWs was employed as methods of data collection.

The findings of the study revealed the following. First, the implementation across provinces varied. For instance, in Limpopo, Mpumalanga and the Western Cape, this responsibility was that of non-government organisations, whereas in North West, Gauteng and KwaZulu-Natal, the process was managed by the provincial departments of health (Murphy et al., 2021). Secondly, the working arrangements for CHWs differed, i.e., in some provinces CHWs would begin their work in the health facility and then proceed and do outreach work in their communities, whereas in some provinces, CHWs only reported once a week in their health facility or health posts (Murphy et al., 2021). However, while these findings were revealed, the precariousness of work for the CHWs was not revealed.

The study also revealed the limitations and challenges that threatened the success of the programme and these included insufficient number of CHWs and outreach team leaders (OTLs), equipment and supplies (Murphy et al., 2021, p. 394). While these findings align with the body of work that focuses on CHWs programme policy implementation, which argued that leadership is a great demand (see Schneider & Nxumalo, 2017) as well as Jinabhai et al (2015) who highlighted how policy is well understood and practiced, resource constraints remain a challenge, and they failed to reveal the precarious working conditions for the CHWs. The study concluded by highlighting the importance of addressing the current policy challenges to implementation, as well as investing in mobile health solutions that assist CHWs in the execution of their duties (Murphy et al., 2021).

Some scholars have provided an analysis of the work of CHWs (see Thomas, Buch and Pillay, 2021), but not its precarious nature. In their work, Thomas et al. (2021) shift the focus on looking at the work of CHWs in the context of disease-orientated activities and provide a detailed analysis of what they do beyond their impact on HIV and TB programmes. Using a descriptive secondary analysis of CHW team activities in Ekurhuleni health district, the findings revealed that CHWs contributed towards reducing the burden of disease in the district (Thomas et al., 2021). In terms of population

coverage, the results of the study showed that the CHWs in this district had “1.7 million headcount activities on screening, tracing, referrals, and linkages to care services were provided to 280 000 households over the 3-year study period” (Thomas et al., 2021, p. 11).

While the above findings from different literature are noted, it is worth noting that none of them referred to the impact of COVID-19 on the precarious working conditions for the CHWs in the Global South. This is the gap that this research seeks to fill. The COVID-19 pandemic has cast a spotlight on the precarious working conditions faced by community health workers worldwide. These frontline healthcare providers play a critical role in delivering essential healthcare services to underserved populations, yet they often work in precarious conditions that are both challenging and put their well-being at risk. Despite the evident importance of understanding the impact of the pandemic on CHWs and their working conditions, there exists a notable research gap in this area. One significant aspect of this gap pertains to the insufficient data on the actual experiences of CHWs during the pandemic.

The preceding discussion of research findings shows that research studies are scarce, and comprehensive assessments of how COVID-19 has affected CHWs' job security, safety, mental health, and access to resources are lacking. This knowledge deficiency hampers our ability to develop effective policies and interventions to support and protect CHWs during crises like the one brought on by COVID-19. Furthermore, the pandemic has exposed systemic inequalities in healthcare systems and how they affect CHWs. The research gap extends to understanding how these inequalities have exacerbated the precarious working conditions of CHWs, particularly those from marginalised communities. To bridge this gap, interdisciplinary research is needed to explore the intersection of public health, labour rights, and social justice issues in the context of CHWs' experiences during the pandemic. Such research can pave the way for evidence-based strategies to bolster the resilience and well-being of these essential healthcare providers in the face of future public health emergencies.

CONCLUSION

The COVID-19 pandemic has shed light on the critical need for more literature and research focused on the impact of this global crisis on precarious working conditions for community health workers. As one of the important officials of our healthcare systems, these dedicated professionals have faced unprecedented challenges and risks during the pandemic. Their roles have been more vital than ever, yet their vulnerabilities have become increasingly apparent. The existing body of literature has begun to highlight some of the hardships and disparities faced by community health workers, but there remains a significant gap in our understanding of the full extent of these challenges. Further research is essential to comprehensively assess the multifaceted impact of COVID-19 on their work, including issues such as job security, occupational hazards, mental health, and the broader implications for community health outcomes. Moreover, this research can serve as a catalyst for policy changes and improvements in support systems for community health workers. By better understanding the unique challenges they face, we can develop strategies to ensure their well-being and enhance their capacity to deliver essential healthcare services to vulnerable populations. This, in turn, will not only contribute to the resilience of healthcare systems, but also promote community health and well-being in the face of future crises.

CHAPTER 3: METHODOLOGY

INTRODUCTION

This study adopts a qualitative research approach to allow the researcher to understand how CHWs interpret the nature of their precarious working conditions. Qualitative research is “an enquiry process of understanding of a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting” (Creswell, 1994, p. 4). In other words, this approach is concerned with understanding how research subjects construct their reality (see Neuman, 1997; Creswell, 1994) and the contexts that shape behavioural patterns (Neuman, 1997). In the context of this research, this approach assisted the researcher in understanding how CHWs understand their working conditions.

In addition to context and emphasis on how research subjects construct and make meaning of their reality, Denzin (1989, p. 83) argues that a qualitative approach allows for a “thick description” of experiences and perceptions. In this research, this approach allows us to understand how CHWs experience and respond to precarity. For Denzin (1989), a thick description refers to the “context, emotion and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience or the sequence of events, for the person or persons in question” (p. 83).

These rich accounts are important and necessary to understand how CHWs interpret and understand their precarious working conditions and lives. Such accounts cannot be quantified and are best analysed using qualitative research methods. This research also makes use of an interpretive paradigm. This paradigm aims at understanding “how participants make meaning of a situation or phenomenon” (Merriam, 2002, p. 6). In this research, this paradigm was appropriate as it allowed the researcher to understand the experience of CHWs from their own viewpoints. The emphasis was on how CHWs interpret their precarious working conditions. Therefore, the use of an interpretive paradigm allowed the researcher to understand the CHWs’ interpretation, perception and

experience of precarity and how they respond to precarious situations. Qualitative research on community health workers' experiences of precarious working conditions amidst the COVID-19 pandemic employs a phenomenological approach to gain in-depth insights into their lived experiences. This methodology involves collecting rich, subjective data that captures the intricate and nuanced aspects of their work environment during the crisis. Data collection methods such as in-depth interviews, focus group discussions, and participant observation are used to understand the unique challenges faced by community health workers. These methods allow researchers to explore the emotional, psychological, and practical dimensions of their experiences. Semi-structured interviews help in uncovering their perceptions of job insecurity, inadequate personal protective equipment, increased workload, and limited access to training and support.

CONTEXT OF THE STUDY

The site of research is the Alfred Nzo District (AND), with a specific focus on two health facilities in Matatiele Local Municipality (MLM). MLM falls under AND. In terms of the Eastern Cape Department of Health demarcation, and has a district office that oversees the running of health facilities in AND. AND is made up of four municipalities: Matatiele, Winnie-Madikizela, Umzimvubu, and Ntabankulu local municipalities. AND is a rural district located in the Eastern Cape Province. This district has very few health facilities and struggles to attract health professionals due to its location and lack of resources.

Nurses in most of the health facilities rely on CHWs to assist them in executing some of their duties, such as following up on chronic patients, screening, and educational outreach to mention a few. CHWs therefore play a significant role

The study was carried out in two clinics i.e. Clinic A and Clinic B. Clinic A is a health facility located in the Magadla Administrative Area. It has nine catchment areas and extends its services to other small clinics close by, as well as to people who live under Elundini Local Municipality due to its accessibility and location. This health facility is more than 20 kilometres away from Matatiele town and more than 40 kilometres away from Tlokoeng (formerly known as Mount Fletcher) which falls under Elundini Local Municipality.

This facility offers primary healthcare services and operates for eight hours from Monday to Friday. This health facility is performing well in delivering its services. However, it is faced with challenges, such as: dilapidated infrastructure; language barriers (staff unable to communicate in Sesotho and Sign languages); limited space, which affects privacy of the patient when being attended to; and poor road infrastructure leading to the clinic, which affects mobile impaired users.

Also, the population serviced by the clinic has a high rate of poverty and unemployment and is largely dependent on social assistance grants.

In addition to the above, due to the high headcount in this health facility and the small number of staff in relation to the population, this facility is unable to meet its targets. Also, this results in long queues in the health facility.

Clinic B is a community health centre (a mini hospital). It is relatively large compared to Clinic A and provides more services to villages that fall under its catchment area than Clinic A.

RESEARCH TOOLS AND THEIR APPLICATION

Data was collected using three qualitative methods of data collection: first, semi-structured interviews; second, observations; and third, document analysis. The researcher also acknowledged her own biases and preconceptions through reflexivity, ensuring that the participants' voices remain central to the study. The qualitative methodology aimed to provide a holistic view of the challenges faced by community health workers during the COVID-19 pandemic, shedding light on the human side of healthcare delivery and informing policies and interventions to better support this crucial workforce.

In this research, semi-structured interviews were useful as it allowed the researcher to collect in-depth data to understand the meanings and perceptions that CHWs attach to their working situations. It also allowed the researcher to probe the CHWs for clarity and to observe facial expressions, gestures and body language. A total of nine face to-face interviews were held in two different health facilities in Matatiele and COVID-19 regulations were adhered to. In taking the necessary precautions of preventing the spread

of COVID-19, the interviews were conducted in the cafeteria (Clinic A) and matron's office (Clinic B). The interviews were held in the workplaces of the community healthcare worker, maintaining social distancing and wearing of masks. The interviews were recorded, and to maintain confidentiality of the research participant, pseudonyms were given to each research subject.

The second method of data collection involved techniques of observation. Observation is used to collect data about people, processes and cultures (Kawulich, 2012, p. 150). Observations can be conducted in two major ways, i.e., participant observation and direct observation (Kawulich, 2012). Participant observation is when the researcher in the study is both the observer and participant, and direct observation is when the researcher observes the research participants without interacting (Kawulich, 2012, p. 151). Gold (1958) as cited in Kawulich (2012, p. 151) states that there are four stances which the researcher may take when conducting observations, i.e., complete participant, participant as an observer, observer as a participant and complete observer. This research adopted the participant approach, which involved the researcher who is "a group member and who observes other members with their knowledge and are fully aware of the study and its purpose..." (Gold, 1958 as cited in Kawulich, 2012, p. 151).

This approach allowed the researcher to gain greater access into the experiences of community healthcare workers on precarity, discourses and perspectives in their own working settings where precarious situations play themselves out. However, due to the period when the data was collected, the researcher was unable to use this method of data collection because of the following challenges. First, the location where the research took place is very remote, and the communities that receive CHW services have difficult terrains to navigate in terms of travelling and reaching out to most of their clients. This required the researcher to have a high clearance vehicle which she did not have.

Moreover, observing the work done by the CHWs in the communities as well as in the health facilities was impossible due to the confidentiality of patients that needed to be maintained at all times.

The last method of data collection is document analysis. This allowed the researcher to use existing textual data (Silva, 2012). In this analysis, official published policy documents were reviewed with the aim of understanding how government policies regulate the work of CHWs. This allowed the researcher to gain a better understanding of the policy framework of community healthcare workers.

SAMPLING

Purposive sampling was used in this study. This allowed for the selection of “information rich cases for the in-depth study” (Gentles et al., 2015, p. 1778). It allowed the researcher to gain “insights and in-depth understanding” of CHWs’ understandings of precarity and how they respond to precarious situations. In addition, it allowed the researcher to select the sample based on his/her own judgment and knowledge of the units of population (Barbie, 1992).

In this study, the researcher believed that the appropriate sample should focus on CHWs employed in a government health facility and based in the Eastern Cape. The size of the sample was determined by the researcher when saturation was reached (see Merriam, 2009; Charmaz, 2003). Saturation refers to a “point of informational redundancy where additional data collection contributes little or nothing new in the study” (Gentles et al., 2015, p. 1781). At Clinic B, the researcher did not generate new additional information. The research participants that were interviewed in this study are CHWs who are above the age of 18 and have been working as a CHW for five years and above.

PROCESS OF ANALYSIS

The data was analysed using an interpretative phenomenological analysis (IPA). This qualitative analytic method concerns “exploring people’s lived experiences and the meanings people attach to those experiences” (Braun & Clarke, 2013, p. 181). This method of analysis was appropriate for this study because it allowed the researcher to interpret the CHW’s understandings and interpretation of precarity in their work settings from their own perspective.

The main feature of this method of analysis is that it focuses on individual experiences and the use of in-depth interviews, allowing the collection of verbatim accounts (Braun & Clarke, 2013, p. 181) of the CHWs on precarity.

The data and interviews were transcribed and translated from isiXhosa to English. Once the translation and transcription were concluded, “significant statements” were identified in the interviews (Kawulich & Holland, 2012) that are directly linked to the lived experiences of precarity by CHWs. From these statements derived from the data, formulated meanings were developed and clustered themes identified (Kawulich & Holland, 2012).

FEASIBILITY, LIMITATIONS AND POSITIONALITY

This qualitative study focused on CHWs from Alfred Nzo District in the Eastern Cape. The nature of this research does not allow for generalisations to be made for the national population. Instead, the findings provide rich and contextualized understandings of precarity from CHWs’ perspectives. The ECDoH granted the researcher provisional approval to conduct the study on 2 November 2021 pending approved final research proposal and ethical approval from the University of the Witwatersrand.

The University of Witwatersrand ethics process approved the research on 2 February 2022. Approval to conduct the study was granted by the ECDoH on 17 February 2022. Due to the COVID-19 pandemic, which significantly altered our ways of doing things, the researcher ensured that the necessary precautions for preventing the spread of the virus were in place.

The face-to-face semi structured interviews were conducted in the matron’s office (Clinic A) and in the kitchen (Clinic B) due to the size that allowed both parties to maintain social distance. Masks were worn during the interview and the provision of sanitisers was in place. Due to the CHWs and their economic position in society, face-to-face interviews were conducted on their date of monthly reporting in the facility to prevent them from having additional commuting costs. The researcher was responsible for data collection and transcriptions of the interviews. However, during the interviews, the researcher noted

that all the participants were not fluent in English. As a result, the researcher conducted the interviews in isiXhosa to cater for the research subjects.

ETHICS

This study adhered to ethical standards of conducting research. It complied with the Wits Ethics Committee which emphasised good research practice and research integrity. Approval to undertake the research was sought from the Human Research Ethics Committee (non-medical) through a submission made by the researcher.

The researcher ensured that the research subjects were not harmed. Informed consent was sought from respondents, with details of the research fully disclosed. The consent letter was explained in isiXhosa for the research participants to understand. In adhering to ethical standards of conducting research, CHW participation in the research was voluntary and they were informed by the researcher that they could withdraw at any time during the research if they did not wish to continue participating.

As part of ensuring confidentiality and anonymity, pseudonyms were assigned to the research subjects (see interview transcripts for reference). In addition to assigning pseudonyms to the CHWs, the data collected was stored in a computer with password protection. There is no bias as the researcher never worked as a CHW, nor in an environment with CHWs. The researcher's interest in community healthcare worker was sparked by their poor visibility in media coverage, despite them playing a huge role in the COVID-19 pandemic.

VALIDITY, RELIABILITY AND DEPENDABILITY

The concept of reliability and validity are applicable in quantitative studies. In the context of this research, the emphasis was on consistency and accuracy, i.e., to what extent are the results consistent with the sample. In ensuring consistency, the concept of dependability, i.e., where the researcher keeps detailed records of all the interviews and observation notes (Garner & Kawulich, 2012) was adhered to.

The keeping of proper records allows for an “audit inquiry” (Garner & Kawulich, 2012) where another researcher outside of the study can look at the data collection methods and analysis and confirm if the meanings and experiences of precarity as articulated by the researcher are accurate. In this research, the two methods of data collection, interview and document analysis were used to strengthen the analytical claims, and also to gain a detailed picture of precarity from the perspective of community healthcare workers. Also, as part of enhancing the validity of the study, only questions that are relevant to the study were asked of the research subjects. Furthermore, validity was enhanced by direct quotes in both chapters four and five.

The results from this research cannot be generalised to the rest of the population of community healthcare workers. However, the findings do permit readers and other researchers to have a richer understanding of the precarious lives of CHWs in the Alfred Nzo District.

CHAPTER 4: PRESENTATION OF RESULTS

INTRODUCTION

In this chapter, the researcher presents the data collected from the interviews conducted with CHWs from both health facilities. The presentation of the data focuses on the two themes that emerged from the data i.e. job security and workload. These findings are presented in a way that provides a comprehensive understanding of the many aspects of CHW experiences during the COVID-19 situation. In do so, this chapter also presents the profile of the study which is crucial in understanding the research subjects.

PROFILE OF THE RESEARCH PARTICIPANTS

DEMOGRAPHICS

The research found that the field of community health work in Matatiele is dominated by elderly black women between the ages of 47 and 60 years old.

The majority of women are between the ages of 50 to 60, with only two in their mid-40s. **Table 2** below lists the ages and clinics the women interviewed in this research are based in:

Table 2: Demographics of participants (pseudonyms)

Name	Age	Clinic
Mrs. Mafunda	55	Clinic A
Mrs. Sokhulu	55	Clinic A
Mrs. Koena	60	Clinic B
Mrs. Kolobe	49	Clinic B
Mrs. Mdlankomo	54	Clinic A

Mrs. Majola	47	Clinic A
Mrs. Lebaka	50	Clinic B
Mrs. Mlandu	52	Clinic A
Mrs. Mdleleni	56	Clinic A

EDUCATIONAL BACKGROUND

In addition to the above, all the women interviewed in this study are from Matatiele and Maluti (a former homeland which is now part of Matatiele in post-apartheid South Africa). They speak isiXhosa and Sesotho languages. Research participants from Clinic A are isiXhosa first language speakers and research participants from Clinic B are Sesotho first language speakers, and so are the communities that they serve.

All their lives they have lived in Matatiele and started working in Matatiele as CHWs. All these women grew up in apartheid South Africa where opportunities were arguably limited for black women.

Due to a lack of opportunities for black women during their time, this resulted in most of them not completing their secondary school and marriage was expected of them. This is articulated by Mrs. Kolobe:

Eehh... I started schooling at Israel JSS where I passed standard 7. I then proceeded to standard 8 in Mtshetshe High School where I failed. I left school and I got married. Later on in life, I studied ABET (pauses), but I forgot the year.

Getting married for these women during their time was not only an expectation, but some were also forced into marriage, and this is expressed by Mrs. Koena in the excerpt below:

Interviewer:
Okay. May I ask Ma, what is your highest level of education? Or you studied until what grade?

Participant:

I studied until standard 6.

Interviewer:

Okay Ma, what did you do after you've passed standard 6?

Participant:

After I passed standard 6 (clicks tongue) I was forced into marriage right after writing the November exams in standard 6. Therefore, I was unable to continue with my studies. It was difficult but I stayed in the marriage. After some time while married, I realised that people in my community are struggling and they need help. I wanted to help people in my community. Also, I loved gardening.

The above excerpts not only highlight one limitation in terms of growth and development for these women, but it also shows how many of them had limited educational opportunities while growing up in apartheid South Africa.

Despite the application of prior recognition of principles being applied to this group, it is evident that the nature of work being contractual comes with many limitations. In the years of service that the CHWs have spent in the field, none of them have been provided with opportunities of further learning.

THEME 1: WORKLOAD

The first theme that emerged from the data is that of “workload”. To understand this theme, it is important to understand the nature of work done by CHWs before the pandemic and during the pandemic. The work done by CHWs is in line with South Africa’s disease burden priorities (National Department of Health, 2018). This area of focus is clarified by Mrs. Mafunda:

Interviewer

What other medication do you collect and deliver other than those you have mentioned?

Participant

There are many medications we collect as there are many people suffering from different diseases.

Moreover, it emerged in the interviews that the training that the CHWs received when the programme started in the late nineties and early 2000s focused on diseases and this is articulated by Mrs. Mdleleni:

...we were also taken to Maluti for training in some workshops where we would learn the importance of a human being, hygiene, importance of clinic visits for checkups for all illnesses. At the clinic all illnesses get checked up from diabetes, high blood pressure, cervix cancer, family planning etc.

The focus on disease is not something that emerged in the Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018-19 to 2023-24 (National Department of Health, 2018).

The 2004 National Department of Health's CHW policy placed emphasis on care and a single disease i.e., Human Immunodeficiency Virus (HIV) (Friedman, 2005). With the increase in HIV and tuberculosis (TB), more CHWs were recruited and trained (Friedman 2005; Schneider et al., 2016).

In addition to disease, health and social care is also part of the work covered by CHWs. In this context, health and social care includes assistance with social services, as highlighted by Mrs. Majola:

We do assist where we can. We also assist with orphans who live with their relatives. We also assist children to access their social security grant as well as those who do not have identity documents and birth certificates.

It also includes providing assistance to the elderly, as explained by Mrs. Kolobe in the excerpt below:

At first we helped them bath, clean for them, talk to them about things they don't have someone to speak about to.

However, the nature of the work done by CHWs also comes with challenges, as expressed below by Mrs. Majola:

As I have mentioned earlier, it is not easy being a community health worker. We are expected to deliver yet we are faced with challenges of people either being receptive or not. We constantly have to be very warm towards the people we want

to help regardless of the situation we are in. Despite all this, I have now noticed how young people, 18 years and above, find it easy to open up about their matters to me. I usually advise them on how to address or manage their challenges.

The challenges are not only limited to people being reluctant in taking up services but includes traveling by foot to distant villages. This comes with a safety issue that is not addressed by the health facilities that the CHWs work under. Some CHWs have indicated that they are unable to cover all the villages that are assigned to them due to distance as well as safety concerns. This concern of CHWs not being able cover all the catchment areas assigned to them is also articulated as a challenge in the *Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018/19 – 2023/24*.

CHWs in this study indicated that working before and during the pandemic were two different experiences accompanied by different challenges. Before the pandemic, the bulk of the work took place outside the clinic, i.e., they worked with the communities and only provided a detailed report to their assigned health facilities at the end of the month.

Each health facility services villages within their boundaries. This means the CHWs in each health facility are assigned to different villages where they conduct door-to-door services, providing health education to pregnant women, following up on chronic patients, encouraging people to visit the health facility for regular check-ups, as well as providing guidance on other social challenges faced by community members. These social challenges include child-headed households without social security, cases that require services of social workers and other issues, such as community members that do not have identity and birth documents, which are a requirement in South Africa in order to access social assistance grants, public health as well as schooling.

In addition to the above, CHWs indicated that they worked three times a week before the pandemic and reported once a month to the health facility. During monthly reporting at their respective health facilities, CHWs compiled monthly statistics reports, and also assisted inside the clinic where needed.

Assistance in the health facility is described by Mrs. Mlandu:

For an example, there is no designated person who is supposed to register patients when they come in. By law, government, or let me say, the Department of Health is supposed to employ a person responsible for administration work. As community health workers, who work shifts here at the clinic, we end up assisting with patient registration.

CHWs felt that this was not within their line of work.

During the pandemic, CHWs indicated that their working arrangements changed. They were expected to work inside the health facility on a day-to-day basis. This resulted in little, or no work done in terms of door-to-door activities for CHWs in Clinic B.

In Clinic A, CHWs worked at the clinic for two weeks and the remaining two weeks of the month were reserved for door-to-door activities in their communities. The day-to-day work during the pandemic included assisting patients with registration for the vaccine, registering patients on site, the screening of patients on arrival, queue management, encouraging community members to get vaccinated and providing education on COVID-19.

CHWs felt exploited as they were not remunerated for the extra hours and additional scope of work. The issue of meagre remuneration was emphasised by all CHWs and they recommended that government should reconsider the nature of employment, as well as their contribution to the public health system. All the CHWs expressed their concerns about remuneration, which has implications for their livelihoods and survival during retirement. At the age of 60, they cannot continue to work, and this is a major concern as they do not have a pension income for survival.

In addition to the above, CHWs further indicated that providing assistance in the health facilities during the pandemic placed them at a health risk as well as incurring additional travelling costs. This illustrates that the nature of the work of CHWs is fluid and not fixed and in the context of COVID-19, the precarious nature of the work of CHWs was exacerbated

THEME 2: JOB SECURITY

In addition to the “workload”, another theme that emerged from the data is that of “job security”. CHWs are also faced with issues of job instability (employed on a contractual basis), no job security, no benefits such as medical aid and pension benefits. These challenges were expressed by all the CHWs interviewed and for them, the lack of these benefits has implications on their livelihoods, e.g., being unable to support their families financially and not having a backup remuneration when they reach retirement age. This data shows how precarity in the workplace extends to the household and this is further discussed in the next chapter.

Job instability has been on-going for CHWs from the beginning of their employment around 1996. The ongoing contractual appointments of CHWs increased the precariousness of CHW work and this is evident in their conditions of service. The precarity of their conditions of service has a negative impact on their household lives. This means that the remuneration that is paid to CHWs is not sufficient to enable them to cater to or meet their basic needs. This can also be linked to Bachieisi’s (2011) argument about precarity transcending the workplace to the household therefore challenging the idea that waged work in post-Apartheid South Africa is a vehicle for change and advancement.

Furthermore, this has led to anxiety about job security for CHWs. This is evident from the data where most of the CHWs expressed that when they reach retirement age, they will not have an income (pension income) compared to permanently employed government employees. This situation will then force them to be dependent on the state social security grant for survival.

In addition to the above, the service of conditions does not create a room for CHWs to advance in their career. This is a result of the lack of opportunities for them to advance their education and explore other areas of growth. Instead, the job keeps them at a stagnant position. This was evident in the data (see Table 3 below) as most of the CHWs have not advanced their qualifications since they commenced in their job.

The highest level of education attained by the respondents is indicated in **Table 3** below.

Table 3: Level of education of CHWs

Research participant	Level of education
Mrs. Mafunda	Standard eight (grade ten)
Mrs. Sokhulu	Standard eight (grade ten)
Mrs. Koena	Standard six (grade eight)
Mrs. Kolobe	Standard seven (grade nine)
Mrs. Mdlankomo	Standard ten (grade twelve)
Mrs. Majola	Standard nine (grade eleven)
Mrs. Lebaka	Standard nine (grade eleven)
Mrs. Mlandu	Standard eight (grade ten)
Mrs. Mdleleni	Standard eight (grade ten)

Of the nine women interviewed, only one passed standard ten, with the majority having completed standard eight. However, the nature of community health work in South Africa does not require a professional qualification. As per the National Department of Health Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018-19 to 2023-24, the minimum requirement for CHWs is grade 12 which is subjected to a training programme (National Department of Health, 2018).

For those who are already CHWs, the recognition of prior learning principles is applied (National Department of Health, 2018). The majority of these women began working as CHWs from 1998 and in the early 2000s before this policy. The lack of career development and advancement for CHWs keeps them at a precarious position.

This precarity is further exacerbated during the pandemic where permanently employed staff members in the clinic were paid COVID-19 allowances and CHWs were not paid because of the contractual nature of their employment. Instead, additional work was

included in their scope of work which placed their lives at risk. In Clinic B, CHWs stated that some of their colleagues contracted the virus while at work because work during the pandemic had shifted from community work to assisting in the clinic. What is reflected here is not the precarious position of CHWs but also job instability.

The implications of this job insecurity results in anxiety about retirement survival as well as

CONCLUSION

In conclusion, this chapter has presented the results of this qualitative study. Drawing on the interviews, this chapter highlighted the two dominant themes that emerged from the data i.e. workload and job insecurity. These results are further explored in the next chapter.

CHAPTER 5: DISCUSSION OF RESULTS

INTRODUCTION

This chapter discusses the experiences of marginalised workers, i.e., CHWs in their delivery of health services before and during the pandemic. This chapter argues that COVID-19 has worsened the precarious working conditions of CHWs, therefore further ensuring that CHWs remain characterised by unstable labour and insecurity. Drawing on interviews and documents, this chapter shows how CHWs navigated their precarious conditions of work before and during the pandemic. It also highlights how precarity, as understood by CHWs, constitutes an interaction between work and life, and the lack of permanent employment with benefits continues to position this type of work as unstable and insecure.

UNSTABLE AND INSECURE WORK

The findings presented show that CHWs play a vital role in healthcare in the Alfred Nzo District, but they face unstable and insecure precarious work conditions. Often employed on short-term contracts or as volunteers, they lack job security and financial stability. This instability not only affects their livelihoods but also hampers the quality of healthcare services they provide. CHWs may experience irregular income, limited access to benefits, and little job protection, making it challenging to commit fully to their roles. This precariousness can result in high turnover rates, impacting the continuity of care in communities. Addressing the issue of unstable and insecure work for CHWs is crucial to ensure resilient healthcare systems and improved patient outcomes.

The *Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018/19 – 2023/24* from the National Department of Health (2017) was developed with the aim of strengthening primary healthcare and to bring primary healthcare closer to vulnerable communities. In doing so, it envisaged a team made up of CHWs, supported by a nurse outreach team leader (OTL) and data capture. This team is an extension of the existing primary healthcare team. The policy framework further defines a community health worker as:

...any worker is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial wellbeing and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.

Moreover, according to Schneider et al (2018, p. 61), the scope of work covered for the CHWs in the policy framework includes the following:

- *Conduct community, household and individual-level health assessments.*
- *Identify potential and actual health risks and assist the household or individual to seek appropriate care.*
- *Screen and refer individuals for further assessment and testing.*
- *Identify pregnant women and conduct home visits during pregnancy and the postnatal period to promote healthy and safe births and identify danger signs.*
- *Provide support for healthy maternal-child behaviours, including exclusive breastfeeding.*
- *Provide screening and health-promotion programmes in schools and early childhood development centres, working in partnership with school health teams and other HCWs.*
- *Counsel on and provide support for family planning choices.*
- *Provide follow-up and assistance to persons with chronic health problems, including distribution of medicines, help with adherence to treatment, and defaulter tracing.*
- *Promote and work with other sectors and undertake collaborative community-based interventions such as early childhood development interventions and geriatric care.*

The above scope of work in the policy framework was also confirmed by the CHWs when describing their training, and their work before the pandemic. Below, Mrs. Mlandu's narrative of their work before the pandemic aligns with the policy framework:

Among the things we were taught there, we were taught how to care for a child. If you have a child, you monitor how they are growing. Also, it is important that as soon as the child is born the mother of the child must only breastfeed. Within six months the mother must not give the child water. There is this belief in the rural areas that you must give a child water with salt and sugar to drink. There they said no you don't give a child anything. You only breastfeed the child. You give them soft food within the six months. You can start cooking pumpkin/butternut for the child, you can give the child sour milk and pap as well. But make porridge with butter, peanut butter for the child. You can even put in margarine (Rama) and milk.

We were also taught about the stigma that exists in our communities, i.e., people not wanting to go the clinic for checkups because of their preconceived ideas about

the clinic. We were encouraged to engage with community members and educate them about the importance of the clinic and doing regular checkups. Regular checkups are important because illnesses are identified at their early stages and attended to before it is too late.

The CHWs interviewed in this study, when describing the nature of their work before the pandemic, paint a picture of loving the work that they do but also expressed difficulties associated with the job. Some of these difficulties are narrated by Mrs. Kolobe below:

I enjoy being a community health worker because I am passionate about community health work. However, we work in difficult conditions. We do not have uniforms. We end up buying them at our own cost because we love our work and the people we work with. Even on wet and cold weather conditions, it is difficult to work but we continue to do the work because we love helping people.

The excerpt above paints a picture of a CHW who is deeply invested in the work she does but also expresses the difficulties of not being provided with proper working tools. This forces her to use the little she earns because she needs the resources to execute her job. Whilst this depicts a CHW who has a strong passion for her job, as well as difficulties that are part of the work, it also highlights what Standing (2015) refers to as a class structure that is exploited and lacks income. This exploitation is not only in terms of remuneration, but also fewer rights in the workplace compared to their colleagues who are afforded benefits because of their permanent employment status. These benefits afforded to permanently employed health workers are explained below by Mrs. Mafunda in her conversation with the researcher:

Participant: I would be happy if our work would be recognised as well as for us to receive the benefits that are being received by other government employees. I want us to be permanently employed. We are aware that permanently employed government employees receive benefits. We would appreciate if we could receive them, this would encourage us to do more in our work.

Participant: They have a lot of benefits that they receive such as the housing allowance.

Interviewer: Mhh...

Participant: We do not receive anything from government. Absolutely nothing.

Interviewer: Mhh...

Participant: They are fortunate because they receive the uniform allowance. As for me, I have to buy it with the little I have.

In addition to the above, i.e., lacking rights that would afford them work benefits, CHWs are heavily dependent on the stipend they receive to buy work resources as well as to make ends meet with regards to their livelihoods. From this, it is evident that CHWs are characterised by “rights insecurity” (Standing, 2015) even before the pandemic. This implies that the rights of CHWs are systematically taken away from them by the state (the employer) by virtue of offering them contractual work. Being a contractual worker, as described above, means that one receives a stipend which is not adequate for living. It also means that they have limited “range and depth of civil, cultural, social, political and economic right” (Standing, 2015, p. 6). These rights are tied up to citizenship. This concept of rights being tied to citizenship and work is further discussed in the next section of this chapter.

Moreover, the lack of income stability puts CHWs in a place of “chronic uncertainty, facing a life of ‘unknown unknowns’” (Standing, 2015, p. 6). As described by Mrs. Sokhulu below, uncertainty is very common during contract renewal, which occurs annually:

Researcher: Okay Ma, do you receive any benefits from your employer (government)? If yes, what are those benefits?

Participant: We are employed on a contract. We only receive a stipend. However, there two months usually goes by without us receiving a stipend.

Researcher: Do you receive the stipend on a monthly basis?

Participant: Yes, we receive the stipend every month however, we do experience some challenges of not receiving the stipend when we renew our employment contracts. Another challenge is that we are expected to provide our uniform sizes for order placement, but we never receive the uniforms.

In addition to the above, CHWs experienced working conditions that went beyond the scope of ‘normal’ individuals in the labour force (Standing, 2015). This was evident before and during the pandemic. For instance, before the pandemic, CHWs expressed how they performed duties inside the clinic which were not supposed to be performed by non-clinical health workers. These duties are expressed in the conversation between the researcher and research participant below:

Participant: We do assist inside the clinic however, based on my assessment, I do not think some of the work we do falls into our work scope.

Interviewer: Please explain, what kind of work are you referring to?

Participant: We assist with the cleaning and registration of patients.

Participant: This is not our line of work!

Interviewer: Besides the registration of patients, what else do you do here at the clinic?

Participant: For instance, when they are drawing blood samples from patients, they would request us to update the register but that is also not part of our scope of work.

Interviewer: Oh okay!

Participant: That's not part of the scope of work.

Not only do they go beyond their normal scope of work as Standing (2015) describes, CHWs also lack employment security. This implies that the employer is failing to adhere to the rules, thus resulting in CHWs performing work that is beyond their scope of work (Standing, 2015). The scope of work for CHWs includes conducting door-to-door visits in their communities, carrying out health assessments, identifying health risks and referring people to the appropriate care, providing support and follow ups to chronic patients, providing health promotion programmes to schools, collaborating with community based interventions, tracing defaulting chronic patients, and assisting with adherence to treatment, as well as distributing medicines to chronic patients (Schneider et al., 2018 p.61). While this scope of work is confirmed by CHWs when describing their work, there seems to be a pattern of work outside their scope of work that is evident. This is enabled by lack of forms of protection in the workforce as well as human resource challenges and nurses being overloaded in these facilities. This is evident in the excerpt below that shows how work is shifted to CHWs by the nurses in these facilities:

Nurses are supposed to dispense medication to the patients however, we end up dispensing the medication. The sisters only write the prescription.

These challenges pose great risk to the Department of Health as errors in the dispensing of medication can lead to litigation.

During the pandemic, the pattern of employment security was evident as well as poor working conditions, as articulated below:

When the vaccine became available, we assisted inside the facility. We assisted in the new block. That is where people collected their cardiac, TB and hypertension medication. In addition to the collection of medication, the COVID-19 vaccine site was also in the same area. Due to all the work being done in the new block, it was overcrowded to such an extent that I struggled to breathe.

The block was overcrowded. We were working under difficult conditions. Due to our frequency in the clinic, we ended up spending a lot of money on commuting to the clinic. It was much better when we used to come to the clinic on Fridays only.

We were helping out the vaccination team. You'd find out that we spend a 1000. This affected our household budgets as we ended up being unable to fulfill some of our household commitments such as our children's needs and affording meals for lunch while we work in the clinic.

The above working conditions and changes during the pandemic reflect an absence of choice that is characterised by low income, no access to justice and no employment protection (McKay, Clark and Paraskevopoulou, 2011, p. 6). This is a result of the employer trying to reduce costs and shifting the burden to CHWs. The absence of choice and conditions of employment leave CHWs without any dignity. Decent work in post-apartheid South Africa has been tied with social citizenship. This means that policies of social inclusion in post-apartheid South Africa emphasised decent and meaningful work which has been tied to citizenship (Barchiesi, 2011). This also means that citizens' participation in the economy is very important. In the context of these CHWs, work is meaningful because of their love for their work, as well as the impact it has in their communities. However, such work is not associated with dignity and citizenship as it leaves CHWs vulnerable. Also, the data in this research shows that work for the poor remains unstable and insecure, and as Barchiesi (2011) states, work becomes a vehicle for poverty, therefore departing from the principles embedded in social inclusion policies in South Africa. For CHWs, they all come from disadvantage backgrounds and their jobs continue to trap them in the same cycle of poverty instead of improving their social conditions.

Also, not only does the above highlight how CHWs work is a vehicle for poverty, but it also shows how precarious work is not only unstable employment but a social condition that they experience in their lives. In other words, precarity cannot be understood as a condition as experienced in the workplace but also in the social lives of CHWs. This is articulated by Mrs. Sokhulu in her conversation with the interviewer below:

Interviewee: I'd also like to get help by being able to help raise my children.

Interviewer: Okay, explain that...

Interviewee: To get money.

Interviewer: Okay, speak mama. I mean explain what you're saying about wanting to help your children.

Interviewee: So that I can earn money. I wish I could get a promotion and be employed permanently. Currently, I'm on a fixed-term contract. I want to be permanently employed so that I can send my children to school because there is at home unemployed. I'm the one looking after the children.

Interviewer: Wait...if you were to be employed permanently what would change as you are not employed permanently currently?

Interviewee: It'd make a difference to me in relation to helping the kids because now when they complete high school, I can't take them to tertiary institutions of learning and teaching.

Mrs. Sokhulu's remuneration is not sufficient to enable her to improve the social conditions of her children. She is unable to send her children to tertiary institutions to further their education. Her inability to do so results in her children being trapped into a cycle of poverty, because the environment she lives in does not have economic opportunities for herself or her children. Being trapped in poverty becomes part of CHWs lives, as during retirement, they do not receive any income to sustain themselves, as explained by Mrs. Koena below:

Are there people who volunteer for 22 years I am aging here. It's been 22 years since I volunteered since 2000. Is there someone who volunteers for 22 years apart for the ones at Alfred Nzo? I am closer to retirement age. I will leave work soon. I'm about to reach 60 years and if I feel like I will make it to 65 but I am worried what will I leave with when I retire? What will I leave with after so many years? You see?

CONCLUSION

In closing, the above shows how CHWs remain in precarious positions, both in the workplace as well as in their social lives. Also, the above concurs with Barchiesi's (2011) argument of work being a problem under neoliberalism, i.e., the work done by CHWs. Therefore, it is important that the data shows that the work of CHWs does not provide them with upward mobility, rather it is a vehicle of poverty.

CHAPTER SIX: DISCUSSION AND CONCLUSION

This chapter will provide a narrative of the key insights of the research. The aim of this study was to examine the precarious working conditions of CHWs. Studies on CHWs have tended to focus on the implementation of the policy framework of CHWs (Schneider et al, 2008; Munshi, Christofides and Eyles, 2019), gendered aspects of CHWs (Thabethe 2011; Maes, 2012; Swartz & Colvin, 2014) and motivations for becoming CHWs (see Akintola, 2011; Nkonki, Cliff, & Sanders, 2011; Olang'o, Nyamongo, & Aagaard-Hansen, 2010; Dageid, Akintola and Saberg, 2016). In joining the conversation on CHWs, this study took a different approach and focused on the subjective experiences of CHWs, as there are few studies that have looked at precarious workers in South Africa (see for instance Sefalafala, 2012; Murahwu, 2016, Fobosi, 2021). Drawing on the work of Standing (2011; 2014; 2015) and Barchiesi (2011), this study aimed at contributing to research on the subjective experiences of precarious workers. The findings revealed that COVID-19 worsened the precarious working conditions of CHWs. The findings, as discussed in chapter five, are not a representation of CHWs in South Africa, but give us an understanding of precarity from the perspective of CHWs in two health facilities in Matatiele, Eastern Cape.

In order to understand the subjective experiences of CHWs, in-depth interviews were employed as a method of data collection. In-depth interviews allowed this research to examine the understanding and experiences of CHWs. The interviews were supplemented with policy documents. The policy documents were vital as they allowed the researcher to verify some of the issues raised by CHWs, such as their job descriptions and some of the challenges that they expressed.

The work of Standing (2011; 2014; 2015) offered insights in understanding the nature of CHW work as narrated by CHWs themselves. This work is unstable and insecure as it is contractual in nature, as well as lacking working resources and support. This is what Standing (2015) terms as “rights insecurity” (Standing, 2015), which is not only limited into their work sphere but interfaces with their lives. This interfaces between work and life, for CHWs illustrates Barchiesi's (2011) argument that precarity is not just insecure work but a condition that a person experiences in their lives. For Barchiesi (2011), employment in South Africa is tied with citizenship, i.e., work is viewed as a vehicle out

of poverty. However, for these CHWs, this is not the case: instead, they continue to be trapped in poverty and in the context of COVID-19, the situation worsened. This was a result of CHWs being expected to assist health facilities daily, unlike before COVID-19, when they reported to the facility once a month. This further added more travelling costs that had to be catered for in the monthly stipend. This left CHWs in a far worse position. As indicated by some of the workers, they are unable to assist in uplifting the lives of their children. Therefore, they all remain trapped in poverty.

The findings in this study also align with the work of Breman (2013) who argues that work in the South has always been precarious. In the context of CHWs, the nature of their work has always been precarious as they all began as volunteers, and later they earned a stipend. Their volunteer status placed them outside formal employment. Moreover, this kind of work not only placed them outside formal employment but brought about insecurity and uncertainty.

In addressing this insecurity and instability as a result of precarity experienced by CHWs, this study suggests that the National Department of Health reviews the current policy, taking into account the academic work on CHWs and the role they play in the health sector. The policy must address the outstanding issues, such as remuneration, nature of employment, scope of work, working resources, and also ensure uniformity across all provinces. In doing so, this will help to address the unstable and insecure work that is articulated by the CHWs interviewed in this study.

In addition to the above, it is important to note the limitations to this study. These included difficulty in accessing most of the community healthcare workers in both health facilities. CHWs report to their respective health facilities once a month. Most of them travel distances to reach the health facilities as they all live in distant remote villages that are serviced by the health facilities. The time they spend during their reporting day at the health facility is limited as they must leave after a certain time to the unavailability of public transportation after two in the afternoon. This resulted in the researcher interviewing a limited number of CHWs.

Language barrier is another limitation to this study. Research participants from Clinic B are Sesotho first language speakers that are not well conversant in isiXhosa and English languages. This posed a challenge for the researcher as she was unable to translate the question to Sesotho for some research participants that were keen on taking part in the study.

Moreover, it is important to note that due to COVID-19 regulations in place as well as the size of both facilities, it was difficult for the researcher to observe the work of the CHWs in communities due to patient and health worker confidentiality that has to be maintained at all times as well as locations in which the CHWs work in that require high clearance vehicles to move around of which the research did not have access to the required resource.

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ANNEXURE A: INTERVIEW GUIDE

My name is Andisiwe Mthatyana and I am a Masters student in Management (Public & Development Sector Monitoring and Evaluation) at the University of Witwatersrand. I am studying the impact of COVID-19 on the precarious working conditions of CHWs. Thank you for agreeing to participate in this study. In an attempt to maintain your anonymity, your name will not be recorded. Furthermore, let me inform you that you have the right not to answer any question on the interview and you are welcome to withdraw from the interview at any time. More so, let me clarify to you that there are no immediate monetary benefits for your participation in this study. The outcomes of the study will be used for academic purposes as indicated in the consent form. Once again, I thank you for agreeing to participate. I will begin the interview by asking you a few closed questions, and then I will ask you some open-ended questions regarding your understandings of and responses to precarity. If there is a question that you do not understand, please ask for clarification.

Name of interviewee: _____

Participant signature: _____

Name of health centre facility: _____

Name of district: _____

Name of interviewer: _____

Date of interview: _____

ANNEXURE B: INTERVIEW QUESTIONS

Section A: Background Information/Being CHW before COVID-19

1. How old are you?
2. Gender?
3. Tell me more about your educational background?
4. How did you end up being a CHW? Why did you choose this particular profession?
5. Please describe your working experiences and challenges before COVID-19?
6. How do you describe community healthcare work in Alfred Nzo District?
7. What are the challenges that your patients are experiencing before COVID-19?
8. Describe the relationship between CHW and formally employed health workers?
9. What do you think CHW is all about?
10. Tell me about the benefits that you receive from government, and what are they?

Section B: Working during the pandemic

1. Please tell me about your working experience as a CHW during COVID-19? What challenges did you face?
2. Describe the work related training provided to you during COVID-19?
3. What has government done to assist you during the pandemic?
4. What recommendations would you give to government in relation to the nature of your work during COVID-19?

Section C: Impact of precarity on CHW

1. What are the differences do you see between CHWs and formally employed health workers?

ANNEXURE C: PERMISSION LETTER



University of the Witwatersrand,
Wits School of Governance
St Davids Place, Parktown
Johannesburg,
2050.

Dr. Rolene Wagner: Head of Department.
Eastern Cape Department of Health
Dukubana Building,
Independence Avenue, Bhisho
Private Bag X0038,
Bhisho, 5605.

30/09/2021

Dear Dr. Rolene Wagner

Re: Permission to conduct research with Community Health Workers (CHWs) at the Eastern Cape Department of Education

My name is Andisiwe Mthatyana. I am currently studying for a Master of Management at the Wits School of Governance, University of the Witwatersrand. The purpose of this letter is to seek permission to conduct research with CHWs at your respective institution; the **Eastern Cape Department of Health**.

I am conducting research on the impact of COVID-19 on precarious working conditions for community health workers (CHWs) in Alfred Nzo District in the Eastern Cape Province. The study is entitled: ***The impact of COVID-19 on Precarious Working Conditions for Community Health Workers in Alfred Ndzo District, Eastern Cape***. The aim of the study is to understand the impact that COVID-19 has had on the precarious working conditions for CHWs. In other words, this research will investigate whether the pandemic has worsened the working conditions for CHWs.

The research will entail collecting qualitative data through interviews and observations from CHWs based in Alfred Nzo District at the Eastern Cape Department of Health through participation in a voluntary face-to-face interviews and maintaining COVID-19 precautions.

I will invite individuals from your organisation to attend a session where I will explain the purpose of the research and issue out consent letters for those who want to take part in the study. All current CHWs employees based in Alfred Nzo District are eligible to participate in the study as

they are working for the provincial government department. If they agree, they will be asked to take part in a 45 to 60 minutes face-to-face interview.

Participants responses will be treated confidentially, and identities will be anonymous unless otherwise expressly indicated. Individual privacy will be maintained in all published and written data resulting from the study. The results will be communicated in the dissertation in partial fulfillment of the Master of Management in Governance (Public and Development Sector Monitoring and Evaluation).

The research participants will not be advantaged or disadvantaged in any way. They will be reassured that they can withdraw their permission at any time during this project without any penalty. There are no foreseeable risks in participating in this study. The participants will not be paid for this study. All research data will be preserved anonymously for reuse by other researchers.

I therefore request permission in writing to conduct my research at your organisation. The permission letter should be on your organisation's headed paper, signed and dated, and specifically referring to myself by name and the title of my study.

Please let me know if you require any further information. I look forward to your response as soon as is convenient.

Yours sincerely,

Andisiwe Mthatyana

Mobile: +27 71 105 1708
N0709525t@students.wits.ac.za

Supervisor: Lihle Ngcobozi
Lihle.Ngcobozi@wits.ac.za

ANNEXURE D: PARTICIPANT INFORMATION SHEET



UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Dear participant,

Thank you for taking the time to participate in this interview. I am a registered as a student at the University of the Witwatersrand – Wits School of Governance (WSG), completing a Master of Management degree in Governance (Public Sector and Development Monitoring and Evaluation).

I am conducting this research as part of the requirements for award of the degree. The purpose of this research is to examine the impact of COVID-19 on precarious working conditions for community health workers (CHWs) in Alfred Nzo District in the Eastern Cape Province.

Taking part in the interview will require about 45 to 60 minutes. Your participation is voluntary. You will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study, you may choose to withdraw without giving a reason, by simply informing the researcher that you no longer want to take part in the interview. The interview will not ask any information that may lead to identification of any participant.

Your identity and responses will remain anonymous. This research is for academic purposes only and the information obtained will be kept strictly confidential.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you (optional). The data collected from this research project will be stored in password protected computer. With your permission the data collected from this research project may be used by other researchers (optional). If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,
Andisiwe Mthatyana

Researcher:
Andisiwe Mthatyana, 0709525t@wits.ac.za , 071 105 1708

Supervisor:

Miss Lihle Ngcobzi, Lihle.Ngcobozi@wits.ac.za , 0117173502

ANNEXURE E: CONSENT FORM

Title of project: The impact of COVID-19 on Precarious Work for Community Health Workers in the Alfred Ndzo District

Name of researcher: Andisiwe Mthatyana

I,, agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
---	-----	----

I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
---	-----	----

I agree that the interview may be audio recorded	YES	NO
--	-----	----

I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO
--	-----	----

..... (signature)

..... (name of participant)
..... (date)

..... (signature)
..... (name of person seeking consent)
..... (date)

ANNEXURE F: ETHICS APPLICATION APPROVAL

HREC (Non-Medical) Ethics Clearance Application – SCHOOL COMMITTEES

University of the Witwatersrand, Johannesburg

Ethics Application Form for Human Research Ethics Committee (HREC Non-Medical) (SCHOOL ETHICS COMMITTEES: Revised January 2020)

Instructions

1. This form must be completed by Honours (4th year) and Masters by Coursework and Research Report students who require ethics clearance, or for ethics clearance for coursework activities as part of a taught degree. Note that staff non-degree applications, PhD and research Masters students must complete the online form.
 2. Completed applications must be submitted to the relevant School Ethics Committee.
 3. Applications may be submitted as hard or soft (electronic) copies, but the first page of the application must contain the signatures of the student and supervisor. Final revised versions must be in soft (electronic) copy as all documentation will be archived.
 4. Incomplete or handwritten applications will **NOT** be considered, including where signatures are missing.
 5. Necessary supporting documents (e.g. *Participant Information Sheet*, *Consent Form*, copies of instruments, permission letters), must be provided.
-

SECTION A

Complete this checklist to show what documents you have submitted and that you agree with the conditions of application.

☒	Completed <i>Ethics Application Form</i> .
☒	Copy of the <i>Research proposal</i> .
☒	Copy of proposed <i>Research instruments</i> (e.g. questionnaires/interview schedules).
☒	<i>Participant Information Sheets</i> (for each different sample group and/or instrument used).
☒	<i>Consent forms</i> (for each different sample group and/or instrument used).
☒	<i>Relevant permission letters</i> if required (from, e.g. company's HR department, National authorities such as Government departments, etc.) - consult the <i>Guidance on the Use of Permission Letters</i> document.

SIGNATURES (REQUIRED)

Declaration: We, the signatories, declare that all information on this form is correct and that we will strive to maintain the highest ethical standards in this research at all times, according to disciplinary and university expectations, recognising that ethical practice in research is always a continuing process.

I recognise that it is my responsibility to conduct my research in an ethical manner according to Guidelines of the University of the Witwatersrand, according to any laws and/or legal frameworks that may apply, and according to the norms and expectations of my discipline. In preparing this Application for Ethics Clearance form, I have consulted the <i>Guidelines for Human Research Ethics Clearance Application / Non-Medical</i> (available on this website https://www.wits.ac.za/research/researcher-support/research-ethics/ethics-	☒ Yes	☐ No
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committees/). In receiving ethics clearance, I agree to abide by the conditions of data collection as outlined in the *Guidelines* document.

By signing this form, the researcher and supervisor of this project undertake to ensure that any amendments to this project that are required by the Human Research Ethics Committee (Non-Medical) and School Ethics Committees are made before the project commences.

	Date	Name	Signature*
Applicant	30/09/2021	Andisiwe Mthatyana	A.Mthatyana
Supervisor	30/09/2021	Lihle Ngcobozi	L.Ngcobozi

*electronic signatures are permitted but there are requirements governing this – please see *Guidelines* document.

SECTION B

1. Summary of risk categories of this research project			
1.1 Does this project involve human participants?		☒ Yes	☐ No
1.2 I have read and understood the risk categories table <i>Applicants must have read the table of risk level category definitions on the final page of this document. This table is also available on the University Ethics Committee webpage.</i>		☒ Yes	☐ No
1.3 The applicant must tick the box for the category that best applies to this project:			
Risk category	Tick the appropriate box		
No risk			
Minimal risk			
Low risk	☒		
Medium risk	☐	Medium or high risk applications must be submitted by the School ethics committee to the University HREC	
High risk	☐		
1.4 Are participants selected as experts ?		☒ Yes	☐ No
1.5 Will human participant research involve vulnerable categories ?		☐ Yes	☒ No
If YES state which ones: N/A			
If YES , how will existing vulnerabilities among research participants be addressed? N/A			

1.6 Does this research expose either the participant(s) or the researcher(s) to any potential risks or harm to which they would not otherwise be exposed? ☐ Yes ☒ No
If YES, how will potential risks or harm be addressed? N/A
NB: Vulnerability is context specific. The term 'vulnerable categories' includes, among others, children under 18, orphans, prisoners, persons with cognitive or communication disorders, people who are traumatised or currently in traumatic situations. Vulnerable categories <u>do not</u> necessarily include poor or marginalised communities, older people, women, people with disabilities (unless it results in diminished capacity to give informed consent). Not all research involving 'vulnerable categories' is Medium or High Risk research: here vulnerability must be considered in terms of the nature of the research and the context in which the research is carried out. Where necessary, include details of steps to be taken to facilitate data collection across language barriers (e.g. interpretation or translation).

2. Researcher's personal data	
Your family name: Mthatyana	Your first name: Andisiwe
Title: ☐ Mr ☒ Ms ☐ Other : _____	
School:	Wits School of Governance
Your student number:	0709525T
Your email:	0709525T@students.wits.ac.za
Your tel number:	+27 7105 1708
Name of supervisor(s):	Lihle Ngcobozi
Your supervisor's Wits email:	Lihle.Ngcobozi@wits.ac.za
Your supervisor's Wits tel number:	0117173502

3. Research project
3.1 Title of research project: The impact of COVID-19 on Precarious Working Conditions for Community Health Workers in Alfred Ndzo District, Eastern Cape
3.2 Is this research for degree purposes? ☒ Yes ☐ No
If so, for what degree? ☐ Honours ☒ Masters (research report) ☐ Other (specify) _____
3.3 Has it been approved by the relevant School or Faculty higher degrees committee or other relevant unit? ☐ Yes ☐ No ☒ Submitted and pending
3.4 Will any additional researchers be covered by this ethics protocol (including translators/interpreters, research assistants, etc. but not including supervisors)? ☐ Yes ☒ No If yes, please specify their names, affiliations and roles:

N/A

3.5 What are the **aims and objectives** of the research? (Please be specific)

This specific research question is “What is the impact of COVID-19 on precarious working conditions for CHWs?” In order to address this question, the following sub-questions will be answered:

- (a) Did COVID-19 worsen precarious working conditions for CHWs?
- (b) How do CHWs perceive of their working conditions in the context of COVID-19?
- (c) How do CHWs navigate their precarious conditions of work?
- (d) What measures have been instituted by government in improving working conditions for CHWs under the COVID-19 conditions?
- (e) In what ways do CHWs feel government could do better to improve their working conditions?

3.6 Summary or abstract of the research This is a qualitative study drawing on the work of Guy Standing’s concept of the precariat to understand the impact of COVID-19 on the precarious working conditions for CHWs in the Eastern Cape Department of Health. The purpose of this research is to explore the impact of COVID-19 on precarious working conditions for CHWs in Alfred Ndzo District, Eastern Cape, with specific reference to whether the pandemic has worsened the precariousness of their conditions. This location has been chosen due to its ruralness and the role that CHWs play in facilitating access to healthcare in this context.

3.7 Do you have any **financial or material interests or a familial relationship** associated with your research participants or with the organisations that you will be involved with in your research?

☐ Yes ☒ No

will **manage any existing or potential conflicts of interest**, if applicable:

If yes, please explain how you

N/A

4. Formal permission

4.1 Where will the research be carried out? (Please give a specific location and /or the names of specific organisations or institutions)

Eastern Cape Department of Health with CHWs based in Alfred Nzo District.

4.2 Has appropriate **formal permission been obtained**, if required (e.g. employer, government department, land owner, etc.)?

☐ Yes (attached) ☐ Not required ☒ Pending (must be supplied before ethics clearance can be given)

NB: Obtaining permission is often necessary when conducting research *within the premises* of a particular site such as an ethnographic study of the functioning of a supermarket or a school, or the way staff interact with clients in a clinic or how members of a closed social media group interact/post on a specific topic. Permission is also required to use data from personal communication with participants or experts. Please note that any research done on Wits University campuses with employees or students of the University requires formal permission from the Registrar. Please read the detailed guidelines on Permission Letters from the Ethics website <https://www.wits.ac.za/research/researcher-support/research-ethics/ethics-committees/>

5. How will data on human research participants be collected (instruments, methods, procedures)? (tick all applicable boxes) (**NB:** All applicable instruments must be attached to the application)

☐	Hard copy questionnaires or diagnostic tests, etc.
☐	Online instruments (e.g. questionnaires, surveys)
☒	Individual interviews (e.g. structured, semi-structured, etc.)
☐	Personal communication (e.g. email or informal conversation with experts)
☐	Group interviews (e.g. seminar/discussion groups, focus groups, etc.)
☒	Ethnographic observation, participant observation, other informal descriptive, and/or interactive methods (you <u>must specify</u> ethnographic methods in the box below)
☐	Autoethnography
☐	Community-based methods or techniques such as drama workshops, community theatre, training workshops, participant rural appraisal, rapid rural appraisal, etc. (you <u>must specify</u> in the box below)
☐	Research on/in therapeutic or counselling contexts
☐	Putting on your own exhibition / public performance
☐	Observation of other public performances, and/or public behaviour observation
☐	Photography
☐	Video recording
☒	Audio recording (e.g. of interviews)
☐	Use of data from social media
☐	Other research methods or techniques (you <u>must specify</u> in the box below)

Explanation of **research methods** specified above, and / or explanation of any other **research methods that are not listed** above:

6. Who will the research participants be?

6.1 List the **different** participant groups (e.g. experts, community members, key informants) that you will be working with in your project:
CHWs employed at the Eastern Cape Department of Health based in Alfred Nzo District.

6.2 Description of these participant groups, including **age range** and **sample size**, for **each group**:

Any CHWs employed at the Eastern Cape Department of Health. A purposive sampling will be used in this study. All employed CHWs regardless of age will be interviewed. The sample size will be determined when saturation is reached.

7. How will informed consent be obtained?	
7.1 How will potential participants be identified / selected / recruited ? Concerning issues of confidentiality, the study will not have access to individual personal information at the Eastern Cape Department of Health, rather a session will be held by the researcher with the District Manager of Alfred Nzo District and CHWs to explain the study in detail. This will be accompanied by formal letter written in English, isiXhosa and Sesotho which will be given to all CHWs, introducing the study. All CHWs will have the option of voluntarily accepting or declining to participate in the study in the letter.	
7.2 Will any incentives be offered to participants? (NB: it is NOT compulsory to offer any incentives. Please note for any curricula incentives, permission is required from the Registrar's office and DVC. Fiscal incentives are limited to R150 – see <i>Guidelines</i> document) If YES , please explain: N/A	☐ Yes ☒ No
7.3 How will informed consent be obtained? ☒ Formal (Signed form) ☐ Informal (e.g. verbal) ☐ Other (e.g. online survey)	
If you cannot obtain formal written consent , explain why: NB: Attach <i>Participant Information Sheets</i> and <i>Consent Forms</i> for each sample group (please label these carefully), and/or other related materials. It is essential that participants in research be fully informed (irrespective of the method used) and then be able to agree on this basis to participate in the research.	

8. Protecting participant identities			
8.1 Can confidentiality of participants' responses be guaranteed throughout the data collection process?	☒	Yes	☐ No
8.2 Can anonymity be guaranteed throughout the data collection process?	☒	Yes	☐ No
8.3 Can anonymity be guaranteed in resulting research reports or publications?	☒	Yes	☐ No
8.4 Explain how you will manage issues of anonymity and confidentiality in your project (What will participants be told in this regard?): The interview questions are designed not to ask any personal or identifiable information. Any biographical information asked is only reported on in broad context as a percentage and used to emphasize a significant finding, e.g., high percentage of black females working as CHWs compared to male counterparts. A thorough participant information sheet will accompany the interview sheet which explain ethical protocols which are reiterated throughout the interview process.			
Definitions: <i>Confidentiality</i> : that any information considered confidential by the participant or researcher will not be disclosed to others. <i>Anonymity throughout the data collection process</i> : that you as the researcher will not be able to identify the participant. <i>Anonymity in the resulting reports</i> : that the participant's name/identifying data will not be disclosed and that anyone reading your results will not be able to identify the participant. NB: While confidentiality may be desirable, it cannot be guaranteed in, for example, focus groups, or ethnographic observations. Similarly, anonymity should be preserved in questionnaires, but cannot be offered in workshop methodologies, focus group research, etc. Participants should have the right to remain anonymous in the final report and this must be respected in handling of all data relating to them. Participants need to be informed about these issues through the <i>Participant Information Sheet</i> .			

9. Protection of data during and after the research

9.1 How will the data be protected while the research is **in progress**? (This includes how the identities of participants will be protected).

All participants will be given pseudonyms to protect their identity. All recorded interviews will be stored securely through the use of password protected files.

9.2 What is to be done with the research data **after completion** of the project? Please note that usage of data should be consistent with what is indicated to participants in the *Participant Information Sheet* and *Consent Form*.

☐	Stored in archives (specify below)	☐	Stored in online database (specify below)
☒	Stored in password protected computer	☐	Stored in digital form with all identifying features removed
☐	Stored for future secondary analysis	☐	Destroyed after ... years (insert numbers of years, if applicable)

Please specify which **archives or online databases** will be used (if applicable):

NB: 'Raw' or unprocessed data, especially **where the identity or personal data of research participants is included, must be safeguarded** and preserved from unauthorised access. Data may be destroyed after use, but **preservation in an archive or personal collection** may also be appropriate, desirable or even essential. For instance, datasets that contain **historically important information** or information that relates to **national heritage** must be preserved and should be placed in a public archive where possible and appropriate. All data should be preserved in a way that **respects the nature of the original participants' consent**. If you are unsure about the procedure of data management and storage, please contact the Data Services Librarian.

10. Summary CV of applicant

ALL boxes in the following table must be completed by the applicant. Do not attach a formal CV to your application.

10.1 List your academic qualifications. Include dates or current registration status	Bachelor of Social Science, Rhodes University, 2009; Bachelor of Social Science (Honours), Rhodes University, 2010; Postgraduate Diploma in Management, specializing in Business and Systems Analysis, University of Cape Town, 2011; Master of Social Science, Rhodes University, 2013 Master of Management in Governance (Public & Development Sector Monitoring & Evaluation), University of the Witwatersrand, currently studying.
10.2 Describe any ethics <u>content</u> training you have previously received in the previous 3 years (e.g. ethics short courses; online courses; ethics CPD courses; ethical input as part of a research methods course)	Received ethics training by Professor Knight at the University of the Witwatersrand. Please see attached Certificate of Competency attached.

10.3 List of instruments or methods used in this project, as listed in Section 5 of the application form (Tick the appropriate boxes and describe these specific instruments if necessary)	☐	Hard copy questionnaires or diagnostic tests, etc.
	☐	Online instruments (e.g. questionnaires, surveys)
	☒	Individual interviews (e.g. structured, semi-structured, etc.)
	☐	Personal communication (e.g. email or informal conversation with experts)
	☐	Group interviews (e.g. seminar/discussion groups, focus groups, etc.)
	☒	Ethnographic observation, participant observation, other informal descriptive, and/or interactive methods (you <u>must specify</u> ethnographic methods in the box below)
	☐	Autoethnography
	☐	Community-based methods or techniques such as drama workshops, community theatre, training workshops, participant rural appraisal, rapid rural appraisal, etc. (you <u>must specify</u> in the box below)
	☐	Research on/in therapeutic or counselling contexts
	☐	Putting on your own exhibition / public performance
	☐	Observation of other public performances, and/or public behaviour observation
	☐	Photography
	☐	Video
	☒	Audio recording (e.g. of interviews)
	☐	Use of data from social media
☐	Other research methods or techniques (you <u>must specify</u> in the box below)	

	Explanation of research methods specified above, and / or explanation of any other research methods that are not listed above: Semi structured interviews will be used to collect in depth data in order to understand the meanings and perceptions that community healthcare workers attach to their precarious situations. These interviews will be face-to-face interaction, following COVID-19 regulations. The interviews will be recorded and in order to maintain confidentiality of the research participant, pseudonyms will be given to each research subject. Observation will also be used in order to gain greater access to the experiences of community healthcare workers on precarity, discourses and perspectives in their own working settings where precarious situations play themselves out. Document analysis will be used in order to allow the researcher to use existing textual data. Published policy documents on the regulation of community healthcare workers work published by government will be reviewed with the aim of understanding how government policies regulate the work of community healthcare workers.
10.4 Describe your previous experience in deploying the instruments or methods of research which you are applying here (refer to Section 5 and table in Section 10.3)	Internal Surveys conducted for Work-Place internal surveys using Google Forms and Survey Monkey

HREC (Non-Medical) Risk level categories definitions (January 2020)

This table identifies broad categories of risk. Schools/Departments can provide specific examples of these categories that are specific to that particular discipline, or the types of data collection methods or participant groups that are most common in that discipline. Please note that any study involving minors cannot be considered by Schools irrespective of the risk level.

Risk category	Definition	Example	Notes
No risk	No contact with human participants	Document analysis or literature review Studies based on theoretical or secondary analysis alone Use of non-human, quantitative datasets (e.g. economic data) Use of previously-collected human datasets (where permission from previous participants have been explicitly granted) Use of anonymized and aggregated human datasets (e.g. census data)	These studies <u>do not</u> require ethics clearance A waiver may be given, however, if required by a university faculty or external body These studies <u>may require</u> ethics clearance, dependent on the type of study and faculty requirements A waiver may be given, however, if required by a university faculty or external body Applications deemed No Risk can be considered at School level
Minimal risk	Where the likelihood and magnitude of possible harm are no greater than those imposed by daily life in a stable society, or routine educational or psychological tests	Questions about people's everyday lives, activities and opinions rather than detailed biographical information No sensitive questions or topics Review of privileged information (e.g. documentation not publically available)	Applications deemed Minimal Risk can be considered at School level
Low risk	Where the only foreseeable risks is that of discomfort, or where there may be some sensitivity involved in terms of the questions asked	Questions about people's everyday lives, activities and opinions – may include biographical information and some potentially sensitive questions and/or topics May include some vulnerable contexts	Applications deemed Low Risk can be considered at School level

Medium risk	Where there is a likely risk of some harm for participants and/or the researcher, but where appropriate steps can be taken to mitigate or reduce risk	Sensitive topics and/or questions that may have potential for trauma and emotional distress May include vulnerable categories or marginalized groups, may include some types of low-level illegal activities, such as artisanal mining Research locality itself may contain potential risks to the participants and/or researcher There is a clear justification to undertake the research using this participant group and/or using the proposed instruments, despite the potential risks	Applications deemed Medium Risk cannot be considered at School level and must be referred to the main committee Support/counselling services must be provided for participants, if appropriate A distress protocol should be given, if appropriate
High risk	Where there is a real and foreseeable risk of harm which may lead to serious adverse consequences if not managed in a responsible manner	Highly sensitive topics, e.g. experiences of violence, rape, illegal activities Vulnerable or marginalized groups, or where multiple vulnerabilities exist Research involving deception of the participants Research involving serious illegal and criminalized activities, such as violence, fraud Where the participants place themselves at risk of harm if they participate Where the researcher may place themselves at risk of harm Where the researcher may place themselves at risk of breaking the law Where the research may reveal information that may place the participant or others at risk (e.g. victims of abuse, violence), requiring intervention from government, university or other institutions There is a clear justification to undertake the research using this participant group and/or using the proposed instruments, despite the potential risks	Applications deemed High Risk cannot be considered at School level and must be referred to the main committee Remedial interventions by external professionals can be taken should harm occur Support/counselling services must be provided for participants and/or for the researcher A distress protocol and debriefing strategy should be given, if appropriate

NOTES:

(1) Definitions of terms

Discomfort refers to a sensation of uneasiness, disturbance or mild pain.

Harm refers to damage incurred (which may include physical, psychological/emotional, social, economic or legal harm) as an outcome of an action, or through emotional distress.

Risk refers to (i) the likelihood of exposure to a particular negative consequence, and/or (ii) the magnitude of the possible consequences of exposure, and/or (iii) the possibility that research could result in harm.

(2) Discussion of risk

Individuals that may be at increased risk include:

- Those who are dependent/reliant on the institution/person who provides/mediates access to researchers;
- Those who are involved in illegal activities or who are criminalized by the state, e.g. drug dealers, sex workers, undocumented migrants.

NB: it is essential to consider the individual – not an aggregated group – when assessing risk.

(3) Discussion of vulnerability

Vulnerability can stem from: a lack of capacity or impaired ability to provide voluntary informed consent; health status; social pressures that may impact on the ability to make a free and informed decision; an inability to protect one's interests in research. Vulnerability may be considered as dynamic and specific to a particular context, and may arise as a result of power asymmetries between participants and researchers/institutions. There may be layers of vulnerability that function and interact within a participant's circumstances. Being vulnerable does not necessarily imply that harm or exploitation will occur, but it does increase the risk of harm or exploitation through research.

In addition to those in vulnerable categories, vulnerability may also include individuals whose ability to provide informed consent may be reduced where:

- Their decision-making capacity is limited due to individual mental health status;
- Their decision-making capacity is limited due to the environment in which they live/work, e.g. prisoners/detainees, residents of drug rehabilitation centres;
- They are under 18 years of age;
- They are dependent on the state to maintain a legal status, e.g. documented asylum seekers, documented refugees.

NB: it is essential to consider the individual – not an aggregated group – when assessing vulnerability.

The researcher needs to minimise the risk of harm, ensure that the consent process supports a truly informed decision, and put in place additional measures to ensure ethical involvement of vulnerable groups. Where necessary, include details of steps to be taken to facilitate data collection across language barriers (e.g. interpretation or translation) and/or in cases of illiteracy.

Useful references:

Bracken-Roche, D., Bell, E., Macdonald, M.E. and Racine, E. (2017). The concept of 'vulnerability' in research ethics: an in-depth analysis of policies and guidelines. *Health Research Policy and Systems*, 15 (1), 8, doi:10.1186/s12961-016-0164-6.

Horn, L., Sleem, H. and Ndebele, P. (2014). Research vulnerability. In: M. Kruger, P. Ndebele and L. Horn (Eds.), *Research ethics in Africa: A resource for research ethics committees*. Stellenbosch: SUN Press, pp. 81-90.

(4) Distress protocol

A 'distress protocol' is a procedure to follow in emergency situations where, for example, a participant becomes clearly distressed during an interview. Under such situations, the interview is terminated and the distress protocol is enacted. Researchers may need to consider:

1. The possible distress experienced by the participant: e.g. questions that address issues of abuse, abandonment, previous negative sexual experiences, or traumatic memories that may induce distress. A distress protocol must include the name and contact details of an appropriate provider who can provide support, at no cost to the participant. This may include counselling services or access to NGOs/law clinics;
2. The possible distress experienced by the researcher: this may include provisions for how the safety of the researcher will be supported, and should be discussed with supervisor and the name and contact details for counselling services provided if needed.