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Case Study: Reporting on fieldwork conducted on health activism, mobilisation and organisation among community health workers in South Africa

Introduction and Background:

South African community health workers (CHWs) are a large and heterogeneous group incorporating a wide range of auxiliary health care providers including home-based carers, lay counsellors, and “community care workers”, among others. They may be based either within the community or at a clinic, or operate as a go-between. CHWs are generally either volunteers or “employed” through management NGOs who usually pay stipends, either through government disbursements or independent funding. Community health workers (CHWs) were selected as the focus of this case study for a number of reasons. First, community health workers played a core role as grassroots community advocates in the deeply politicised health activism of the 1980s. Second, as the neighbours of many poorer South Africans as well as their first point of contact to the health system, their stories represent the lived experience of many of the people public health services do not reach. And finally, CHWs have recently risen to prominence on the health systems agenda, both locally and globally. Globally, they are increasingly being hailed as a panacea for “weak” or under-resourced health systems through universal health coverage and filling the gaps caused by an international health workforce shortage. Locally, there are ambitious plans for the intended overhaul of the national public health system through “reengineering” primary health care and the proposed National Health Insurance (NHI). Together, these global shifts and local policy changes position CHWs as central to the delivery of critical primary care, as well as linkage to health and other social services. Almost invisible in these government representations is a view of CHWs’ capacity to act as community advocates and health activists, to pursue the less medical elements of comprehensive primary health care, and to play a role in governance and the policy changes affecting them.

The latter foci are, in contrast, central to the People’s Health Movement South Africa (PHM-SA). PHM-SA’s core goal of working toward securing *comprehensive* primary health care (as

well as a long history of health activism) allows for a natural alignment with CHWs. As such, PHM-SA has been working toward capacity-building and knowledge dissemination among CHWs. Over the last year, the University of Cape Town's Division of Social and Behavioural Sciences (DSBS) has conducted collaborative fieldwork in five provinces across the country, in parallel with related events and a series of PHM-SA's awareness-raising and knowledge dissemination workshops. One of the core functions of PHM-SA's countrywide workshops has been to spread what little information exists about the NHI, PHC reengineering, and the current state of the public health system. The workshops focused heavily on the nature of community health work, the circumstances of CHWs, and encouraging CHWs to think critically about responsibilities in the provision of government health services. There was also a strong emphasis on their support for CHWs and their conviction that CHWs are key to uplifting the country's health and wellbeing, as well as in advocating on behalf of their communities.

This report presents some of the findings from this work and where appropriate, links these with the overarching project's core interests: campaigns and advocacy, movement building, knowledge generation, dissemination and use, capacity building, and engagement with global health governance. In the process of mapping and exploring CHWs' day to day lives, we have engaged a wide range of stakeholders (see Appendix A for a full list). Through conversations, interviews and observations, the project particularly focused on identifying and better understanding how activism and CHWs currently dovetail. Although this was not our initial intention, there is also some attention to an emerging CHW labour movement. A flurry of significant activity in this regard coincided with our fieldwork and in the interests of accuracy and responsiveness, this report engages with these events.

The complex network of relationships explored in this case study should contribute to a fuller sense of the social, political and economic context surrounding community health work and CHWs in the country. In addition, the country is often praised for its strong historical tradition of civil society activism which persists today, in new guises – but often echoing the patterns and tropes of apartheid era activism. Situating the apparent local and global prioritisation of CHWs within the context of their ongoing undervaluing by the state and the formal health system provides an interesting entry point for the discussion of the broader politics of organising and health activism in post-apartheid South Africa. Locally, these insights are

especially important in light of the democratic government's continued failure to deliver health for all and its proposed (fraught) restructuring of the struggling public health system.

Methodology:

Building on an existing relationship between the People's Health Movement South Africa (PHM-SA) and the Division of Social and Behavioural Sciences (DSBS) at the University of Cape Town's School of Public Health, the team was formed based on a shared interest in community health work and the lived experiences of CHWs. Fieldwork was carried out by DSBS researchers, following discussion with PHM-SA. Fieldwork locations were chosen according to interest or invitation (more details below). The research team met regularly throughout the process to discuss findings and plan directions for subsequent research. The team has a combination of both practical and academic research experience and is comprised as follows:

- David Sanders (PHM-SA) – principal investigator (PI)
- Anneleen de Keukelaere (PHM-SA) – project and financial administration
- Christopher J Colvin (DSBS) – project lead; research dissemination
- Alison Swartz (DSBS) – fieldwork researcher; research dissemination
- Zara Trafford (DSBS) – fieldwork researcher and project coordinator; write-up, analysis and research dissemination
- Bridget Lloyd (PHM-SA) – desktop research and interviews for national political and historical context; literature review
- Alex Paone (DSBS) – student fieldwork researcher

Primary data was collected through extensive qualitative interviews and participant observation. Fieldwork was conducted in five of South Africa's nine provinces: the Western Cape, Eastern Cape, Northern Cape, Gauteng and Free State. In the process, researchers interacted with multiple stakeholders including CHWs from around the country, CHW labour movements, non-governmental organisations that facilitate community health work, and relevant supportive civil society activist organisations. Activities included individual and group interviews and participation in training or knowledge-building workshops (e.g. PHM-SA training/awareness-raising) and meetings (e.g. union gatherings), as well as attendance at the

trial hearing of Free State CHWs who were arrested for protesting their suspension from work.

Interviews were usually fairly informal and aimed to elicit informants' own stories about their experiences, rather than closed questions with little space for additional explanation. Guiding questions focused on challenges and motivations in day to day life and work, the future of the health system, practices of self-organising, politics of legitimacy and representation, and CHW relationships with supporting civil society organisations. Our rationale for this methodology was that in-depth, multi-province ethnographic research allows for a more complex but also a more nuanced, comprehensive and accurate view. In order to counteract the focus on quantitative measurement often dominant in donor, employer and global health discourses, we also believe this ethnographic research enriches the more common vision of CHWs as "little more than caricatures of humble and heroic health technicians who wield technologies including bikes, smartphones, forms, medicines, and diagnostics; who transmit information for monitoring and evaluation; and who save lives" (Maes, 2015:1).

Data Analysis:

The material collected thus far includes non-verbatim interview transcripts, some audio recordings, and field notes with extensive detail (comprising summaries and general reflections on interviews and workshops). Data analysis has been concurrent to the process of research and has proceeded in several rounds, all grounded in a comprehensive ethnographic approach. Firstly, as with all qualitative data analysis, a process of iterative analysis of the data (and relevant additions to the interview guide) was conducted throughout the data collection period. Secondly, a thematic analysis was conducted on the interview data to identify key themes and initial conclusions, as presented in this report. At a later stage, data from other ethnographic assessments of similar topics and relevant context (e.g. policy shifts and the current nature and status of activism in the country) will be combined with the findings from the thematic analysis to produce a number of peer-reviewed publications.

Results:

A. Are CHWs aware of the relevant high-level policy changes (especially related to PHC reengineering and the NHI) that may affect them and if so, how are they responding to them? *[knowledge generation, dissemination and use; capacity building]*

i. Critical information is unevenly disseminated and there is often little or very rare contact with the Department of Health, particularly in smaller towns or rural areas. In addition, CHWs feel very excluded from and undervalued by the state, the formal health system, and social services:

- Across the country, CHWs were especially unhappy about the way they're treated at clinics, where they say nurses generally do not appreciate or acknowledge them. This is happening concurrently with an increasing workload. They also commented on the severe lack of resources and supplies (including masks, testing kits, information). In short, they do not feel valued.
- In another story, an Mdantsane (Eastern Cape) organisation had applied for funds from the Department of Social Development (DSD), they had always been refused. Despite this, *"when [the DSD needs] help in the community, they ask [us]"*.
- CHWs explained that:
 - *"the government doesn't see us... We are just doing their dirty work"*
 - *"they are there in their big chairs, telling us what to do. They don't know the challenges. And actually they do know, we've told them, but they ignore us. There is no employer who doesn't know his or her staff's problems."*
 - *"[the DoH] have the capacity to change it but they deliberately aren't"*
 - *"They don't care about the care workers. They discriminate. They just say 'go and take the sputum!'"*
 - *"We are making stats but no one is talking about us. Who is making that stats? It is not made by professional nurses. We taking their responsibility to our shoulders."*

ii. Many CHWs – even those living in PHC reengineering pilot districts – have never heard of these important health policy shifts.

- A group of CHWs working in Mthatha (in the Eastern Cape, within the Thabo Mofutsanyana pilot district) were based at the provincial traffic department. On

visiting, we walked past an abandoned and broken down NHI school health service pilot vehicle. When asked, the CHWs had no information about the NHI besides having once heard about it from the Department of Health (DoH).

- During a PHM-SA workshop also in Mthatha, CHWs from other areas explained they had been directed from one facility to another when looking for more information about the NHI. They were very confused about the location of the pilot site.
 - A source in the Free State branch of the Treatment Action Campaign (TAC) confirmed that this is true there too, explaining that in QwaQwa (an area within the pilot district, Thabo Mofutsanyane) no one knows anything about the NHI.
- iii. In contrast, some had heard about these policy changes but many of those who are knowledgeable often felt more threatened than supported. This makes sense in the aforementioned context of feeling undervalued. Also, some CHWs expressed an interest in policy shifts' potential but many expressed doubts that the high ideals therein would be possible. For example, in Mthatha (Eastern Cape) a male CHW explained that as so many of the "clinics" in the rural Eastern Cape do not even have electricity, he had trouble believing they could be completely overhauled to provide a more comprehensive and efficient health service.
- *"We don't know who is going to benefit from this programme"*
 - *"We are just making money for these people (the officials) and getting them promotions"*
 - *"The DoH using us for whatever they want. They are running away from the responsibility"*
 - *"These trainings mean nothing to us"*
 - *"Reengineering is exploitation"*
 - *"We told DoH 'We don't want reengineering, we don't want NGOs!'"*

In one town, a couple of CHWs noted that they were "working for reengineering". We asked more about this later and it turned out about 1/3 of the CHWs present had been employed under reengineering. When questioned on the benefits of this process,

people commented that the clinic queues were much shorter and people were healthier. An ex-nurse explained: *“The health system without us is nothing. The implementation of WBOT is a great thing [for the community!!] because they’ve got retired nurses like me moving house to house identifying problems, diseases, diagnosing, doing social service work... Hidden atrocities in the house are being revealed by us”*. However, when asked more directly what the benefits for CHWs themselves were, they said it wasn’t beneficial at all. It seems they get paid slightly more but are also required to complete a huge workload – they are each assigned 250 households to look after. They are also still very short on supplies and have only received one stage of training (five years ago, in 2011). In other words, the clinic is being “brought to the patients” and they are less ill, but this may be at the cost of the CHWs’ wellbeing.

B. Are CHWs advocating on behalf of their communities? Are CHWs self-organising or mobilising for change? Are they united? *[campaigns and advocacy; movement building]*

- i. Small-scale advocacy is apparent in many of the groups of CHWs interviewed. For example, CHWs from one organisation in Mdantsane (Eastern Cape) explained that they had started a garden to support the nutritional needs of local orphaned and vulnerable children (OVCs), pensioners, and people on antiretroviral treatment (ART). Another group in the same area explained that they often assisted old age pensioners in securing identification documents so that they could claim pensions and some modest fundraising efforts to try and clothe and feed local school children. In the Northern Cape, CHWs relayed stories of assisting with out of pocket payments to help their clients who did not have access to cash (cf. Sips et al., 2014). Free State CHWs noted that:

- *“It [was] not only for the money, that’s why we were happy to volunteer – a lot of people are dying because of lack of knowledge”*
- *“When we were working, the stats [TB, HIV prevalence, defaulting, new infections] were very low – now they’re very high”*

Indeed, for most we talked to, “lifting people’s standard of living”, “help[ing] people”, and “help[ing] the country” were among the primary motivations for doing this work.

CHWs are easily able to clearly and compellingly relay the situation of their patients or “clients”, many of whose day to day problems they also experience.

ii. Despite awareness and shared experience of systemic problems, there were few examples of CHWs acting collectively in local spaces on this basis and almost no evidence of CHWs combining organising and advocacy on a large scale, to speak on behalf of their communities and the state of the health system. One example of an exception to the pattern is the case of almost 100 Free State CHWs who had been dismissed from their work despite providing support to a severely dysfunctional health services (more detail in the Discussion). Following a peaceful night-time protest, they were arrested. Their feedback during their trial (18 months later) included the following:

- *“our patients are suffering”*
- *“we wanted to go to jail because we wanted to make history. Even if we get 3 or 6 months we will go. We have no money for bail. When you have prepared your mind, you are ready [re going to jail]”*
- *“I’ll go to jail again, I don’t care... They can even keep me until Monday”*
- *“I’m not afraid of [the magistrate]”*

iii. Thus, while certainly not universally apparent across the country, some self-organisation is occurring. However, rather than motivating for broader social change, most organisation is manifesting in the form of appeals for better protection and improved labour conditions. These are primarily focused on motivating for the categorisation of CHWs as workers (rather than volunteers) and lobbying for associated labour rights, including better working conditions and appropriate recognition. These appeals are premised on widespread distress about their mistreatment and lack of protection in their current employment context:

- *“the climate we are working in is too severe for us”* (lack of resources)
- *“I can look after myself but women are in danger”* (lack of physical protection while in the field)

- *“I didn’t get anything from the government [after contracting MDR-TB while working]” (lack of health protection)*
- *“Truly speaking, I’m losing interest – people can come in and just get a cleaning or clerical job while someone else has been volunteering for a while already” (lack of job security and its associated benefits)*
- *“No more empty promises. As carers, we have to stand up and fight for our rights. Because the government only cares about the community/patients, they don’t care about us – we have to stand up and do something.”*

iv. In the last few years, a number of structures have emerged to address these issues and critically, to attempt to improve the flow of relevant information and policy updates. These include the South African Care Workers Forum (SACWF) and more recently, the nascent National Union of Care Workers of South Africa (NUCWOSA). There are also smaller, provincial groupings including the Free State Community Health Worker Task Team and the more-established Gauteng Intervention Task Team (GITT). However, significant conflicts between and within different groups is apparent. For example, social service workers in the Northern Cape did not feel included in drives for union recruitment, revealing already-present fault lines and distinctions between care workers. In another example, an individual in one province was represented differently by different CHWs, variously praised for his ability to negotiate with government or lambasted for speaking on behalf of those who did not support him.

C. What is the relationship between CHWs and support organisations/the health activism network? *[campaigns and advocacy; movement building; knowledge generation, dissemination and use; capacity building; engagement with global health governance]*

i. Health activist organisations play a significant role in supporting CHW organising. This is sometimes in the form of some financial or logistical support. More often, it is in the form of leveraging established networks for social resources (e.g. securing pro bono legal advice for Free State CHWs or publicity for CHWs’ cause), conducting awareness/information sessions (e.g. PHM-SA/Wellness Foundation’s touring workshops and training programmes), or trying to ensure that CHWs are kept up to

date with their rights and policy development (e.g. TAC and Section 27's meetings).

This input is generally positively-received:

- *"We love them – they wore the tshirts and came here and we wanted to get involved"*
- *"we decided it's better to join them because there's life there, there's knowledge"*
- *"The striking thing about the video (shown during a PHM-SA workshop) is that the problems they're dealing with are exactly the same as ours"*

ii. Notably, the "conscientisation" and critical awareness which underpinned most apartheid-era activism is most apparent in those who have had extended contact with/are members of existing health activism organisations. Common themes include campaigning for more equitable access and the right to health, as well as the importance of government accountability. These appear to come directly from the organisation in question, rather than emerging organically. This is not necessarily problematic and may often be necessary:

- *"[The organisation] was facilitating all their efforts. As individuals they do not know about their rights, the policies. There's no way that they could fight that battle"*

However, a key informant explained that once the organisation withdraws, creating and sustaining movements in that vacuum can be very difficult. There are also complicated dynamics which emerge in the context of different organisations' agendas and missions and how these intersect with CHW movements' intentions. For example, another informant likened the relationship with support organisations to that of a parent and a child explaining that sometimes, parents don't want to see their parents growing up and standing on their own. This seemed to suggest he felt that some organisations were struggling to allow CHWs the space to do their own organising.

Discussion:

1. Historical context and contemporary national policy changes affecting CHWs

Community health work has a long history in South Africa, where the impact of an oppressively racist government clearly illustrated the effect of political, social and economic

factors on health outcomes. It initially emerged in the 1970s in parallel with a growing international interest in and commitment to addressing the social determinants of health. In this era, South African CHWs' role as primary care providers in under-resourced communities was only one aspect of their role. CHWs were also envisioned by local health activists as ideal representatives of their usually voiceless communities. In other words, genuine grassroots activists, capable of communicating their neighbours' challenges as well as providing comfort and valuable health education. Under apartheid, the notion of equitable and preventative health care was inherently political in its subversion of a divisive system.

When apartheid ended, the social determinants of health and the negative effects of inequity were officially recognised in the total reworking of national health legislation. However, health policy did not formally acknowledge (let alone appoint) CHWs, partly due to the perception that much of their activist role would no longer be necessary under a democratic, non-discriminatory government. As such, CHWs' work continued but was mostly supported by international funding and largely constituted by volunteers. During these years, CHWs played a particularly significant role in providing care and a bridge between the health system and communities, conducting HIV/AIDS transmission and stigma-reduction education, and where possible, providing treatment support. In retrospect, many have commended the role they played in the context of a government refusing to acknowledge or provide treatment for HIV. As the country transitioned to state-sanctioned provision of ARVs, CHWs came to the forefront once more and they were officially included in health policy in the mid-2000s. Their importance in supporting those living with HIV, TB and other chronic diseases has been widely publicised. However, following the withdrawal of considerable international funding in 2008/2009, there was once again a dearth of financial support for community health work.

As previously noted, South African community health workers are a large and heterogeneous group including home-based carers, lay counsellors, and "community care workers". They may be based either within the community or at a clinic, or operate as a go-between. CHWs are generally either volunteers or are "employed" through service NGOs who pay stipends, either through government disbursements or private and/or international funding. Recent years have brought a shift in attitudes toward them once again, with both the proposed National Health Insurance and the "reengineering of primary health care" situating CHWs as

central to the delivery of critical primary care as well as linkage to health and other social services, particularly in rural or underserved areas. This process is slated to happen progressively, through a three-stage process beginning with ward-based outreach teams (WBOTs) operating in ten pilot districts (those which are most severely underserved).

In other words, CHWs are seen as important for securing equitable, accessible health care for a greater proportion of the population. As one health activist put it, “If they don’t have enough CHWs [the NHI] will fall apart”. However, existing guidelines are primarily focused on making CHWs as technically “useful” as possible. In addition, draft plans stipulate that there should be about 45 000 CHWs nationally, or approximately one CHW for every 250 households. While formally recognising its value and importance then, community health work continues to be unclearly defined and the state seems to be primarily focused on creating a more easily manageable body of health system extenders. These guidelines are also at odds with the current situation. For example, although difficult to enumerate exactly, there are approximately 65 000 CHWs currently working in the country. In addition, most of these are middle-aged women, many of whom do not have formal educational qualifications.

As noted in this paper’s results section, the majority of CHWs already feel that they are excluded from the formal health system. The lack of clarity about their role, continued perception of exclusion from the health system, and lack of support from government are ongoing. These factors, combined with the historical role that CHWs played in rebelling against an unjust system, seem to provide an ideal breeding ground for mobilisation and protest.

2. CHWs’ awareness of and response to current health policy changes and the nature of current organising

Many of the CHWs interviewed were unaware of the abovementioned policy shifts, which are directly relevant to their work. For those CHWs who *are* aware of either PHC reengineering or the NHI, rather than feeling more secure in light of policy shifts which highlight their importance, the formalisation of the category seems so far to have made many feel even more alienated or excluded. For example, in Mdantsane (Eastern Cape) some CHWs

commented on having seen WBOTs (ward-based outreach teams) coming “from outside” to work in their areas. One man explained that he “saw a van once” and that sometimes he would arrive at a house and his work would already be done. Another complained, saying it was unnecessary, a duplication of work, and wondering, “Why don’t they use us?” During the same fieldwork trip, CHWs attending a PHM-SA workshop in Mthatha (Eastern Cape) sang:

We are the carers,

No carers - no health!

We are in the struggle,

Zabalaza (struggle), zabalaza, zabalaza, zabalaza, zabalaza!

This song is strongly reminiscent of apartheid “struggle” songs, a recognisable format for anyone who lived through this era and indeed, for most in the new South Africa where the legacy of this period is still palpable. Notably however, these examples of stated dissatisfaction do not appear to prompt any self-driven mobilisation or activism. The “struggle” described in the song seems simply to be an extension of the difficulties that have been apparent throughout many CHWs’ lives, being habitual rather than indicative of any intended protest or mobilisation.

In contrast, another example of CHW dissatisfaction *did* lead to mobilisation. After protesting their summary dismissal and the rapidly deteriorating state of the Free State health department, almost 100 CHWs were arrested (and later convicted) for gathering without proper notice. This was the culmination of ongoing tension with the Free State health department leadership. These CHWs seemed to display a stronger sense of their role in the health system and a drive to act against the injustices they observed. However, fieldwork interviews indicate that all of those who were convicted (as well as many others) are members of the Treatment Action Campaign (TAC). With their longstanding commitment to HIV/AIDS-related issues in the country, TAC made the “Free State health crisis” one of their primary campaigns and provided considerable support for the CHWs in question. While this association has been beneficial in many ways and CHWs associated with the trial have been vocal in their appreciation of the organisation, this connection has also limited alternative opportunities for employment which may have been possible. CHWs in Botshabelo (Free State) explained: “If I’m still a TAC member, I must forget about getting a job at the Department [of Health]” because the latter do not want information about the terrible state

of the health system to “go outside”. Indeed, media sources, CHWs themselves, and support organisations all commented on the likelihood that these CHWs received disproportionately harsh treatment by the state as a result of the embattled relationship between TAC and the Free State provincial DoH.

In other words, while CHWs certainly feel disenfranchised and mistreated, advocacy and protest do not seem to grow organically and rather, emerge when there is extended contact with existing activist organisations. This highly diverse (and difficult to unify) group are not necessarily all “activists” in the formal or familiar South African model. When action *is* taken or dissatisfaction expressed, CHWs seem to be concerned primarily with daily challenges, working conditions, and appeals for employment by government and the Department of Health. In the context of severe economic and other pressures on their own lives and wellbeing, this is not altogether surprising. However, recent years have signalled an observable increase in labour movements and potentially, the possibility of organisation through these structures.

3. CHW labour movements as potential catalyst of organisation/activism for change; implications thereof

Over the last few years, various groups have begun to champion and advocate for CHW labour rights. These groups have often been spearheaded (or at least supported) by health activist organisations, advocating for “decent work” for CHWs and their inclusion in the formal health system, a trend also reflected in global health priorities (cf. Colvin & Swartz, 2015). This discourse is thus predominately focused on establishing CHWs’ legitimacy as workers and securing certain associated rights, in light of the government’s apparent lack of interest in “caring for the carers”. Further, much of the recent activity in this area motivates for CHWs’ absorption into the state-employed workforce. These themes also seem to be the basis for the foundation of a new union. That is, that in order to obtain benefits, proper protection and contracts in the workplace, and a living wage, CHWs ought to be employed by the state. This seems to have emerged from observing the gap between the treatment of nurses as opposed to CHWs, as well as a powerful and understandable desire for stability and the potential for further career prospects and training (“upskilling”). Further, an informant explained that in many cases, the government is disinterested in engaging with CHWs as they are not a unified

body. It also seems likely that more abstract associations with unions (being leftist, collective, interested in mass mobilisation) have been transferred, despite their more chequered contemporary reputation.

It is possible that community health worker (CHW) labour movements may offer an opportunity for increased recognition, unity, mass mobilisation, compensation, and participation in relevant political processes and social change. However, such movements also raise important questions about legitimacy, inclusion and exclusion, representation, hierarchy, and independence.¹ For example, while the brand new National Union of Care Workers of South Africa (NUCWOSA) speaks to a very real desire for formalisation, recognition, and unity, ethnographic fieldwork suggests that this process has been neither simple nor universally acceptable among CHWs. The union is forming in the context of considerable tensions: between the union and established structures (such as the South African Care Workers Forum), between CHWs and support organisations who have helped build these structures, and even within the union. Accusations of corruption have already emerged, membership has not yet met the target needed for registration of a union, and individual personalities (rather than a groundswell of mass mobilisation) appear to drive much of the activity. Indeed, early stage research suggests that while this sort of labour movement has the potential to improve working conditions and allow for more active involvement in relevant policy processes, they may also reinforce existing power dynamics through the construction of new hierarchies and the politics and implications of representation.²

Finally, relationships with the state are a critical consideration. While government employment *should* ideally offer protection, a key informant cautioned that it could also produce a number of difficulties with regard to autonomy. For example, what effect would state employment have on the capacity for activism? In the current political climate, is it possible to be both activist (organiser and advocate) and state employee at the same time, or

¹ To be explored at length in a forthcoming DSBS publication.

² Although this may be true according to our interviews, observations of private training meetings did indicate attempts to deal more constructively with the need for proper CHW participation, undermining the existing class hierarchy, and flattening socioeconomic stratification. These plans are in the future though and currently, the majority of activity is focused on obtaining the numbers needed for recruitment and registration.

is some distance required? Is complaint possible or are you “biting the hand that feeds”? Further, formalisation does not necessarily entail the bargaining possibilities or status hoped for by the union. Another informant explained that although he was a member of a provincial decision-making council and was supposed to be a representative of his community, he felt “like window-dressing”.

These complicated stakeholder relationships, the difficulties of unifying and standardising such a varied cadre, and the degree to which CHWs do or could participate in relevant policy and social changes are all relevant and will be explored in detail in forthcoming DSBS publications.

Conclusion:

In summary, organisation and awareness among CHWs seems to happen in an erratic manner. Further, while the growth of a number of labour movements seems to indicate a desire for unity and mass mobilisation, on closer examination these appear to be driven by strong individual personalities. The majority of activity is also orientated toward advocating for CHW labour rights with far less attention focused on ensuring increased CHW participation in governance, health policy, and advocacy on behalf of their community. Less apparent is a drive for increased CHW participation in governance, health policy, and advocacy on behalf of their community.

The Results and Discussion above highlight the combative nature of the current political climate. Any activism in post-apartheid South Africa differs from – but is greatly influenced by – anti-apartheid activism and the politicisation of the right to health. Although the context is now different, inequalities persist and the public health system is quite obviously incapable of serving the population effectively. Thus activism around and advocacy for health improvement is ongoing, with many of the same people who were active during apartheid once again being involved. In so doing, new ideas of struggle mix with old, creating a complicated but influential network of relationships and discourses. These echoes are observable in, for example, “borrowing” slogans and ideas from apartheid struggles and repurposing them now. The symbolic weight and power of these concepts is transferred, even though the particular context and people’s attitudes may have changed. As a result, while

association with these groups may yield positive results for CHWs in terms of support and publicity, it also intensifies (and may further polarise) their relationship with the state.

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