Healthcare workers at risk

in a society that does not value the work of caring

By Nina Benjamin

Nina Benjamin is the Gender Program Coordinator for the Labour Research Service (LRS). She has worked at the LRS since 2007 coordinating its work in building cultures of gender equality in trade unions, the workplace and the community.

NINA BENJAMIN reflects on the lessons of a three-year pilot social action initiative to reduce violence in a health institution in Gauteng. Using a multi-stakeholder approach, the initiative experimented with individual and collective actions for reducing violence and changing perceptions about the value of care work and healthcare workers.

Healthcare workers are being *ordered* to care – in a society that does not value the work of caring! What we are seeing is a contradiction, where healthcare is portrayed as moral work, a gift to society, while the reality is that healthcare work is exploited social reproduction (Goodman, 2016).

In South Africa, authors like Hlatshwayo (2018) have shown how community healthcare workers are recruited to act as a stopgap measure to deal with the chronic underfunding crises in the health system. Falling public investment in the health system results in work reorganisation that includes the recruitment of workers, such as community healthcare workers who receive stipends or minimum wages and work long hours under poor working conditions. They face increased pressure on working time arrangements and generally experience an intensification in the devaluing of their paid reproductive work; this is the exploitation of social reproduction.

With the increasing privatisation of the healthcare system comes a commodification of care. Its qualitative and emotional nature is treated as invisible, abundant (Goodman, 2016), and not worthy of fair remuneration because it is women's work – work that is merely a public extension of the unpaid care work done in the home.

As more workers are drawn into this commodified and increasingly precarious form of work in the health system, violence, in all its forms, is exacerbated.

A trade union challenge

At the end of 2014, the Health & Other Services Personnel Trade Union of South Africa (Hospersa) approached the LRS for support. The union wanted strategies for responding to the rising levels of violence against their members in health institutions. They were concerned not only for the safety of their members, but also for the ability of their members to provide quality services under stressful and at times traumatic conditions. In November 2014, representatives from 11 health institutions across four provinces met with the LRS to share their experiences of violence in their workplaces. Worker leaders spoke of feeling ''terrorised'' by communities angered by the lack of health services and what they perceived as the lack of care on the part of the healthcare workers.

Baby Ntoula, a nurse clinician and Hospersa shop steward at Meadowlands Clinic in Soweto, Gauteng, reflected back on the levels of violence in the clinic in 2014 at the time of the initial meeting between LRS and the union.

> These people from the Meadowlands Community used to terrorise us. From the time they come into the gate they start singing songs because they said our services were so poor and that we don't care for them. [They said] we take our time, we go for lunch for three hours and leave them unattended. When we come in they will be singing, you could not get a glass of water because the minute you leave your station they start singing. They said "we are going to burn the clinic down with your guys inside". We did not take this lying down because if they say you are going to be burnt in the

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clinic and you know that they have done it somewhere else, it is serious. (Health Care System Stakeholders, 2017)

Stories of workers fearful of having their tyres slashed or of being attacked when they left the clinic during lunch hour left a very sombre mood in the meeting. Reports of threats by community members who claimed that they would burn down institutions with the staff inside were indicative of a very grave situation that left healthcare workers traumatised.

Out of this meeting a partnership was forged between the LRS and Hospersa with an agreement that a pilot social action initiative would be launched at one of the institutions represented at the meeting, the Meadowlands Clinic. The aim of the pilot was to deepen the unions' understanding of the causes of the violence and to experiment with different actions to reduce the level of violence in one institution. The knowledge gained would be shared across the union.

The focus was on experimenting with different activities to find out which could help to give value to the essential nature of care work and to the people involved in carrying out this work in the health system. From the start of the initiative it was clear that there was no ''quick fix'' solution or any single strategy to address the rising violence. Interventions would need to take place on many levels including in the policy and advocacy spheres.

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From our initial discussions it was clear that unequal gender power relations were fuelling the violence, and it would need more than policy changes and demands for improved infrastructure and working conditions. As long as care continues to be seen as undervalued "women's work" by institutions and individuals, the propensity for using violence to maintain relations of domination over those carrying out the care work will remain in place. The stakeholders involved in the Meadowlands initiative were more adept at intervening in the policy and advocacy spheres, but less so in processes focused on changing individual behaviour and social norms.

The Meadowlands Clinic pilot social action initiative started at the beginning of 2015 and continued until mid-2017. Meadowlands Zone 2 Clinic is a primary healthcare facility in Soweto. The clinic is part of Region D within the city of Johannesburg and offers services in immunisation, family planning, communicable diseases, health education and chronic illnesses.

The different stakeholder groups included shop stewards from Hospersa and three other trade unions represented in the clinic, the Democratic Nursing Organisation of South Africa (Denosa), the National Education, Health and Allied Workers Union (Nehawu) and the Public Servants Association of South Africa (PSA). Also part of the initiative were representatives from the Meadowlands Clinic Health Committee, the District Health Forum, the local community policing forum, local ››

church organisations, as well as local non-governmental and community organisations. Department of Health officials participated in some of the stakeholder engagement processes.

An international phenomenon

Protecting our frontline healthcare workers was a rallying cry from the start of the Covid-19 pandemic at the beginning of 2020, yet healthcare workers all over the world report experiencing high levels of verbal, sexual, psychological and physical violence in the workplace. The World Medical Association has recently described violence against health personnel as "an international emergency that undermines the very foundations of health systems and impacts critically on patients' health" (Vento *et al.*, 2020).

A systematic review (Njaka, 2020) published online identifies workplace violence against healthcare workers as a worldwide public health challenge, with South Africa having the highest prevalence of healthcare institutional workplace violence on the African continent. The report concludes that while a high prevalence of workplace violence against healthcare workers exists in Africa, there is very little research available to inform policy formulation to address the negative impact workplace violence has on the healthcare system. Poor reporting of incidents of violence, particularly by nurses, creates further challenges in addressing the problem.

An ILO Working Paper, *Gender-based Violence in the World of Work* (Kruz and Clinger, 2011), reports that even though healthcare workers are eight times more likely to have experienced the threat of violence than those in the manufacturing sector, close to 70% of incidents among nurses are not reported.

Challenging perception of the 'uncaring healthcare worker'

The initiative in the Meadowlands Clinic worked from the understanding that healthcare workers, who are predominantly women with many working in the communities in which they live, need to create alliances and foster relations and support from the communities they serve to reduce the levels of violence in the clinic. This would also assist their response to the impact of the state's restructuring and privatisation of the health system on the levels of service provision and working conditions. The LRS and Hospersa understood that by remaining silent and internalising the pain and trauma of the daily experience of community anger and violence, resentment and anger would increase and the gulf between workers and the community would deepen. Trade unions protecting their members needed to take into account the volatile workplace situation their members experience. Hospersa recognised that limiting their response to marches and strikes for improved conditions could deepen the gulf between healthcare workers and the community, which is desperate for improved health services and likely to direct their anger and frustration against the healthcare workers.

A public perception has emerged that the healthcare worker and more particularly the nurse is cruel, uncaring and deserves to be punished if patients' needs are not met. This sentiment on the part of the public has at times been fuelled by the Department of Health; former Health Minister Dr Aaron Motsoaledi released a statement on International Nurses Day in May 2016 describing nurses in public health institutions as "devils in white" (*Pretoria News*, 2016). The perception of the uncaring healthcare worker is so pervasive that initially even the role players in the Meadowlands Clinic initiative, excepting the trade union representatives, argued that nurses had only themselves to blame for the violence they were experiencing.

Challenging and shifting the negative perceptions patients and community members had of healthcare workers and, in turn, the fear and anger healthcare workers felt towards patients and community members, was essential for building any kind of solidarity among the stakeholder groups in the Meadowlands Clinic initiative.

A core group of stakeholder representatives from the four trade unions, the Clinic Health Committee, the District Health Forum, a church group and three community organisations was formed at the start of the initiative in 2015. They met regularly to share their diverse experiences and strategies for addressing the violence in the clinic. The group acted as a vehicle for building solidarity and community. Through extensive group discussion on what ''being cared for'' and "taking care of others'' meant to each one of them, they reflected on the dissonance they experienced between recognising care work as systemically and individually devalued, while simultaneously recognising it as the key element in ''life making''.

The group became an incubator for experiments to create an identity as a community of stakeholders with a shared intention i.e. reducing the violence in the clinic. The incubation process was carefully facilitated and continued over many sessions during the three years of the initiative. Unlike a traditional workshop process, the initiative was less about internalising knowledge about violence, gender relations and social reproduction, and more a process of building a group identity within a sustained community of practice and extensive social negotiation (Carr *et al.*, 1998).

As an incubator for testing ways of creating solidarity, the core group of stakeholders was well placed to facilitate broader dialogues that brought together healthcare workers, patients, civil society organisations and government officials. The dialogues often resulted in heated discussions.

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Each of the stakeholders had a particular perspective on the causes of the violence and how to respond to it. While they all had an interest and stake in the process, not all of them had equal status in the eyes of the stakeholder groups. The Department of Health officials, for example, brought their formal power and authority into the dialogical spaces, but were not treated as the experts. It was the stories, the subjugated knowledge of the healthcare workers, patients and community members, which gave them "epistemic advantage" (Harding, 2004) and they were able to create a praxis to respond to the violence in the clinic. In feminist theory epistemic advantage is the advantage that women and other marginalised groups have in understanding the power relations in their own context.

In the dialogical spaces stories of violence were shared and discussed. Through the conversations the actual people caught up in the violence, the ''uncaring healthcare worker'' and ''angry patient'', had a name and a face. Through questions in the discussions, participants were encouraged to make sense of why they were experiencing the healthcare worker as uncaring or the patient as angry. Here we were drawing on Freire's (2005) basic concept of problem posing.

For the stakeholders working directly with the community, such as the Clinic Health Committee or the church groups, the dialogues raised the importance of care work both in the private and public spheres and the responsibility they have to work with healthcare workers to challenge the state's devaluing of public healthcare. This opened the space for participants to explore how violence is used to maintain unequal gender relations that define care work as ''women's unpaid responsibility''. Clinic patients who participated in the dialogues were challenged to think differently about the challenges healthcare workers face and about their own impatient and often violent responses to workers who are being forced to care in a system that places very little value on the work of caregiving.

Individual and collective responses to the violence

The stakeholders involved in the initiative experimented with a range of activities they believed would demonstrate the value of the healthcare workers' work. The idea was to help healthcare workers to become more confident and assertive about the important role they play in the wellbeing of society, as well as to strengthen relationships of solidarity between community members and workers.

The initiative used multiple actions to respond to the violence. For example they took collective responsibility for improving the physical infrastructure of the clinic, creating safe spaces where people could talk about their experience of the violence, strengthening internal and external channels of communication, initiating patient wellness groups, and later reflecting on the impact of these actions on both patient and staff morale and relationships. Through this process individual and collective standpoints began to emerge about the kind of individual as well as systemic changes needed to reduce the levels of violence in the clinic. The move towards creating ''standpoints'' on the violence in the health sector was what Harding (2012) calls becoming ''knowing subjects'' who in this way gained more control over their lives.

Working with a feminist pedagogy

From the start of the social action initiative we recognised that there was no ''quick fix'' solution for the violence in the clinic. While more direct policy addressing violence in the health sector and improved resources would be important, challenging the gendered division of labour and systemic devaluing of care work would need patient and persistent work to dismantle the patriarchal norms and practices deeply embedded in the health system.

The Meadowlands initiative started at a moment of deep crisis for the stakeholders, but they were able to turn this into an interactional moment, a moment of learning. Alison Jagger (cited in Hesse-Biber, S. 2012) argues that emotion is a central aspect of knowledge-building. Anger, frustration and fear were very dominant emotions in the early engagements with the Meadowlands stakeholder community and it was therefore important to create a space where dialogue was encouraged, where stakeholder groups felt ''safe'' and where the emotional and psychological impact of the violence was acknowledged.

Singleton's (2015) "Head, Heart and Hands" model for transformative learning supported the social action initiative of working holistically and foregrounding what is usually ignored in activist spaces, i.e. the affective domain. It requires work that goes beyond the transformation of individuals to focus on working ''holistically'' with the entire healthcare ecosystem as it presented itself in the clinic. The ''whole community'' ››

approach was adopted as it was recognised that the propensity for violence was embedded in the consciousness, norms, culture, behaviour and institutional practices and policies of all the role players.

Challenges

At the start of the social action initiative our assumption as the LRS was that healthcare workers at the clinic would welcome the initiative as it held the promise of reducing the high levels of violence in the clinic. What was not anticipated was the high levels of fear and victimhood. Care workers feared being physically attacked by members of the community but also had a sense of being the victims of different forms of emotional and psychological abuse by patients and the Department of Health. Establishing ongoing staff involvement in the initiative was a struggle as staff members reported high levels of fear and trauma that impacted on their ability to respond to challenging situations. What union leaders initially described as ''apathy'' on the part of workers proved to be a much more complex mix of fear, anger, disillusionment and a perception of being undervalued.

Sharing methodological insights

The Meadowlands initiative helped us see how the violence in the health system is a result of a complex mix of structural inequalities and hidden webs of individual and institutional patriarchal relations and norms that keep the gendered division of labour in place.

Over the three years of the pilot social action initiative, stakeholder groups explored the lived reality of gender-based violence in the health system. They explored their individual experience of this violence, reflected on their experiences in collective spaces and, as the webs of their individual and collective situated knowledges coalesced, they developed standpoints (Harding, 2012). Donna Haraway's (n.d.) concept of situated knowledge recognises how the production of knowledge is situated in political and gendered contexts.

For those participating in the clinic initiative the analysis of violence was from the inside out. Their starting point was their personal lived experience of the violence. This meant shifting from speaking only with the voice of a stakeholder representative to being able to feel safe enough to share their own thinking, feelings and actions with others. Cognisant of the unequal gender power relations and positional power relations between stakeholder groups, guiding the process meant being able to work with discomfort and for this discomfort to become part of the learning process (Hooks, 2015).

Conclusion

The notion of ''life giving'' captures the intention of the social action initiative. The coronavirus pandemic that started in 2020 brought into sharp focus the important role that all forms of reproductive work plays in keeping society alive and it was during the pandemic that we saw healthcare workers being lauded for their ''life giving'' work. The Meadowlands initiative was an example of concerned individuals and groups experimenting with actions that would do what we saw during the pandemic, give value to the ''life giving'' work of healthcare workers. This strategy is significant in that it was used to reduce the violence in the clinic by drawing a direct relationship between the devaluing of the reproductive work of healthcare workers and the rising levels of gender-based violence in the health system.

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