Section 03
Gender

In this section, Nosipho Twala discusses the importance of the proposed International Labour Organisation (ILO) standard on ending violence and harassment against women and men in the world of work. Such a standard was adopted by the ILO on 21 June 2019. The standard was adopted as C190 - Violence and Harassment Convention, 2019 (No. 190). Twala uses two significant movements namely the #MeToo movement and the Total Shutdown Intersectional Women's Movement against GBV (#TotalShutdown) as examples highlighted the extensiveness of gender-based violence in the world of work in both well-known and powerful industries and marginalized sectors.

Further, Nina Benjamin recalls her experience of being a facilitator in a pilot social action project at the Meadowlands Clinic in Soweto, Gauteng. The pilot was aimed at bringing together different actors in the health system to take up actions that will collectively impact on reducing the high levels of gender based violence in the Meadowlands Clinic.

03

The new proposed standard on ending violence and harassment in the world of work

By Nosipho Twala

On 21 June 2019 C190 - Violence and Harassment Convention, 2019 (No. 190) was adopted by the ILO.

The proposed International Labour Organisation (ILO) standard on ending violence and harassment against women and men in the world of work is extremely important. Some people may argue that the issue of violence and gender-based violence (GBV) is addressed by other conventions and recommendations, but a stand-alone convention and recommendation is essential given the way violence has been normalised.

The two significant movements, the #MeToo movement and the Total Shutdown Intersectional Women's Movement against GBV (#TotalShutdown) highlighted the pervasiveness of gender-based violence in the world of work in both well-known and powerful industries and marginalized sectors often invisible to public scrutiny. This also demonstrates the prevalence of violence at work and how it is both tolerated and endured by an especially high percentage of women seeking to obtain or maintain employment.

This paper will focus on:

- The need of a stand-alone standard on ending violence and harassment in the world of work;
- The impact of violence and harassment on women workers in the workplace;
- Strategies to put gender-based violence on the trade union movement and workplace agenda;
- A new approach to collective bargaining;
- Strengthening the hand of the trade unions to give gender based violence greater prominence, urgency and ensure that there is equal application to individuals of any gender identity and to all workplaces.

Demanding a New Global Standard

There are more than 500 multilateral treaties aimed at protecting nations against a variety of ills, from anti-corruption measures and control of greenhouse gas emissions to those that tackle doping in sports and substance misuse. Despite this, no single UN treaty addresses violence and harassment in the world of work.

In its 2016 meeting of experts , the ILO noted that gaps in legal protections relating to violence and harassment in the world of work include a lack of coherence in laws; a lack of coverage of workers most exposed to violence; and an overly narrow definition of the term “workplace.” The ILO also noted that criminal justice approaches are not sufficient for responding to sexual harassment and bullying and that an employer’s general duty to protect the health and safety of workers often excludes protection from violence.

Where laws do exist, they are often weak, or their related policies, practices and resources are too inadequate to be effective. A study by the World Policy Analysis Centre revealed that more than one-third of the world’s countries have no laws against sexual

harassment at work, leaving nearly 235 million women vulnerable. Similarly, the World Bank's "Women, Business and the Law 2018" report found that 59 out of 189 economies had no specific legal provisions covering sexual harassment in employment.

A global coalition of trade unions, gender activists, labour rights and human rights organisations are demanding a new global standard to end violence and sexual harassment in the workplace. A global convention on ending violence and harassment in the world of work has the power to offer recourse, protection and savings by reducing costs of absenteeism, turnover or litigation. A convention with a strong focus on preventing and remedying gender-based violence at work would support trade unions negotiate policies and agreements that would establish procedures for processing complaints, as well as preventing sexual harassment. The question is not whether we need a global treaty to protect women from the endemic issue of abuse and harassment at work, but rather, why we don't have one yet.

Who's at risk?

A key objective of the convention would be to promote a systematic approach to prevention and elimination of violence and harassment at work. Some workers may be at greater risk of harassment and violence at work because of the sectors they work in. Migrant workers and those in precarious employment may not have equal protections against workplace violence under labour laws as other workers because of the discrimination they face because of their gender, sexual orientation, immigration status, race, ethnicity, or other status. Domestic workers, for instance, described psychological abuse where their employers make them feel humiliated and invisible. They are often afraid to report sexual harassment because they work alone in intimate spaces and private homes.

Women workers and gender non-conforming workers are particularly vulnerable to sexual harassment at the workplace. Sexual violence and harassment remain a barrier for women to enter and evolve in the labour market, or to perform certain jobs. Gender-based discrimination remains high across the world and often occurs at the recruitment stage based on grounds of pregnancy, potential child bearing and rearing and the dress code. For instance gender non-conforming workers say that they are not hired if they "come out" at the job interview. For many, advancing their careers meant accepting work opportunities where the expectation of LGBTQ inclusivity simply is not on the table. Some considered a liveable compromise because employers are not investing in diversity.

At the same time, the continued segregation of women in precarious, low paid and low status jobs and positions, increases the risks for these women workers. Violence and harassment in the workplace has an impact not only on workers and employers, but also on their families, communities, economies and society as a whole. Women are particularly vulnerable to violence and harassment at work, which hinders their economic empowerment and independence. Gender-based violence both reflects and reinforces inequalities between women and men.

The impact of domestic violence on the world of work.

Domestic violence often occurs behind closed doors in the secrecy of one's home. But statistics show the effects of domestic violence spill over into many areas. One in three workers have experienced domestic violence (Canadian Labour Congress). Often abusers will try and prevent victims from getting to work, causing them to be late or to have to miss work. An abuser can do a number of things to make life really miserable for the victim in the workplace. They may excessively call, email, or text victims while they are at work, come into the workplace, or stalk them.

Over 80 percent of domestic violence victims report that their work performance was negatively affected. Absenteeism and poor work performance can leave victims vulnerable to discipline, and some even lose their jobs. Here are some direct quotes from domestic workers:

"Dealing with my ex-husband left me feeling anxious and tired due to lack of sleep."

"It affected the pleasure my work usually gives me."

It is the job of the employer to try and make sure that all workers are safe at work, but it is also the role of trade unions. Work can be a safe haven for someone who is experiencing violence at home.

The financial security of a job and some time away from their abuser can help a person experiencing violence seek support or make a plan to leave the relationship. Co-workers and others in the workplace can also experience the negative effects of domestic violence through increased workloads, stress, calls or visits from their co-worker's abuser, and other potential safety risks.

Health and safety is one of the cornerstones of the labour movement, they have to ensure that employers provide a safe and healthy environment for workers. This means being free of violence and harassment in all forms.

The role of trade unions

Unions play a key role in raising awareness about violence and harassment among their members. According to the ILO Bureau for Workers' Activities' report on violence against men and women in the world of work, there is a strong connection between access to decent work, non-discrimination and being protected by a trade union.

Unions play a key role in putting gender-based violence on the agenda, raising awareness about sexual harassment among their members, negotiating policies and agreements that establish procedures for making and processing complaints, as well as preventing sexual harassment.

Ending violence and harassment in the world of work is a union issue. Unions must ensure that work is safe for everyone as well as protect the rights of all workers, including young women seeking employment. If one worker is vulnerable, all workers are affected. Unions create connections and a sense of belonging amongst their members. This means unions play an important role in breaking the barriers of silence and isolation that, too often, come with gender-based violence.

Many collective agreements contain clear language about workplace violence. Today, unions are working to add new language that addresses gender -based violence as a workplace issue. For example workplace safety planning, paid leave for victims, protection from discrimination or adverse action, and access to a women's advocate or other designated support persons within the workplace.

Unions must take the lead to end violence and harassment against women. They can provide education around what gender-based violence looks and sounds like, and what resources are out there for workers who are experiencing violence, whether they are victims or perpetrators. The other thing that unions can do is to ensure that negotiators get training on putting language and clauses in collective agreements that deal with gender-based violence at work. They can also ensure that collective agreements provide paid leave for victims of gender-based violence and harassment. One of the things that keeps women in violent situations is fear of loss of financial stability.

Union participation is essential to eradicating violence and harassment. The unions should be innovative, organize, fortify their structures and bring the labour rights of all workers, men and women, to the collective bargaining table. They should do this from a human rights perspective that guarantees workers' dignity. Trade unions must monitor the violence and harassment that workers face. It is essential for labour unions to be permanently connected with the global society, establishing agreements that facilitate egalitarian measures against the exploitation, violence, and harassment of workers in the various countries that are key locations for the investment of global capital.

Trade union gender structures have been actively popularising the convention and working hard to build partnership and buy-in from government and employers organisations. Some trade unions have already included gender clauses focusing on GBV in the collective agreements. They have convened forums and dialogued with different stakeholders in order to get consensus.

For example both COSATU and FEDUSA have developed successful campaigns focusing on the standard. The male champions for gender equality in the trade unions are coordinating the campaign in their trade unions. The gender coordinators of the federation are part of the International Labour Conference (ILC) delegation. They are working tirelessly to lobby their peers in the region to buy-in.

Conclusion

Negotiators for the standard report that they have consensus on almost everything. Their only area of disagreement was the inclusion of LGBTQ workers. There is a debate currently of whether trade union gender activists should adopt the convention with a list groups covered or adopt it without a list and domesticate it in our own countries. If we go with the latter suggestion, we stand a chance to exclude other vulnerable groups. The question is, do we want a comprehensive convention that supports and protect all vulnerable groups? Or do we want to adopt the convention and exclude other vulnerable groups?

Employers should also take into account factors that can increase the likelihood of violence and harassment against employees even where it may be committed by a member of the public. For instance, requiring workers to work late at night but without offering them transport home can leave female workers more vulnerable to harassment or violence on public transport on their commute home.

The trade union movement should activate a global campaign to influence the member states of the ILO so that the standard takes the form of a binding international instrument.
The proposed instruments, could take an integrated approach and recognize the interactions between anti-discrimination laws, labour laws, occupational safety and health laws and other civil laws to provide essential protections for workers, and complement the penalties under criminal provisions, which often focus solely on the most extreme forms of violence and harassment. The definition and coverage should be inclusive of all forms of violence and harassment including sexual harassment. It should recognize that gender-based violence is a form of discrimination.

For the first time in history, we are edging closer to that convention and to protecting women who are prevented from freely exercising their right to be part of a safe workforce. By ratifying the convention, signatories will be committing to applying it in their national

contexts. The Conventions can accelerate national legislation and regulation, and can mobilize authorities, businesses and society to address a widespread problem. The moral case for tackling this issue is clear. But so is the economic case. Violence and harassment result in direct costs to businesses due to absenteeism, turnover, litigation and compensation. There are also indirect costs in terms of reduced productivity and harm to the business's own reputation and market competitiveness.

References

World Bank "Women, Business and the Law 2018," http://wbl.worldbank.org/en/reports (accessed May 18, 2018). 2 International Labour Organization (ILO).

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Ending violence and harassment at work 2 violation, there is little by way of international law specifically addressing violence and harassment in the world of work.

Akhtar and Moore, 2016 (1969, p. 171) .

The Issue of Dignity in Our Health Facilities

By Nina Benjamin

For the past 3 years in my capacity as a LRS staff member, I have been a facilitator in a pilot social action project at the Meadowlands Clinic in Soweto, Gauteng. The intention of the project is to experiment at a local level and in one locality.

The project brings together the different actors involved in the health system, including all the providers as well as beneficiaries, to take up actions that will collectively impact on reducing the high levels of gender based violence in the Meadowlands Clinic.

Together with a co-facilitator we supported a core group of worker- and community leaders' work with a collective impact[4] and emergent learning[5] approach to experiment with actions for reducing the levels of gender based violence in the clinic. In addition to this, this core group was encouraged to then share what they are learning across their organizations: in the union, through clinic and district health forums and through the community organizations and structures they are part of. All of this as a means of influencing what is taking place in the health system more generally.

Over this period we have seen a decrease in the levels of violence in the clinic. More recently, however, the core group in Meadowlands report feeling increasingly frustrated at their attempts to sustain the initiative in a context of deteriorating facility infrastructure and working conditions. In our monthly forums with the core group, numerous challenges[6] in the health system have been discussed.

For the purposes of this paper I will focus on two key infrastructure challenges: the lack of effective sanitation facilities; and the working conditions of community health care workers who form part of the Ward Based Primary Health Outreach Teams (WBPHOT's). WBPHOT's form an essential component of the primary health care provision promised by Government.

While Health institutions are public places there is almost an unconscious entering of the private space when the patient or worker uses the toilet or when the health care worker working in the community enters the home of a patient. Within the gendered sphere of health care as devalued reproductive work,[7] we are seeing a further devaluing of conditions and work associated with some of the more intimate aspects of the patient and staff's conditions in the health system i.e. the individual use of sanitation facilities and the health care work provided in the home of the patient.

In our monthly forums, the Meadowlands Core Group members have started exploring the intimate experience of the patient and staff member who is forced to use the toilets of the public health facility.

For the Core Group a key approach to addressing Gender Based Violence in the health system is about restoring the dignity patients and staff will experience with proper sanitation facilities, as well as the dignity of care workers will experience when their work is recognized as being essential to the functioning of the health system and their conditions and remuneration reflect their status as employed health care workers.

Sanitation and Dignity

Every time we use a clean, functional toilet we are exercising a basic human right to dignity, the dignity of the person using the toilet but also the dignity of the worker who is cleaning the toilet. Dignity, in the words of a member of the Core Group, "is about having a private, clean, safe space that at times is the space that allows you to regain your composure when you feel stressed or vulnerable. For workers it is about having the proper protective clothing and equipment".[8]

Patients attending the health facility and staff working in the facility are away from home and forced to use the toilets in the health facility. Even though sanitation is a cornerstone of public health, patients and staff speak about unhygienic conditions; a lack of sufficient toilets; an absence of toilets for patients or staff with special needs and the absence of maintenance. A 2016 Public Health Facilities audit[9] by the Office of Health Standards Compliance (OHSC) results identify the lack of cleanliness as a

challenge in clinics in all of the nine provinces. While no specific mention is made of toilets, one can infer from the survey that the lack of proper sanitation is a key feature in what is being described as the lack of cleanliness.

Inadequate and unhygienic sanitation services affects the clinic population differently. Elderly chronic patients at times soil themselves if there are not sufficient toilets catering for their special needs. With unhygienic conditions women and girls face the possibility of reproductive tract infections. During menstruation and pregnancy it is even more critical that women have adequate sanitation facilities. Where the toilets are situated, the lighting used and the proximity of security guards, are all factors that play a role in whether women and children feel safe using the toilets in the clinic. Keeping the toilets clean also falls largely in the hands of the female cleaning staff at clinics. The lack of proper protective clothing, equipment and the appropriate chemicals, puts at them at huge risk of falling ill. All of this is happening in the clinic, the very health institution that is responsible for supporting wellness and raising awareness about healthy living.

Union representatives, Clinic and District Health Committee Members, Ward Counsellors, representatives from community structures all form part of the Meadowlands Core Group. All of the actors in the group are committed and passionate about restoring dignity to the staff and patients working and attending the clinic. Focusing on improving the toilet facilities is one example of different actors working together to address a challenge that affects everyone. The union representatives are committed to addressing the occupational health and safety issues facing the cleaners as well as the inadequate conditions of work i.e. the lack of adequate toilets facing health care workers and support staff in the clinic.

The Clinic Health Committee representatives are committed to highlighting the different needs of all of the clinic population. Representatives from the community organizations and ward committee together with the Clinic Health Committee are committed to encouraging patient responsibility in maintaining the toilets clean and preventing vandalism. The Clinic Health Committee also acts as the "eyes" and "ears" of the community in following up on existing and planned interventions at the clinic. The intention is to bring on board the clinic management as part of the ongoing lobbying for improved maintenance and resource allocation e.g. building of toilets for people living with disabilities; increasing the numbers of toilets taking into account the specifics needs of the women, men and gender non-conforming people who attend the clinic, proper signage indicating where the toilets are situated; ensuring that materials like soap and paper towels are regularly available and employing sufficient staff to maintain the toilets.

Communication with the Department of Health remains a challenge for the core group. Inadequate sanitation facilities is one example where the voices of women, people living with disabilities and the elderly are ignored. Through the gender sensitization discussions in our monthly forums, the trade union and Clinic Health Committee are encouraging all voices to be heard at the facility level through the management committee, through the district and provincial bargaining forums and through the District Health Committee[10].

In the group there is a growing awareness of how the concerns and needs of women or the elderly are very seldom taken into account in the provision and design of sanitation facilities. One example in the Meadowlands Clinic Context is the ramp for wheelchairs which clinic staff describe as completely "wheelchair unfriendly".

Dignity for members of the Ward Based Primary Healthcare Outreach Teams WBPHOTS

WBPHOT's are the first national attempt to formally integrate community health and care workers into the public primary health system[11]. With the primary health care system there is a focus on addressing what the World Health Organisation[12] defines as the social determinants of health i.e. the conditions in which people are born live, grow, work and age. There is an expectation on the part of the Department of Health that while professional nurses with their clinical training are largely responsible for the curative aspect of health care, the WBPHOTS will have the range of skills, competencies and attributes to provide community and home-based interventions, care and support[13].

WBPHOTS might have a similar ring to the word Robots, the robots that ostensibly will be taking over the workplace with the 4th Industrial Revolution and promising a move away from manual labor, yet the working conditions facing community health care workers resemble more that of the Victorian era[14] than some futuristic society.

I arrive at the clinic at 08.00am. I take my backpack with all my kit and then I take about a 45minutes walk from the clinic to where I am working. I am working in an informal settlement doing home visits. I visit 6 households per day. In each household I spend about 1 hour where I bath the patient, make her porridge, make sure that the patient takes all the medication that is necessary for the day and then visit another patient. Not all of the patients are sick in the same way every day. Perhaps I will have a chronic patient, a HIV positive one and an elderly person. After 15.00 I have made all my visits for the day. I walk back to the clinic so I will arrive at the clinic after 16.00. I will need to give a report to the facility manger. Then I will take a taxi home just before 17.00[15]

Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) Resolution 1 of 2018 on the standardization of remuneration for community health workers in the department states that a community health worker who forms part of a National Department of Health Data base will receive a non-service remuneration payment of R3500.

A google and dictionary search did not provide any definition of the term "non-service" so the conclusion one can draw is that non-service remuneration is actually a stipend of R3500. The use of the term "non-service" instead of stipend seems disingenuous creating the impression that the payment is something more than a stipend. While a stipend is an acknowledgement and form of compensation for the work performed, the community health care worker is not considered an employee with the rights and benefits afforded to employees under South African labour law. If the WBPHCOT is seen as an essential part of the primary health care system, why is it that the role of community health worker has shifted just slightly above volunteer? Is it because the work being performed is seen as "women's work", the reproductive role that is supposed to come naturally to women and is therefore not real work, not salaried work?

The PHSDSBC Resolution speaks of ensuring appropriate implementation and management of occupational health and safety processes for all members of WBPHOTS. The workplace for the Community Health Care Worker is primarily the home.
The community health care worker travels from home to the clinic and then walks to her[16] primary place of work i.e. the homes of her patients. She is most likely to be walking alone and will carry out her work alone. She is not provided with a cellphone or airtime to raise any kind of alarm if she is in danger. Inside the home she is expected to assist patients with essential services like bathing patients without any support or equipment for lifting or supporting the patient exposing her to overexertion, possibilities of tripping and falling and musculoskeletal injuries. Without sufficient and proper protective clothing and gloves, she runs the risk of exposure to infectious diseases. In the work of cleaning and disinfecting the work areas, there is the possibility of exposure to harmful chemicals if the Department of Health has not been provided her with the appropriate cleaning and disinfecting chemicals.

An ever present risk in the homes she visits is the threat of violence from the patient, the family members and neighbors. Then there is the question of sanitation, or toilet facilities for the community healthcare worker. What provision is made for her to relieve herself or does she have to wait until she returns to the clinic after the home visits? So when the resolution speaks about OHS measures, it is important that the voices of the health care workers are heard and that the specific challenges of their work and workplace is understood and appreciated.

Back at the clinic the community health care work has no real work space. In an Albertina Sisulu Executive Leadership in Health Program 2015 publication *Rapid Appraisal of Ward Based Outreach Teams*[17] and appraisal of teams in selected districts and sub-districts in all 9 provinces the problem of physical space and a general shortage of essential office equipment, stationery, access to phones was identified as a challenge in functioning effectively. WBPHOTS are located in clinics but are not made to feel part of the clinic, they have no dedicated physical space, or place to keep their work materials and are generally left feeling like they are "imposing and adding further to the over-burdened clinic staff workload."[18]

There is then also the challenge of team leadership. The PHSDSBC Resolution identifies the professional nurse as being accountable for the oversight of community healthcare workers. The resolution makes provision for the professional nurse to be supported by trained enrolled nurses. There is a dire shortage of trained nurses in our health facilities, making it difficult for the existing clinic staff to fulfill these leadership roles leaving teams without team leaders. The absence of team leaders or reluctance on the part of proffesional nurses to take on the leadership roles further exacerbates the community healthcare workers sense of isolation.

Community Health Care Workers are treated like the housewives of the health system, expected to serve with a smile and with no consideration for their own safety and wellbeing, while denied the status of worker, denied a salary, without support and without the required tools. What they do is not seen as work, where they work is not seen as a workplace and what they say is not heard.
In our monthly forums in the Meadowlands Clinic we have observed the members of the WBPHO Team leave in the morning and return in the afternoon, quietly going about their business, visible but silent. All of the role players in the Core Group have committed themselves to breaking this silence.

Conclusion: Strengthening Social Dialogue for Collective Impact

Over the past three years the Meadowlands Core group has focused on creating safe spaces to encourage dialogue between the different role players in the clinic and community. This has led to a wide range of actions from different role players committed to reducing the levels of gender based violence in the clinic. The LRS has supported the Core Group in creating these safe spaces and this has been important in role modelling ways of engaging and working collectively.

Historically the Clinic Health Committee and Trade Union have worked in isolation or competed with each other. With their common commitment and passion to restoring dignity for patients and workers they are exploring ways of having a more collective impact where they are officially represented. They are using their different spaces of engagement and bargaining to have their voices heard and are exploring joint engagement with the Department of Health MEC at a District Level.

Presently the union engages with clinic managers at a sub-district level and the Department of Health at a provincial bargaining council level. They are now exploring the possibility of labour and the community representatives both meeting at district level with the Department of Health to place the restoring of patient and worker dignity at the heart of future collaboration.