Exploring Health and Variation of Work Place Informality of Women Working within the Informal Sector in Central Durban

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Abstract

The informal sector serves as a poverty reduction platform that provides paid employment for those who do not have adequate education and skills to obtain or sustain a "formal" employment or livelihood. Women are more likely to be found in vulnerable forms of work, and within the informal sector there are more women employed compared to men.

Research has typically focused on how different forms of employment within the formal economy impact on the health of individuals, showing a relationship between employment conditions and health outcomes. This study aims to explore how variations in employment in the informal sector may impact on the health of women.

A qualitative study was conducted among women working in the informal sector in Durban. Initially, a snowball sampling approach was adopted, and a criterion sampling approach was used. A total of 18 in-depth interviews were conducted with waitresses, domestic workers, and street vendors, characterising increasing levels of informality.

Thematic analysis was used to analyse the qualitative research. The themes were divided, based on employment category i.e. domestic workers, street vendors and waitresses. The themes that emerged looked at employment, health, children's health, health protection and informality.

None of the women interviewed had medical health insurance as a means of protection, and were largely reliant on the public health sector. In addition to a lack of medical aid, most of the women were confronted with not being able to collect any form of paid leave, or did not have an additional income that could take care of them when they did not go in to work.

Challenges in public health care facilities such as long waiting hours as a result of short staffing exacerbated the loss of income through hours spent away from their stalls in the case of street vendors, when they needed to seek health care. The study found that based on informality, government orientated funds like the Unemployment Insurance Fund only paid out to domestic workers and waitresses, yet at the same time not all of the women within these two categories were able to receive these funds. For street vendors the receiving of any form of reimbursement relating to health care was not feasible.

Women in the informal working sector faced different challenges as compared to women in the “formalised/informal” working sector. Street vendors in the study were shown to be the most vulnerable participants, as they were faced with a lot of challenging factors like transportation, irregular working hours, not enough time to seek health care, no paid leave and no protection programmes to cover their health needs. There is a need to distribute adequate resources to public health care facilities, regardless of social status, as this provides quality health care for all persons.

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Acronyms

CSDH - Commission on Social Determinants of Health

ILO - International Labour Organisation

OHS - Occupational Health and Safety

UIF - Unemployment Insurance Fund

WHO - World Health Organisation

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Chapter 1

1.1 Introduction

Background

In the 1950s and 1960s, there was increasing recognition of the informal sector of employment as different from formal sector employment by academics, and as a result research into the topic also increased (Blau & Scott, 1963; Gouldner, 1954 in Gerxhani, 2004). With time, the informal sector became recognised as an economic entity by those working outside of academia and there was increased interest from policy makers (Ram, Edwards & Jones, 2017).

Based on a review of 20 studies conducted in African and South American countries from the period 1980 – 1985, De Soto (1989) concluded that in a typical developing country, the informal sector produced about 35 per cent of the GDP and employed around 70 per cent of the labour force (De Soto, 1989). Globally, the contribution of the informal economy to the GDP has remained fairly constant, as Schneider, Buehn & Montenegro (2011) estimated that the second or informal economies of 162 countries on average contributed 34.5 per cent to the official GDP between 1999 and 2006/2007. However, in Africa the informal economy accounted for 50 to 80 per cent of the GDP and as much as 90 per cent of new jobs (Benjamin & Mbaye, 2014).

As it continues to grow the informal economy comprises more than half of the global labour force and more than 90 per cent of Micro and Small Enterprises (MSEs) worldwide (ILO, 2018). One of the main reasons the informal economy is so important is because of its size. Although difficult to measure because of its informal nature, some estimates value the informal sector at around 28 per cent of South Africa's GDP (Van Der Heijden, 2012). Therefore, the size of the informal economy was estimated at R160 billion, or $13 billion, which was 2.5 times as large as the entire agriculture sector, or 70 per cent of the size of the mining sector (Van Der Heijden, 2012). Even with huge contributions based on calculations done in 2015, there was a total of 74.2 per cent of women working for wages in Sub-Saharan Africa. In Southern Asia 63.2 per cent are currently not contributing to social protection, which is linked to high levels of informality in those regions (ILO, 2016).

In 2003 at the 17th International Conference of Labour Statisticians (ICLS) it was proposed that informal employment should be defined in terms of the employment conditions (Yu, 2010). This included factors such as type of employment and type of occupation into account. So any form of employment looks at the environment, job title, work days, salary, number of hours, unpaid leave and paid leave. These would be employment conditions that help show what characteristics exist among informal employment, which then helps define informal employment. For most informal jobs they do not have standard cohesive employment conditions, in addition they lack benefits such as health insurance/medical aid, protection services and retirement plans. So based on protection and the nature of employment one is then able to define if a job is informal or not.

In addition, informal employment should also include people employed outside the informal sector, but with employment that has informal characteristics (Yu, 2010). This then includes those working for "formal" entities, under informal conditions. For example waitrons who earn a small standard salary, which might be taxed, yet the majority of the income they earn is from the tips they are given. This is not guaranteed as it is customer dependent, and further this income is not regulated nor taxed, hence it is informal in this regard. Typically waitresses are hired by a formal entity, but payment conditions in addition to irregular working hours and the part time nature of the work are features that characterise the employment as informal.

Therefore, the informal economy incorporates both (i) employment in the informal sector and (ii) employment in the formal sector that displays informal characteristics i.e., unprotected or unregulated jobs that lie outside the regulatory framework and are not covered by basic legal and social protection, taxes or employment benefits.

Furthermore, Chen, (2005) states that the term informal sector connotes underlying issues of legality or illegality with the mistaken belief that the informal economy is somehow illegal or even that it is comparable with the underground, or even criminal, economy.

1.2 Definitions of Informality as it Relates to Economic Activities

The workforce is defined by two entities, one of which is the recognised formal labour market characterised by contractual employer and employee relationships and a second labour market that works outside of this official economic structure. The formal economy is generally characterised by regulated economic units and protected workers (Chen, 2005). In the early 1970s, Keith Hart (1970, 1973) a social anthropologist was the first to use the term informal sector, in a developing country context in academic literature. He described those working in the informal section as a part of the urban labour force, but working outside the formal labour market (Gërxhani, 2004).

In addition the "informal sector" refers to the activities in which many, if not most, urban workers regularly engage as full participants in the existing economic order (Peattie, 1980; Davies, 1979 in Portes & Sassen-Koob, 1987). The informal sector was viewed as the entry point. Thus allowing people to partake as contributors in the economy, when they have limited options, as a consequence of lack of opportunities. In the case of South Africa for example the inequalities in access to opportunity was historically linked to the colonial and apartheid legacy (Coovadia, Jewkes, Barron, Sanders, McIntyre, 2009). The apartheid regime isolated, suppressed and deprived certain groups of quality education, making entry to many formal sector employment opportunities difficult to impossible, depending on the level of education required.

The International Labour Organisation (ILO) (1993) on the other hand states that it is all individuals who work in small unregistered enterprises, both employers and employees, as well as self-employed persons who work in their own or family businesses. This then caters to units such as unlisted business, comprising of owners and personnel of companies, plus independent people that establish their own businesses. This definition implies that entry into the informal sector would be a matter of choice rather than a lack of alternatives.

Since one is looking at the informalities within the informal sector, one needs to distinguish and understand formality and informality. "*Formality* refers to the nature of business exchanges as explicitly prescribed, exogenously imposed, and rigidly enforced by vertical authority powers in a universalistic and depersonalised process (e.g., objective, rational, task-oriented, and instrumental" (Lin, Lu, Li, & Liu, 2015 p. 317). "*Informality* is implicitly

assumed, endogenously embraced, and flexibly enforced by horizontal peer pressures in a particularistic and personalised process (e.g., subjective, non-rational, people-oriented, and sentimental)" (Li, 2007, p. 229).

Informal' employment relationships may be drawn as a practice of labour force arrangement, collective and/or individual, constructed primarily on unwritten customs and the tacit understandings that arise out of the collaboration of the parties at work (Ram, Edwards, Gilman & Arrowsmith, 2001). The issues that come up are based on the relations and associations at work.

Many studies lack definitions of any kind relating to formality or informality; at best, 'common sense' interpretations direct or there is a conjecture that 'formal' parallels to rule based and 'informal' to social negotiation (Marlow, Taylor & Thompson, 2010). Formal does not always mean correct or right, for example slavery was legal in the past but it was not right. Formality may be defined in terms of impersonal exchange (e.g., legal contracts and explicit rules) over elements related to personal relationships (e.g., social relationships and implicit norms) (Lin, et al., 2015).

Informality may occur in both the formal and informal sector. The predisposition for informality is essentially formed by the influential context which encompasses both formal and informal institutions (North, 1990; Chavance, 2008). Informality is not only linked with informal establishments but is also associated with the recognised formal sector. The premise for informality is mainly made by the unconventional perspectives which come along with the economic sector. Informality of this nature then relates to the type of subjects chosen for this dissertation for example, domestic workers and waitrons. Personnel in this market are organised to function in the arranged in the formal sector but are isolated from this market. For example, domestic workers in South Africa are placed under the formal sector because of the formalisation of regulations related to domestic work in the Basic Conditions of Employment Act in South Africa. As the place of work is in private households, it is still associated with the informal sector (Chen, 2012). With waitrons on the other hand, based on personal experience, are typically employed in a business that falls under the formal sector. Waitrons earn tips at the same time, which is not regulated and some waitrons make more money with their tips than the standard salary they receive.

Informality comes with its problems. These problems constrain inclusive growth by preventing workers from obtaining higher wages, benefits and work stability (Loayza, 1997). Informality creates difficulties and pressure in any working environment. It may constrain sufficient development, as a result the possibility of attaining a proper income, privileges and work in a stable environment may be obstructed.

For instance, individuals prefer the formal sector because of the returns of formality within the sector, which entails accessibility of social protection, yet not everyone has the same opportunity. This is because of the high entry barriers to particular sectors, such as minimum educational qualifications that are either clear in legislation or implied as in the case of segregation referred to as 'induced informality' (De Soto, 2000). As a result, some people do not have a strong educational background because of laws that prevented them from studying, or an oppressing system did not allow them to develop educationally. Consequently, people find a place in the informal sector where some occupations do not require formal qualifications, but unfortunately they do not have the privileges that the formal sector entails.

1.3. Variations in Informalities within the Informal Sector

Firstly, informality could to a large extent be seen as a result of the type of economic development that fails to generate sufficient good jobs for all. This has been exacerbated by the limited capacity of the private and public sectors to accommodate rapid population and labour force growth. This has been worsened by labour market discrimination and segregation between men and women, social groups and different occupations (Huitfeldt, Henrik, Jütting, Johannes and Sida, 2009; Jakubowski, 2010).

It has been postulated that there is a hierarchy of informality even within the informal economy. Within this hierarchy, informal industrial outworkers earn the lowest wages, followed by casual wage workers and domestic workers. These are then followed by own account workers, and finally followed by "regular informal employees" (Rosaldo, Tilly & Evans, 2012). So in the informal working sector there are different forms of employment, some are more formal than others but are still under the informal sector. This serves as a reminder to investigate specific natures of employment within the informal sector which ranks and measures different types of employment and what it has to offer within the sector (Henley, Arabsheibani & Carneiro, 2006).

However, Pratap & Quintin (2006) note that informality is defined as whether the individual receives any benefits from their employer. For example medical aid (health insurance) cover, educational packages or retirement benefits that the employer may provide. For example, those who make a living as street vendors, selling goods and services on a small scale from the side of the road do not receive the same privileges as domestic workers and waitrons. For example, domestic workers get paid when on leave, unlike street vendors, if there is no one else to help out at the shop/stall then that day goes unpaid. Some waitrons contribute to Unemployment Insurance Fund (UIF), which mean when they can go on maternity leave and get some money back. So depending on the type of employment others benefit by getting paid when on sick leave, for example domestic workers. Yet for others this is not the case, street vendors have no way of regenerating income if they do not work.

South Africa's apartheid history has had a significant impact on the current economic structure in South Africa. Throughout apartheid, 'informal', 'black' and 'illegal' were often treated as synonyms in labelling economic activities, that stayed formally discouraged by the apartheid government, and then an economic response by black people to apartheid policies took rise (ILO, 2002). Since the formal ending of apartheid, the informal economy has grown (ILO, 2002). This allowed the sector to undertake complete involvement in profitable enterprises. In the past South African women, alongside those in Kenya, were very high contributors in the informal sector and still play a role in contributing to the economy through the informal sector. Women's share of employment in the informal economy from 1997-2000 in South Africa was very high; their share of non-agricultural employment in the informal economy was 53 per cent. Women's share of non-agricultural employment in informal enterprises was 45 per cent and their share of non-agricultural informal employment outside informal enterprises was 61 per cent (ILO, 2002).

1.3.1 Link between Informal Employment and Health

General Employment

Employment status is an essential determinant of health, because it conditions more proximal developments, such as access to benefits (Link & Phelan, 1995). If one is employed, there is more of a balance with regards to receiving health services whilst maintaining employment. Without employment there a lack of compensation and people are prone to illnesses.

Unemployment is the focal reason of socioeconomic health discrepancies. The prevalence of poor mental health because of unemployment stood at 3.5 per cent (Thomas, Benzeval & Stansfeld, 2005). While severe mental disorders, for example, schizophrenia, were at a high (80–90%) (Marwaha & Johnson, 2004). Lengthy periods of unemployment are additional to enlarged risks of all-cause mortality of 63 per cent (Roelfs, Shor, Davidson & Schwartz, 2011), and an 80 per cent amplified risk of fatal and non-fatal cardiovascular illnesses (Meneton, Kesse-Guyot, Méjean, Fezeu, Galan, Hercberg, & Ménard, 2015). In addition, unemployment has been associated with 1.5 times increase to the prevalence of excessive alcohol use (Hammarstrom & Janlert, 2003), and a twofold increase prevalence of smoking (Arcaya, Glymour, Christakis, Kawachi & Subramanian, 2014). Thus, unemployment may lead to poor health.

Informal Employment

When people are employed they are able to provide themselves with many resources, which will assist them to sustain their well-being. Employment helps provide basic necessities like food, clothing shelter and education. Mirowsky & Ross (2017) contend that educational attainment, the skills and abilities learned and fostered during the educational experience in particular, drives most of the relationship between social status and health (Mirowsky, 2017). With low level education attainment people would inevitably have less working opportunities open for them, this same characteristic most of the people working in the informal sector share. The link is based on their type of employment, economic status and if their income can fulfil their wellbeing.

Workers in informal employment may face greater demands or have lower control over the work process, resulting in higher levels of stress, higher levels of discontent, and more adverse health outcomes (Muntaner; Solar, Vanroelen, Martínez, Vergara, Santana EMCONET Network, 2010). This would then mean that informal workers require more medical attention, but are usually confronted with constraints to receive proper health care, for example they cannot just seek health care whenever they want. This might take away from revenue for the business, and with irregular or low salaries chances of retaining quality health care may be difficult.

In addition, Barasa, Mwaura, Rogo and Andrawes (2017) mention that health care insurance is challenging for people who work in the informal sector. This is because they are usually less well-off and have unpredictable incomes, thus they have a lower ability to pay for health insurance, which leads to membership to medical aid and premium payment often being voluntary leading to low uptake and poor maintenance.

Problem Statement

For those who do not choose to work in the informal sector it serves as a source of employment to generate income. The problem stems from not having the fundamental essentials to work within the formal working sector. This may be caused by being born into a lower socio economic household, environmental dynamics, educational background or political influences. Most informal work is minimum wage, which means there is not a lot of income coming in and ultimately an income is supposed to sustain a livelihood. On top of trying to sustain a livelihood or take care of a family, some circumstances are inevitable and require out of pocket funding. Working in the informal sector comes with its challenges as it is an entity that stands alone with no assistance from government. Government does provide public services that people working within the informal sector would adhere to. The study aims to answer the question if these services doing enough to protect the wellbeing of the citizen regardless of their employment category. There is a disparity even within the informal working sector itself, as there are some privileges for certain types of employment that do not extend to all persons working within the informal sector and that is the gap that needs to be bridged.

1.4. Theoretical framework: Social Determinants of Health (SDH)

The major reason for inequalities appears to be caused by the conclusion of social economic status on health, through more specific determinants of health, such as material factors (e.g. working and housing conditions) and lifestyle dynamics (e.g. smoking and alcohol consumption) (Davey Smith, Blane & Bartley, 1994). Therefore more reason to look at the social determinants of health.

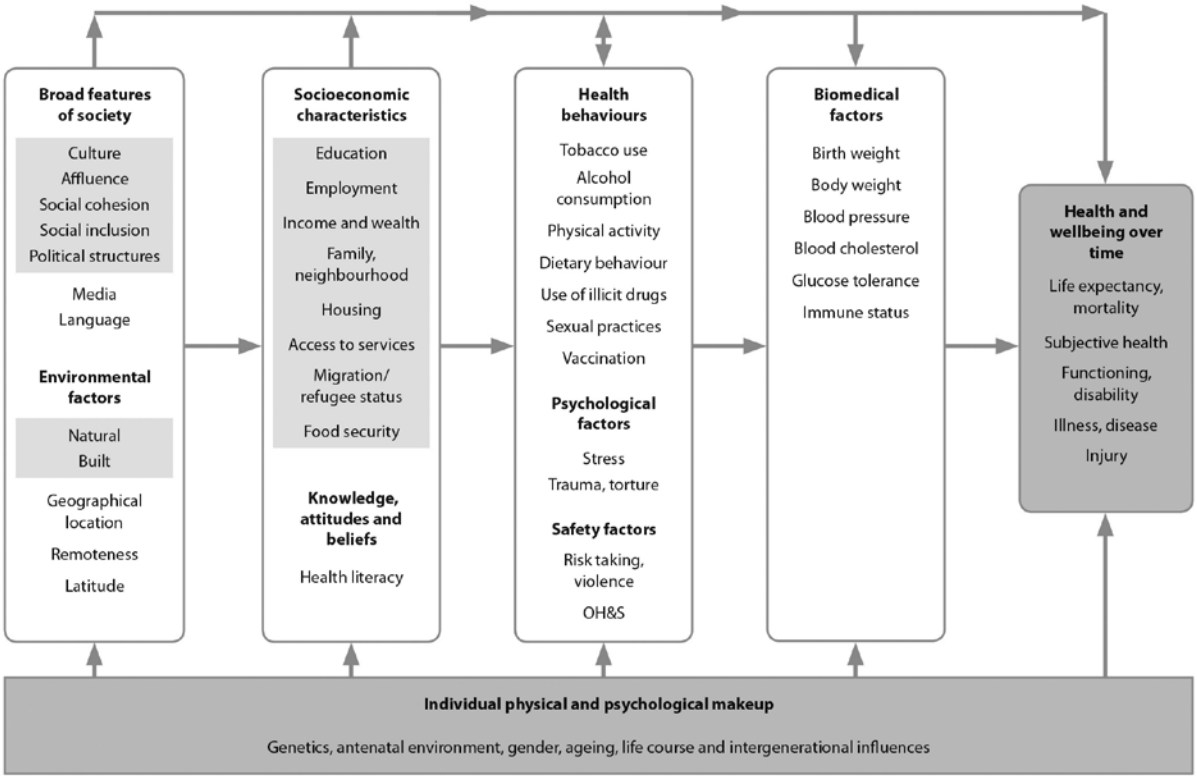
Social determinants of health (SDH) are known as the social, political and economic conditions in which people are born, live, work, play and socialise (Commission on Social Determinants of Health (CSDH), 2008). So based on how people exist in a society is

determined by numerous factors. This may be influenced by their community, local government, employment and their financial circumstances. These factors can then have an effect on one's health.

Moreover, Braveman & Gottlieb (2014) state that the health impact of social factors is supported by the strong and widely observed associations, between a wide range of health indicators and measures of individuals' socioeconomic resources or social position, typically income, educational attainment, or rank in an occupational hierarchy.

> The poor health of poor people, the social gradient in health within countries, and the substantial health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives, their access to health care and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life (Marmot, Friel, Bell, Houweling, Taylor, & CSDH, 2008, p 1661).

The social determinants of health are mostly responsible for health inequities, the unfair and avoidable differences in health status seen within and between countries (WHO, 2018). What the framework does is to show that the link between societal factors have an effect on health and other life outcomes.



Note: Grey shading highlights selected social determinants of health.

Figure 1.1: A framework for the determinants of health

Source: Australia's Health 2012, AIHW.

Mwaba (2010, p. 14) argues that "social factors and cultural priorities, constraints and opportunities, form the basis of what people hope to achieve and how they go about meeting their goals". Depending on the type of livelihood one is brought up in this will facilitate what people will achieve in the long run. As a result this determines if people will obtain better quality education, have the adequate skills to get employment, financial stability and able to provide sustainable intergenerational wealth. Considering the type of livelihood one is brought up in, this raises the question if that livelihood can withstand health necessities.

Informal workers face greater job insecurity and stress, than workers who are officially employed. They have little or no access to affordable, quality health care (Rockefeller Foundation, 2013). The pressure for people in the informal sector is increased compared to people working in the formal sector. This is attributed to many factors. The focus of this study will draw upon society, environmental factors, socioeconomic characteristics, attitudes,

health behaviours, safety factors, health and wellbeing. In order to tackle the topic at hand, one needs particularly to look at women working in the informal sector.

1.5 The Informal Sector and Women

Two billion of the world's employed population aged 15 and over work in the informal sector, representing 61.2 per cent of global employment (ILO, 2018). Africa has a vast majority of employment of which (85.85) is informal (ILO, 2018). Emerging and developing countries represent 82 per cent of world employment, but 93 per cent of the world's informal employment is in these countries (ILO, 2018).

Globally, informal employment is a greater source of employment for men (63.0%) than for women (58.1%). Yet this universal picture hides important differences; by distinction, in low and lower-middle income countries, a higher proportion of women are in informal employment than men (ILO, 2018). In Africa, 89.7 per cent of employed women are in informal employment in contrast to 82.7 per cent of the men (ILO, 2018).

In sub-Saharan Africa, more than 90 per cent of women are in informal employment compared to 86.4 per cent of men (ILO, 2018). Not only are women the majority in the informal sector, by they are also high economic contributors within the Southern Region. The United States Agency for International Development (USAID, 2012), noted that women contributed enormously to the region's economy. The estimated value of trade conducted by women in the SADC region is approximately US$7 billion annually with regards to the informal sector.

However, regardless of their numbers globally in informal employment, women in the informal economy are more often found in the most vulnerable situations, for instance as domestic workers, home-based workers or contributing family workers, than their male counterparts (ILO, 2018).

Women have a considerable array of duties, which are prolonged throughout their life. Take a carer's job for instance; evidence shows there are significant impacts on health (NSW, 2013). The underlying factors of this might be education, leading to impact on other features like the type of employment, income and access to services that one attains. Therefore, with using

social determinants of health, one will be able to look into the livelihood and health of women working in the informal sector.

What are the health issues do women in the informal working sector face? For example, in a report on 422 women street vendors trading in 323 city blocks in Johannesburg, South Africa, 54 per cent of the women, mainly those over 40 years and self-employed, complained of work-related illness or injury, mainly burns, cuts, headaches and musculoskeletal problems (Pick, Ross & Dada, 2002). This indicates that there is a connection with work and health problems. Accessibility to health services might also contribute to their well-being. Therefore, looking at different factors will help understand the root causes of these problems amongst women working in the informal sector.

The informal sector gives a platform for people to generate income themselves and be in charge of their own business. Yet there are some underlying factors that need to be dealt with holistically; therefore how can the gap of formality and informality be bridged in order to create an environment that takes care of its citizen in terms of protection and health constrains. Economists who adhere to a free market approach have tended to perceive self-employment in the informal economy as offering women opportunities for social and economic empowerment. They argue for the need to remove legal and cultural barriers to increase women's participation in the informal economy (Langevang, Gough, Yankson, Owusu & Osei, 2015).

1.6. Research Objectives

The objectives of this study are to:

- Describe the working conditions of women employed in the informal sector.
- Describe self-reported health status of women employed in the informal sector.
- Describe the experiences of women working in this sector in obtaining preventative and curative health care.

1.6.1 Research questions

Questions to be asked

- What are the main health problems amongst women working in the informal sector?

- What are the challenges based on the degrees of formalities that women face among different sectors within the informal sector?
- What are the differences and similarities in health and health services, and protection between the type of employment (variation in informality), amongst women working in the informal sector?
- Do the working conditions or does the working environments have an impact on their health?
- What protective conditions are in place that protects the health of women employed in the informal sector?

1.7. Framework of the Chapters

The following comprises of five chapters. Chapter one offers a brief overview of the study and an outline of the background of the study area. The literature review in chapter two contains a review of previous research of the informal sector, informality, formality and women working in the informal sector. The chapter highlights the understanding of women working in the informal sector.

Thereafter, the third chapter is the methodology which looks at how the study was conducted in terms of how data was collected, and how one went about collecting it. There is detail on how participants were picked as candidates, addressing the employment status of the women in the study. Furthermore, the limitations experienced during fieldwork and the study are detailed.

Chapter four presents the findings of the study followed by a discussion of the findings in chapter five.

Chapter 2

2. Literature Review

2.1 Introduction

This chapter looks at informality and how the formal and informal are linked, as well as showing their differences. It then attempts to review a global perspective on women working in the informal sector and how their roles in society have progressively evolved over time. Thereafter the study addresses the women in South Africa working in the informal sector with high regard to the South African context, and how it influenced the current standing of women working in the informal sector today. The study then aims to draw a link between employment and health, and how this is translated among women working in the informal sector and their health concerns across regions. Lastly the exposition elaborates what protection and services entail for people working within the informal sector, especially since the phenomenon is perceived as illegitimate

The informal sector in South Africa comprises of a wide range of vending, production, and service provision activities in rural and urban areas, the inner-city, peri-urban and suburban communities as well as in informal settlements (Peberdy, 2000). Even with many entry points to the informal sector in South Africa, the country faced numerous difficulties in creating equal opportunities for all its citizens, as the apartheid period left a huge impression on who benefits in the economy an how that would determine their livelihood. South Africa inherited an immense number of inequalities in education, health, and basic infrastructure, such as access to safe water, sanitation, and housing (Özler, 2007). Therefore, this generated a lot of obstacles for the majority that was marginalised. In order to make ends meet some were impelled to work in the informal sector to bring in an income for their families. Then again this was not as easy as the informal sector constituted its own problems. Verick (2006) states that informal workers typically have lower levels of education and rates of literacy, compared to those working in the formal sector. In addition, the informal sector comes with lower wages. As a result, degrees of poverty are consequently higher amongst informal workers and they are usually faced with longer working hours.

2.2 The Informal Economy/Sector

Chen (2005) argued that the informal economy is significant in the sense that it is not a short-term phenomenon or stagnant. It has been argued that it is permanent feature of modern capitalist development, and is associated with both growth and global integration. Hence, the informal economy should be viewed not as a marginal or peripheral sector but as a basic component (the base) of the total economy.

People make and remake their economic lives, and that has to be the foundation for thinking about economy (Lopes, 2015). The strategies adopted by humans in assisting them to adapt to their surroundings, is their solution to survival. Only a small proportion of the population is born into a family of well-established wealth, or into a setting were the economy is controlled by formal regulations. Therefore such context may not be fair to all, as it can determine whether an individual or family will have food, clothing, and a roof over their head or proper education. In looking for means of economic survival; individuals have created a space outside the formal sector where they can create their own means of income in the informal sector. Ludermir & Lewis (2005) also mention that most people live and work in the informal economy, not by choice but out of a need to survive.

2.3 Informality

There is obviously a relationship between the formal and informal sector as they draw on each other. Formal and informal enterprises are often dynamically linked; be it through production, distribution or consumption (Katusiimeh, Burger & Mol, 2013). For this reason, the definition of informal employment is related to the nature of the occupation, and encompasses those people whose main jobs lack basic social or legal protections or employment benefits, and may be found in the formal sector, informal sector or households (ILO, 2012).

Windebank and Williams (1997) identified the interrelation between informal wage workers and formal/informal wage workers:

There are two different types of informal work: 'organised' (formal), paid informal work in which employees work either for companies which operate exclusively underground, or for regular companies which employ some staff on a paid informal basis. The second 'individual'

(informal) paid informal work, which range from the casual one-off cash-in-hand job for a friend, relative or neighbour or by self-employment.

Informality then includes all economic activities by workers and economic units that are - in law or in practice - not covered or inadequately covered by formal provisions (López-Ruiz, Artazcoz, Martínez, Rojas & Benavides, 2015).

This is where informality comes in, McFarlane & Waibel (2012) state that informality inhabits a spatial and temporal category, as it is associated with low-income where formal service provision is exceeded by demand, and takes on an organisational form through formally unregulated labour relations. There is an association between the formal and informal sectors, where most of the formal/informal workers earn wages similar to those in the informal sector. However, at the same time since some may be employed in the formal sector, they would still have certain benefits pertaining to them for example the UIF which does not apply to informal workers.

Persons that work in the informal sector usually receive low wages, and therefore cannot afford proper healthcare or protection for Occupational Health (OH) or diseases and illness outside of work. Furthermore, informal workers have less access to de facto health insurance and health services, including occupational health services due to a lack of knowledge of their entitlements, less ability to negotiate the bureaucracy, and leakages, blockages, and lack of coordination in health insurance and health services (National Academies of Sciences, Engineering & Medicine, 2016). “A large informal employment sector affects how working conditions are regulated in the formal sector, decreasing both compliance with norms and enforcement of legislation created to protect workers” (Benach Muntaner, Solar, Santana & Quinlan, 2010a, p. 318).

Wills, (2009) mentions that informal work that forms a ‘‘large and growing percentage’’ of informal wage employment in South Africa, although domestic work (which is formally regulated in South Africa, but takes place in private residences) is still an important source of employment. Almost all people employed in the informal sector are in informal employment; however, not all those in informal employment belong to the informal sector: there may be persons working outside of the informal sector (ILO, 2012). For example, domestic workers

are not considered "real" workers, yet have the same terms and conditions as other workers. These factors may attribute to low formal skills and educational levels, high incidence of informality, lack of collective representation, weak individual bargaining power and vulnerable social status (ILO, 2016).

2.4. Global Perspective of Women Working in the Informal Sector

'Norms can call for behaviour that leads to underperformance and unemployment. Boundaries of race, ethnicity, and class also limit who people are. Because identity is fundamental to behaviour, such limits may be the most important determinant of economic position and well-being' (Akerlof & Kranton, 2010, p. 16). The ideal ways of how girls and boys should conduct themselves are norms created by society. Girls are required to be more feminine and boys masculine. As they grew older females were associated with more domesticated chores and therefore had no business working putting food on the table as this was seen as a male's job. This is recognised by Floro & Komatsu (2011) due to women being seen as caregivers within the family, while men are viewed as bread-winners

Historically, women were denied the opportunity to accumulate human and physical capital, and hence fought to be part of the working class. Also note that this situation still persists in many contexts. For example before 1918 women were not allowed to vote worldwide, women were first given the right to vote in 1918 "The Representation of the People Act was passed, allowing men over 21 and women over 30 to vote" (People Act 1918. Catalogue reference: C 65/6385).

In addition in the United Kingdom 'The Sex Discrimination (Removal) Bill' at its Second Reading in 1919, "the Bill intended to fulfil the pledges given by various members of the Government during the general election, to remove such obstacles that prevent the appointment of women to public offices and the fulfilment by them of public functions" (*House of Lords Debates*, 5s, 891 in Shackleton, 1999). The Sex Discrimination Removal Act 1919 reformed the law on women being ineligible from certain jobs on the basis of their gender.

Furthermore “American women, before the Pregnancy Discrimination Act in 1978, could be fired from their workplace for being pregnant” (Turner, 2013, p. 1). With all these historically barriers, the fight for women working in any economy sector whether formal or informal has been a struggle.

Women from a global context were traditionally viewed as inferior to men, where men had authority over woman regardless of their thinking capacity. Women were considered subordinate to men and their work was confined to the domestic sphere. Women were not seen as having the will to think intellectually and be able to work outside the home. They were required to doing the washing, cooking, cleaning and raising offspring. This is critical, when it comes to employment, women with limited formal education, are predominantly employed to undertake these activities, which are considered relatively unskilled (Alfers & Rogan, 2015).

However, for many, the informal sector is perceived as a stepping stone to formal employment: individuals who are unemployed have a much lower probability of finding a formal sector job compared to those working in the informal sector (Anand, Kothari & Kumar, 2016). For example the findings done for a study in Addis Ababa, shows the main factors determining the reasons for street vendors to engage in the informal sector are the inability to fulfil the criteria of the formal sector, and lack of job opportunity in the formal sector (Ethiopia Etsubdink, 2014). Where the point of entry into formal employment was difficult, based on requirements like education, people would then opt for the informal sector. Furthermore with regards to conditions of high unemployment, underemployment and poverty, opportunities in the formal economy are scarce, the informal economy is the only source of income-generating work (Ludermir & Lewis, 2005).

Leach (1996) argued that the influence that fuels women’s involvement in the informal sector relates to ingrained socio-cultural practices that prevent women from attaining any formal education. The informal sector offers an opportunity to those women who are responsible for children and elderly relatives, those with less education, and those who would otherwise not be able to get jobs in formal employment (Pathania, 2017). Moreover, declines in public sector employment have meant job-shedding in sectors with high female employment. This has resulted in women moving increasingly into the informal labour sector (Kane, Dennerstein & WHO, 1999). As a result during times of recession, enterprises need to

downsize, and governments decrease public sector employment, leading to an increase of employment in the informal economy (Chen, 2012; Lund, 2009 in Ulrichs, 2016). Some of the resulting factors which might enlighten the understanding of this phenomenon are:
The rate and pattern of growth, including the labour-intensity and sectoral composition of growth; economic restructuring or economic crisis, including privatisation of public enterprises and cutbacks in public expenditures; and global integration of the economy, including the restructuring of global production through outsourcing or subcontracting (Chen, 2001).

2.5 Women Working in the Informal Sector: South African Context

Among the informally self-employed, street vendors comprise as much as 15 per cent of the total urban employment and 25 per cent of the total urban informal employment in low-income countries, and between 2 per cent and 11 per cent of urban informal employment in middle-income countries (Herrera, Kuépié, Nordman, Oudin & Roubaud, 2012; ILO & WIEGO, 2013). In South Africa the informal sector, which accounts for 17,4 per cent of total employment, plays an important role in providing employment for those who cannot find work in a formal private, government or non-governmental organisation

Informal sector employment is mainly concentrated in trade (Stats SA, 2018). This would then include a majority of the participants as they fall under the trade industry. There are more women than men employed in the informal sector, while just under a third of women were employed in the informal sector community, social and personal services in the second quarter of 2018 compared to 9, 6 per cent men during this period (Stats SA, 2018). Which gave premise to this study to explore women working within the informal sector, as they are an increasingly growing population. As the study learned, there are higher risk factors to being a women which made them vulnerable in different settings of the informal sector, and that the women in this study are aware of susceptibilities of being unemployed.

As the history of South Africa along with its previous laws have had an impact on the economic system of South Africa, Preston-Whyte & Rogerson (1991) mention that South Africa's apartheid history shaped the development and nature of the informal economy. In the pre-1993 era, apartheid introduced racial segregation into the organisation of life, comprising healthcare, education and housing (Hammond, Clayton & Arnold 2009; Ntim, 2015).

In 1952, Section 10 of the Native Laws Amendment Act restricted the right of Africans to live permanently in urban areas, to those who had been born there, or had lived there continuously for 15 years, or had worked for the same employer for 10 years (University of South Africa, 2002). In the same year (1952), the Natives (Abolition of Passes and Co-ordination of Documents) Act required all Africans to carry reference books as a measure to gain greater control over African movement into towns, which increased the hardship in the reserves or tribal areas where most of the African population were resident. Both laws contributed to the removal of hundreds of thousands of Africans from urban areas in the 1960s, 1970s and 1980s (University of South Africa, 2002).

The sole purpose of these laws was to tie black workers to a specific employer, thus inhibiting their movement, consequently ensuring that they would be incapable to participate in the more formal labour market (Choe & Chrite, 2014).

Natives (Abolition of Passes and Co-ordination of Documents) Act, Act No 67 of 1952

> "The Act prescribed the introduction of the reference book bearing photographs, details of place of origin, employment record, tax payments, fingerprints and encounters with the police. Africans were expected to carry passes with them wherever they went. Failure to produce a pass on request by the police officer was an offence. Africans could not leave the rural area for an urban one without a permit granted by the local authorities. Upon arrival in the urban area a permit to seek employment had to be obtained within 72 hours. After realising the significant role played by the workers in industry, the government extended this system to women. For the first time in the history of South Africa, women had to carry passes." (South African History Online, 2016, p. 1031).

In addition to the control of movement, there were efforts to control access to and the quality of education for Africans. The *Bantu Education Act, 1953: Act No. 47:* provided for the transfer of the administration and control of "native" education from several provincial administrations to the central Government of the Union.

Bantu Education was not only an ideology, it was also an economic strategy, designed to reorganise the settings of social reproduction of the black working-class, all together constructing conditions to stabilise black people, creating an under-class group of semi-

skilled labourers and seeking to prevent black political militancy among urban youth (Fleisch, 2002). Therefore without proper education it left black people with significant challenges in participating in any workforce. African people had been dispossessed of most of their land, faced restricted opportunities for employment or self-employment, were limited to low-quality public education and health care, and were physically confined to impoverished parts of the countryside or cities (Seekings, 2007).

These structural inequalities meant that although in 1994 South Africa became a democracy, overcoming the previous disadvantage was a huge challenge. As such, this racial group are still less likely to obtain formal employment due to the lack of experience, which only fosters people who are already in the employment sector, leaving the unskilled behind. This situation has been worsened by the increasing number of women entering into the labour force, following the abolition of apartheid, creating a surplus supply of relatively less skilled and formally educated workers, as a result, contributing to an increase in unemployment (Banerjee, Galiani, Levinsohn, McLaren, & Woolard, 2008). Accordingly, people will seek jobs that are out of the formal sector, where skills and higher levels of formal education are not required, which predominantly falls under the informal sector.

Transition to the post-apartheid era resulted in a great number of unskilled, displaced, vulnerable persons, mostly women, which resulted in the increased high unemployment rate. Lack of educational performance has an increased significant outcome on the type of work status that people were pushed towards, hence creating unskilled and semi-skilled workers resulting in a great quantity of people who do not have work experience. With the lack of formal resources to work in the formal sector, most found other means to generate a living without all the formalities. This then created vast forms of inequality which hindered certain groups to receive quality education.

Globally, informal work is a greater source of employment for men (63%) than for women (58%), despite this, women are more often to be found in the more vulnerable categories of work, for instance as domestic workers or self-employed home-based workers (ILO, 2018). In a majority of countries, women in the informal economy tend to live in households that are poor (ILO, 2018).

Looking at domestic workers, they are seen as a more vulnerable category and constitute a large portion, in terms of employment shares according to Stats SA, (2018) 97 per cent of their population were female.

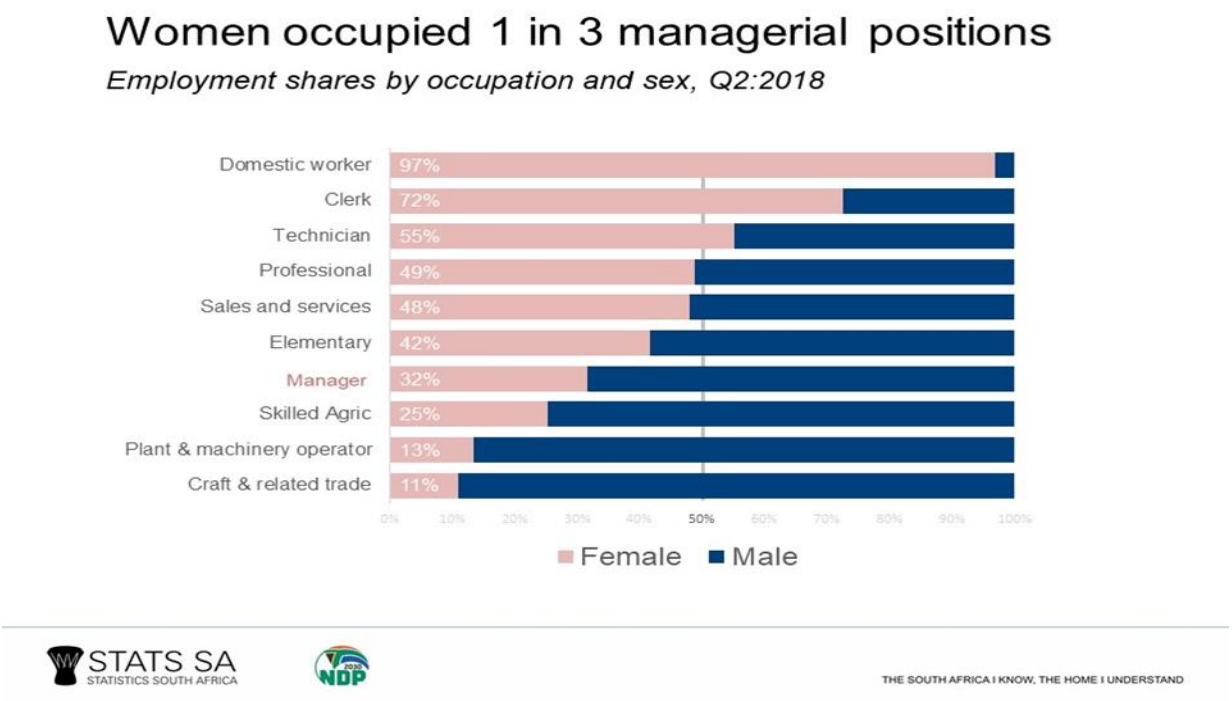


Figure 2.1: Quarterly labour Force survey

Source: Statistics South Africa (2018)

Every region needs to be dealt with in relation to their context to address any matter, South African is no different. As a result of past happenings a lot of people were absorbed into the informal sector post-apartheid, particularly women. Women's share of employment in the informal economy, between 1997 and 2000 in South Africa was very high; women's share of non-agricultural employment in the informal economy was 53 per cent, women's share of non-agricultural employment in informal enterprises was 45 per cent and women's share of non-agricultural informal employment outside informal enterprises was 61(ILO, 2002). People employed in the informal sector include informal jobs in informal enterprises plus formal jobs in informal sector enterprises. Now people employed in informal employment outside the informal sector are those employed in the formal sector, but produce goods for own use or employment within the formal sector that does not provide polices or programmes

that take care of their financial stability and social dangers through their work, for example paid domestic workers (WIGO, 2018).

In South Africa employment increased from 12.5 million in 2005 to almost 13 million in 2007, raising in total almost half a million jobs. Employment growth increased among both men and women, however, employment increases were only exhibited among women while employment contracted slightly among men (Wills, 2009). The growth of women within the informal sector grew consistently over the years.

In 2015 the Department of Women and South Africa (2015) illustrated that overall, 16.8 per cent of the employed were located within the part of the informal sector in 2015, with the vast majority being in the informal sector, in absolute numbers this equated to 2.6 million individuals. This did not include domestic workers, if they were included in the informal sector, the proportion would rise to 25.1 per cent of the total employment. These records are from 2010 to 2015 and the numbers grew within those 5 years.

Now based on the last census done in South Africa, South Africa's population sits at 55,6 million, 28 406 428 of that are women, 51 per cent (Stats SA, 2016). The South African working-age population currently sits at 22 370 000, of which 2 828 000 work in the informal sector (Stats SA, 2018).

Table 2.1: Informal work today: Significance % of total, rural & urban employment globally & by country income group & geographic region

Geographic Regions (excluding developed or high income countries in these regions)	%
Sub-Saharan Africa (excluding Southern Africa)	92
Sub-Saharan Africa as a whole	89
South Asia	88
Southeast & East Asia (excluding China)	77
Middle East and North Africa	68

Latin America and the Caribbean	54
Eastern Europe and Central Asia	37

Source: ILO 2018

Based on table 2.1 Sub- Saharan Africa as a whole contributes 89 per cent of the global income in the informal sector. South Africa alternatively has the highest unemployment rate in the Brazil, Russia, India, China and South Africa (BRICS) region, which reached 27.3 per cent in 2017. Unemployment affects women more than men, with 29.5 per cent of women compared to 25.5 per cent of men being unemployed (2017), (ILOSTAT, 2018). In addition to being more likely to be unemployed, those women who are employed are more likely to be employed in the informal labour sector, where women in informal employment have increased from 2,9 to 3,2 per cent where men have not changed as much, with their increase being 2.5 to 2.4 per cent (Statistics SA, 2018).

2.6. Women Working in the Informal Sector and Their Health

There is evidence which points to an association between work and negative health outcomes (Santana, 2003; Santana & Loomis, 2004). Informal workers are not eligible to social security benefits and legal labour rights, henceforth forced to deal with poor work conditions, a lack of safety and health protection and are exposed to poor work environments (Dias Oliveira, Machado, Minayo-Gomez, Perez, Hoefel, & Santana, 2011).

Social determinants include education, occupation, income and wealth. “People who have more resources in terms of knowledge, money, power, prestige, and social connections are better able to avoid risk and to adopt the protective strategies that are available at a given time and a given place” (Link, Northridge & Phelan, 1998, p. 376). This states that with the privilege of attaining good quality education one would be more knowledgeable about their health. With this education one may secure a sustainable job to provide for “better” health care for themselves and their family. Kane (1999) indicates that people faced with motherhood, along with socioeconomic environment, offers few options for growth or development hence depression and other mental health problems may well result. Women working in the informal sector with children face more challenges. They not only have to take care of themselves but also their offspring. When they need to seek health care their income comes to a halt.

In addition, low incomes and strenuous working conditions mean that access to health services may be limited, as time away from work may mean lost income (Dinat & Peberdy 2007). If one is confronted with psychological and physical problems, seeking health care should be a priority. Unfortunately, conditions are not the same for all, where providing food on the table is a priority otherwise children of that particular household will go to bed with an empty stomach. The level of income has been shown to be an important determinant of access to health information and health care (Pick, Ross & Dada, 2002). Therefore, ones' socioeconomic standing justifies or has an impact on their health. Yet this is not the case for most individuals residing in developing nations. Most women are own-account workers involved in home-based work or street vendors, which are largely the most insecure and unremunerated forms of informal work (Ludermir & Lewis, 2005; ILO, 2003).

Chen (Table 2.2) illustrates risks and barriers through examples of home-based workers and street vendors, to provide an opportunity to better understand the populations, characteristics, and needs of members of the informal economy (National Academies of Sciences, Engineering, and Medicine, 2016, p. 14.).

Table 2.2: Informal workers' occupational health risks and barriers to health care

Occupation	Risks	Barriers
Home-based workers	• Musculoskeletal stress • Exposure to toxic substances • Psychological stress from irregular work and earnings • Place of work is small, cramped with poor ventilation	• Isolation • Lack of knowledge about preventive health measures • Lack of bargaining power • Limited ability to negotiate bureaucracy • Lack of integration in health insurance and services

Street vendors	• Musculoskeletal stress from transporting goods • Physical abuse by police • Psychological stress from fear of evictions, confiscation of goods, irregular work and earnings • Exposure to the elements and pollution • Lack of water and sanitation	• Lack of knowledge about preventive health measures and health entitlements • Lack of bargaining power • Limited ability to negotiate bureaucracy • Lack of integration in health insurance and services

Source: Marty Chen presentation to workshop, July 29, 2014 in (National Academies of Sciences, Engineering, and Medicine, 2016, p. 14)

Data analysis in a European Social Survey, in 2010 found that there was a significant relationship between most indicators of low employment quality and poor mental well-being (Julià, Ollé-Espluga, Vanroelen, De Moortel, Mousaid, Vinberg, & Benach, 2017). Furthermore, employees with weaker socioeconomic backgrounds are more vulnerable and more exposed to certain low-quality employment opportunities which perpetuate significant socioeconomic inequalities in employee mental well-being (De Moortel, Vandenheede, Muntaner, Vanroelen 2014; Julià, et al., 2017).

Informal workers in Thailand account for 62.6 percent of the Thai workforce, and yet the workplace accident rate among those in the informal sector was ten times higher than formal workers (Kongtip, Nankongnab, Chaikittiporn, Laohaudomchok, Woskie, & Slatin, 2015). Thai social security laws fail to provide informal workers with treatment for work-related accidents, diseases and injuries; unemployment and retirement insurance; and workers' compensation (Kongtip, et al., 2015). In addition, workers employed informally could more easily be forced to work in dangerous work environments, where risks of occupational injury

or disease are high, while being vulnerable to termination of labour and low wages (Benach, et al., 2010(2)). With all these health setbacks people are bound to get strained physically which would make it difficult to come to work to regenerate lost income.

In a study based on informal workers in Central America, overall, 33.8 per cent of the women reported poor self-perceived physical health and 29.7 per cent poor mental health. The prevalence of poor self-perceived physical health in women was highest among those employed by an employer with fewer than five employees and no social security coverage (López-Ruiz, Artazcoz, Martínez, Rojas, & Benavides, 2015).

There are inequalities in women's access to comprehensive health care across their lifespan, due to a complex web of sources of inequality including poverty, poor education, lack of empowerment, weak health care systems and gender discrimination (Langer, Meleis, Knaul, Atun, Aran, Arreola-Ornelas & Claeson, 2015).

In relation to women in South Africa, while a number of studies in South Africa have shown a connection amongst general socio-economic status and health outcomes, few have concentrated on the relationship between employment status (formal versus informal) and health outcomes (Alfers & Rogan, 2015). The type of employment, may it be formal or informal needs to be addressed with the health outcome. For example, not having legal work protection means that people may not be allowed to take leave when a child is sick, which is likely to be an additional source of stress. Street traders for instance usually have limited access to affordable and appropriate health care for themselves and their families. They may not seek care, particularly when they have an insecure legal status, or are apprehensive with the potential cost, or loss of income associated with seeking care (Sassen, Galvaan & Duncan, 2011). The lack of labour protection can mean that they are not able to adequately care for themselves; for example, by taking time off work to visit the doctor when they are ill (Alfers & Rogan, 2015).

There is a need for data on occupational health and safety (OHS) of informal workers, especially women, including the measurement and assessment of their health. Maintaining a database is currently a gap that needs to be addressed, as an inclusive and evolving approach to OH for informal workers is crucial, in the wider context of universal health care (Andharia, 2013). Good health status mean successful and healthy economies. A country with a strong

and healthy workforce are good indicators for a thriving economy. This would yield an economy that would be able to take care of everyone outside the working labour force, as they depend on them to create a structure that will provide resources for sustainability mainly through the form of taxation. South Africa is a high-inequality, middle-income country, and is therefore an ideal and distinctive setting to study income, inequality, and its relation to health and to help explain some of the remaining questions about how income inequality operates on health and the levels or varieties in which changes in income inequality matter with health (Adjaye-Gbewonyo, Kawachi, Subramanian & Avendano, 2018).

2.7. Protection and Services

Informal wage workers may be found working for informal enterprises in unconventional and unprotected places of work such as roadsides, informal marketplaces, and landfills, or they may be working under formal labour regulations (such as domestic workers), but in atypical places of work such as private residences which are difficult to regulate and monitor. They often "lack protection rights and representation" (Ludermir & Lewis, 2005, p. 623). In addition, they may work in formal workplaces, but under an informal arrangement that does not provide labour protection (Alfers & Rogan, 2015).

The majority of urban informal sector labour lack basic health and social protection services and work in an unhealthy and hazardous environment (Wrigley-Asante, 2013). In most cities or metropolitan areas people that work under the informal sector are usually confronted with lack of simple needs that everyone should receive. The state of well-being and social protection are necessities, if facilities and regulations are not put in place for people they are prone to impediments and harmful actions that cannot be accounted for.

Informal work tends to be insecure and dangerous in terms of both its reliability and the exposure to hazardous work conditions, hence risks are higher and responsibility for OHS is increasingly at the cost of only workers themselves (Lund, 2002). Informal workers have greater exposure to health risks due to their living and working environments. Less protection against loss of income associated with health risks, and less protection against the costs of health risks because of the lack of employer contributions to health insurance and limited access to universal coverage (National Academies of Sciences, Engineering, and Medicine, 2016).

Informal employment is a global problem, basically characterised by tasks performed outside of labour legislation and social protection (ILO, 2008). In reality informal workers have less access to health insurance and health services, including occupational health services to which they are entitled. This is due to a lack of knowledge of their entitlements, less ability to negotiate the bureaucracy, leakages, blockages, and lack of coordination in health insurance and health services (National Academies of Sciences, Engineering, and Medicine, 2016, p. 14).

In Thailand laws that protect informal workers lack practicality and are ineffective because they lack employment contracts and awareness of their legal rights. Therefore they do not have legally protected job security, fair wages, or legally mandated occupational safety and health (OSH) programmes at work (Kongtip, et al., 2015).

In the findings done in Central America, the most important outcome was found among different dimensions of informal employment; where not having social security coverage was the strongest predictor of poor health status for both women and men (López-Ruiz, 2015).

In 2007 the Ghana Health Service reported that Ghana's challenge of mainstreaming OHS practices in its national developmental agenda is certainly mitigated by lack of national OHS policy, for example, indicated that, the majority of Ghana's legal provisions on OHS is limited in scope as a vast majority of industries, including agriculture and most of the informal sectors are not specifically covered (Clark, 2005; Puplampu & Quartey, 2012).

The lack of social protection, such as insurance against work-related injuries or health insurance, means minor health shocks can have drastic economic consequences on the livelihoods of informal workers, given high out-of-pocket health expenditure (Ulrichs, 2016). Most informal workers have to use their own means in order to maintain their health and days lost are not accounted for, since they have no revenues of protection.

2.8 Conclusion

The informal sector across the globe consists of various economic entities which can take place in any setting whether rural or urban, private or public. South Africa is unique in a

sense, that based on its historical background it played a huge part in controlling the trends and growth of the informal sector within South Africa. As a result it carries an immense amount of inequalities based on labour, employment status, health, protection and services.

This review has attempted to explore the livelihoods of women working in the informal sector in different contexts. The paper has illustrated how the informal economy/sector in a holistic outlook has contributed over the years in shaping the informal sector today. Informality is a significant characteristic of the informal sector which plays a huge role in constructing livelihoods from the type of employment to level of income; type of health care and protection services that person's acquire. In receiving a global understanding on women working in the informal, it shows how times have evolved and the importance of studying women in the informal sector. The study has displayed a link between employment and health, and how the type of employment can influence one's health. The review shows that there are various protection and service issues relating to people working in the informal sector, as they reflect a number of inadequacies and informalities.

Chapter 3 Methodology

3.1 Introduction

What encouraged the researcher to accumulate realistic information on women working in the informal sector, is the different experiences the researcher has encountered with these different type of women in everyday life. In addition, to further understand how different women that fall under the same umbrella experience their vulnerable work within the informal economy.

Therefore, the purpose of this section is to deliver comprehensive details of the approach used to explore the health and variation of workplace informality among women working within the informal sector in Central Durban. This chapter begins with a description for the location of the research. It then explains the methodological approach that the researcher has decided to employ. Moving on to sampling, the review explains the method of data collection used in the study by means of snowballing which looks at how the participants were gathered and qualitative interviews. With all the data collected, it then needs to be analysed and discussed in detail. The last and very important part of this section is dedicated to ethical considerations of this study. It looks at how the researcher will display principled action towards the participants and study at large.

This chapter details the study design and the sampling strategy employed in this study. It reports on the process of data collection and data analysis, and then concludes with a section on the ethical consideration of this study.

3.2 Choice of Study Area: Durban

Besides Durban being the hometown of the researcher, Durban has a great number of informal economic activities at its feet. In validating this a number of earlier area case studies show that, at least in peri-urban townships near Johannesburg and Durban, perhaps 30 per cent to 50 per cent of households were engaged in some informal economic activity in the 1970s and 1980s (Valodia, 2008). Durban, the seat of the eThekwini Metropolitan Municipality, is one of the fastest-growing urban areas in the world (web 1). “KwaZulu-Natal and eThekwini had 446 000 and 197 000 people in the same period, making up 18 per cent and 16 per cent of the provincial and local employment respectively” (Ethekwini

Municipality, 2016, p. 8). Durban is therefore the hub of the informal sector in KwaZulu-Natal and contributes to the supplementary purpose to study within this area.

Stretching for 800kms along the east coast of South Africa, KwaZulu-Natal is divided into eight distinct geographical destinations centred on the capital, Pietermaritzburg, and its largest city, Durban. The eThekwini Municipality is located on the east coast of South Africa in the Province of KwaZulu-Natal (KZN). The Municipality spans an area of approximately 2 297 km² and is home to some 3.5 million people, with a female population of 51.1 per cent and male population of 48.9 per cent (Stats SA, 2016).

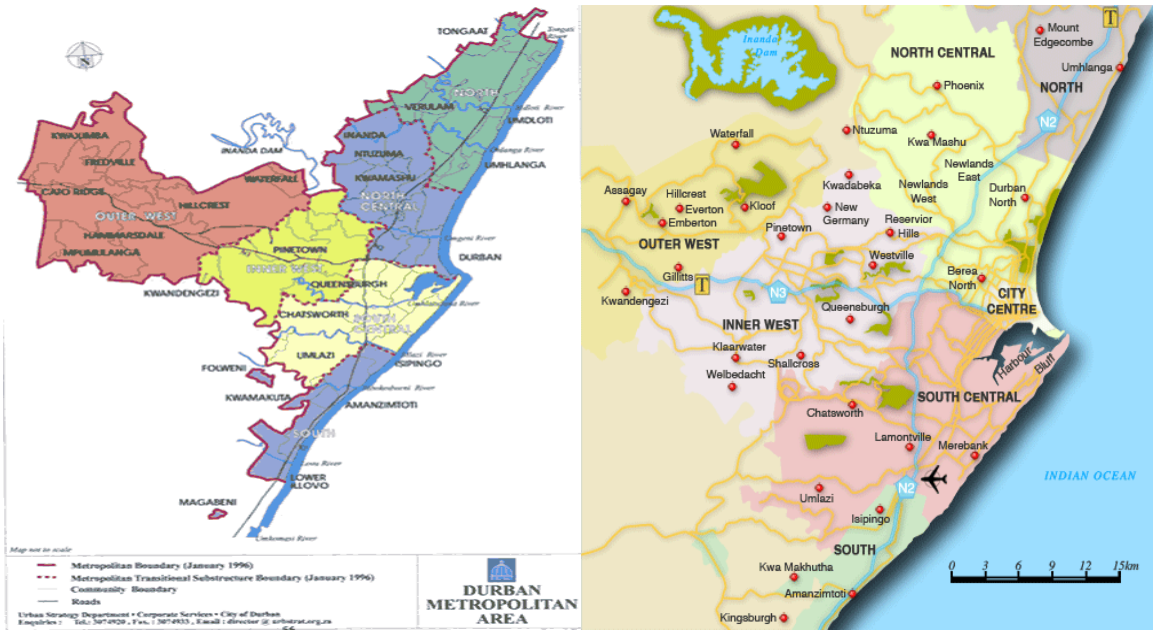


Figure 3.1: Map of Durban Metropolitan Area

Source: Political maps of world, South Durban Community Environmental Alliance (SDCEA) - All Documents eThekwini Municipality

The metro is predominantly black African (74%) with the coloured population group in the minority at 3 per cent (Stats SA, 2016). The dominant home language is IsiZulu spoken by around 62 per cent of the population followed by English at 26 per cent. In terms of education, almost a third (35%) of the population has completed some primary school, 21.4 per cent completed secondary school and only 3.4 per cent had completed post school qualifications (Stats SA, 2016).

Every day as a South African citizen residing in Durban KwaZulu-Natal, raised in a household dependent on the employment of a domestic worker and being a former waitress, this researcher walked through the market place and saw people (mostly women) making a living from selling goods and services as street traders. For these reasons, these three types of informal work and their implications for the health of women have interested the researcher.

3.3. Methodological Approach

As the goal was to provide rich, thick descriptions of the lived experiences of women in these three types of informal work, a qualitative study was employed. Qualitative methodologies consist of philosophical perspectives, assumptions, postulates, and approaches that researchers employ to render their work open to analysis, critique, replication, repetition, and/or adaptation (Vaismoradi, Turunen & Bondas, 2013).

Qualitative investigators study the world in their natural surroundings, attempting to make sense of, or to deduce, occurrences in terms of the values people bring to them (Denzin & Lincoln, 2000, p. 3). The researcher conducted the study where they grew up, and was very familiar with the study area, as this made it easier in knowing where to find the participants, knowing the language and understanding the social background of the area.

According to Burns & Grove (2009), qualitative research is a systematic and subjective approach to highlight and explain daily life experiences and to explore the meaning created around them. The study did explore lives of women from different walks of life that share similar characteristics based on their type of employment. It also exhibited the differences among them and how their social status impacts their livelihood holistically.

3.4 Sampling

3.4.1 Method of data collection

Bernard (2000, in Guest, Bunce & Johnson, 2006, p. 61) “observed that most ethnographic studies are based on thirty-sixty interviews”, whereas Bertaux (1981, in Guest et al., 2006) contended that 15 is the smallest acceptable sample size in qualitative studies. The study consisted of a small sample made up of 18 participants. The researcher used a stratified quota

sampling method as it illustrates characteristics the particular subgroups of interest and facilitate comparison (Patton, 1990). As such the sample was allocated as follows: six in-depth interviews with domestic workers, six in-depth interviews with street vendors and six in-depth interviews with waitresses. Six was the number of interviews targeted in each category as Guest, Bunce & Johnson (2006) noted that this number would be typically sufficient to reach saturation of main themes. This view is supported by Fugard & Potts (2005: 671) who noted "Studies have reported saturation after as few as six interviews" (Fugard & Potts, 2015, p. 671). Hence the reason the researcher decided on six interviews per category.

The first set of interviews were conducted amongst domestic workers, the first participant interviewed was Joyce. The researcher found her through a student residing in private accommodation. Joyce worked as a domestic worker in private accommodation and was willing to participate in the study. Mbali and Rose were then referred to the researcher as they were Joyce's neighbours but worked in a private households. Based on the snowball approach mentioned the researcher expected participants to make references to other people in order to be interviewed, however the snowball effect came to an end as they did not know of any other domestic workers that would have been willing to participate in the interview. The researcher had to walk around and look for new participants, and found Happy and Zama who worked in the same road, also in private households and who were willing to participate in the study. The researcher went to the area where they had grown up and found Jean. The researcher did encounter persons that did not want to participate, as it was working hours for them, and they did not want to take time away from their jobs, while others were just not comfortable in discussing their personal lives.

All the interviews were conducted on different days, as they were scheduled based on participants availability. Joyce's interview was conducted in the morning (8:17 am), indoors in one of the bedrooms of the private student accommodation, and she seemed very comfortable doing the interview. All the other interviews were conducted outdoors on the side of the road. Rose's interview followed at (9:42 am) and Mbali's in the afternoon (2:09 pm). Mbali and Rose seemed apprehensive in doing the interview hence their responses remained brief. On the other hand Happy (11:20 am), Zama (12:50 pm) and Jean (8:00 am) were more excited to participate in the study, and thus were more open in sharing their

experiences. There were no interruptions while conducting the interviews, except for cars that were driving by which did not really affect the interview process.

With the street vendors the researcher approached one street vendor, Clare (8:15 am), with whom they were familiar and was able to get other participants with their assistance since they worked near each other. The researcher had to go to each stall to conduct the interviews; all in a public space on the pavements where most street vendors were set up. This was challenging because there was no privacy, it was noisy because of the motor vehicles and hooting taxis, and most of the street vendor participants continued to sell their goods during the interview, hence the interview would stop for a few seconds and would attend to their customers. Clare referred the researcher to Sandra (9:35 am) then Sandra referred the researcher to Yenzi (10:48 am), and then Yenzi referred the researcher to Lerato (11:50 am). The researcher found the last two Gayle (10:19 am) and Abu (12:27 pm) herself. This was also done through walking around and asking if persons were willing to participate in the study; most people were not interested and did not want to take part in the study. Clare, Sandra, Abu and Yenzi were all very comfortable doing the interview. Lerato and Gayle were brief in conveying their answers, this might have been related to Lerato's religion and her take on health. Gayle's brief responses were most probably because of her age as she was the oldest participant in the study.

All the waitresses' interviews were conducted at their restaurants. The researcher had to speak to the all managers first before conducting the interviews. The interviews were conducted on the days least busy, after the breakfast shifts as this was a quieter period in the restaurants after the morning rush. The researcher would have liked to schedule the interviews on their off days, but for most it would have been inconvenient as that would have been a time for them to rest or to do their personal errands. Having worked as a waitress this was very helpful in knowing who to approach and what times were appropriate in conducting these interviews.

Unfortunately all the waitresses that the researcher knew did not work within Durban, and they therefore had to approach different restaurants in order to acquire the participants. Hope (10:30 am) was the first candidate and worked at The View, she was easy going and delighted to partake in the interview. Angel (11:05 am) followed and she worked at Mimos. At first she was anxious but as the questions were more personal and required her opinion she

was more vocal in sharing her experiences. Interestingly Patience (11:07 am) and Mary (11:56 am) both worked at Spur and were both keen on doing the interview. Esihle (11:00 am) worked at Wimpy and was very brief in responding and seemed like she wanted to get back to her tables instead. Sethu (11:39 am), on the other hand, was very open and worked at Nino's. The interruptions while conducting these interviews were when they were called to attend to a table or close it.

Table 3.1: Demographic profile of participants

3.4.2 Demographics Profile of Respondents

Type of Employment	Year of birth	Age	No. Of children	Highest level of education	Paid when on leave
Domestic Workers					
Jean	1978	39	5	grade 11	Not sure
Mbali	1989	28	1	grade 11	No
Zama	1975	42	3	grade 11	Yes
Joyce	1977	40	4	grade 10	No
Rose	1973	44	3	grade 9	Not sure
Happy	1963	54	4	grade 4	Yes
Street Vendors					
Abu	1961	56	2	none	No
Gayle	1962	55	6	primary	No
Clare	1988	29	0	grade 12	No
Yenzi	1996	21	1	grade 12	No
Sandra	1967	50	4	grade 12	No
Letrato	1977	40	3	grade 12	No
Waitresses					
Angel	1991	26	1	grade 12	Yes
Esihle	1988	29	2	grade 12	Yes
Hope	1994	23	2	grade 11	Yes
Mary	1984	33	2	grade 12	Yes
Patience	1987	30	1	grade 12	No
Sethu	1993	24	1	undergrad	Yes

Table 3.1 reflects the basic demographic information of the participants of the study. It specifically documents the number of years the participants have worked within the informal

sector and if they receive paid leave based on their respective occupations within the informal labour sector.

The participants' ages ranged from 22 to 57. Domestic workers' median age was 41, street vendors 42 and waitresses 28, with the overall median age being 37. Domestic workers had the most number of dependants, 20 altogether, followed by street vendors with 16, and lastly waitresses with 9. The total fertility rate (TFR) among women in South Africa sits at 2,46 births per woman (Stats SA, 2016), so the number of children identified in this study could be as a result of the age distribution across the sectors, as most of the older women have more than the average number of dependants and waitresses, who constitute a much younger working force, are more in line with the national average.

In terms of education levels, only one person had a partial tertiary education (waitress), 44 per cent of the sample had attained their matric, 33 per cent had partial secondary education, 17 per cent had partial primary education and one person did not have any form of education at all (street vendor, but who had the highest number of years worked within the informal sector at 25 years). None of the domestic workers had attained their secondary education. This might be because of the age distribution across sectors, as domestic workers and street vendors were older than the waitresses as well as how the apartheid regime played a role in an unjust education system.

3.4.3. Qualitative interviews as a method of data collection

In-depth interviewing is a qualitative research technique that encompasses discrete interviews with a small number of respondents. This explores their viewpoints on a particular idea, programme, or condition (Boyce & Neale, 2006). This then allows for a more comprehensive approach to obtaining data. This form of questioning is directed to concentrate on specific discussions with a more intimate approach, allowing candidates to engage freely and share their perceptions on a particular topic. An interview "provides a unique opportunity to uncover rich and complex information from an individual" (Cavana, Delahaye & Sekaran, 2001, p. 138). A dialogue arranges for an exclusive opportunity to ascertain more in depth and elaborate material from the interviewee. As shown in chapter four, most participants spoke freely and were able to convey their experiences. This allowed people to share their perspectives accurately, therefore helping the researcher to explore the topic profoundly in relation to well-being, inequities and protection.

The researcher prepared a list of questions which were used to guide the conversation. The interviewer conducted semi-structured interviews which allowed the interviewer to not have to follow a formalised list of questions too strictly. This enabled the researcher to ask more open-ended questions, allowing for a discussion with the interviewee rather than a straightforward question and answer format. When interviewing the subjects that were not as willing to participate or who were too busy attending to customers this was relatively hard to carry out, as they would give brief answers or would say "I don't know" in order to move to the next question. This made it harder to probe and get more detailed explanations or experiences. Others were very free and open in their responses, and additional questions were not needed as they would share their experiences in more detail, for example Jean the domestic worker, Clare and Abu the street vendors, and lastly Sethu the waitress.

People are not always keen to open up and express their personal experiences, especially when it comes to health and their health problems. The researcher therefore created an engaging, safe environment wherever possible, to help the interviewees feel more at ease. The researcher shared their own experiences to ease the participants into the more difficult/sensitive questions, and this allowed the participants to comfortably open up about their own experiences. For example, the researcher mentioned their own health status and mentioned illnesses like influenza, tonsillitis and severe headaches so that the participants were not apprehensive about answering the health related questions. When they did not understand the question regarding paid leave, the researcher as a former waitress explained to some of the street vendor participants how they would be able to obtain funds from the UIF if they had maternity leave.

The researcher added questions regarding their demographics, like date of birth that revealed age, and their home address which revealed the geographical demographics. These geographical demographics helped explain why some people worked so far from home, as explained in chapters two and five. Open-ended question were used to help explain the question, for example when asked what they would like to change about their work, the interviewer continued to ask: what do you like or what do you not like about your work? The researcher included the question: does your child have any health problems? If yes, what are they? This was included in order to find out the health related outcomes of the children of these women. The livelihoods of the women working in the informal sector could possibly

determine the future of their children and the potential health implications they could face. The questionnaire continued to ask the participants what type of treatment their children received when seeking health care. In addition some terms needed to be explained, like the word “treatment” when seeking health care as some thought this was the type of medication received at the pharmacy.

3.5. Method of Data Analysis

Thematic Analysis

All interviews were transcribed verbatim prior to the analysis.

Thematic analysis focuses on recognisable themes and patterns of living and/or behaviour, and creates a developed story line that helps the reader to comprehend the process, understanding, and motivation of the interviewer (Aronson, 1995). Thematic analysis describes the thematic content of interview transcripts by identifying common themes in the texts provided for analysis, therefore it is the most foundational of qualitative analytic procedures and enlightens all qualitative methods (Anderson, 2007).

This method, then, is a way of identifying what is common in the way a topic is talked or written about and making sense of those commonalities (Braun, Clarke & Terry, 2014). The use of the open-ended responses from the interviews plays a fundamental role in contributing to the data that is analysed in chapter four and discussed in chapter five. Thematic analysis allows the researcher to consider both underlying content as a theme, and make content evident as a category in data analysis (Vaismoradi, Jones, Turunen & Snelgrove, 2016).

The study had a main theme, namely the informal sector. Within this theme findings were distributed across the three categories that shared similar characteristics under the headings of: street vendors, domestic workers and waitrons. The explanatory component comprised of developing themes that evaluated the sub-questions presented in the initial chapter. These themes validated that the study concentrated on discussion of the objectives identified initially. These included: working conditions, health status, preventative and curative health care, informality and protection of women employed in the informal sector. Thematic qualitative measures were used in order to analyse the data and to draw a conclusion.

The aim of the study was to collect experiences among women working in the informal sector, based on their health and informality. The data collected produced stories that were highly significant in revealing other issues that the women working in the informal sector faced. For example Abu shared (in chapter 4) her income situation and how she would like to provide more for her family but was unable to. These types of stories provided underlying key issues that needed to be addressed among these women, and which suggested that there were deeper fundamental aspects at play. The researcher then used thematic analysis to analyse the stories found. The methods were complementary and helped the researcher to obtain results that provided more explanations, which helped investigate the data in greater depth. Thematic analysis was also used in identifying similarities and differences across the participants. This was done through shared themes and perspectives on each category and how they fared in the informal sector. Thematic analysis allowed the researcher to see and make sense of collective or shared meanings and experiences (Braun, Clarke & Terry, 2014).

In chapter four the topic is broken down using the collected data and discussed thereafter in chapter five. Thematic analysis helps facilitate the discussion in chapter five where the researcher will develop themes according to the participants' responses, for example age, education, differences and similarities in informality, protection and health problems.

3.6. Ethical Considerations

Ethical approval was obtained from the University of KwaZulu-Natal Humanities and Social Sciences Ethics Committee. Prior to each interview, the researcher explained the study and its purpose to ensure that the participants gave informed consent. Participants were assured of privacy and confidentiality, and as such they were only referred to by pseudonyms in this study. Participation was entirely voluntary, and participants were informed that they could withdraw from the interview at any time without notice and without repercussions.

3.6.1 Reliability and Validity

To develop an analysis and understanding of the work done so far by other researchers, this researcher performed triangulation involving several investigators or peer researchers' interpretations of data on the topic at different time or locations (Golafshani, 2003). This was used throughout the study but mainly in the literature review to acquire an in-depth

evaluation of the topic at hand. A qualitative researcher could "use investigator triangulation and consider the ideas and explanations generated by additional researchers studying the research participants" (Johnson, 1997in Golafshani, 200: p. 284 3). So pioneers of the research helped the present researcher to understand how social happenings or ideologies came about. The other researchers either attested or critiqued empirical findings through additional investigations on their own and accordingly discovered new findings, created debates, formed theories, or elaborated more on the topic. Primary data was used to discuss and explore the findings of the study carried out and this will be detailed in chapter four.

As established by Lincoln & Guba in the 1980s, the value of research is strengthened by its trustworthiness, and it involves establishing:

- Credibility - confidence in the 'truth' of the finding
- Transferability - showing that the findings have applicability in other contexts
- Dependability - showing that the findings are consistent and can be repeated
- Confirmability - a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Amankwaa, 2016, in Lincoln & Guba, 1985).

"The credibility of a qualitative study is affected by the extent to which systematic data collection procedures, multiple data sources, triangulation, thick and rich descriptions, external reviews or member checking, external audits, and other techniques for producing trustworthy data are used" (Yilmaz, 2013, p. 321).

The researcher undertook to reveal the true revelations of the study, to be revealed in the results. Different platforms of secondary data were used throughout the study, specifically in the literature review, to ensure a vast narrative of the topic. Observation of the study area was done prior to conducting the field work as this allowed the researcher to analyse and understand the study area at hand. A pilot study was conducted to test the study in order to evaluate the practicality of the different variables that existed within the study area like time, cost, and area constraints, in order to progress upon the study design prior to the research project. In order to validate and ensure that the study is credible the researchers' supervisor will evaluate and examine this paper and it will thereafter proceed to an external panel of examiners for examination.

In qualitative research, consistency and dependability of data and analysis are two terms that are theoretically comparable to reliability in quantitative research (Lincoln & Guba, 1985). The researcher will therefore use this for stability, and to illustrate consistency and believability. This will be done by showing the responses of the participants and how their responses develop themes that form under one category. Data communicated in chapter two also shows dependability, as it has drawn from different eras in order to compare the informal sector holistically over time.

The researcher will show transferability by demonstrating that the results are relevant in other contexts, this was also evident in chapter two. It is also valuable to give pure representations of the culture, context, selection, and characteristics of participants (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014). This was done by using different groups within the informal sector, and how their outcomes and responses are relevant to understanding the study at hand as well as other perspectives.

Confirmability refers to the researcher's aptitude to demonstrate that the data represents the participants' responses and not the researcher's biases or viewpoints (Tobin & Begley, 2004, in Polit & Beck, 2012). The researcher will convey the thoughts and experiences of the participants without imposing the researchers' ideas, as stipulated in the ethical considerations above.

Chapter 4 Presentation of Findings

4.1 Introduction

As the overall aim of this study was to explore how different levels of informality impacted on health, this chapter begins by exploring the nature of the relationship the women in the study described with their employers, and their perceptions of their employment conditions. It then reports on the health status of the participants and their children, as reported by them in the interviews. The third section explores how the level of informality impacts on the health of the women and their children.

4.2 Working Title

A ‘working title’ describes a function of responsibilities, this provides a more immediate understanding of what the job should entail. This helps distinguish certain specialties within a workforce. Working titles make it easy to recognise and understand people’s roles and what is expected of them. As such the women were asked what their job description was. The answers varied from category to category, and for the more ‘formalised’ line of work i.e. waitrons - their titles spoke for themselves in representing a more formal entity. However, the domestic workers and street vendors provided more disparate responses, which could help explain why these categories were typically more easily identified as having informal sector characteristics.

Domestic Workers

Surprisingly most of the women who were employed as domestic workers did not refer to themselves as domestic workers, ; they referred to themselves as ‘aunts’, ‘housekeepers’ and ‘helpers’. The domestic workers in this study found themselves having a personal relationship with their employers and their families, while some of the other domestic workers were considered as part of their employers’ families. Some not only ensured that the house was clean, they also looked after some of their employer’s children and that was why some employers and their families referred to them as ‘aunts’.

> *The lady (employer) said I must teach them respect like a parent. For example if one of the children mentions a word that has strong language… Like the little one, she likes to shout and scream. I [told] her nicely 'if you are speaking to someone you do not raise your voice, if there was something that was said and you did not like it, you go to that person and say this hurts my feelings. Do not shout if there is something you need, let me know and I will assist you*' (Jean, domestic worker, 39).

With regards to this domestic worker, she was no longer just a domestic worker but also served as a childminder. She did state in the interview that she had worked as a childminder before. With the other domestic workers in this study the language of 'aunt' or 'helper' was apparent and therefore raised the questions of how much they were paid and what they were hired to do. They could unknowingly be taken advantage of by being asked to do 'favours' which were not part of their job description and should be considered as extra paid work. If this was revealed it would require further investigation. The additional questions would relate to their employment criteria and what their contract stipulated in terms of what they were required to do as domestic workers.

While the majority seemed to be content with their job titles, this raised a question regarding their rights and how they would respond to being mistreated? Only one of the participants expressed that they would stand up for themselves by maintaining a clear working relationship with their employer.

> *for example if they ask you to kneel in order for you to clean the floor, I tell them I do not have time for that because at the end of the day I will be the one suffering with bone problems. They must buy [the items] required in order to clean properly* (Zama, domestic worker, 42).

It was important that these workers were able to address certain issues that could impact negatively on their health in the long run. This also raised other health concerns that are further discussed in this chapter.

Street Vendors and Waitrons

Women sampled in the category of street vendors referred to themselves as ‘business women’ and ‘sales ladies’ as typically they were self-employed. Only one participant was hired as an employee. The women in the waitron category were also very clear about their titles; they referred to themselves as ‘waitrons’. Only one participant had two titles, namely waitron and cashier at a restaurant.

4.3 Relationship to Employer and Employment Conditions

Domestic workers

Most of them had found their jobs through a friend or someone they knew, whereas some had found their employers through the internet. One was hired through a small local newspaper, The Highway Mail.

> *The way in which I started was I was walking around looking for a job, and then sisThandi found me here in the street* (Joyce, domestic worker, 40).

When asked to describe their working conditions most of them were very positive in their responses. Some enjoyed the luxury of not being followed around and micro managed.

> *I work well with the students, I enjoy my work. [When] you want to leave you leave, there is no one to [check in with], there is no Mrs following you around* (Joyce, domestic worker, 40).

Joyce was hired by the landlord, which was unlike a general cleaning job, especially since cleaning ladies usually worked for companies that paid UIF, and she did not receive any paid leave. Some working days were described as good while others were not, and some participants expressed indifference.

> *Well sometime good, sometimes bad* (Rose, domestic worker, 44).

Another displayed a good working relationship where they and their employer had found a common ground of understanding.

> *Otherwise there is nothing wrong; you see the people that we work for in different households are not the same. One day they may be having a bad day, and if something [happens], like with the lady I work for, she comes to me and apologises* (Jean, domestic worker, 39).

Some of the participants saw their working environments as homes to be nurtured, and as home where employees were seen as family.

> *It is like a home because you have to treat it like your home where you live; you have to take care of it* (Zama, domestic worker, 42).

> *We are friends, we are comfortable [and] it feels like home. I have no problems, I will not lie. We should not criticise even when it is needed. They give me holidays, [a] bonus, I get paid well, I am proud* (Happy, domestic worker, 54).

Most of the women agreed that while their employers were different, they could inform them if there was something they did not like, and vice versa.

The study found that they faced challenges of salaries that were 'too small', long working hours and inequality. When asked what they would like to change, Rose (domestic worker, 44) mentioned that she would change her operational hours.

> *My working hours, I work too many hours* (Rose, domestic worker, 44).

> *I would say to treat each other equally because sometimes it does arise that 'I am white and you're black'* (Zama, domestic worker, 42).

The historical background of South Africa contributed to this viewpoint. Changing the mind-set of employers with regards to race still appeared to need attention in some cases, given that it has been 25 years since liberation from apartheid. Perceptions of race and superiority should not be a problem in a working environment.

Street vendors

Similarly, many of the street vendors started their jobs following the recommendations of someone they knew.

> *There was a lady who use[d] to work next to this stall [selling biscuits], she helped me. She told me there is some man who [is] looking for someone to work for him. I said I was available, then worked for him. The lady is my neighbour so I came with her and started* (Yenzi, street vendor, 21).

Unlike domestic workers there was no formal application process to become a street vendor, besides obtaining a permit which authorised them to sell on the street. For most of them, the process of obtaining the permit was protracted as permits were only issued when a stall became vacant. Most of them were inspired to start their own business as they did not enjoy working for someone else:

> *I used to work for a cleaning company, there was too much work and less money, yet the boss was too bossy so I decided to [work] for myself* (Clare, street vendor, 29).

Others were conflicted with the challenges of poverty and just wanted to put bread on the table and provide for their children.

> *What brought me here is that I was not working; I could not send my children to school. Even their father was not taking care of them, we were living separate lives. He did not support them. [I] then looked for a job to see how I can make ends meet, I saw some ladies sitting here, selling, I asked them if you want to sell what do [you] do? They [told me] you have to have a permit in order to sell. I asked how one [got] a permit, they [then] explained it to me. I then applied for a permit and started selling. I was then able to send my children to school. There was a point where they were not going to school at all because I could not afford [it]* (Abu, street vendor 56).

For street vendors working conditions were different to those of the domestic workers, especially since they worked out in the open. The study found that the weather played a crucial role in determining how the business was run or whether the stall was opened at all.

> *It is very windy since we are next to the beach so [when] it rains sometimes [it is] not good* (Gayle, street vendor 55).

> *Like when it is cold, I [am] too cold and when it is hot it is too hot, then the rain is [also] a problem* (Yenzi, street vendor, 21).

While weather was one of the main problems, hygiene was also a factor

> *This is a good area for business but the toilets are not clean. I realised [this area] with the climate is not good for fruits but good for cakes. This area [is] quiet, there are no robbers* (Sandra, street vendor 50).

The main thing that grouped the women in this category together was the masses of people they saw every day. Just like the domestic workers they had good working relations with the people they worked with. Evidently most of the women liked and understood their clientele and this was the core of their business.

> *It is a busy area with a lot of people. It has a lot of tourists, most tourists go past through here. It is an area were most people like what I sell* (Lerato, street vendor, 40).

They worked hand in hand with the people around them as well, for example if someone stole from one stall, it created a domino effect where everyone got involved in catching the perpetrator.

> *You see, the other day there was someone stealing at that table (pointing) and some men tried to stop him. Until the lady across the road stopped him. We are a very close community on our own but at the end of the day it is a risk, because when we leave we leave individually. Most of us here are women, and there are no jobs, so it is not right just to watch someone else lose their money so we have to help each other* (Clare, street vendor, 29).

This revealed that the women in this sector understood the risk factors associated with being a woman making a living in an informal setting. What they mainly wanted to change was to

have some sort of cover over their tables, or to convert their tables into containers as this would protect them from harsh weather and they would be able to expand their businesses to generate more income.

> *I would like for it to be closed off, because sometimes it is too hot or very windy since we are close to the harbour* (Sandra, street vendor, 50).

> *I do not like the table anymore. I would like it to be a big container to add more goods to sell* (Yenzi, street vendor, 21).

Just like the domestic workers, most of the women stated that their working conditions did not affect their health. However considering that most street vendors worked outdoors, they had no control over their working environment. This was a huge factor which determined if some street vendors would open their stalls or not.

(Sandra, street vendor, 50) mentioned "*Wind and smoking from other people*".

For those for whom this was their main source of income, it was not easy to take time off of work, since most did not have other colleagues to stand in for them. They would thus rather endure the harsh weather conditions and as a result getting ill was inevitable. In addition to smoking, they were also well aware of the dangers of secondary smoking, so some of them had stopped selling cigarettes.

> *Some people will buy cigarettes and light it up next to you and that is dangerous. You [understand that] with someone who smokes and someone who does not, the person who does not smoke gets more affected* (Clare, street vendor, 29).

Waitresses

Unlike both domestic workers and street vendors, they had not accessed their work opportunities through relatively informal means, but instead had applied formally for their positions. Most of the women had started out by submitting their curriculum vitaes (CVs) personally by walking in to the restaurants, by mailing them or by submitting them via the Internet. Others had started out in trainee positions, and then graduated on to working as

qualified waitresses. This could have been attributed to their age distribution, since they constituted a younger population with a higher education status as some had certain qualifications that allowed them to secure this type of employment.

> *I just came and asked for a job, they said [I must bring] my CV, thereafter they called me* (Patience, waitress, 30).

> *I handed in my CV at the …. Springfield offices* (Sethu, waitress, 24).

> *I saw it online on the internet. Since I have a cooking certificate I thought I should [hand] my CV in. I [handed] my CV in and that's how I got the job* (Hope, waitress 23).

> *I first did training then I started working* (Angel, waitress, 26).

Comparable with the domestic workers, waitresses also described their working conditions as good.

> (Sethu, waitress, 24) stated, *We are well taken] care of.*

> *I do not work night shifts but some other waitrons work night shifts. I asked the manager [since] I do not have anyone to look after my kids at night, so I only work day shift. I enjoy working here, it is a very good environment* (Mary, waitress, 33).

The working environment was flexible in the sense that it allowed Mary to control her working hours in order to accommodate her children's needs.

Some of the waitresses stated that they would change "*nothing*" (Esihle, waitress, 29) about their work. The problems found in this category in relation to work were transport, the employer (like domestic workers), operational hours and salary.

> *I would say transport, if they could provide us with transportation that would be great, because sometimes we [work] late hours and that would be helpful* (Hope, waitress, 23).

I would say the boss would be the one [who] needs to change (Angel, waitress, 26).

Salary since we get paid by commission (Sethu, waitress, 24).

4.4 Health

4.4.1 Personal health

Domestic Workers

Among the domestic workers all of the women described their health as good, but they faced health problems like arthritis, high blood pressure, diabetes and accidental injuries. Most of these illnesses would most likely have been due to their ages, as they were common age related illnesses. The women mentioned that when not well, they took medication and went to the doctor or clinic. Based on their treatment and regardless of whether they attended a clinic or a hospital, most stated that they received good treatment at both types of health care facilities.

They treat me well. If there is anything that I need to know I am able to get information whenever I need it (Mbali, domestic worker 28).

I am not used to going there, I will not lie. I just [went] for my eye and that it is. I went after three, six and nine months and they did a good job [with] my operation. I received the operation when it was still St. Aiden. Even when I [went] there, my bosses [did] not withhold my salary; they give it to me as it is, even enough to pay the hospital. Yes I would be lying, it is not right [what] God has given unto us and we do not appreciate (Happy, domestic worker, 54).

While some reported being satisfied with the public hospitals or clinics they had used, others reported less positive experiences.

The problem at the clinic is that it is very full. [We arrived in the morning], you sit there for a very long time [until] one or two pm (Joyce, domestic worker, 40).

Jean also mentioned that "…*because of our clinic by my home … you have [to] leave early in the morning around four or five am because it gets very full*" (Jean, domestic worker, 39).

Most of the clinics in the townships were overcrowded, because of the dense population and limited health care facilities. There was only one in each area and it did not cater for the patients' needs as it usually lacked resources.

In order to keep healthy all the different categories of respondents saw the need for exercise and referred to the work that they did as exercise. Others mentioned eating healthily, drinking water, and walking as their means of keeping healthy.

> *Well you see where I stay, I live … maybe you know it, I walk in the morning I leave my house at 4:30 am. [There are no] taxis around my neighbourhood. It's like I am exercising every morning, I leave at 4:30 [am] and reach the bus stop at 5:30 am because of [what] the distance is. I had bp once, at the clinic they said I must bring down my cholesterol and reduce [the] spices I use. Then they asked if I drink [and] I explained to them [that] I drink only when I get paid. Then they asked what I drink and [I] told them Savannah Dry. The nurse said I must drink water along with it, a glass of water after each bottle and not a bottle [one] after the other. She then explained that I must eat healthy food and I must not always [fry], I should boil my food and [not] use too many spices. Since I have ulcers the doctor said I must not use butter but I should use olive oil, eey but I struggle with it, it smells like castor oil. So I did that, and the food that I eat is usually beans, my favourite samp and spinach imbuya nocadolo. Other than that I have no illnesses. I am ok, now they [have] given me treatment and I am alright* (Jean, domestic worker, 39).

Based on their future prospects for health, all of the women laughed as they were unsure of what the future held for them. Nevertheless the study found that across all the different informal categories, the women were very well aware of their health and potential illnesses.

> *There are a lot of illnesses* (Mbali, Domestic worker, 28).

> *I am very scared of cancer. Maybe even HIV is better, since there are pills, but [I am very afraid of] cancer. TB, Cancer, HIV, I do not need it* (Jean, Domestic worker, 39).

KZN Health MEC Sibongiseni Dhlomo mentioned in an article "In the province (KwaZulu-Natal), there are at least 365 new cancer patients every month and 1 400 patients attend our oncology clinics as follow-ups every month" (Kubheka, 2018).

Contrary to the fears expressed by Jean, another domestic worker noted that:

> *In my life I have always been like this and I am living. I dated the father of my children [from a] young age until now, even condomising. I do not know what that is actually* (Joyce, domestic worker, 40).

This response reflected that although she was aware of the campaigns promoting condom use, they did not have relevance for her personally. It should also be noted that some protective behaviours were not entirely under an individual's control. Mays & Cochran (1988) noted that condom use required that women negotiate or communicate with their sexual partners about condom use and HIV risk. They expanded that verbal communication about risk could be unrealistic and irrelevant in the lives of poor women who "may not [have] bother[ed] to ask men about previous sexual or drug use behaviours, because they [knew] the men [would] lie or discount the risk" (Mays & Cochran, 1988, p. 54).

Street Vendors

With regards to street vendors all of the women described their health as good but similarly to the domestic workers they were faced with the same health problems like bone problems/arthritis, low and high blood pressure, diabetes and accidental injuries. Some of these illnesses may also have been age related. Just as with the domestic workers, when not well, the women mentioned that they took pills or went to the clinic. Lerato (Street vendor, 40), however, did not believe in medical care and left it all to religion:

> *I pray, I do not believe in the doctor* (Lerato, street vendor, 40).

Clare stated that it was up to an individual to take care of themselves as there was more access to facilities, regardless of race or gender:

> *You see now it is not the same as [in] the past. It is up to you to take care of your health, but if you are the one who does not take notice, you can die. But if you notice*

> *it is sore and [you are] not well, then do something. It is not easy to die these days [be]cause even with HIV there is treatment, it is up to you. It is not like in the past where they use[d] to say black people cannot go in here but now you can go anywhere. So I do not see myself having problems because I know I have to [take] care of myself* (Clare, street vendor, 29).

Just like the domestic workers, this category of women liked to keep healthy by maintaining a healthy diet. In order to keep healthy, the women typically reported eating healthy foods such as fruits and vegetables. Stress was recognised as a factor that affected their health. For Abu, the stress of not being able to feed or provide for her family contributed to her blood pressure and diabetes rising.

> *I [try to] calm down to bring my stress levels down, and not think of all of my problems. As long as I think that I have enough to provide and get me by I am fine. The only thing that can stress me is my youngest one since she is young* (Abu, street vendor, 56).

Efforts to reduce her stress levels were therefore a coping mechanism to control her illnesses. While Abu was also well aware of her health condition, as most women had indicated in the study, she understood that anything could happen at any time concerning her health.

> *You never know hey, life is forever changing. You might be fine the one year and the next it is a different story. There might be an illness that you were not anticipating. The only thing I can say is that as I get older it is pains that will give me a problem, since I am getting older. I can feel that certain pain is not because I am sick, but it is because I am getting old* (Abu, street vendor, 56).

She also acknowledged that some of the pains of growing old were inevitable and had accepted growing old gracefully.

Waitresses

Typically the waitrons reported overall good health, with some reports of problems in relation to their skin, weight, asthma respiratory illnesses and contagious respiratory illnesses like influenza.

> *Right now I would say that it is my weight* (Hope, waitress, 23).

> *I have had [flu] for [three] times* (Mary, waitress, 33).

Waitresses concurred with both the domestic workers and the street vendors that when they were not well they would go to the doctor, clinic or hospital. (Hope, waitress, 23) on the other hand used "*home remedies, I hate the hospital*". Half of the sample expressed that they received good treatment at the clinic or doctor. (Hope, waitress, 23), however, stated otherwise:

> *The problem is that some go after money. You tell them the problem and they just prescribe without checking you properly. You tell them you have a back problem and they give [you] something for muscular pain instead* (Hope, waitress, 23).

Sethu attended a clinic near her home and stated:

> *They have no problem; it is just short staffed* (Sethu, waitress, 24).

To keep healthy, one of the waitrons spoke of managing her chronic condition by using medication as prescribed.

> *I use my asthma pump [and] spray, and I am fine. There are two of them, one is for when you [have an] attack and the other one is for every day* (Patience, waitress, 30).

Like the domestic workers, most considered their jobs as their means of exercise and preferred a healthy diet.

> *Cause every day I am here, that would mean I am always exercising. I am a waitress I am always moving up and down* (Angel, waitress, 26).

> *Drink water! Eight glasses [or] even more than that. I also eat healthy food like salads* (Sethu, waitress, 24).

> *I don't work out but I eat healthy food. I like healthy food* (Mary, waitress, 33).

They also identified lifestyle behaviours that could later negatively impact on their health. Sethu mentioned what could happen to her health in the future in relation to her smoking:

> *No not really, besides that fact that I smoke [and could] get cancer in [the] future. But I will stop* (Laughs) (Sethu, waitress, 24).

In addition, like Joyce the domestic worker, Sethu did not use a condom.

> *I would be lying, I would say I use a condom but I do not. The nurses shout [at me] and I always have to [have a health] check* (Sethu, waitress, 24).

In her opinion she protected her health by going to check on her health status, and said

> (Laughs) *You just cannot trust men, hey* (Sethu, waitress, 24).

This then brought up the question of how men/partners influenced the health of women in the informal sector. Based on their social background and how they had grown up, they were accustomed to being submissive to their partners; as that was part of their cultural beliefs and they assumed that men were not to be questioned about their sexual practices. On the other hand, some understood that regardless of the risks that came with sexual activities, their partners would not be open to discussing the topic as they perceived it as offensive.

In addition to taking personal responsibility and seeking health care when ill, Hope (waitress, 23) noted the need to engage in proactive healthy behaviour when she brought up the issue of weight. "*It would be being overweight, then I would need to exercise*". (Laughing) "*I munch on anything, so I would say it isn't good*".

4.5. Children's Health

The children of these women had the following health problems: skin sores, appendicitis and heart conditions. When seeking or attending the clinic or hospital some of the women mentioned that the treatment they received was very good yet others had unfortunate encounters, like Jean.

> *My child [was] very [ill, some spoke] meanly, [but] there are some [of] them that are nice. Not all of them are nice, but I cannot say that they are good. The moment you take the child there they shout at you, my child used to drink breast milk, [but] now that I have a job, I give him both milk and rooibos tea with different flavours. When I go to the clinic I carry both and a little water bottle. So now that my child is sick and coughing, when she saw the rooibos tea she scolded me and said 'why are you making the child drink tea. Who told you that you should do that? Is [this] because you gave birth at an old? I stopped her and said 'no this is tea for children and it was recommended by one of the nurses where I stay, who works at King Edward [Hospital]'. Then she went on, ok, I understand but do not stop feeding him breast milk… In the afternoon give him the formula once, then rooibos and water… I left the clinic crying* (Jean, domestic worker, 39).

Jean mentioned that since she had started this job, she had started to feed her son both bottled milk and tea. This would help with the transition for the child, since she would not be around as much as she would be at work. The child was two years of age at the time of the incident. The nurse told her "*since the child has reached two years, [it is] ok, but do not stop feeding him breast milk. Only give formula once, then tea and also give him water*".

There are nearly 1.3 million child deaths per year (13% of deaths of children aged less than five years). The number of deaths could be reduced significantly if universal coverage of exclusive breastfeeding was increased to 90 per cent amongst infants aged less than six months (Doherty, Sanders, Goga & Jackson, 2011). One could justify the concern of the nurse as she was looking out for the child's health, especially looking at statistics globally, and South African statistics where 30 per cent of pregnant South African women were HIV-infected (South African National Department of Health, 2012). It could be said that the approach when addressing Jean's situation was incorrect and it was unnecessary for the nurse

to have referred to Jean's age when addressing the problem. One of the reasons that people did not attend clinics was that some health professionals acted as disciplinarians while attending to patients. This would make seeking health care problematic, as some would be concerned about other people's perceptions and the stigma associated with their health concerns. As a result, patients would then not receive the health care required, which would lead to other health risks or consequences.

Typically the domestic workers reported using a clinic or doctor for health care for their children, but other more traditional approaches were also described.

> *Uchatho (enema) if they are not well. I have learned with boys, since I have three, that if a boy child had a sore it takes a while for you to see it. Their eyes change and [they] have eye bags like they have worms. So I check their bottoms and if it is red, it means inside there is something wrong. I [then] use Sunlight with water and insert. It goes the same day, they vomit and have high temperature and it works. I do not really like the clinic but if they get sick [I] sometimes take them there* (Jean, domestic worker, 39).

Since Rose was a migrant worker her situation was even harder. She did not reside with her children but rather on her employer's property, because of her employment conditions. This meant that she was too far away from her children to allow her to oversee their health, because of her employers' restrictions.

> (Sigh) *I talk to my neighbours to take care of them* (Rose, domestic worker, 44).

Street Vendors

The children of the street vendors presented with health problems like warts, asthma, sinus problems, tonsillitis and heart conditions. As with the domestic workers, the street vendors sent their children to the clinic or hospital for health care. While traditional health practices were apparent among the domestic workers the study disclosed that religion played a very significant role in health care decisions.

When seeking or attending a clinic or hospital some of the women stated that the treatment they received was very good.

> *They are good, they take care of you. They take care of everything that concerns you and everything you complain about* (Yenzi, street vendor, 21).

Some wished that they had the means to take their children to a private health care institution.

> *If I had the money I would go to [a] private [health care provider]* (Sandra, street vendor, 50).

Sandra wanted better health care for her children, but simply could not afford it. For her private health care equated to better health care. Since she was a street vendor she did not receive the benefits of formal labour. If people were formally employed and had to go and seek health care, their companies would probably cater for their workers' needs with health privileges or packages, which in South Africa constituted medical aid/health insurance.

Waitresses

Their children faced health issues like skin problems, toothache, sinus problems, asthma and chest problems. Waitresses also sent their children to a clinic and in some cases to a doctor.

> *It depends on how sick they are. If they are really sick they go to the doctor* (Esihle, waitress, 29).

Hope (waitress, 23) preferred clinics to hospitals:

> *Clinics [are] very good compared to private [doctors] and hospitals*.

Esihle (waitress, 29) liked both:

> *They treat [you] well at both places*.

> "*Obviously they take care of the children, since it's a child*" (Angel, waitress, 26).

> *The doctor takes good care of him, only one [doctor] has been taking care of him since he was born, he is six now* (Sethu, waitress, 24). *They write it down for us and they say we will find it at the pharmacy*.

Looking at the waitresses' responses, most of them had the expediency of sending their children to private doctors and private hospitals. This may have been due to the fact that they were able to afford the medical health care they received. Based on the researcher's subjective observation, some of the informal workers had partners who fully invested in their children's wellbeing and capable of providing their children with quality health care. This then questioned the role of spouses or partners and how they contributed by providing for their families. It also raised the question of how the spousal/partner support varied between the women in all three categories, for example, what responses would the street vendors have given regarding their partners and did they have the same benefits as the waitrons?

(Mary, waitress, 33) stated that:

> *They do treat the child well, but [not] the medicine; they usually do not have medicine. So we go to the pharmacy*.

In terms of receiving proper medication for both mothers and their children, this was a problem that half of the sample faced. In addition the type of medication seemed to be problematic, as respondents mentioned they were prescribed the incorrect medicines. For example, Angel's child suffered from asthma, which was typically a challenge to treat, but she expressed concern that the type of treatment was inadequate:

> *The treatment there is not good, because my child uses it and it does not work* (Angel, waitress, 26).

4.6 Health Protection Plans and Medical Aid

None of the women across all the different lines of work viewed medical aid or medical insurance as health protection. The responses to what they considered as protection varied.

Domestic workers

Domestic workers mentioned going to a clinic, and a doctor as their means of protection.

Street vendors

Street vendors included going to their local clinic, just like the domestic workers. However, they also considered gardening, fetching wood, covering up their stall during cold weather conditions to protect them from the weather, and praying as their means of protection.

However, in terms of protection from organisations and government departments, Clare noted:

> *We are not protected. [We pay] Metro in order to get a permit. Once approved you are on your own. If you get hurt no one will take care of you, for example if a car were to hit me I do not see anyone assisting me, unless the car's [driver] is in the wrong. I would probably get money. There is literally no place where I could go to and state 'I got injured at a certain table'. It's really bad, even where I am near Clicks and the African Bank, all these places have/deal with money and the [money arrives by armoured truck]. Anything can happen anytime. What if they get robbed and shots are fired [and] I get shot; who will pay me? I really do not see anyone paying. Even when my aunt died, she was working outside a Pep Store. When the guys were robbing the store they took all their money, [and] as they were leaving cops were there and there was a shootout. She got shot while she was pregnant and died along with the baby. Till this day [her family] has not been paid, that is because she was outside and not inside the store. So I also always wonder, if that had to happen to me they would [only] take care of whoever is on their premises and [not] whoever is outside, it is not their business. So protection is very low here and it is very important. [The] Metro is part of the police [so] why are we not protected?* (Clare, street vendor, 29).

Since street vendors paid indirect taxes, the municipality should have been obliged to protect them when they were at work. Considering the spaces in which street vendors worked, they faced a high risk of being caught up in numerous tragedies like being robbed, and being exposed to violence or fatalities. Clare raised an interesting point on compensation and how

the process would work, considering that she was a street vendor. This then raised issues of legality and property status. This would require further investigation on how that would affect people trading on public government property, and what the government provided when certain events occurred. Was there a government and private business partnership that attended to the needs of these people in such circumstances? Also looking at formal or private businesses, and considering that most informal workers worked within close proximity to these companies, what precautions were put in place to protect these people?

In agreement with this was Gayle:

> *The police need to ensure that we are secure and taken care of, [and] remove all those people without permits who keep bothering us* (Gayle, street vendor, 55).

In addition this illustrated that there was illegal trading of goods within the informal sector that needed to be removed. This posed a threat in terms of increased competition, when the Durban Beach Coastal line was already saturated with a number of informal workers.

Waitresses

The majority of women under this category stated "*nothing*" when asked what they did to protect their health. Two participants had different responses:

> *I make sure I have my medication* (Patience, waitress, 30).

> Mary (waitress, 33) stated: *I make sure that I eat healthy food*.

This was the younger population of the group. Young people tended to overlook health care, and in most cases people only became aware of their health needs when their life or health was in danger. Young people had probably not factored health into their long term plans.

4.7 Health and Informality of Employment

Domestic workers

Most of the participants working as domestic workers stated that they did not go in to work when they were sick and would call and ask for the day off if their children were sick, in order to take them to a hospital, doctor or clinic. Others who worked long hours did not get a

chance to visit a clinic when ill because of work: "*I continue sick like that*" (Rose, domestic worker, 44). Even when her children were sick or needed her it was a problem, especially since she was from Lesotho and it was far away.

> *You see right now, I just came back from home [and] my boss is not talking to me nicely. When I went home my first born[']s] husband [had] passed on, [and] my boss is not very happy when I leave for home to sort my problems [out]. I come this Monday from home but she was not happy that I went home to see my child and how things are going with her* (Rose, domestic worker, 44).

Evidently most of these women started working in order to provide an income and they depended on their type of employment to cater for all their necessities before they reached retirement age. Thereafter they would fall under the elderly population that received a State Old Age Pension Grant. It is a monthly income for persons over 60 with no other means of financial income.

> *All I want is for [the] government to give me my pension and sit down* (Laughs) (Happy, domestic worker, 54).

Street vendors

Some street vendors stated that they had people assisting them if they did not go in to work, for example their mothers, husbands and friends. These women thus did not go in to work when they were sick and would take a week off when their children were sick, in order to take them to a hospital, doctor or clinic. Others depended on the Lord as their only hope.

> *Since we work for ourselves, you can feel when you are not doing alright. Then you do not come in. There is no money for that day since there you left no one behind to sell for you. You rest for as long as you want. Once you are well you come back and pray [and] ask the Lord to help you* (Abu, street vendor, 56).

Waitresses

Waitresses could be grouped in the same category as the domestic workers. Most of them did not go in to work if they were sick, and followed through with formal documentation in the form of a doctor's note as proof of their illness.

> *I call in to say I am sick [and] then go to a doctor* (Angel, waitress, 26).

> *I have to bring in a doctor's letter, then find someone to fill in for my shift. I cannot just not come in* (Sethu, waitress, 24).

> *I am not even allowed to work when I am sick, they cannot allow me* (Patience, waitress, 30).

> *You get sent straight home if you are sick here* (Esihle, waitress, 29).

So what happened with most of the waitrons was that they swapped shifts with colleagues when they were ill. "*We swap shifts*" (Mary, waitress, 33). Waitresses followed a more formal procedure when it came to dealing with their health, since their occupation had regulations that they had to abide by.

4.7.1 Paid leave

Domestic workers

One domestic worker, based on her positive relationship with her employer, stated that she received paid leave and even a bonus (Happy, in 4.2.1).

> *I get paid 100 per cent, [and] they give me clothes as well… everything. God is wonderful. I started working here while the boys were still in school, [and] now they [are] all working. They even helped me [with] their education, I cannot fault them* (Happy, domestic worker, 54).

While some were not sure how the leave payment process worked, others did not get paid at all when seeking health care, or when on leave. As a result they had no means of recouping

that income from lost working time, and instead had to come in to work as for the street vendors.

> *Even when we bring in a letter, I do not get paid since I do not work in a house where there is someone to not pay me* (Joyce, domestic worker, 40).

> *No, no there is no way in getting it (earnings) back* (Mbali, domestic worker, 28).

Street vendors

Unlike some of the domestic workers, none of these women got paid when they were ill and sought health care, or when they went on leave, since they worked for themselves (Abu).

> *You see, [here] you do it for yourself, [and] if you [are] sick there is no money* (Gayle, street vendor, 55).

Yenzi, a sales assistant for an employer, and who was therefore not running her own business, did not get paid leave. The researcher noted that most of the women in this category mentioned the municipality when communicating paid leave, and spoke of how they felt about their relationships with the municipality.

> *We are under the municipality but the municipality does not assist us in any way* (Lerato, street vendor, 40).

> *There is nothing that the municipality helps [us] with, I have seen nothing…* (Yenzi, street vendor, 21).

Waitresses

Only one participant stated that they did not get paid when on leave:

[With] us waitrons [we] do not get paid when on leave, we don't… No work no pay (Patience, waitress, 30).

Otherwise the majority of the waitrons got paid when on leave in contrast to the street vendors. Patience and Mary worked in the same restaurant, but had different responses when it came to the question of paid leave. So what most of the waitresses were referring to as paid leave was the compensation they received from the UIF, which would cover maternity leave, for example. Restaurants were different; some paid their waitrons based on the number of sales made/tables served, namely commission, while others paid their waitrons for a standard number of working hours.

Based on the researcher's subjective experience as a waitron, waitrons did not get paid for sick leave or annual leave. They were paid based only on the number of days they had worked, which was their basic salary, and tips were not included in that salary. They received their income at the end of the month but were not paid for any days missed. These would have to be remunerated by coming back to work and making up for days missed, and by asking for extra shifts. Tips usually went directly to the waitron, (depending on the restaurant) and these helped sustain waitrons on days when they could not go to work when required, and for out of pocket expenses.

Chapter 5

5. Conclusion

5.1 Introduction

The study used qualitative methods to gather data and conduct the study. The study focused on women working in the informal sector, specifically focusing on street vendors, domestic workers, and waitresses. Street vendors were considered to operate within the informal sector. Domestic workers were considered as informal workers that worked outside of the informal sector, as were waitresses. Waitresses, however, were usually hired by a formal entity with its own regulations, but they also exhibited characteristics of informal sector employment. This study focused on women as, according to Chen (2016), women tended to be concentrated in the more vulnerable forms of informal employment. The study intended to explore the health and the various work informalities that the women of the informal sector went through.

5.2 Discussion of Findings

Working Environment

Informal work environments were usually characterised by low-skilled labour that required little training, which meant that most of the persons found in this sector had low education levels. As demonstrated in the findings, only one participant had a higher education level, having progressed to a tertiary level. Evidently none of the participants had needed to acquire particular skills in order to secure their jobs. As a result, the characteristics of working within the informal sector were unescapable. For example, labour hours were not fixed as in most formal occupations. This meant that working hours for persons working in the informal sector were irregular and lacked consistency, and the study illustrated that these extensive working hours were hard to endure. When participants were asked what they would change about their jobs, the hours of work were highlighted; not only in terms of the total time worked but the time of day that their work ended as well. Those working late into the night highlighted issues related to the lack of transport available at that time of day.

Long or irregular hours came with the burden of not being able to see family members as much, transportation constraints, and not being able to seek health care when needed.

Inconsistent working structures could also impact on the source of revenue as it could happen that someone would not be able to work enough hours to sustain their standard of living. The study showed that when participants' income levels were low, it was very hard for them to eke out a living, let alone try and support an entire family's needs while taking care of their own needs, from health to education. Additionally, some labourers worked long hours for low wages, as stipulated by some of the participants in the study.

In addition, street vendors also had issues with the transportation and storage of their goods as most did not live in central Durban. Most street vendors did not have access to fixed and secure storage space near to their stalls. This meant that they had to transport their merchandise every day, and based on the researcher's own observation from travelling in and out of Durban, their working day started from as early as 6:00 am. Those who resided on the outskirts of Durban thus had to wake up very early and travel long distances while carrying all of their stock, to get their stalls ready in time for business. This was revealed by Jean, a domestic worker, in chapter four.

5.3 Discussion of the Social Determinates of Health

Physical and Social Environment

The history of South Africa has played a major part in the creation and maintenance of the informal sector today. For most, the informal sector served as a place of employment that did not require formal qualifications and which allowed them to support them families.

Most of the older women in this study were born and had grown up during the apartheid regime, and had been constricted by the laws and regulations of the time that had not allowed them to participate as freely they could have in the economic world. As time passed and the political climate evolved, women became more liberated but they still carried the burdens of the past, particularly the older women. Women were limited by the types of employment opportunities available to them, and this led to the creation of the economic structure (formal/informal) and ultimately determined their health outcomes.

Based on geographical divides created during apartheid, white people lived in urban areas and black people were segregated to the townships and leftover unwanted homelands. They were only permitted to come into the urban areas if they had documentation (a pass) that

permitted them to work in that area, thus most people travelled long distances from their destinations to get to their places of work. As shown by the study the effects of the previous laws and regulations had carried over and helped to explain why most of the informal workers did not reside in central Durban. Jean, a domestic worker, explained in Chapter four that she had to wake up very early each morning just to take public transport to get to work on time.

"Work can provide financial security, social status, personal development, social relations, self-esteem and protection from physical and psychosocial threats; hence employment conditions and the nature of work are both important to health" (Marmot et al., 2008, p. 1663). The socio-economic characteristics of the women in this study were low education levels, low wages, and a lack of formality due to their types of employment.

With social status being measured by education, the level of education among these women cannot be ignored as half (50 percent) of the study had not reached or completed secondary education. Therefore, one cannot overlook how education has facilitated the narration of these women working in the informal sector. In addition, most of the women complained of low wages, which makes it difficult to have a sustainable livelihood. With working in a world that is not structured is accompanied by its own challenges like informality, were not everyone within that working force receive the same benefits. This then makes women working in the informal sector more susceptible to vulnerability, poverty and health impediments. Alternatively, these women would lack basic human needs simply because they cannot afford them.

Ageing population

The average life expectancy in South Africa was estimated at 61, 1 years for males, and 67, 3 years for females (Stats SA, 2018). Females were expected to live longer and formed the greater number of the elderly population. Globally, there was great importance placed on the effects of the ageing population's health, hence the necessity for health care services (Day & Gray, 2016). In 2017 it was estimated that the proportion of elderly people (60 years and older) in South Africa was growing, reaching 8, 1 per cent of the total population. There were 4, 6 million people in South Africa who were over the age of 60, according to estimates (Stats SA, 2017).

There were many challenges and limitations faced by aging people. For example they faced neglect, poverty, physical vulnerability, discrimination, lack of access to basic services, gender issues, inequality and strenuous labour. The older women in this study confirmed these limitations and challenges, and pointed out that poverty was a very crucial point. Elders, like every other human being, had living standards that had to be met but they were faced with prohibiting factors like "the lack of involvement in [the] labour market, compelling them to survive on a minimum wage" (Arber & Ginn, 1991; Calasanti, et al., 2006; Krekula, 2007 in Sidloyi & Bomela, 2016). Since some were frail but had not yet reached retirement age, they resorted to jobs that would accept them and depended on their meagre earnings to survive.

As described by some of the participants, this was their livelihood and they were just working until they could receive their pensions. Turner (1989) emphasised that rules regarding retirement age were an essential part of the whole industrial-relations system, providing negotiators with at least one potentially effective rule for making judgements between the conflicting claims of different sectors within the workforce.

5.4 Health

Working conditions served as contributing factors when coordinating their lives and their health security. The women in this study described unpleasant working conditions which entailed low salaries, long working hours, lack of health protection, safety concerns and since the street vendors worked in the open, they were at the mercy of the weather conditions which could make or break their businesses. As mentioned in chapter four, some of the participants were not able to seek proper health care as this would hinder their income and they could not afford that happening. When it came to their children's health, however, all of the respondents ultimately stopped working to see to their children's health needs. For the street vendors this meant that no one would be available to run their stalls for them and they lost income.

Based on some of the findings, age helped to explain the health problems that the older participants had. The main health issues found amongst the women working in the informal sector were arthritis, low and high blood pressure (hypotension and hypertension), diabetes, accidental injuries, skin problems, weight-gain, asthma and contagious respiratory illnesses

such as influenza. Their children experienced skin problems, appendicitis, heart conditions, warts, asthma, sinus problems, tonsillitis, toothache and chest problems. Most of the women and their children had a high prevalence of non-communicable diseases.

Even though most of the participants were not well educated, they had a reasonable understanding of the issues related to their wellbeing. They understood the risk factors of most illnesses, and were well aware on how to prevent them. In order to keep healthy most women followed a healthier diet, they considered the work that they did as a means of exercise, and took medication when needed. They maintained good health literacy, as they were well aware of their wellbeing and other health concerns. Most stated that their work did not affect their health, yet most were unable to seek health care whenever they wanted, due to their irregular working hours and the reduced income that resulted when they did go in to work.

This revealed the link between the type of employment (low formality/informal) they were in, how it affected their income (low wages) and how it affected their health (basic public health care). Even though they were able to access public health facilities freely, some stated that with a proper income they would have joined a medical aid as they would have preferred private medical health care. This was because they had the perception that not all of the required services and medicines were readily available at the public health facilities. As for others, seeking basic health care was unlikely as instead they relied on religion or traditional home remedies to meet their health needs.

Based on the *National Health Act of 2003, Act No. 61*, most workers in the informal economy, whether contract or casual workers, received their health services from the provincial Department of Health at clinics or hospitals located near them. They received services in the disciplines of family medicine and internal medicine, and also had access to surgical and emergency departments. These services were funded by general tax revenue and thus rendered almost free of charge to the public (Moyo, Zungu, Kgalamono, & Mwila, 2015). Most of the participants in the study made use of these services offered to them by the state, as they had indicated that when seeking health care they attended clinics, hospitals and even saw doctors if confronted with higher risk health problems.

The problems encountered by the participants when accessing public health care included examples of malpractice, short staffing and overcrowding. Some even experienced health workers imposing their ideas on them. This may have been due to past inequalities and present insufficiencies, exhibited by the past impediments the country underwent. Were you find in where some areas only had one clinic, despite the fact that one clinic was not able to cope adequately with the number of people residing in the area. As a result the clinic staff became overwhelmed by the sheer numbers of patients. This lack of equality and sufficiency was the reason for the lack of quality basic services that should have provided quality health care. As mentioned by most of the participants, they did not receive proper treatment when they sought health care for themselves or their dependants.

In South Africa:

> *The health system falls far short in [the] provision of equitable access to needed, effective health care. The poorest groups have lower rates of health service use and derive fewer benefits from [the] use of health care, despite the burden of ill health being far greater on these groups. There are considerable barriers to access, particularly for the poorest people. There is an absolute shortage of health workers and an uneven distribution between sectors and geographical areas* (Ataguba, Akazili & McIntyre, 2011; Alaba & McIntyre, 2012; Ataguba & McIntyre, 2013; Cleary, et al., 2013; Health Economics Unit, 2013 in Marten, et al., 2014, p. 5).

Everyone deserved to receive proper health care. There were public clinics and hospitals in place which most of the participants stated they attended. While half received good health care and treatment from these facilities, the other half stated otherwise. This showed that the government needed to improve the provision of quality health care for all its citizens. This could indicate underlying poverty related trends among informal workers, as socio-economic status could determine the type of health care a person received. It also related to providing services and government funds that provided for all.

5.5 Informality and Protection

Informality persisted when the type of employment involved lacked social security and workers were not eligible to receive any form of employment benefits. These conditions were usually found in the informal and formal/informal sectors. This dissertation elaborated on what protection and social services were needed for people working within the informal

sector, particularly since this sector was generally perceived as illicit. It established the extent to which various regulations and institutions had assisted or hindered the work of the informal sector employees. Informal workers stood on their own, as they did not have representatives or unions that attended to their workplace needs. This was mainly because of they did not belong to unions their non-taxed status and how they exchanged their commodities or services. They could have been employed in a business enterprise, been self-employed or worked for private individuals, as shown by the women represented in the study. Most of the street vendors were self-employed and one was an employee.

The study also looked at the differences between street vendors and the linkages in the firms in the formal/informal sector. Formal/informal workers usually worked for formal companies or formal public or private entities. Unlike the informal sector which stood alone, formal/informal workers had representation and regulations that protected their social welfare. This was because in most cases the employers had registered their employees with the UIF, and both employers and employees contributed to this fund monthly. This sector included the domestic workers who were employees hired in private households, and all waitresses who were hired to work in formal business enterprises (restaurants), who had participated in this study.

Informal work came with little or no opportunities for the workforce to address any complaints/issues that they had. This was evident as with the exception of one, the street vendors were self-employed and thus had no supervisors or employers to convey their issues to. No authorities were available to address their issues either. Domestic workers, on the other hand, were able to inform their employers if they had problems and *vice versa*. All these women experienced informality in some way or another. Their variations of informality were presented in chapter four and included low wages, lengthy working hours, inadequate working environments and the absence of social security usually secured by the formal/informal employees. Most of the formal/informal workers reported receiving paid leave, some were not sure if they were entitled to receive paid leave or not, while others just did not receive paid leave.

There were actually programmes in place for them, but they either did not know about them or did not know how to access them, for example medical benefits. This was evidenced by the fact that none of the women mentioned medical insurance, savings, pension fund

contributions, trade union subscriptions, rentals, loans or advances which could have been deducted from their wages. These types of monthly deductions were regulated and were not allowed to exceed ten per cent of their total pay. These amenities were in place, but did not work effectively in catering for all within the formal/informal.

In 1993 the *Basic Conditions of Employment Act of 1983* was amended to include paid domestic workers, offering them more protection in terms of paid working hours, minimum annual leave, sick leave, and termination of contracts of employment (Burger, Von Fintel & Van der Watt, 2018). The minimum wage for domestic workers was prescribed by the Department of Labour, and those working in urban settings were entitled to receive a minimum wage of R2,545 a month in 2018 (Business Tech, 2018). Only one participant mentioned that they received medical protection (medical aid) from their employer, based on the length of their employment and the fact that they had a good working relationship with their employer. As stipulated, the rest did not indicate any means of protection.

In addition domestic workers were entitled to severance pay of one week for each year of service, as well as four months' unpaid maternity leave, during which time they were eligible to claim maternity benefits from the UIF. Some of the participants were unsure if they were eligible for paid leave, some reported that they did not get paid at all when on leave, while others received paid leave. Based on research by the Development Policy Research Unit (DPRU) in 2012, despite regulatory changes paid domestic workers were still very unlikely to receive any benefits as part of their employment (Burger, Von Fintel & Van der Watt, 2018). This study also found that most were unlikely to receive their full employment reimbursements.

The Unemployment Insurance Fund (UIF) provided assistance to workers when they become unemployed or were unable to work because of maternity leave, adoption leave or illness. All employers were required to register their employees with the UIF and to sign a service contract with their domestic workers. The respondents (domestic workers) that responded “yes” to the paid leave question were probably referring to the UIF aid. In South Africa only 0.4 per cent reported that their employers paid towards a medical aid scheme for them, 2.2 per cent reported contributions to a pension fund, and just 15 per cent of the domestic workers reported receiving paid annual leave (DPRU, 2012; Burger, Von Fintel &

Van der Watt, 2018). The participants in this study most likely to receive paid leave were the waitresses and some of the domestic workers.

In as much as there was a fund in place, not all were able to gain from it successfully, as some participants were not sure if they had paid leave, while others did not receive paid leave at all. Alfers & Rogan (2015, p. 211) found that "*Low formality workers tend[ed] to fare slightly better in terms of having a written contract (39.3%) or employer contributions to the UIF (37.1%), but they were still less than half as likely to have access to these benefits when compared to medium formality employees (88.1% and 89.8%, respectively*)".

Domestic workers paid UIF; their employers were required to deduct one per cent from their wages and pay these sums over to the UIF. The employers also had to pay an additional one per cent of the wages themselves, thus a total of two per cent of the domestic workers' salaries were paid over to the UIF on a monthly or annual basis. These domestic workers were therefore insured and received a certain degree of protection. The study showed that waitresses also received paid leave, and this meant that their employers had most probably also registered them with the UIF provided by the state. The waitresses were also required to pay minimal taxes on their earnings.

On the other hand, people that worked in the informal sector were believed to avoid the different taxes paid by workers in the formal sector and by the formal enterprises, including registration fees, corporate income tax and payroll taxes (Chen, 2005). The street vendor participants in this study were, however, not able to escape all of these fees and taxes, as they were required to have permits in order to render their services, and thus paid registration fees. Even though informal enterprises were not officially registered on a national level, they could be registered on a local municipal level and pay registration fees on top of operating fees for the use of urban space (Chen, 2005). This was the case in this study, as the participants had to register at the eThekwini Municipality's offices and pay a permit fee.

Furthermore, street vendors were predominantly predisposed to indirect costs, for example some vendors paid for space to store their goods (Chen, 2005). As most of the street vendors did not own storage spaces they had to pay for storage. Since most of them did not reside in the area and had to pack up their stalls each day, many of them had runners that they paid to retrieve their goods from their storage areas.

None of the street vendors were able to claim paid leave, as they did not contribute to the UIF fund, but most had made reference to the municipality's interest in receiving their rental and permit payments without offering any benefits in return. The problem lay with the fact that the municipality worked as a landlord providing space for informal workers to work. At the same time the municipality was required to provide services for them as citizens that they served. This might have created confusion for the participants as they had a sense of expectation, but the municipality was not their employer regardless of them paying for permits and rental space.

Besides the municipality providing law enforcement, the municipality also needed to look at what the street vendors needed, whether it was: removing competitors that sold goods without a permit, as mentioned in chapter four; providing storage facilities; providing more sanitary toilet facilities, providing care packages that catered to their health needs since they did also contribute to the economy; or establishing a programme like the government fund (UIF) that would aid them when on leave. This would probably occur through some form of legislation, but would obviously require much more probing in order for the process to be carried out with strict regulations. Leaders in health care had an imperative stewardship role across all outlets of society to guarantee that policies and actions in all sectors developed health equity, and health care had to be for the common good, not a market commodity (Marmot, et al., 2008).

The difference between domestic workers, waitresses and street vendors was that street vendors did not have the privilege of receiving any of the benefits mentioned above, since they did not follow formal practices. As a result they took leave on their own time, but this was usually hard since there was no way to make up the lost income, unless they asked family or friends to keep their businesses going. The one street vendor who served as an employee stated that no one would fill in for her; she had to take unpaid sick leave and returned to work when she was well again. This further validated the reason for this study as there was a gap that needed to be filled in providing for all, so that all employees could be treated equally and so that everyone (employers and employees) involved could become "informally literate".

The informal sector has evolved over time, and a number of studies have been done in order to help understand this sector. This study aimed to obtain realistic evidence that could not be found while quantifying. The experiences encountered by these different types of women working in the informal sector were different and needed to be understood in their own contexts. The South African context explained in chapters two and five has influenced and shaped women working in the informal sector today. In addition, this study has made the readers comprehend that different women fall under the same classification, and experience their vulnerabilities differently or similarly within the same sector.

5.6 Limitations

This study depended on having access to people and representatives of the informal sector. There were factors that the researcher could not control, such as limited access, because the processes that needed to be undertaken before conducting the field work required time. In addition, time constraints were a major problem for the researcher, and a certain protocol had to be followed in order to address people of the public, which took even more time.

Since a snowball approach was initially adopted, the researcher had hoped to obtain additional interviews in this manner. However, the domestic workers and waitresses interviewed were unable to suggest further participants. This approach was more successful among street vendors since they worked in close proximity to each other and knew other women that were affiliated to their line of work. In many cases, across all working categories, potential participants were reluctant and refused to partake in the study. This delayed the process of recruiting appropriate candidates to be interviewed, and in the end the researcher relied heavily on adopting a criterion approach to sampling and approached many women to see if they fulfilled the criteria before acquiring the preferred sample. The criterion approach considered all potential participants that met the predetermined criterion of importance (Patton, 2002, p. 238 in Suri, 2011).

In addition, this was a qualitative project, and qualitative research required more time than quantitative research. This study was undertaken because the informal sector was largely undocumented, but conducting interviews with the participants while they were at work was quite problematic. The initial problem was location. Most of the interviewees could not leave their work stations to conduct the interviews, and subsequently there were many interruptions

and lots of noise, since some of the interviews were conducted in public spaces. Secondly, some of the participants did not want to slow their work pace as this would hinder their turnover/take home income for the day. Lastly, since income generation took priority some of the interviewees hastened the interview process, so information may have been missed. The fact that the data collected then still had to be interpreted and analysed may have impacted negatively on the time available to the researcher and potentially limited their ability to receive more information. All of these limitations may have influenced the study's results to a slight degree.

The open-ended questions could have been given more time for elaboration when conducting the interviews. There needed to be sufficient time to capture any unexpected information that came to light; to explore various possibilities; to pre-test any new topics that arose during the process; to measure the interviewees' knowledge and to explore their reasoning. Regardless of having some issues, the interviews were still effective and intuitive. Considering the demographics along ethnic lines, the researcher was able to communicate in isiZulu and isiXhosa with the participants who could not converse in English, or who felt more comfortable conveying their replies in their home language. This helped them to elaborate further on questions that required more detailed responses.

The researcher was not able to show a link between informal workers and their health as there was not enough data to establish such a link. More research is therefore needed in this regard. The study could be improved upon by including questions to obtain information regarding income and household factors. This would provide a clearer picture of minimum wage earnings, and how they affected the informal workers' livelihoods and their ability to look after their health and the health of their children. In addition, questions regarding spousal assistance that related to health would be very helpful in explaining other health behaviours presented in the study.

5.7 Conclusion

The purpose of this research was to study a marginalised population and create a backdrop to address the reduction of inequities faced by them and reach this frequently marginalised population within society (National Academies of Sciences, Engineering & Medicine, 2016). As part of efforts to reach marginalised populations, individuals from these groups were often grouped according to their relative ability to contribute, as well as their relevant political,

social or cultural characteristics (National Academies of Sciences, Engineering & Medicine, 2016, p. 14). Improving the work conditions and work environment of poorer informal workers has been shown to be the key to improving their health, by preventing and mitigating the risks and in turn enabling them to work more productively (Chen, 2016).

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Appendices

Appendix 1: Informed consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date:

Greetings

My name is Buhle Khumalo, a student from the University of KwaZulu-Natal: (cell: 0798530994 or email: 212511350@stu.ukzn.ac.za).
You are being invited to consider participating in a study that involves research to look at women working in the informal sector and their health. The aim and purpose of this research is to explore the underlying implications of being in such a sector.
The study is expected to enrol 18 participants in total, 6 interviews with domestic workers, 6 interviews with street vendors or service providers and 6 interviews with waitresses, the focus area is in the Republic of South Africa, KwaZulu-Natal, central Durban.
It will involve an interview schedule. The duration of your participation if you choose to enroll and remain in the study is expected to be 45 minutes.

The study may involve the following risks and/or discomforts in terms of looking at health.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

The participation in this research is voluntary (and that participants may withdraw participation at any point), and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. There are no consequences to the participant for withdrawal from the study.

The information will only be shared amongst the supervisor and student. It will be stored on the supervisor and students' computer and usb to keep work safe. After five years both will delete files of databases.

CONSENT (Edit as required)

I have been informed about the study entitled (Exploring Health and Variation of Work Place Informality of Women Working within the Informal Sector in Central Durban) by (Buhle Khumalo,212511350).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at (cell: 0798530994 or email: 212511350@stu.ukzn.ac.za).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview	YES / NO
Use of my photographs for research purposes	YES / NO

Signature of Participant	**Date**
Signature of Witness (Where applicable)	**Date**
Signature of Translator	**Date**

Appendix 2: Data collection tool

Possible questions to be asked

Surname _____

Name _____

Address _____

_____

Date of Birth day M Yrs

☐☐ ☐☐ ☐☐☐☐

Do you have any children? Yes ☐ No ☐

No. of children? (If No skip to the next section) _____

1) Highest level of education:

1. Primary ☐ 2.Matric ☐ 3.Undergraduate ☐ 4.Postgraduate ☐

2) Job title_____

3) When did you start working here?

4) How long have you been employed here?

5) Please describe your working conditions?

6) What would you like to change about where you work?

7) How would you describe your health?

8) What do you do to keep healthy?

9) What health concerns do you have currently?

10) What do you do to protect your health?

11) When you are not well, what do you do?

12) What kinds of things do you do to protect your child's health?

13) Do you have any health problems? If yes, what are they?

14) Does your child have any health problems? If yes, what are they?

15) Does the job/working condition affect your health?

16) What happens with work when you are sick?

17) What happens with work when your child is sick?

18) Where do you go for health care?

19) How often do you visit the doctor/hospital/clinic?

20) How would you describe the treatment you receive there?

21) Where do you take your child for health care?

22) How would you describe the treatment your child receives there?

23) Do you get paid when on leave? (E.g. sick leave or maternity) if not how do you recover the income lost while you were on leave?

24) Does getting healthcare stop you from getting income?

25) Over the next five years, what health challenges do you think you may face?