Institute for Economic Justice
NPO Number: 210-583-NPO
3rd Floor, 62 Juta Street, Braamfontein
www.iej.org.za

Terms of Reference:
Health care and the Care Economy
November 2026

Terms of Reference	
Project Lead	Juhi Kasan
Research Collaborator	Tsega Girma Tefera
Suggested title (to be confirmed)	Health Care, Unpaid Care Work and Decent Work in South Africa
Output type	Research report
Pages of the report	30 pages
Brief background	Health care sits at the heart of the care economy. It is among the largest sites of paid care work in South Africa and a decisive determinant of whether people can be sustained across the life course: in pregnancy and childbirth, childhood, illness, disability, and old age. Yet the demands on the system are heavy and unevenly met, and the gap between what people need and what the system provides is bridged, silently, by unpaid and underpaid carers, overwhelmingly women. The healthcare system features a two-tier system characterised by an overwhelmed and under-resourced public sector and a well-financed private sector. Only 14% of the population is covered by private medical aid, while the majority depend on an overstretched public sector and still pay out of pocket for essentials (Stats SA, 2026). Despite the rising demand, real public health spending has fallen to roughly R4,028 per public-sector user in 2026/27, from R4,108 in 2019/20 in constant prices (Institute for Economic Justice, 2026).

	Furthermore, the Minister of Health projects a shortage of 97,000 health workers by 2030. Importantly, among many factors, HIV shapes the system as a whole. Some 7.9 million people were living with HIV in 2024, the largest epidemic in the world, and prevalence among women is about 16%, against 9% among men (Human Sciences Research Council, 2023; UNAIDS, 2024). The lifelong management of HIV, alongside tuberculosis and a rising tide of non-communicable disease, has turned much of health care into long-term care, work that falls heavily on clinics, community health workers and families alike. **Problem Statement** It is in this landscape that National Health Insurance (NHI) is being introduced. The NHI Act was signed into law in May 2024. It is the central policy intervention of the coming period, an attempt to pool public and private resources into a single fund and move the system towards a more equitable, universal model, one that government has framed as directly benefiting women and girls as the primary users of public health services (South African Government News Agency, 2019). Its promise, however, rests on an institutional base and a workforce that are themselves in crisis. The NHI primary health care model relies on ward-based outreach teams of community health workers, making their employment conditions central to whether it can deliver. The paid health workforce is predominantly female, and its least protected workers are those closest to households. At the system's frontline, community health workers, who carry much of primary care, HIV support, and home-based care through household visits, have long been paid stipends, outsourced through non-governmental organisations on insecure contracts, often without maternity leave, pension, or the protections of formal employment (Malatji *et al*., 2024). Following a January 2025 Labour Court ruling, the Department of Health agreed to absorb some 27,000 community health workers with matric into permanent posts at around R6,000 a month (Buthelezi, 2025). By February 2026, about 19,000 had been appointed, while those without matric, some 17,000 to 20,000 workers, remained on stipends (PHSDSBC, 2026), and the Western Cape had declined to absorb its community health

	workers at all (Stuurman, 2026). How far formalisation reaches, and on what terms, is now a central question for decent work in the sector. What the formal system cannot provide is absorbed elsewhere. When clinics are distant, understaffed, or out of stock, when patients are discharged early or managed as outpatients, the work of nursing the sick, managing chronic conditions, and caring for the dying falls on households, and within them, on women and girls, as unpaid labour that is neither counted nor compensated. Time-use data show that women spend 15.6% of their day on unpaid care and domestic work, against 6.5% for men. A failing health system does not reduce the need for care; rather, it transfers the cost of that care onto those least able to refuse it.
Purpose of the activity/output	The study examines the intersection of health care, unpaid care work and decent employment in South Africa's public health system. Its focus is the boundary between facility-based health services and the care provided in homes and communities, where gaps in public provision are absorbed by unpaid family carers, mostly women, and by a low-paid, largely female community health workforce. The study seeks to answer four broad questions: 1. **Unpaid care:** How do features of public health service delivery, such as distance to facilities, waiting times, medicine stock-outs, early discharge and the community-based management of chronic conditions (including HIV, TB and non-communicable diseases), shift care responsibilities onto households? What does existing evidence, including time-use and household survey data, show about the scale, gendered distribution and costs (in time, income and out-of-pocket spending) of this health-related unpaid care? 2. **Decent work:** What are the employment conditions of nurses and other health care-associated workers such as community-based health care workers, including pay, contracting arrangements, social protection and career pathways, assessed against decent work standards? What is the status of policy commitments and processes

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<tr><td></td><td>to formalise their employment, and what do existing costings suggest formalisation would require?

3. Health outcomes: What are some of the consequences of an under-resourced and overburdened health care system, and specifically how does this manifest in the health outcomes of the population?
4. Policy implications: How do these dynamics interact, as under-resourced public provision is substituted by unpaid household care and by underpaid community-based care? What does this mean for the rollout of National Health Insurance, particularly its primary health care and community outreach components, and for the Draft National Care Strategy, and what policy recommendations follow?</td></tr>
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<tr><td>Target Audience</td><td>● Departments championing care programs and policies, such as the National Care Policy: the Department of Women, Youth and Persons with Disabilities (DWYPD), Department of Social Development (DSD), Department of Employment and Labour (DoEL) and the Department of Health (DoH)
● Civil society organisations
● Policymakers and independent researchers</td></tr>
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<tr><td>Outputs/Activities</td><td>
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<tr><th>Sn</th><th>Activities and outputs</th><th>Deliverables</th></tr>
<tr><td>1</td><td>Conduct an inception phase, co-developing with IEJ the analytical framing and final focus of the study, and refining the methodology, work plan and literature review strategy.</td><td>Inception report</td></tr>
<tr><td>2</td><td>Undertake a structured evidence review on health-related unpaid care in households and the</td><td>Evidence review and preliminary findings report and presentation</td></tr>
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		employment conditions of community health workers, supplemented by a limited number of key-informant interviews	
	3	Analyse the findings to identify policy gaps, implementation and budgetary constraints, and recommendations for NHI and the Draft National Care Strategy	Draft research report and executive summary
	4	Review by reference group and consolidation of comments.	Review and consolidation
	Throughout the assignment, the consultant will meet the project staff every two weeks to provide progress updates.		
Method	The paper must rest on an empirical basis. IEJ envisages a mixed-method approach, to be specified by the consultant: ● Desk-based analysis of relevant policy documents (including NHI and community health worker policy), official budget data and the secondary literature, with accurate and properly referenced figures. ● Secondary analysis of existing quantitative data where feasible, such as time-use, General Household Survey or labour force data, to describe health-related unpaid care and the community health workforce. ● Qualitative evidence on the lived experience of the health system, drawn from key-informant interviews and/or a structured synthesis of existing qualitative research, capturing the perspectives of patients, unpaid caregivers and community health workers.		
Connection with the project	The study contributes to the project by generating evidence and policy recommendations to inform South Africa's Draft National Care Strategy, particularly on understanding the issues,		

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<tr><td></td><td>challenges and gendered dynamics within the healthcare system in South Africa.</td></tr>
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<tr><td>Integration of gender issues</td><td>Gender is integral to this commission. Section 27(1)(a) of the Constitution guarantees everyone the right of access to health-care services, “including reproductive health care”, yet there is a persistent gap between this right and women’s lived experience of public-sector service delivery (Mbali & Mthembu, 2012). The paper should treat the following as core threads:
Unpaid health-related care: how barriers to public health services, which fall hardest on poor and rural women, and the design of health policy shift care responsibilities onto families, and within them onto women and girls.
The feminised community health workforce: the predominance of women among community health workers and other frontline carers, and the link between the undervaluation of this paid work and the undervaluation of women’s unpaid care.</td></tr>
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<tr><td>Translation</td><td>None</td></tr>
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<tr><td>Budget</td><td>R68,000</td></tr>
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<tr><td>Production Schedule</td><td>3 months<table><tr><th>Timeline</th><th>Deliverable</th></tr><tr><td>5 Feb’</td><td>Inception report</td></tr><tr><td>5 Mar’</td><td>Evidence review, preliminary findings report and presentation</td></tr><tr><td>19 Mar’</td><td>Draft research report and executive summary</td></tr><tr><td>31 Mar’</td><td>Final report</td></tr></table>Final timeline to be confirmed after contracting.</td></tr>
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<tr><td>Request for Proposal</td><td>The following should be submitted to Nonhlanhla Ndlovu at nonhlanhla.ndlovu@iej.org.za by 25 November 2026
CV illustrating relevant expertise
A research abstract (maximum 1 page) outlining the proposed approach to the study, including a brief description of the methodology, the proposed data</td></tr>
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	collection and analysis methods, and illustrative examples of key literature and documents to be reviewed, as well as the key stakeholders to be consulted. ● Sample of writing