

Issues facing primary care health workers in delivering HIV and AIDS related treatment and care in South Africa

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School of Public Health University of the Western Cape



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Executive summary

This study explored the possibility of joint health worker and community activism at a primary care level in South Africa, and the human resource requirements needed for the effective treatment and care of HIV/AIDS within the public health service. The research was undertaken by SAMWU shop stewards Motladile Frank Kitsa, Mamflo Ntsubane, Sharon Spandeel, Samuel Maroele Seruoe and co-ordinated by the SAMWU National Health Co-ordinator, Soraya Elloker. The research process and reporting was facilitated by Nikki Schaay and Uta Lehmann, School of Public Health, University of the Western Cape. Technical edit of this version of the report was done by R Loewenson and R Pointer TARSC/ EQUINET.

The research was carried out in the context of the EQUINET theme work on *Human Resources for Health* and AIDS and health systems, supported by SIDA Sweden and IDRC Canada. It built on work done by SAMWU in 2004 investigating occupational health and safety in municipal health clinics in South Africa (IHRG et al, 2005). The study used participatory approaches and involved five SAMWU shop stewards in the design, data collection and analysis of the research. The study was implemented between October and November 2005 in five primary health care (PHC) clinics in the Western Cape, Free State and KwaZulu Natal. Twenty-four health workers (fifteen of which were interviewed in depth) and eighteen health committee members were interviewed across the five different sites using a semi-structured interview guide.

Various limitations in the methods and data collection make many results of the study exploratory and tentative. A number of areas of learning and recommendations are proposed for future studies. Nevertheless, the key issues raised are more robust and may be useful for further discussion within SAMWU, and given the current process of transformation of municipal health services, where appropriate, with the relevant health authorities.

The findings from the study include:

- HIV and AIDS had impacted on health workers work over the past few years. Despite this, few health workers were familiar with the extent of the HIV burden in their district.
- Health workers were similarly unaware of the existence of an HIV and AIDS workplace policy. Of the four respondents that reported having experienced a needlestick injury only one followed the standard protocol and reported the incident to their supervisor. The other three health workers chose to seek medical and counselling assistance outside of the public health sector.
- Most respondents (twelve out of fifteen) said they had not witnessed colleagues in the clinic being absent from work or dying because of an HIV and AIDS-related illness.
- Thirteen respondents said that the workload increased. Seven respondents indicated that employing more nurses and dedicated, as opposed to part-time, doctors could improve the management of HIV and AIDS. This supports the findings of the IHRG research which indicate critical staffing shortages (IHRG et al, 2005).
- Only one of the three sites appeared to have established a formal system of support within the clinic to help health workers with problems and stress from work. Health workers working in non-designated ARV sites (ten of the twelve respondents) called for training in administering antiretroviral therapy (ART) so that they could manage the side effects of their clients on treatment.
- The health workers were generally supportive of local health committees, but have little knowledge of the committees' roles and membership, and give their clinical work precedence.

- The health committee members were also not certain of their role, the extent of their responsibilities, to whom they were accountable and what they could expect from the facility in terms of logistic, training and material support. Two of the three committees were primarily providing support to the clinic's HIV and AIDS outreach and educational activities and all three committees had limited input into the planning and evaluation of the clinic's HIV and AIDS interventions.

The study team recommended that:

- more information be provided to all workers at health facilities and health committees on the HIV and AIDS burden in the community and on ARVs to support communication with communities;
- SAMWU discuss priority HIV/AIDS training needs amongst its membership, including how to support shop stewards to negotiate for these inputs;
- SAMWU strengthen knowledge and implementation of workplace policies on AIDS and review and address barriers to reporting and responses to needlestick injuries;
- SAMWU further clarify the different roles and responsibilities of staff around HIV and AIDS in health facilities;
- SAMWU shop stewards encourage a review of the overall function, current and potential responsibilities of the health committees in relation to HIV and AIDS, and for the facilities to clarify the support members can expect from facilities to reflect on current partnerships; and
- SAMWU integrate lessons on the timing, process, tools and approval process, and shop steward support needs from this research into future research design.

The way these recommendations are implemented ought to be considered in the context of the current shift of municipal health services to the province, and the changing membership of SAMWU.

1. Background and methods

1.1. Introduction and objectives

This research was initiated by the South African Municipal Services Union (SAMWU), EQUINET and the Municipal Services Project (MSP), and aimed to build on the research focus created by SAMWU following their implementation of a participatory research project which investigated the state of Occupational Health and Safety (OH&S) in municipal health clinics in South Africa in 2003-2004 (IHRG et al, 2005). The research was carried out in the context of the EQUINET theme work on Human Resources for Health and AIDS and health systems, supported by SIDA Sweden and IDRC Canada.

Previous SAMWU research on the occupational health of health workers revealed concerns from health staff over OH&S, infection control in the work environment, workloads and resource support for more effective management of HIV and AIDS. Health workers felt these concerns were not always adequately addressed in HIV roll out programmes (SAMWU, 2005:3). This resonated with other EQUINET research pointing to additional demands on health workers in ART rollout adding to existing concerns over risks and interventions to 'care for the carers'.

According to the 1977 Health Act (and its subsequent amendments), municipal health clinics have been tasked to focus on the prevention of communicable diseases, the promotion of community health, to offer basic treatment for injury and disease and the provision of essential medicine. Over time however, municipal clinics have taken on additional responsibilities from the Provincial Departments of Health and now offer more curative services (IHRG et al, 2005: 20-21). The services for HIV and AIDS include provision of voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT), treatment of opportunistic infections and provision of health education.

With the National Health Act of 2003, which came into effect in May 2005, municipalities will be required to provide 'municipal health services' or environmental health services only (such as waste management, pollution, water quality and communicable diseases), with the Provincial Departments of Health taking over the responsibility of providing PHC services. This shift in responsibility is scheduled to be finalised by June 2007. This marks a significant change – not only in service responsibilities but also for those employees, who will become employees of the province, causing uncertainty and insecurity amongst health workers.

The proposal was developed by SAMWU in co-operation with EQUINET (Training and Research Support Centre (TARSC) and Health Systems Trust (HST)) and adopted by the National Executive committee (NEC) of SAMWU in December 2004. The research aimed to actively involve SAMWU shop stewards in a participatory process and to further develop SAMWU members' research capacity. The School of Public Health, University of the Western Cape (SOPH, UWC) provided technical and capacity building support to the project. The objectives and methods were further refined by participating shop stewards and the SOPH, UWC and adopted at an introductory workshop with shop stewards in October 2005.

The research explored how to strengthen HIV and AIDS health care delivery at a primary level in South Africa by improving equity and the quality of services, focusing on the

roles of health workers, the community health committees and the relationship between the two. It aimed to:

- explore the human resource needs required to provide adequate primary care services for HIV and AIDS from the perspective of the primary health care workers;
- explore the role of community health committees in HIV and AIDS related preventative and caring services;
- document and discuss the findings with stakeholders in SAMWU and the public health service to strengthen links between clinic-based staff and community health committees in HIV and AIDS services; and
- build the research capacity of SAMWU shop stewards and support SAMWU interaction with public health services and communities to improve the working conditions of health workers and the quality of the HIV and AIDS care.

1.2. Methods

Five SAMWU shop stewards were nominated by their respective Provincial Executive Committees to participate in the research study. In October 2005 the team participated in a three day consultation and training workshop facilitated by SOPH, UWC.

Originally six PHC settings (one rural and one urban across the three provinces of the Western Cape, Free State and KwaZulu Natal) were chosen as sites in which to conduct the research. The sites were selected to reflect differences in the HIV burden across provinces (from KwaZulu Natal with the highest HIV prevalence, to Western Cape with the lowest (National Department of Health, 2003)); and the involvement of the provincial SAMWU offices in prior SAMWU research. The specific clinics included were the constituency of the SAMWU shop stewards nominated by their Provincial Executive Committees to participate in the research study. One of the six sites (Site 1b: Western Cape, rural) did not participate in the research, as the local union branch preferred to wait until the transfer of authority of the clinics (described above) had been completed. The sites were numbered as follows:

- Site 1a: Western Cape, urban
- Site 1b: Western Cape, rural
- Site 2a: Free State, urban
- Site 2b: Free State, rural
- Site 3a: KwaZulu Natal, urban
- Site 3b: KwaZulu Natal, rural.

Four of the five research sites, being managed by local municipalities, offered a range of basic preventive and curative health services for children (such as child health, growth monitoring, immunisation) and for adults (family planning, STI treatment, TB treatment, VCT, the care and treatment of minor ailments and chronic diseases, and in some instances PMTCT). Local non-governmental (NGO) and community based organisations (CBOs) provided support to these clinics (through their employment of lay counsellors, home-based carers and health educators) which enabled the clinics to provide:

- additional health education for their clients;
- community-based directly observed treatment (DOTs) ;
- individual and family counselling; and
- support groups for people living with HIV and AIDS (PLWHAs).

The fifth research site (rural KwaZulu Natal) was an anomaly in that it was managed by the provincial health department, open 24 hours and offered a wider range of services

(such as maternity and psychiatric services). This site was chosen, even though it was not managed by a municipal health authority, because it was in the constituency of the shop steward and accessing a rural site further afield would have been logistically difficult. Only two of the five sites (both in KwaZulu Natal) were providing ARVs.

The study team obtained ethical clearances, procedures and permission from authorities and respondents. Interviews were conducted over a one month period in October/ November 2005, with a range of categories of personnel at each site relevant to HIV and AIDS management (see *Table 1*).

Table 1: Category of health worker interviewed in the five sites

Category of personnel	Site 1a	Site 2a	Site 2b	Site 3a	Site 3b	Total
Administrator/ clerk	X	X		<u>x</u>		3
Community Health Worker	X					1
Lay counsellor		X	X	<u>x</u>	<u>x</u>	4
Assistant nurse	X		X	<u>x</u>	<u>x</u>	4
Professional nurse	X	XX		<u>x</u>		4
Snr professional nurse			X		<u>xx</u>	3
Doctor			X			1
Facility manager		X	X	X	<u>x</u>	4
Total						24

Note: x (KwaZulu Natal) indicates interviews covered only sections of the health worker interview guide¹, affecting the depth or level of data collected at these sites.

Community Health Workers (CHWs) were only interviewed in the Western Cape site as they were only formally found at that site. In fact clinics do have other cadres of community-based health workers – “community-based volunteers” - that provide community-based DOT support and/or home-based care, and/or Lay Counsellors (who offer VCT and in some cases also provide community-based DOTs). Interviews with this cadre of health workers were conducted in each of the other sites (see *Table 1*). As, in looking through the interview schedule the Western Cape facility manager felt that the focus of the research had little to do with her (pers. comm, SAMWU shop steward, 24 February 2006), no interview was conducted with her.

Twenty three of the 24 respondents were female, mainly nurses; the one male was a facility manager, responsible for overseeing one of the research sites and two other clinics in the local municipality. Health committee interviews were done either with the facility health committee or the local area health, welfare or development-related committee or forum. Eighteen health committee members participated in these interviews which were done at three sites, one rural and two urban.

¹ The SAMWU shop steward conducting interviews at these sites struggled to convince the health workers to participate in the research project. As a way of accessing their opinions she negotiated to ask them *some* of the questions in the interview guide.

1.3. The research tools and process

Semi-structured interviews were implemented by SAMWU shop stewards and written or verbal consent obtained from each informant using a consent form as a guide. *Box 1* and *2* below show the information gathered from health workers and health committees.

Box 1: Information shared by health workers

- Background information on the informant, their position within the clinic, the length of time in this position and within the clinic and membership of the trade union.
- Current responsibilities related to HIV and AIDS, and changes to workload and responsibilities because of AIDS.
- Knowledge of district HIV prevalence and awareness of AIDS workplace policies.
- Training and supervision received on AIDS roles and adequacy relative to work roles.
- Perceived risk of exposure to HIV at work, and experiences of needlestick injuries.
- Willingness to test for HIV, perceptions of AIDS stigma and workplace impacts of AIDS.
- Impact of introduction of ARVs on their work.
- Relations with and perceptions of community or clinic health committee and their roles in AIDS related work.
- Areas for improvement of HIV and AIDS management at facilities.

Box 2: Information shared by health committees

- Information on the committee members, position and time served on the committee, constituency represented.
- Understanding of the HIV and AIDS services offered by the facility to the community.
- Knowledge of district HIV prevalence and training received on HIV and AIDS.
- History, role and function of the committee especially in relation to HIV and AIDS.
- Perceived roles of the committee in supporting HIV and AIDS services at the facility, barriers to and facilitators for these roles.

After obtaining permission from the facility manager and the provincial or municipal health authority, interviews with health workers were generally conducted within the health facility and lasted between 45 minutes and two hours. In some cases this meant conducting interviews with breaks as health workers completed work assignments. Discussions with health committee representatives proved somewhat difficult to organise due to competing time commitments of committee members, or in one case, delays in getting the approval of the Chairperson of the district's health forum.

1.4. Limitations of and bias in the methodology.

There were thus a number of limitations in relation to the methodology:

- The number of health workers interviewed across the five sites was relatively small (24), and in two sites (KwaZulu Natal) only certain sections of the health worker interview could be administered. These constraints were due to interviews being done outside of working hours and health worker reluctance due to time constraints and

uncertainty of the risks in participation. This affected the depth or level of data collected at the two sites. The study thus presents experiences and opinions of a small, purposive sample and not a representative sample of general health worker opinion or experience.

- There was considerable variation in the categories of health workers interviewed in each site making it more difficult to make direct comparisons across sites.
- In most cases (except for the category of Professional and Senior Professional Nurse) only one representative from each category of personnel was interviewed at each site. This limited observations on how specific categories of personnel responded to HIV and AIDS responsibilities.
- It is possible that responses may have been more guarded given that personnel were being interviewed by work colleagues from a specific union (SAMWU) than had they been interviewed by a more 'neutral' interviewer. The shop stewards did not feel this had had an obvious or a negative impact on the data, although they did indicate that respondents might have provided responses which showed them 'in the best light'.

In November 2005, after having conducted their interviews, the shop stewards participated in a follow-up two day data analysis and reporting workshop.

2. Results of the interviews with health workers

Key findings from the interviews conducted with the health workers are presented below.

2.1. Length of service and union membership of health workers

Despite a common perception of rapid staff turnover in health facilities, many health workers had been working in the same facility for several years (see *Table 2*). Of the eleven health workers asked about their union-affiliation, four were SAMWU members, seven belonged to other unions (IMATU/DENOSA, MESHAWU, and PSA) and one did not belong to a union.

There were variations in the employment status of lay counsellors and CHWs: in one site in the Free State lay counsellors (also known as community-based volunteers) were affiliated to a local NGO, managed by the Area Director and provided with a stipend from the Provincial Health Department. A similar situation seemed to exist in KwaZulu Natal. In the case of the Western Cape, the CHW was employed by the municipality.

Table 2: Length of service and union membership of health workers

Category of personnel	Years of service				
	Site 1a	Site 2a	Site 2b	Site 3a	Site 3b
Health workers at facility	8	7	7.5	4	9
Lay counselors /CHW	5	5	1	4	4

2.2. HIV and AIDS roles of different categories of health workers

Health workers were given a list of HIV and AIDS-related activities and asked which one of these they performed as part of their regular duties (as summarised in *Table 3*).

Table 3: Roles of health workers related to HIV and AIDS by category

Category of personnel	Administration and management	Provision of HIV and AIDS information and referrals	Clinical management of patients	ARV provision
Facility manager	Primary role. At Site 2a only do this. At sites 2b, 3a and 3b also do nursing duties.	Facilitate referral to support groups and counselling with NGOs and other staff.	Not involved.	Not involved in provision. Do refer patients for ARVs. At sites 3a & 3b support adherence to treatment.
Senior and professional nurse	Not involved.	Provide HIV and AIDS information to patients and at public events.	Clinical support to VCT services; TB and STI screening; basic clinical care, nutritional advice and psychosocial support.	<ul style="list-style-type: none"> • Support PTMCT, CD4 counts in sites 3a & 3b. • Provide ARVs only at site 3b.
Nursing assistant	Not involved	<ul style="list-style-type: none"> • Provide HIV and AIDS information to patients and at public events (four sites). • In four sites refer patients to support groups and counselling with NGOs and other staff. • In two sites facilitate support groups. • In one site refer clients for income support grants. 	Providing pre- and post-test counseling and taking blood; Some TB and STI screening.	Support adherence to treatment and PTMCT in two sites.
Lay counsellor and CHW	Not involved.	Provide HIV and AIDS information to patients and at public events. pre- and post-test counseling, psychosocial support to HIV+ patients, referral to and facilitating support groups.	Little involvement in TB screening.	Provide adherence support and assist in PMTC programme by providing formula milk to HIV+ mothers.
Clerk		Provide HIV and AIDS information to patients and at public events on an ad hoc basis.	Not involved.	Not involved.

2.3. Perceived impact HIV and AIDS on work and roles

All but one of the fifteen respondents felt that HIV and AIDS had impacted on their work over the past few years. The impacts they reported were largely related to an increase in consultations and workloads. It was not clear if health workers thought this was due to increasing client numbers or an increased number of clients being ill with AIDS and demanding more of health workers. For example, one health worker noted:

You (try to) spend more time with the clients to build a stronger relationship ... but then there are so many clients that you end up spending little time with them because you are thinking of the next client.

One of the facility managers noted:

With the increasing workload I find that I need to check more on staff because of a decreasing quality of care.

Some respondents were able to illustrate a direct link between AIDS and workloads:

There is an increase in children and women who are part of the PMTC programme ... the folders are kept separately in a box in the record room. This box is filling up, and we now need a second box.

Others noted that they saw more TB patients, more low birth-weight babies and make more referrals for disability grants, that they spent more time with patients and their families counseling and giving support and that AIDS was impacting on treatment outcomes. Health workers reported that managing AIDS impacted on them personally putting them into difficult situations with patients, with no place where they could themselves talk through these issues.

They also reported that there were new expectations of what they would do beyond their traditional roles: some gave assistance to families with funeral arrangements and some gave material support to HIV+ clients. As one clerk explained:

Although it does not happen always, clients get so attached to you and rely on you a lot ... they end up being your friends. When they need to go for X-rays or a consultation with the doctor I will supply them with money to go and I will organise food parcels for them. Sometimes I will admit a patient without the knowledge of the (person) in charge if they have been deferred or are ignored ... and I will request that the doctor sees them because I feel that they can't leave (the clinic) without being treated – as I can see how (bad) their clinical condition is.

Only one facility manager felt that HIV and AIDS was impacting on an organisational level:

I (have to manage) more sick leave of staff ... (and) relieve other clinics due to the absence of their (own) staff.

2.4. Health worker awareness and training for AIDS related roles

Despite this perceived shift in roles and workloads, health workers were not aware of the HIV prevalence in their areas, referring this to their facility managers and noting that statistics were not supplied to them. The doctor and three facility managers were also not able to provide these estimates. When they estimated the HIV sero-prevalence only two provided correct estimates. In other cases the figures they gave were much higher than reality – as high as 50-95%. It appears that either there is very little information

being provided to health workers in the facilities about the extent of HIV within their local communities, or information is being provided – but not in a way that health workers are able to understand and interpret it.

Despite this, eight health workers were able to provide information on the numbers of HIV+ patients that attend the clinic on a weekly or monthly basis, linked to the programmes they managed. They were less informed of the total HIV+ clients seen in their clinic on a monthly basis, with estimates varying from 100 to 1000. They also indicated that this figure was not possible to give as they “don’t label clients... (and) only those attending to the client would know the client’s HIV status” or because “we don’t have specific care for HIV+ clients”.

Many of the nurses and the counselors had received training on a wide range of issues related to HIV and AIDS. However, ten of 24 respondents said they felt adequately informed, skilled and educated to cope with the demands placed on them in relation to HIV and AIDS only half the time. They raised some of the challenges they faced, and asked for more information on ARVs, including basic information to provide to patients and information on the side effects of ARVs and to manage referrals to the district ARV clinic, as explained by one CHW:

In the community people approach me for advice and assistance. At the clinic, due to the lack of my counselling skills, I can refer them (to someone else). But at home you need to give answers, and when a family approaches you to counsel and support their relative – you need to have the HIV/AIDS counselling skills and knowledge. You also need to know about ARVs so that you can give positive advice with regard to the ARV side effects.

They felt the field was rapidly changing and they needed to remain skilled and informed in this area. Facility managers felt they too needed this training, and often gave preference to clinical staff to attend training:

I need update and retraining on HIV/AIDS because HIV/AIDS changes every time (Lay counsellor).

Clients are well informed – they shop around or deny things (in relation to HIV/AIDS) and they ask you questions that are very tricky and difficult to test your knowledge (Professional Nurse).

Other areas of training referred to included HIV and AIDS counseling, and basic information to respond to patient queries. The latter was particularly requested by clerks.

I have the (general) awareness of HIV/AIDS but I need more to be able to answer or assist an HIV+ patient.

Few respondents knew that there was a workplace HIV and AIDS policy: this was found in only three sites and only in six of fifteen respondents at those sites. Of the six respondents, one was a facility manager, four were professional nurses and one a nursing assistant. Only two were familiar with the contents. Only two workers had their own copy of the policy – the rest reported that it was locked away.

Health workers at the same facility had different responses: some knowing about it, some saying it did not exist and others being unsure. For example a facility manager reported that there was no HIV and AIDS work policy in the clinic as there was no national policy on this, while a professional nurse at the same clinic reported having her own copy of the local municipality HIV and AIDS workplace policy.

Despite the low level of awareness on such policies, all thought it was important to:

- provide guidelines for the management of occupational exposure to HIV such as through a needlestick injury;
- offer health workers - as an employee and, if the health worker is HIV positive, their clients - with some form of protection; and
- provide some overall guidance on the management of HIV/AIDS.

2.5. Health worker experience of HIV and AIDS

The health workers reported various personal responses to their risk of exposure to the virus, including fear, worry, and concern, although most (eleven of 24 respondents) reported “never” feeling concerned or worried about it. This latter group was made up of clerks, facility managers, lay counsellors and CHWs and only two were nursing staff. Thus it appears that nurses, who face a higher risk of exposure, are also more worried.

My exposure to HIV+ clients sometimes makes me uneasy ... it is not easy to do an HIV test ... and although I use protection (at work) I do feel uneasy. I am now having doubts about my own status.

This was not always the case: for example some health workers, like lay counselors, reported feeling frightened or worried about exposure to HIV even though their risk was low. On the other hand nurses who had been exposed to a needlestick injury previously reported rarely or never feeling frightened or worried about exposure.

Fear of exposure was reported to come not only from accidental needlestick injuries. For example, an assistant nurse shared how she had felt threatened by an HIV+ patient:

An HIV+ patient once made a comment that he will prick us with the needle that we were injecting him with. There is no security inside so our lives are in danger. The patient knew that he could infect us if he pricks us with the needle.

Neither was it limited to the health workers only:

My partner is very uneasy about the work I do. He is scared of the potential infection. My family will suffer if I'm infected because I am not in full-time employment. We receive only R 500/month.

The response to exposure is also relatively low: of the four respondents that reported having experienced a needlestick injury, in only one case (an assistant nurse) was a standard protocol followed and the incident reported to their supervisor. In the other three cases the incidents were not reported. These incidents may be noticed but those affected reported outside the facility (such as a partner, family member, or close friend) and seeking medical and counseling assistance outside of the facility. At clinic level, most health workers said they had not observed colleagues being absent from work or dying because of an AIDS-related illness. They felt this had not happened, and if it had, it had not been disclosed.

2.6. Health worker supervision and support

Only one of the three sites appeared to have established a formal system of support for health staff within the clinic which all staff recognised as being provided for this purpose. In this site a psychologist met with members of the clinic team every fortnight. A similar system was established in another site with students from a local university but had

stopped “due to university exams” and staff were now being referred to the employee assistance programme.

Respondents had however developed various coping mechanisms to deal with the stresses of HIV and AIDS:

- talking to nurses
- holding social functions
- having prayer sessions once a month
- acceptance, commitment and dedication.

These coping mechanisms were reported to not always offer an adequate solution. Respondents reported that they met from weekly to seldom with their (immediate) supervisor to review their work and/or performance, and to discuss any problems or questions they might have about their work. In some cases there were group or staff meetings, and in some cases individual, supervisory meetings. It appeared that in each site the staff met on regular basis for a staff meeting, weekly or monthly.

In terms of evaluation, health workers generally said they evaluated the HIV and AIDS related activities in the clinic through routine monthly data collected, although five of the fourteen respondents said they were “not sure” or that they did not do this personally. There thus appeared to be limited monitoring of HIV and AIDS-related services by the teams.

2.7. Health worker views on the role of the health centre committee

Some interesting variations in how health committees are perceived and understood by health workers were uncovered in the study, as presented in the two case studies below:

Case study 1:

In one facility that did not have a committee, all but one of the four respondents suggested there was “never” a health committee or that they had “never seen one.” One respondent said the committee “was not accepted by the facility manager” perhaps because “she did not understand their importance”.

Case study 2:

In one facility that did have a clinic committee, there were variations in the participation and knowledge that those interviewed had about the clinic committee. For example:

- The facility manager had attended two clinic committee meetings in the year (January-October), felt that there was a “close working relationship between the committee and the clinic” and described having a general understanding of the committee’s role.
- Whilst one professional nurse reported having a detailed understanding of the role of the committee, had attended one meeting in the year and knew all the committee members, another professional nurse reported never having attended any committee meetings and being unaware of who was on the committee.
- The lay counsellor at this facility was a member of the clinic committee and attended meetings on a monthly basis.
- The clerk never attended meetings, was unsure of the role of the clinic committee but

was familiar with the members of the committee as they “reported at the reception when they visited the clinic.”

It thus appeared that there were inconsistencies in:

- the level of knowledge the team had about the role the committee played in the clinic; and
- whether the committee in fact had formal terms of reference or not.

Unless one attended the clinic committee meetings oneself there did not appear to be an alternative or collective way of providing input into the meetings or of obtaining feedback from the meetings. Lastly, the clinic committee members were not familiar to all staff.

Despite the seeming lack of engagement by most the health workers interviewed in the community or clinic health committees², health workers thought the health committee could play a role in supporting the clinic deliver good HIV/AIDS services by:

- meeting and setting the way forward on how to work (1);
- highlighting the social needs and problems of the community and reporting those that need grants to the facility (1);
- mediating between the clinic and its staff and the community (or clients) (2);
- helping with the suggestion box (1);
- assisting very ill clients with home-based care (2);
- helping patients access the clinic by bringing them to the clinic and making a doctors appointment (1);
- volunteering at the clinic and be in attendance at the clinic (1);
- educating clients by arranging mass meetings - for information, and distributing pamphlets (1);
- raising awareness amongst client about attending the clinic and the services offered (2); and
- informing them about the ARV clinics (1).

Two respondents highlighted training the committee members as an important consideration, and one health worker noted that in order for a committee to function it needs to be “first recognised and accepted by the facility manager”. When asked about how they saw themselves, as health workers, being able to provide support to the committee, respondents suggested they could “engage and listen to their (the community representatives) problems”, “volunteer to be part of the committee”, “encourage the (municipal) Council to give training to community health committees” and “encourage constant communication and interaction (between the clinic and the committee.”

The main mechanism used at the clinic to obtain feedback from clients about the quality of services was a suggestion and complaints box. In one facility it was noted that clients also report complaints verbally to the clinic manager where they are kept in a register. The suggestion box was however observed to be relatively unused in all the facilities that had them; people were not sure of its purpose or were not willing to use it.

A small number of health workers were also not sure what happened with the feedback, felt that nothing was done with it, and in one case suggested that it was something

² Taking two facilities as an example, 2 of the 10 respondents attended meetings on a regular monthly basis, 3 respondents had attended two meetings or less in 9 months, and 5 had not attended meetings in the year.

“management dealt with”. However, most respondents (nine of fourteen) suggested that problems and suggestion were either personally followed up with the client concerned or discussed in a clinic committee. For example, one facility manager observed that:

“We write down the complaint and present it to the clinic committee and arrange a meeting and eventually resolve the concerns that have been raised”.

Other’s suggested that “we will look at the complaint and try and change and if there is a positive note or a suggestion we will implement it and respond to that as well” and “we try to do more and improve and set time frames.”

2.8. Health worker views on areas for improvement in responding to HIV and AIDS

At the end of each interview health workers were asked to suggest how, if asked by the Head of the Health Department in their municipality, they felt that their experiences as health workers managing HIV/AIDS at a facility level could be improved. The respondents came up with a variety of suggestions, including:

- **Training:** Increasing the number of staff trained on HIV/AIDS (8), specifically regarding ARVs and counselling. Some emphasis was placed on the need for more “non-professional” staff such as nursing assistants and clerks to be trained on HIV/AIDS related issues (2). One respondent suggested that authorities should also “recognise volunteers (more)”.
- **Staffing:** Hiring more staff (7) and increasing their pay (2). One respondent suggested that more nurses in particular should be employed and another suggested that there be “dedicated, as opposed to part-time doctors”.
- **Facility:** Upgrading (3) and increasing the budget of the facility (2).
- **Management and support:** Improving the management above the facility level (1) and providing “support to staff in their management of stress” (1).
- **Outreach:** “Increasing the level of education and our campaigns (about AIDS) to the community” (4) so as “to empower them as they can play a big role in the community” (1). Specific examples were given that included “put in an HIV/AIDS programme in schools” (1) and “have more open days and lectures and workshops” (1).
- **Community support:** “Improve the disability grant system” (1), give “nutritional supplements to HIV+ clients” (1), and “build more hospices.” (1)

3. Results of the interviews with health committees

The major features of each of the health committees interviewed are shown in *Table 4*. Apart from obvious differences in the formality and way in which members were either nominated or elected to be on the committee, and whether they represented a particular or general constituency, there seemed to be similarities in the size and regularity of meetings between the committees.

Whilst detailed information was not obtained about the characteristics of the committees’ members, the shop stewards observed that:

- one committee reported a decline in membership from when the committee was first established (and the membership was twenty) to less than ten (as it stands now);
- in one committee all of the members were unemployed and/or retired; and
- in all three committees a man assumed the position of chairperson (with one being a pastor and another a retired teacher).

Table 4: Background information on the three health committees interviewed

	Site 2a	Site 2b	Site 3b
Length of time committee has been in operation	Almost 1 year	2 years	2 years
Number of committee members participating in the interview	7 of the 9 members	2 of the 6 members	All 9 members
Constituency of the committee members	Represent “different wards within the district”.	Non-specific representation - they are “part of the community” that surrounds the clinic.	Represent community members in each of the nine sub-districts that nominated them.
Way in which the committee was formed	The Ward Councillor “advertised on the radio and people were invited to form the committee”.	Members were nominated as community members and confirmed at the AGM. One member was co-opted from the local AIDS Council.	One representative from each of the 9 sub-districts surrounding the clinic is nominated and then elected “by secret ballot” from their local sub-district on to the committee.
Frequency of committee meetings	Once a month (on a week day morning in the clinic). Attended by a professional nurse, who “represents the health workers from the facility”.	Once a month (on a week day morning in the clinic). Attended by the facility manager and assistant facility manager.	Once a month. Attended by the facility manager, one clinic health educator, and a health worker responsible for “auxiliary clusters”.

3.1. The committee’s understanding of HIV, AIDS and services offered

Representatives in all three committees had a good understanding of the kinds of HIV and AIDS-related services available at the clinic. When given a scenario of a woman and her child that were both potentially HIV positive and needing care, committee members talked about the availability of VCT and health education, the possibility of receiving treatment for any opportunistic infection (OI), TB and the provision of nutritional supplements, having her CD4 count checked and being referred for ARVs. They also talked about the availability of a support group and in one instance suggested that the women be shown “love and not stigmatised”.

The committee members had far less knowledge about the level of HIV within the district, suggesting for example that the prevalence of HIV was “99%” in the district and that “800 clients in the clinic test HIV+ every month”; or that of every 10 people being

tested in the clinic 8 would be HIV positive. They indicated that these statistics were not made available to them. They reported however their concerns about AIDS:

(We are) worried about males because males do not go for voluntary counselling as they are afraid of being positive. Most men do not use condoms. They beat the females if they want to use condoms. The men think that condoms cause HIV/AIDS.

3.2. The committee's understanding of its own role

The interviews revealed that there were various ways in which the roles and responsibility of each health committee was formally documented – or not:

- At the KwaZulu Natal rural site the committee gave the shop steward researcher a copy of a constitution outlining the role and functioning of the committee (including the fact that if a member of the committee does not attend a committee meeting three times their membership will be discontinued).
- In the urban Free State site the committee indicated that they did not have a constitution, and while they reported that they knew their roles, later discussion revealed that they were not sure of the purpose of the clinic, what its scope was and who they are accountable to.
- In the rural Free State site the committee referred the researchers to the clinic for the written document on the committee and verbally reported that they saw the role as facilitating a link between the health facility and the community (with an emphasis on resolving problems and complaints), and providing some support to the facility's community-based outreach activities (such as providing health awareness and informing the community about the available services).

The community link was differently viewed across the committees. Two reported a role of communication between community members and the health workers, and encouraging and educating community members on health issues, on services offered at the clinic and on patient and health worker rights. All three reported a role in making sure the clinic was running smoothly, to monitor complaints, problems and suggestions and facilitate client-health worker communication.

The role of advocating for patients' rights was not a common theme, and not discussed broadly, although one health committee shared with the shop steward that:

The greatest thing we have done this year is ask the Department of Health to give the clinic doctors. We now have a doctor on a daily basis ... we heard rumours that the communities were organising a march to the clinic to ask for doctors. We stopped that and said they must start reporting their needs to the health committee. They now have trust in this committee. We also fought for a place (at the clinic) where the youth can be taught about health education.

Interestingly, the committees appear to play little role in relation to management – for example, in being part of strategic planning or review processes. As a member of one committee noted, “we are not much involved in administrative matters”. When another committee suggested that one of their roles was to “manage the clinic” the shop steward asked them to elaborate further on this point. They then said that they were actually not directly involved in management and administration but rather to “see that things are running smoothly” more generally.

Specifically in relation to HIV and AIDS, two of the three committees shared that they:

- provide health education to clients and family members;
- encourage clients to go for VCT;
- provide condoms;
- identify orphans and report this to the social workers;
- fight for HIV/AIDS patients to get the (disability) grant early; and
- act as the link between the health educators coming from the clinic and the community.

As one committee member put it:

In our meetings we talk about how to improve the standard of the clinic and improve the standard of health in the communities, especially around HIV/AIDS – the killer ... We support the health workers by holding a meeting with the (Clinic Sister). We also have had this idea of having a vegetable garden for all those patients that were HIV+.

When asked what they thought their role as a committee should be in supporting health workers deliver effective HIV and AIDS services at the facility, two committees suggested “nothing should change ... they should continue doing what they are doing”.

They did however suggest that they ought to add the following to their current activities:

- When doing door-to-door campaigns they should also be able to provide “on the spot” counselling.
- Educate people about the HIV and AIDS services that are rendered at the clinic.
- Discuss with clients about their condition (being HIV positive) and the importance of taking their medications (if on ARVs).

One committee also suggested that they wanted now to “have traditional healers as part of the committee, so that they can be trained (about HIV and AIDS), about what not to do (e.g. stomach washouts or give medicines that loosen the stomach for those patients that are on HIV/AIDS treatment) and be involved in the (clinic’s) health programmes”.

Committee meetings were in all cases recorded by the Secretary of the committee. In two cases these were then distributed to all members of the committee, and in one case only “written in a specific book, not distributed to the committee members due to a lack of resources”. The process of providing feedback on the meetings to those beyond the committee appeared to be relatively ad-hoc:

- “We give feedback to clients during health education sessions we run in the clinic.”
- “We understand that a report goes to the local clinic forum and sometimes to the constituencies.”
- “Committee members go individually back to their sub-districts and give information back to the community.”

3.3. Factors affecting committee functioning

The three groups reported differently about what they perceived as impeding their role as a committee. In one instance, a comprehensive list was developed by members ranging from “internal” issues (like the commitment of their members to the committee) to the challenges they faced “externally” (like the difficulties encountered in their relationships with health workers). In another instance members only raised practical issues (e.g. provision of transport re-imburement and a suitable meeting place).

The health committees generally reported that their functioning was affected by:

- Uncertainty about their role, limits in terms of responsibility and the accountability of the health committee:
 - *Our role is not clarified – what happens if we act beyond our scope? How does our role relate to that of the facility manager?*
 - *Should we open the suggestion/ complaints box, or does the manager do that?*
 - *What must we do if there is a lack of communication between the clinic staff and the committee? Who do we report this problem to?*
 - *To whom are we accountable?*
- Uncertainty about what they, as committee members, can expect in terms of training and practical support from the facility:
 - *Will there be training on HIV/AIDS for the committee?*
 - *Will we ever be provided with access to a telephone? Many of us are not working and if we want to convene a meeting – how do we do this?*
- The lack of material or practical support, including for transport to attend meetings:
 - *We have no space to meet – apart from being allocated a space (when we have our monthly meeting) when the clinic is closed because of staff training, and we are able to find a space to meet.*
 - *The committee that did have an office said “our offices (are a problem) - the ones that we have in the clinic are all out of order”.*
 - *We have a lack of materials – health promotion materials like posters.*
 - *Transport – at times members have had to borrow money to come to the clinic. Despite that they have never postponed a meeting.*
- Difficulties in their relationships with health workers:
 - *(We experience) a “lack of co-operation and recognition” from some of the staff.*
 - *We feel that the staff gets irritated by the committee.*
- The “lack of commitment” of some committee members:
 - *“Committee members need to be more serious and active”. Some members lack of commitment members was cited as something which reduced the effectiveness of the committee.*
 - *Sometimes we experience difficulties like intolerance or in-fighting amongst committee members.*

For example at one of the facilities a member of the health committee alerted the clinic staff that part of the clinic’s roof was loose and expressed their concern that it presented a danger to the clients walking past it. Apparently it took a long time for the maintenance department to repair the roof and in this time a heavy storm made the roof worse. The committee member felt that the health workers were not listening to his concerns. When the shop steward asked the health workers about this incident they pointed out that maintenance takes a long time in the municipality because it requires authorisation and in this case was contracted out to a private company. They suggested that it was not a matter of “not listening” to the committee but rather that the process of authorisation and contracting out was lengthy – and something which is beyond their immediate control. Evidently these procedures and processes were not explained to committee members. Committee members felt they could overcome these difficulties and fulfill their role if they:

- received greater recognition from the health workers;

- were introduced to and included in the activities of the clinic;
- had more capacity development and training, including on HIV and AIDS;
- were provided with the necessary material support, including materials like posters for community-based education; re-imburement for transport and an allowance.

Only one committee member suggested that they should be provided with “incentives” to be a part of the committee. Apart from requesting a transport allowance to attend meetings it appeared that most of those interviewed understood that this type of work was of a voluntary nature.

4. Discussion and recommendations

This section of the report will consider the original intention and objectives of the research project and, given the results obtained by the shop stewards, discuss some of the implications of the findings for SAMWU, and where appropriate, for the public health services at primary level.

The study findings are considered exploratory given the small number of health workers interviewed comprehensively (fifteen) and the sources of bias noted in section 1. These findings are thus suggested as a basis for discussion in SAMWU with other sources of evidence to inform SAMWU’s training of shop stewards, particularly for a new focus on the collaboration between health workers and community representatives in advocating for the necessary human resource requirements to address HIV/AIDS.

Given the current process of transfer of municipal health workers to the provincial health authorities, the timing of such a training initiative might now be inappropriate until this is complete. Bearing this in mind, the study none the less highlighted some key issues which would be useful for SAMWU to consider, including, on how best these could be explored with the relevant health authorities.

4.1. Health worker needs for HIV and AIDS services at primary care level

We suggest that whilst the differentiation of HIV/AIDS responsibilities across the different job categories is by no means conclusive, having a clinic team identify and list the HIV/AIDS-related responsibilities associated with each job category (including those in support positions like clerks and general assistants) could potentially assist a facility to:

- identify what the specific responsibilities for each job category and/or individual members of the clinic team are, and thus what their unique contribution is in providing quality HIV/AIDS prevention, care and treatment services to their clients;
- reach agreement on how the team members, having different functions, can work collaboratively to ensure that each client is provided with comprehensive care – and that the client is managed in a co-ordinated and ordered manner; and
- agree on what the collective responsibility of the team is in ensuring that each one of their clients receive quality HIV/AID services.

Identifying these different, but complimentary roles, might also help local health committees become familiar with what the responsibilities of the health team at a facility in relation to the delivery of HIV and AIDS related services – and thus strengthen their ability to monitor aspects of the delivery of these services.

It was surprising to find that not one respondent was able to report more accurately on the level of the HIV burden in their district – including those in management or more senior positions (like the doctor and the three facility managers). This indicated that this information is not being provided to health workers in the facilities, or is being provided in a way that health workers are not able to understand and interpret.

The study showed a low level of awareness amongst health workers about the existence of an HIV and AIDS workplace policy, and the inconsistencies in knowledge within a facility about the existence of such a policy. Further health workers appeared to follow the required procedure of reporting needle-stick injuries infrequently, with only one completing the necessary procedures at the clinic and three others choosing to access support outside of the public sector. This is an obvious area in which SAMWU can intervene – firstly, in ensuring that their union members and health worker colleagues are familiar with the content of workplace policies, and secondly, to address barriers to reporting of needlestick injuries and consequent support.

The changes that health workers reported experiencing in their workplace as a result of HIV/AIDS related to:

- an increase in the number of consultations perceived to reduce the quality of care;
- a need for training on ARVs - ranging from basic information for all staff to information on clinical management for those staff with clinical roles; and
- the limited formal systems of support that appear to have been established to provide regular counselling or de-briefing to health workers so as to help them with the level of stress they experience at work.

There was little report of changes in illness and loss of colleagues from AIDS-related illnesses, and while some demands on them were reported for providing guidance and material support for their HIV+ clients and their families, this was not found in all cases.

It is suggested that SAMWU discuss priority HIV and AIDS training needs with members, and support shop stewards' information and awareness around some of the gaps that exist (which may be affected by the current process of transformation and the shift of municipal health workers to the provinces).

4.2. Community roles in HIV and AIDS services at primary care level

We would suggest from the findings that to identify and reach consensus on the most appropriate contribution that a health committee can make to the delivery of HIV and AIDS services, the committee needs:

- to be operational;
- to be recognised or acknowledged by the health workers as having some value; and
- all stakeholders, especially the committee members themselves, to be clear about the purpose of the committee, their mandate and their associated responsibilities.

This was clearly not always the case in the facilities in which this study occurred.

The absence of a health committee tends to limit the extent to which facilities are able to listen to, engage with and consider the priority needs of their clients. The suggestion box, popularly used by facilities to obtain feedback and suggestions from clients seemed to be under-utilised and considered, by some community members, an inappropriate mechanism through which to elicit feedback.

Where a local health committee did exist there seemed to be some variation in the extent to which different members of the health team engaged with the committee. Variation was found in:

- the level of knowledge that the health team had about the role of the committee;
- the weak or absent formal processes for providing health worker input into, or obtaining feedback from the monthly committee meetings; and
- the extent to which current members of the health committee were familiar to all the clinic staff.

Whilst the health workers interviewed were supportive of the committee, this weak knowledge of, and familiarity with the existing health committees (specifically about their role and membership) weakens the health worker support for the health committee.

Communities also raised a number of obstacles to the committees functioning, including:

- uncertainty about their roles, responsibilities and accountability;
- uncertainty about the training and support they should get from the facility;
- lack of practical and material support;
- lack recognition and co-operation from some facility staff; and
- uncertainty about where and how such matters can be resolved and varying levels of commitment amongst committee members.

It is suggested that more cognisance needs to be given to the current role that health committees play and the activities that they do in relation to HIV and AIDS, and whether the opportunity exists to strengthen these, and/or to modify or to change them.

In the interviews with two of the three health committees the shop stewards found that committee members were:

- providing support to the facility's preventative and promotive HIV and AIDS outreach activities through community education;
- facilitating links between community members and health workers; and
- encouraging uptake of services and social welfare support in communities.

They had some, more limited, advocacy role for the rights and support of those living with HIV and AIDS. Committee members generally thought these were useful roles and suggested that they could additionally:

- inform community members about the services offered at the clinic; and
- provide adherence counselling and support to clients taking ARVs.

Committees did not appear to have any role in strategic planning or evaluation of facility services, such as:

- assisting health workers with a needs assessment;
- designing an educational programme;
- establishing or maintaining the PLWHA support groups; and
- monitoring and evaluation of the services that the facility provides to its HIV+ clients.

Considering that the committee members are volunteers, the time they 'donate' to the facility ought to be seen as something precious, a resource that ought to be nurtured and conserved by health workers. Perhaps the existing activities are those that both parties feel most comfortable with at this stage. However it does seem that, at the very least, more consideration ought to be given to how committees can play a more active strategic role, be more involved in the design and evaluation of programmes as opposed

to “opening up the suggestion box”, dealing with the occasional complaint and providing educational HIV/AIDS input to clients on an ad-hoc basis.

Working collectively to address issues related to HIV and AIDS requires that both parties, in this case health workers at a primary care facility and the health committee:

- be cognisant of their different roles;
- share a common understanding of the extent and nature of the problem;
- are familiar with the resources and interventions available to them; and
- on the basis of this can think creatively about how to develop a joint, realistic strategy and work plan.

If the health committee is considered to be a viable platform or mechanism through which to explore how health workers can work alongside community members in strengthening the delivery of HIV and AIDS services, then consideration needs to be given to how both parties can begin to engage with one another more proactively so as to create a plan for strengthening service delivery.

It is thus suggested that, where appropriate, SAMWU shop stewards encourage a review of the overall function, responsibilities and support of health committees in relation to HIV and AIDS, to provide an opportunity to reflect on the nature of the current partnership between health workers and committees. Where a health committee does not exist, SAMWU may open dialogue on the possibilities of establishing such a committee, followed by discussion on the roles, functions, responsibilities and areas of support.

4.3. Lessons for future research initiatives

Once the shop stewards had completed their interviews, they were asked to reflect on what they found to be the strengths of the participatory research process and what they found particularly challenging. They were also asked to provide recommendations on how, if SAMWU were to conduct similar research in the future, the different phases of the research process could be refined. The reflections of the shop stewards, along with those of the SAMWU national health co-ordinator provide useful information for future research initiatives in SAMWU and other institutions involved in this process.

The research process was hindered at times by competing priorities and responsibilities within SAMWU. For example, one shop steward after attending the first training workshop was then seconded to work on another union campaign, leaving the remaining shop steward in the province responsible for data collection in both sites. In the Western Cape a shop steward from a rural site was never identified by the provincial office resulting in the loss of one of rural research sites.

It is recommended that more consideration be given in the future to how the SAMWU National Office could secure the necessary support for a research process from the respective provincial SAMWU offices. For example, the National Office could explicitly outline:

- what the expectations are on shop stewards in terms of their time and commitment to the study (both in conducting interviews and in participating in group meetings);
- what skills or interest is required or important in order to participate in the research process; and
- what concrete support and resources are required from the provincial office to support the research process.

Ascertaining their level of interest and commitment to the research process in the beginning would reduce obstacles during the process of the research, as raised by the shop stewards themselves:

When SAMWU begins a research study they should look for those (shop stewards) that are willing, those that volunteer, and those that value the research topic – not just choose someone to take part because they work in a clinic. They should also check on their education level or their ability to ask questions accurately, or be able to re-phrase questions accurately ... It will be a waste of money to choose people that don't have the time or interest to commit to the project – this only leads to incomplete work.

The questionnaire administered to health workers was too lengthy given the significant time constraints many health workers face in clinics, while interviewing clients after working hours was equally difficult for health workers who were rushed after their working day. It is recommended that greater consideration be given in future research to how to organise sufficient time to interview health workers during or after their work hours, such as by shortening the length of the interview, or offering some form of reimbursement for health worker's time outside of their work hours.

Insufficient time was allocated between the first workshop and the data collection phase to obtain approval from the relevant health authority to conduct the research study and, having obtained this documentation, to meet with the facility manager to introduce the study and obtain his/her approval for it to be implemented in the site. This was particularly difficult where approval had to be obtained from more than one health authority. It is recommended that research processes include in the design the steps for such approvals and that timelines allocate adequate time (such as at least a month) for the approval process to be completed.

Timelines should also make clear the time commitments needed for the shop stewards to work on the project and be prepared for unplanned eventualities. For example, municipal strike action in August 2005 delayed the original timelines for this research by two months, compressing the rest of the time for the work on the project. Time is also needed to communicate with and obtain community commitment. These and other time issues need to be quantified and factored into the design at the outset of any research.

In some instances shop stewards experienced difficulties in accessing respondents or administering the full questionnaire. In these instances it would have been beneficial if they had been provided with more regular support and supervision during the data collection process. Specific consideration ought to be given as to how best the national office can provide such support in the future, so that this can be explicitly built into future research proposals.

The research experience was found to be useful by the shop stewards involved, who thought their involvement in the design of the research process and tools and in the analysis and reflection on the data ought to be continued. Other members of the research team from UWC noted that the research had been useful for the members of the union to reflect on the delivery of quality HIV and AIDS services, and to consider how HIV and AIDS is impacting on the work and life of fellow health workers. They suggest that in future SAMWU think critically about what research needs to be done in a participatory manner and what needs more quantitative type data through a wider survey. This, it is suggested, will be affected by the type of issue under investigation and

how the union seeks to pursue it. In either case, issues of training and support of field teams and the resources for it would be critical.

5. Conclusions

Through the work of five of its shop stewards this study has provided SAMWU with a further opportunity, although on a small scale, to explore how the HIV and AIDS epidemic is impacting on the work and life of health workers. Like the previous study, this one indicated how health workers were experiencing an increase in their workload because of HIV and AIDS-related illnesses, and were frequently a witness to the hardships that families affected by HIV/AIDS in their communities had to face. This study also found that despite the potential for occupational exposure to HIV, the HIV and AIDS workplace policy appeared to be inaccessible to many health workers – with half of the health workers interviewed being unaware that such a policy existed within their facility.

On a more positive note, the study has been able to document how three local health committees, aligned to primary health care facilities, view their current and potential role in relation to HIV and AIDS. Despite the challenges faced by these committees, it appears that the potential exists, if accompanied by sufficient support from the clinic, for such committees to play a more active role in the design and evaluation of the clinic's HIV and AIDS programmes as opposed to some of the typical tasks they undertake at present like opening up the suggestion box, dealing with the occasional complaints from clients and providing educational input to clients on an ad-hoc basis.

The study team recommends that:

- more information be provided to all health facility workers and health committees on the HIV and AIDS burden in the community and on ARVs to support communication with communities;
- SAMWU strengthen knowledge and implementation of workplace policies on AIDS and review and address barriers to reporting and responses to needlestick injuries;
- SAMWU further clarify the different roles and responsibilities of staff around HIV and AIDS in health facilities;
- SAMWU encourage a review of the functioning, responsibilities and support of health committees and facilitate a dialogue on this between health workers and committees; and
- SAMWU integrate lessons on the timing, process, tools and approval process and the support needs of shop stewards from this research into the design of future research studies.

Just as this research process began – with a proposal that was developed by and discussed within the SAMWU membership, so too must discussion regarding the outcome of and recommendations from this research, given the present context of transformation, be considered internally by the union. It is through such a process that the next course of union action can be taken.

The shop stewards own words in the research on how the union could play an active role in improving access to quality HIV and AIDS services may be a first contribution to this next step of reflection within the union:

I think what we need more in our constituency meetings ... to have more discussions on basic HIV and AIDS information, and what ought to be expected at a clinic in terms of good service. For example, SAMWU members should know that there ought to be always condoms available at a

clinic for patients to take home with them, and that VCT should always be available, and that they should feel secure that what they share with the health workers is kept confidential and private.

The members of the union themselves need more information about HIV and AIDS – I see that some members are still stigmatising the issue. I think they need to be trained more especially about VCT. They also need to be provided with information so that they can raise awareness and give advice about HIV in their communities.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET:
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