

RAISING OUR VOICE, BREAKING OUR SILENCE
Health Workers' Experiences and Needs around
Occupational Health Services in Cape Town, South Africa



A PRA PROJECT REPORT
June 2006



Facilitated by the Industrial Health Research Group (IHRG) with support from the Regional Network for Equity in Health in East and Southern Africa (EQUINET)



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The **Industrial Health Research Group** is an occupational health and safety training, advice, research and resource development unit based in the School of Public Health and Family Medicine at the University of Cape Town. IHRG has provided OH&S services to the trade union movement in South Africa since 1980. In recent years, IHRG has developed a significant programme of capacity building, skills training and participatory research in occupational health and safety with health workers and the trade unions organising in the public health sector.

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Executive Summary

The culture of occupational health and safety (OH&S) within the public health sector in South Africa is predominantly one of neglect. It is characterised by minimal legal compliance, by reactivity rather than proactive prevention, and by a reliance on compensation. Employers, the Department of Labour, public health sector trade unions, and health workers themselves all act to reproduce this culture of neglect in various ways.

In the course of recent training and research programmes with the Industrial Health Research Group (IHRG), health workers in the Western Cape province identified weaknesses in the occupational health services available to employees of the Provincial Department of Health (DOH). Although the DOH has developed draft policy on occupational health services, health workers have had no engagement with, or knowledge of this policy.

The culture of “sacrifice” that is typically imposed on the health care profession encourages a culture of silence amongst health workers regarding their health and safety in the workplace. This silence is facilitated by the lack of attention given by trade unions in the public health sector to workers’ occupational health and safety rights.

Within this context, and as one stream within IHRG’s broad engagement with health workers and their trade unions, this Participatory, Reflection, and Action (PRA) project on occupational health services offered an opportunity for IHRG and a small group of unionized health workers to use innovative learning and research methodologies in an attempt to investigate and intervene in real experiences of workplace injury and illness.

Following IHRG’s participation in a regional training workshop hosted by EQUINET, IHRG piloted its use of selected PRA tools within a broader methodology of experiential learning and participatory action research. The project consisted of three workshops, workplace-based investigations, and the dissemination of networking resources among the participants.

The PRA project proved to be a valuable learning experience for the participants and for IHRG. In particular the combination of workplace-based case investigations and the process of critically reflecting on these interventions provided a very powerful action-learning experience. Through the use of PRA methodology and tools, participants were also able to critically examine their own learning experience.

Processes of change were evident even in this short term project. Participants’ workplace investigations uncovered real cases of workplace injury and illness that have been buried under a culture of ignorance, neglect, silence, and denial of workers’ health and safety rights. The perspective offered by participatory action research is that by uncovering these cases, collectivizing the issues, and engaging authoritative role players, the researchers (being role players themselves as employees and union shop stewards) start to challenge that culture. By raising their voices and challenging patterns of power relations, participants also began to experience change within themselves.

An important challenge facing us at the end of the last workshop was how to provide some continuity to the action learning process that was begun with this short project. Participants committed themselves to taking part in IHRG’s wider capacity building programme through the Western Cape Public Health Sector Trade Union OH&S and HIV Forum (PHS Forum).

1. Introduction

1.1 Objectives of the PRA project

The objective of this project was to use participatory reflection and action (PRA) workshop and research methods to stimulate, and contribute towards strengthening the role and voice of a community of health workers in identifying their occupational health service needs and determining how those needs should be met.

Against the background of IHRG's wider programmes of capacity development, skills training, and participatory research in OH&S with trade unions in the public health sector in South Africa, IHRG attended a PRA regional training workshop conducted by EQUINET in March 2006. Following this training experience, EQUINET facilitated IDRC funding support for an IHRG project that would pilot IHRG's use of PRA methods and tools.

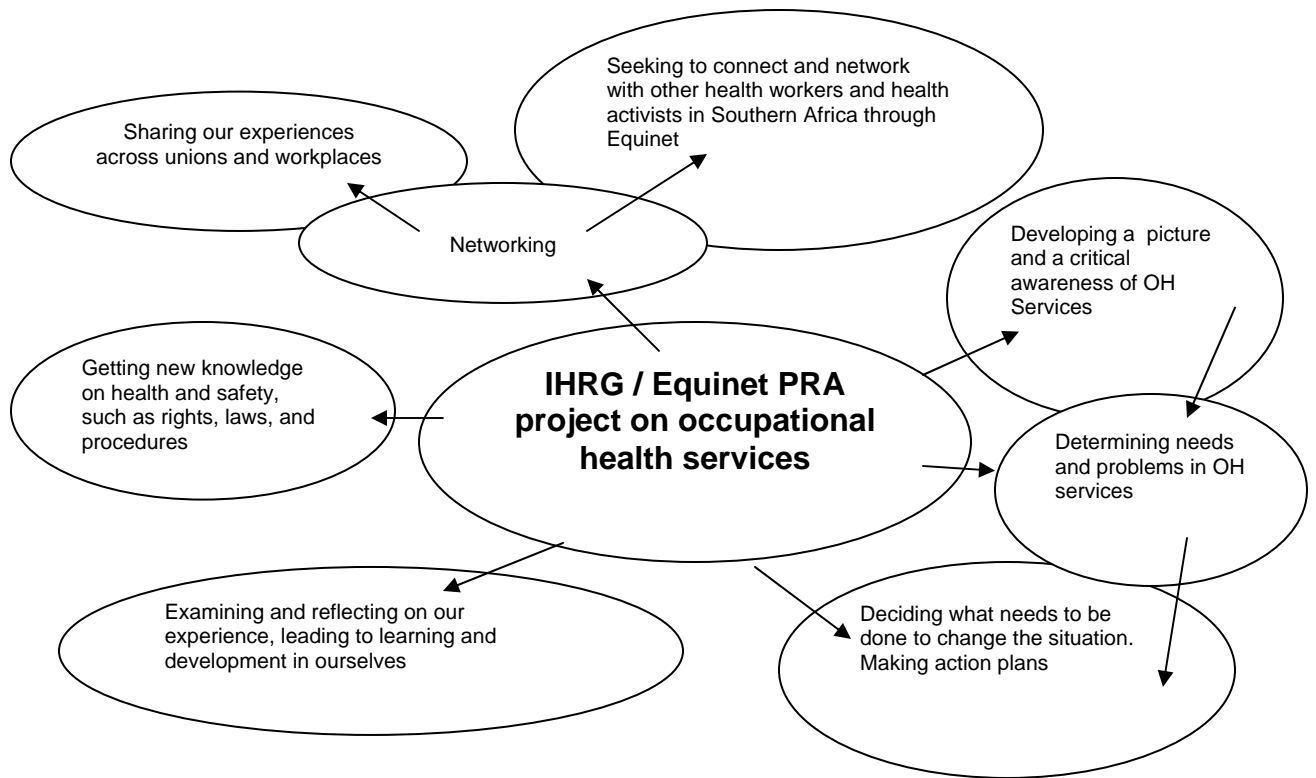
In this PRA project, IHRG facilitated a process through which a small group of health workers from provincial and municipal health institutions in the Cape Town area began to explore and reflect on their experiences, identify problems and needs, and formulate plans for action and recommendations relating to occupational health services.

Through an overall participatory, reflection, and action approach and by using specific PRA methods and tools, this project had specific objectives. These were discussed and formulated in the course of the first workshop in the following way:

- To bring to the surface and identify what exists in our (health workers') experience of occupational health services;
- To reflect critically on this experience so that we can identify and understand weaknesses and problems in the occupational health services;
- To identify what it is that we need, and what should change regarding occupational health services; and,
- To identify the action steps and recommendations that are needed to bring about these changes

The overall aim of this process was to encourage the health worker participants to explore and develop their individual and collective capacities for investigating and supporting workers' cases of workplace injury and illness, and to use their trade unions to engage their employer in shaping an occupational health service that meets the needs of the community of health workers. Critical for this perspective to take root, was a process that would allow project participants to recognise their own learning experience and transformation.

At the beginning of the third and last workshop of the PRA project, participants who had been present in the previous workshop were asked to explain to a newcomer what the PRA project was all about. The Spider Diagram result of that process offers a valuable summary of the objectives of the project and is reproduced below.



1.2 Background to the PRA project

The PRA project on occupational health services, and its focus on strengthening the voice of health workers around their needs and experiences, was developed by IHRG out of a long experience of occupational health skills training and participatory research activity with unionized workers in the public health sector.

The practice and experience of OH&S in the public health sector in South Africa is dominated by a management-led culture of neglect, reactivity, minimal legal compliance, and reliance on compensation. Rather than workers' rights to a healthy and safe working environment being a guiding principle, it is not unusual for facility managements to resort to recycling used protective gloves and breathing masks in order to cut costs.

This culture of neglect is reinforced by habits of silence on the part of health workers. Their reluctance to make known their health and safety needs is encouraged by the prevailing social culture of "sacrifice" which suggests that workers' rights are somehow in opposition to the rights of patients. Trade unions in the public health sector do not prioritise occupational health and safety, further compounding traditions of silence, ignorance, and rightlessness.

In December 2005, IHRG convened a health workers' OH&S conference at the University of Cape Town with the purpose of discussing OH&S skills training needs and developing a

training curriculum¹. The conference provided health workers with an opportunity to explore and discuss the culture of neglect, silence, and sacrifice that dominates occupational health in the public health sector.

Following a presentation from the South African Municipal Workers Union (SAMWU) to the conference on the findings and experience of the “Who Cares for Health Care Workers?”² participatory research programme of 2004, conference participants spoke of how health and safety is neglected in their workplaces.

There is a lack of compliance by the employers.

There is a lack of support for health workers by the unions.

There is silence from health workers.

We rely on compensation but we get frustrated by bureaucracy.

We look for cure but should be looking for prevention.

One nurse who shared the story of her struggle with her employer and the compensation commissioner to get proper recognition and treatment for her occupationally acquired latex allergy, challenged the conference participants to speak out on their health and safety needs and experiences,

How does one care for someone when we do not care about ourselves? Health care workers have kept silent for so long. Do you know what is silence? Silence is the absence of sound. Sound is when you make an impression and from us as nurses there is no sound or impression. That is why the government can make legislation without asking the health workers. The message of silence – it is “unagreed”, but everyone accepts it as a YES. I appeal to everyone to consider your silence because if you don’t want to say yes, raise your voice and say NO.

One of the things that discourages health workers from vocalizing their health and safety needs is the culture of sacrifice that surrounds health care. When Dr June Fischer, a medical doctor and health and safety activist from the United States of America, spoke to health workers at a workshop of the PHS Forum³ in November 2005, she said:

¹ The First Provincial Working Conference on Occupational Health and Safety Curriculum Development. 6 – 7 December 2005. Convened by the Industrial Health Research Group and the Western Cape Public Health Sector Trade Union OH&S and HIV Forum.

² IHRG/SAMWU/msp (2005) “Who Cares for Health Care Workers? The State of Occupational Health in Municipal Health Clinics in South Africa.” Municipal Services Project Occasional Paper No 8.

³ The Western Cape Public Health Sector Trade Union OH&S and HIV Forum (PHS Forum) is an informal forum of representatives from public health sector trade unions in the Western Cape which is convened by IHRG for the purpose of networking, sharing, and capacity building around occupational health and safety issues affecting workers in public health sector institutions. The PHS Forum was established in 2002. During 2005 it met on a monthly basis as part of the PLP curriculum development programme funded by the Federatie Nederlandse Vakbeweging Mondiaal.

All over the world health workers put their patients first. Unfortunately this is part of a culture that neglects the health and safety of health workers. We need to show that quality health care for patients depends on workers' health and safety rights being protected, not sacrificed.

IHRG's interest in using the PRA project on occupational health services to encourage health workers to find and develop their voice around their occupational health experiences and needs, was shaped by the determination of health workers at the December 2005 OH&S Conference to find ways to make themselves heard.

*We must **break the silence, learn to talk.** We must seek for information, network, learn more, and influence management to make the workplace a better one for all.*

*Our challenge is to get nurses out of their submissiveness so that they can start to **speak for themselves.***

*The time has come that all health care workers must **speak out about all their problems** and to take a stand.*



Health workers speak out at the December 2005 OH&S conference convened by IHRG and the PHS Forum

Health workers are not adequately recognised as a community requiring health care. Specifically, their need for preventative, diagnostic, treatment and compensation services for occupationally acquired injuries and diseases, including HIV, is not being met. Occupational health systems, structures, procedures and policies in the public health system are weak and fragmented and do not enjoy active participation from the community of health workers.

In the course of recent training and research programmes with IHRG, in the monthly PHS Forum workshops, and at the December 2005 conference, health workers in the Western Cape province have identified the weakness and inadequacy of occupational health services available to employees of the Provincial Department of Health. Although the DOH has developed draft policy with regard to occupational health services, health workers have little engagement with this policy or with the fragmented services that are in place. One example of this is the Reed Street Clinic which has offered a dedicated occupational health and HIV service to employees of the Metro District Health Clinics. Current evidence shows that health workers do not make use of this service.

1.3 Establishing the PRA project

IHRG's PRA project on occupational health services took shape through an opportunity presented by a training workshop in Participatory, Reflection and Action (PRA) methods conducted by the Training and Research Support Centre (TARSC) in collaboration with the Ifakara Health Research Development Centre for a selection of Southern African partner organisations of EQUINET. The PRA for a People Centred Health System workshop was held in Bagamoyo, Tanzania in early March 2006. Alongside the PRA training, participants were invited to submit ideas for small PRA projects that would be funded through EQUINET.

PRA training in Bagamoyo, Tanzania, March 2006



IHRG's PRA project proposal was accepted and formalised through a grant agreement with CHESSORE at the end of April 2006. As a unit based at the University of Cape Town, IHRG was required to submit a research protocol to the Ethics Committee of the Health Sciences Faculty. As part of this process, IHRG designed a Participant Consent / Confidentiality Form for health workers participating in the project who might share sensitive personal information.

At the time of the development of the project during March and April 2006, IHRG made contact with the Labour Caucus of the Institutional Management Labour Committee (IMLC) of the Metro District Health Services (MDHS) in Cape Town. The MDHS includes forty two Provincial Department of Health clinics in the Cape Town Metropole. The Labour Caucus of the IMLC brings together representatives of 7 trade unions organising in the public health sector in the province. IHRG's meeting with the Labour Caucus related to a range of occupational health training and advice work issues, and the developing PRA project offered a valuable opportunity for us to engage with this group of shop stewards. At the time of establishing the project, 3 cases of occupationally acquired TB had come to light in one of the MDHS clinics. The PRA project provided participants from the MDHS Labour Caucus with an opportunity to investigate this situation.

While IHRG was keen that the PRA project pay particular attention to the MDHS experience, we also wanted to draw in health workers from other public health institutions in Cape Town. One reason for this was to provide a forum and an activity for us to keep alive some of the challenges and issues that had emerged from the December 2005 Conference with health workers in the Western Cape Province. After consultation with the PHS Forum on March 15, 2006, IHRG invited delegates from the public health sector trade unions that are represented in the Forum as well members of the MDHS Labour Caucus.

1.4 Participants in the PRA project

From IHRG's side we had hoped to establish a group of about twenty health worker participants in the PRA project. IHRG felt that this number was appropriate for the in-depth nature and short duration of the project and it also met our budget constraints. We were also keen to get representation from all the PHS trade unions that have been active in IHRG programmes to date and to get representation from different kinds of public health institutions in the Cape Town Metropole.

We were not able to achieve the number of participants that we had hoped to get, and some of the fourteen participants who did take part did not attend every workshop. The reason for these problems of participation and attendance were the short notice given (due to the need to carry out and complete the project by the end of June 2006) and difficulties that shop stewards had in securing 3 days off for the workshops during the single month of May.

A list of the participants, their workplaces, and their trade unions is provided below.

Health Worker Participants	Union	Workplace
Elizanne Hanevil	Denosa	Volkcentre Clinic (MDHS)
Lena McKenzie	Denosa	Groote Schuur Hospital
Patsy Collins	Denosa	Mitchells Plain CHC (MDHS)
Katrina Reid	Hospersa	Hanover Park CHC (MDHS)
David Meyer	Hospersa	Heideveld CHC (MDHS)
Daniel Vermeulen	Hospersa	Jooste Hospital
Nawaal Prins	Nupsaw	Green Point CHC (MDHS)
Freddie Sam	Nupsaw	Red Cross Hospital
Leonard Hoeane	Nupsaw	Groote Schuur Hospital
Beverley Wilcox	Pawusa	Lotus River CHC (MDHS)
Craig Appels	Pawusa	Retreat CHC (MDHS)
Jocelyn Hartzenberg	Samwu	Westridge Clinic
Shabira Adriaanse	Samwu	Elsies River Clinic
Duncan Pakati	Sadnu	Alexandra Hospital

From the side of IHRG, the overall project co-ordinator was Richard Jordi, the IHRG staff member who attended the PRA training in Tanzania. Borneshia Wood, Ashraf Ryklief and Nick Henwood also participated in and facilitated the workshops and the overall programme. Borneshia Wood and Shirley Pettit provided administrative support. Richard Jordi took responsibility for producing the workshop packs, the Networker Notes that were sent to participants between workshops, the workshop records, and the project report.



**Participants at the first
PRA workshop on 2 May 2006**



**Participants at the second
PRA workshop on 16 May 2006**



**Some of the participants at the third PRA workshop
on 30 May 2006**

2. Methodology

2.1 Experiential learning and participatory research methodology development in IHRG

As a unit based at the University of Cape Town that provides a service to communities of organized workers, IHRG sees its role as being to facilitate a dialogue between the experiential knowledge and expertise of workers on the one hand and the scientific, legal, and policy-making expertise of medical practitioners, lawyers, and government in the field of OH&S on the other.

In its experience as an OH&S training, advice, investigation, research, and resource development unit that offers its services to workers and their trade unions, IHRG seeks to build the independence and capacity of organized workers to advance their health and safety interests and rights. With an objective of capacity-building, IHRG has sought to develop experiential and action learning methodologies as well as methods and practices of collective participatory research.

This approach to training programmes, advice work, research programmes, materials development, and curriculum development work has led us to identify and develop methods and tools that allow workers to explore, value, and build on their experiential knowledge as a basis for critical reflection, learning, planning, and action.

While much of our practice in IHRG is self-taught and has developed organically, we have recently sought to develop these experiential, action learning, and participatory methods more consciously. It is with this background and in this context that we were able to appreciate the opportunity provided by the TARSC / Ifakara PRA training workshop and sought to apply our learning through the PRA Occupational Health Services Project.

2.2 TARSC / Ifakara PRA training

The training in PRA tools carried out in early March 2006 by TARSC and Ifakara in Tanzania (under the auspices of EQUINET), gave IHRG an opportunity to engage more consciously with participatory tools and methods that connect strongly with the overall methodology and approach to learning and research that has been practised and developed in IHRG. We found the training workshop to be of great value and have been able to incorporate and adapt some of the tools into our work.

In what follows in this section we outline and review critically, our use of these tools and the overall PRA approach in our recent PRA project.

2.3 An outline and reflective assessment of IHRG's use of PRA methods and tools in the PRA project

The PRA occupational health services project facilitated by IHRG consisted of 3 one-day workshops conducted over a period of a month (2 weeks between workshops). Between the workshops participants carried out research / investigation tasks related to occupational illness and injury cases in their workplaces. Between workshops IHRG communicated with participants through two issues of *Networking Notes*.

The project was carried out within a framework that was defined by two dominant PRA tools. Other tools were used as specific activities within that framework. We separate these two levels out below as **framework tools** and **activity tools**.

Project Framework PRA tools:

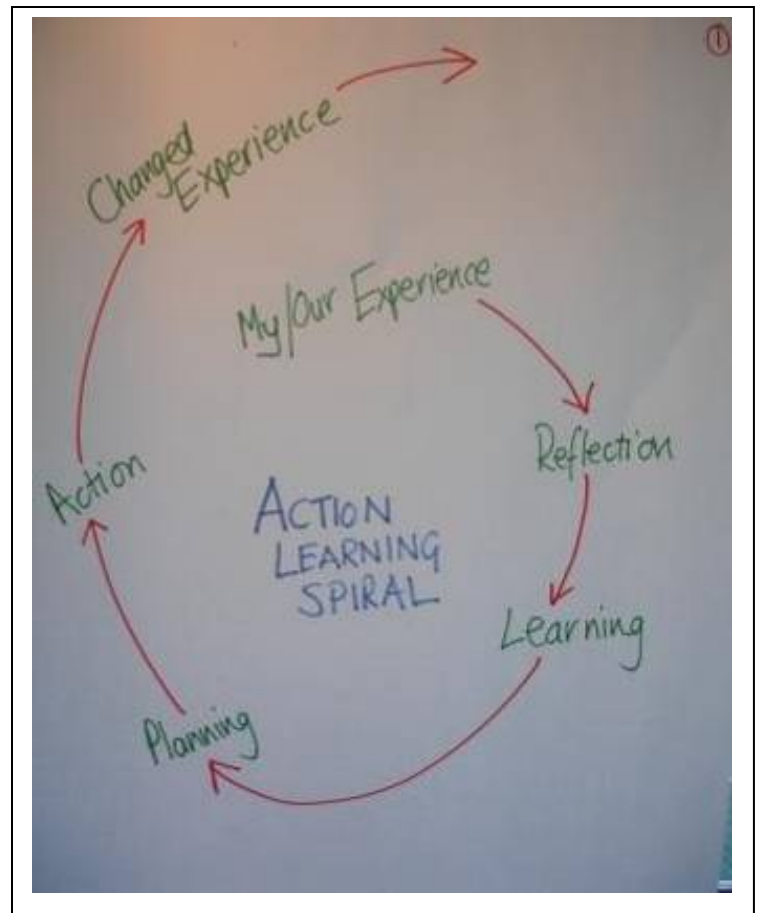
Two PRA tools constituted an overall framework tools for achieving the objectives of the project. These were: the **Action Learning Spiral** and **OH&S Case Investigations**.

The **Action Learning Spiral** was developed with the group and posted on the wall of the workshop venue.

It would occasionally be referred to in passing in order to encourage participants to step back and recognize their learning process.

It was brought forward and discussed directly on a number of occasions.

We also used it as a method of evaluation at the end of the last workshop where participants were given the spiral on sheets of paper and wrote down their learning experience along the route of the spiral (See Section 4).



While the Action Learning Spiral provided us with this important reflective framework for pursuing our project objectives and for observing our learning, the PRA tool that served as the dominant vehicle for learning (and for moving from reflection, to learning, to planning, to action, and so on) were the **OH&S Case Investigations** that participants carried out in their workplaces. Analysis of the findings of these investigations and reflections and the learning that emerged in the workshop discussions are presented in Section 3.



Within our recent experience of training and capacity building in occupational health and safety in IHRG, we are becoming increasingly aware of the value of OH&S Case Investigations as tools for learning.

Firstly, they provide situations that contain and reflect all the problems and dynamics of the prevailing culture of neglect and minimal compliance and thus act as important experiences through which learners can identify those broader issues and challenges.

Secondly, because real cases of workplace injury and disease

require action they provide ideal opportunities for participants to experience the reflection-learning-planning-action cycle when they are incorporated into training contexts.

Project Activity PRA tools:

Within the framework provided by the Action Learning Spiral and the OH&S Case Investigations, we made use of the following PRA tools to facilitate certain kinds of exploration, reflection, learning, and planning during the three workshops:

- **Story-telling and sharing of experience:** Sharing stories challenged participants to value their knowledge and experience as the starting point and foundation for the activities of the project, and it encouraged them to look to themselves as primary agents of their own learning and transformation. It also facilitated a collective sharing of individual experience which is very important in any project that is seeking to develop and strengthen a community's voice.
- **Recording Brain-Storming on a Spider Diagram and Institutional Map:** These served very well to bring together participants' knowledge and experience of OHS,



Participants preparing to report back from a small group discussion

There were a number of occasions when the IHRG facilitators did not make use of PRA tools that they had intended to use for certain activities at specific points in the workshops. There were a number of reasons for this:

- The activity or process that a tool was intended to facilitate happened organically within an earlier part of a workshop
- Time constraints
- Facilitator's unfamiliarity with the tool
- A sensitivity to a tool being inappropriate in the face of how things unfolded at the time when the tool was intended

On reflection, we tended to make use of the PRA tools that were most familiar to us. Our conscious use of PRA methods and tools certainly enriched the process for IHRG and for the participants and has provided us with a basis of confidence from which to become more adventurous. Probably, the most exciting aspect of the project was the powerful impact that the integration of Case Investigation with a conscious use of the Action Learning Spiral had on us and on the participants.



Capturing our brainstorming on a spider diagram

3. Summary and analysis of the findings of the PRA project

3.1 Participants identifying OH&S issues from their experience

At a number of points during the three workshops that made up the PRA occupational health services project, participants were asked to identify from their experience important issues relating to occupational health and safety (OH&S) in general and occupational health services in particular.

This sharing of individual experiences, knowledge, and opinions provided us with a framework of shared understandings of the issues we were wanting to explore in the project. It also allowed us to identify priority issues and questions facing the participants.

OH&S was identified by participants as being important to health workers because health workers spend a lot of time working in an environment that is full of risks and hazards, ranging from exposure to infectious diseases like TB to facing the threat of gang violence. It was also argued that the health and safety of health workers is important because it impacts directly on the quality of health service that they are offering to the public.

Participants gave a clear indication however, that OH&S is seriously neglected in public health institutions. In particular, participants pointed to:

- very little awareness among workers of OH&S issues in the workplace or of their OH&S rights;
- a culture of reacting to OH&S problems rather than building practices of prevention;
- even where knowledge and problems exist, there is a lack of proper remedial or preventive action;
- a lack of information and stats from the employer that could be used to develop preventive approaches; and,
- inadequate OHS systems and process that provide for proper diagnosis, treatment and management of workplace injury and illness.

Workers are really not aware of hazards at the workplace. They only become aware when they get injured or become ill.

We may have lots of protective equipment but there are no procedures to ensure prevention of injury or illness.

There is such a problem of delay with forms that have to be submitted. We can see that there is just chaos and no systems.

Workers are not aware of OH&S issues and rights.

We so often hear complaints but what is lacking is action – like workplace inspections

Participants argued that “management is not serious about health and safety” in the way that it is passive around problems in the workplace, does not comply with the law, and often obstructs workers exercising their rights. More attention however was given to highlighting

the weakness of health worker organisation as a major factor in the neglect of OH&S in public health institutions. This criticism related to three areas:

- the lack of worker control over workplace health and safety structures;
- lack of capacity, skill and knowledge among trade union shop stewards; and,
- the lack of attention given to OH&S by the public sector trade unions.

We need to give attention to the health and safety committees. Representatives on these committees are appointed by management and not elected by workers. There is no feedback from the health and safety structures to the workers, so they are left in the dark around health and safety. We must see that this is changed.

Shop stewards don't have a clue about health and safety, yet it is the shop stewards that workers will bring their problems to. I think we need to focus on the trade unions and the shop stewards.

The trade unions are not doing enough. They are not paying attention to workers' issues. The trend is to rather focus on political issues and to neglect issues like health and safety.

Beyond identifying problems, project participants asserted the value and importance of this kind of project, and education and training programmes more generally, in order to raise the awareness of workers and to develop the skills and capacity of shop stewards around health and safety. Importantly, the challenge of turning discussion and knowledge into action was also presented by some of the participants.



We need trained reps who can help the workers.

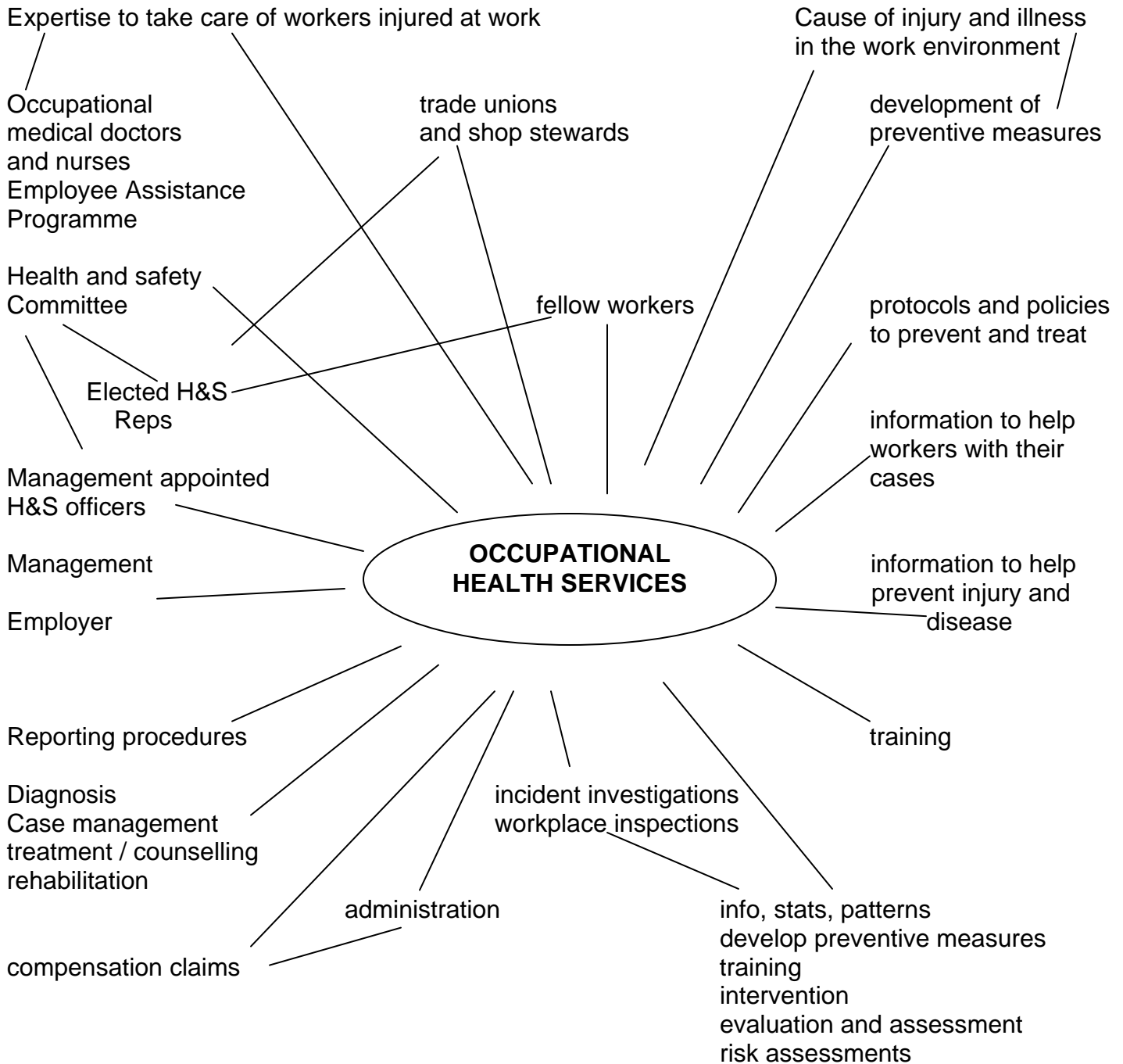
It is important for me to develop my skills and knowledge so that I can assist workers with health and safety problems.

We need this kind of programme because workers do not know their rights.

It is all well and good for us to research and discuss. What really counts is what we do with this. We need action on health and safety issues

3.2 Mapping the system of occupational health services in Cape Town and the role players involved

On the basis of the framework of perspectives, knowledge, and opinions put forward by participants on the basis of their experience of OH&S in their public health workplaces, we collectively brainstormed a map of the various systems, processes, role players and relationships that make up occupational health services in Cape Town.



3.3 Collectively identifying the problems in occupational health services

During and following our brainstorming and mapping activities, we sought to identify and explore the major problems and patterns that had arisen in our collective discussions.

- (a) While we were able to map out a range of systems, processes, role players and relationships that make up the system of occupational health services, participants argued that **this is not a system that functions effectively**, and certainly not in the interests of workers.

Occupational injuries and illnesses are not handled according to any standard procedure.

Investigation and reporting of occupational diseases does not follow time frames.

There are no properly functioning and accessible OH medical services.

There are inadequate and incomplete inspections of our workplaces.

There are so many role players but no systems in place that work.

- (b) Participants identified **management opposition to workers' OH&S rights, their negligence and disinterest, and their bureaucratic obstructionism** (paralleled by the slow bureaucracy of the Department of Labour's Compensation Commissioner) as being an important factor in causing the chaos and paralysis of OHS.

Health workers' experiences of medical practitioners not complying with proper diagnostic and reporting procedures encourage them to see these services working in the interests of management.

The DOH and the CC bureaucracies put obstacles in our way even when we do everything properly. You just sit and wait, and who pays your costs while you wait?

We must be careful what management feeds us. People out there see the policies as belonging to management.

Employers infringe on workers OH&S rights.

- (c) The **ineffectiveness of workplace health and safety structures in representing and communicating workers' interests** and workplace OH&S information was identified as a major reason for the ignorance and neglect amongst health workers of their rights. Trade unions and management were seen as responsible for not facilitating proper worker representation in OH&S in the workplace.

Employers and unions are not complying with the General Admin Regulations regarding the requirement for the election of health and safety representatives.

Health and safety reps and health and safety committees are not functioning as they should be.

Workers do not get OH&S feedback or information on workplace health and safety problems.

There is poor communication between shop stewards, health and safety reps, and workers on OH&S issues in the workplace.

Health and safety representatives are not capacitated.

- (d) Participants indicated that **action by shop stewards is often difficult and often does not take place**, even though workers report their problems to them. The barriers to action by shop stewards that were identified by participants included:

- Inadequate knowledge around OH&S rights, law, policies and protocols;
- Lack of confidence, skills, resources or time to act;
- Lack of support from trade union, clinic staff or management;
- Not confident or successful in engaging management for time off to address problems;
- Not appreciating health and safety needs and problems until personally affected;
- Not knowing options available to solve problems; and,
- Facing very complicated and inaccessible system of reporting, investigation and action in the current OHS and confronting bureaucratic and oppositional resistance from managerial, government, and medical authorities.

This problem of action is important. I have seen that shop stewards don't act. Members come to shop stewards but they don't take action. They say they are too busy or they are short staffed. They struggle to act. Does that mean they can't learn or change? What does their resistance mean?

- (e) Not only are health workers, their elected health and safety representatives, and union shop stewards not familiar with workplace OH&S policies and protocols, but these policies and protocols do not reflect their needs, interests and experiences. The fact that **workers play no role in shaping these workplace policies and protocols** is an indication of the lack of attention that health workers' trade unions are giving to OH&S.



- (f) The **impacts of a seriously dysfunctional system of OHS**, of management obstruction and resistance to workers' OH&S rights, and of trade union neglect of members' health and safety needs and interests in the workplace are:
- Cases are not recognized or neglected, causing huge physiological, psychological, emotional, and social hardship on affected health workers.
 - Occupational injuries and diseases are left as isolated individual problems and are not recognized as collective issues. A result is that workers are often stigmatized.
 - The causes and prevalence of specific occupational injuries and diseases remains hidden, and therefore there is little basis for the proactive development of preventive measures.
 - Health workers are not recognized as part of a community that requires health care. The important influence that the health and well being of health workers and the quality of health care that they are able to provide is not recognized and positively developed.

3.4 Exploring occupational health services through workplace case investigations

Alongside the workshop discussions and our development of a collective and critical picture of the system of occupational health services experienced by health workers in a number of different public health institutions in the Cape Town Metropole, participants also carried out investigations into occupational health problems in their workplaces. In most instances, these research projects involved investigating cases of workplace injury or illness experienced by health workers in the workplace.

During the first of the three workshops of the PRA project, considerable time was spent on analyzing and discussing two documented case studies of health workers who had contracted occupational TB. These two cases had emerged during a OH&S skills training and participatory research programme that IHRG had carried out with the union Denosa in the Western Cape during 2005 and 2006. This activity allowed participants to relate real attempts by workers to take up their cases of occupationally acquired illness to the general problems of the OHS systems that were being discussed in the workshop. The activity also presented a picture of the kinds of difficulties, questions and challenges that participants would face in carrying out case investigations in their workplaces.

Because participants were carrying out investigations in their own workplaces, these projects inevitably constituted interventions. By initiating investigations into OH&S problems or into cases of injury and illness at work, participants had to engage with fellow workers, supervisors, management, and sometimes with their union structures in a way that was likely to have a real impact on the status quo of relationships and power dynamics.

For the most part, participants undertook their research/investigation/intervention projects individually. In some cases where it was appropriate to the issue and to the nature of the intervention (as with members of the Labour Caucus of the MDHS), group work was encouraged.

PRA participants workplace investigation projects:

- Project 1: Investigation into a case of trauma
- Project 2: Investigation into a case of occupational TB
- Project 3: Investigation into a case of upper limb injury
- Project 4: Investigation into a case of occupational TB
- Project 5: Investigation into 3 cases of occupational TB and an engagement with management on issues related to occupational TB (group)
- Project 6: Investigation into 2 cases of occupational TB
- Project 7: Investigation into weakness of health and safety committees (group)

Much of the time in the second and third workshops of the PRA project was taken up with discussions of the participants' case investigations. This consisted of:

- Reports by participants (and groups) that were both unstructured and in response to questions offered by IHRG facilitators;
- Group discussion of the report facilitated by IHRG which offered a process of analysis, critical reflection, and the identification of new questions and challenges; and,
- An opportunity for each participant (or group) to comment on their learning experience and to identify the next steps that they need to take.



Apart from the specific details of each case, the investigative projects revealed the following:

1. “Management is effectively out organising the unions in occupational health and safety.”

All of the projects revealed that management is calling the tune with regard to occupational health and safety in the workplace and in relation to how and whether occupational health services are functioning. A big part of management's power around OH&S relies on their control of information:

- *Management does not report cases of workplace illness and injury to the health and safety committee.*
- *Management only gives out information when it suits them. When we ask questions, they are just defensive and they postpone giving any answers. Meetings are postponed and information is not disseminated.*

- *We asked management for stats and policies on occupational TB. We asked this by email and in a meeting. We are still waiting for a response.*

None of the projects showed workplace or district management to be playing any kind of proactive or facilitative role with regard to investigating or administering cases of workplace injury or illness. Most of the participants spoke about the hostile and obstructive role that management figures played in relation to their investigations:

- *The assistant director of nursing wanted to know how I had found out about the two cases of occupational TB that I was investigating. It was like I was not supposed to know.*
- *The nursing managers do a lot of obstructing. I keep phoning them without any progress.*

From this project I can see how management likes to do one-on-one actions with workers. It is divide and conquer. If you as an individual don't know your health and safety rights, management is not going to make you aware of them.

The obstruction by management was not only around information and investigation. Participants' projects revealed the lengths to which management went to avoid taking responsibility for their employees' occupational health:

- *Management disclaimed responsibility for the nurse with occupational TB because they said they were not the employer because she came from a nursing agency. This is illegal. The nursing agency is a labour broker and not an employer. The nurse was not aware of her rights, and was made to be the victim.*
- *When we had 3 cases of occupational TB at our workplace the Deputy Director of the district came to speak to the staff. He said that health risks are part of the job and we should spend more time caring for our patients than worrying about ourselves. He also said that if we contract TB then our immune systems are stronger and we are better able to work in the TB wards.*
- *When workers get ill or have a health problem, or with something like alcohol abuse, the first steps of the management are punitive. They do not treat patients like this.*

In contrast, trade union activity and involvement was not evident in any of the cases being investigated:

- *The shop steward only heard of the case through workplace gossip and has not been involved in any investigation.*
- *The worker is a member of the union but did not report her illness to the union.*
- *Shop stewards do not know how to take up compensation cases or how to investigate. They do not get this training in the unions.*

2. “Workers tend to be secretive about health and safety issues. They keep things private that we should share.”

Some of the cases investigated by participants showed the important therapeutic value of a shop steward showing interest in the workers’ experience and in the difficulties they had faced with pursuing their case. Nevertheless, workers were also very guarded about sharing their stories:

- *I was not able to get consent from the worker to share the details of her story. She is afraid of stigma. In fact not everyone in her family even knows.*
- *It was important for her to speak to me because she is traumatized and stressed. Much of this is because of how management has handled her case. But she is also scared of victimization. In fact I am worried that my investigation could be a disadvantage to her. She has a deep fear of being disciplined or dismissed.*

Clearly the culture of sacrifice and silence that prevails around workplace injury and illness (especially with regard to stigmatised diseases) is reinforced by management’s punitive attitude. Interestingly, some of the projects helped to open up some of the patterns of isolation and silence:

- *Since we have been making our enquiries workers are talking more about issues related to occupational TB. Some of them are asking for the policies and protocols.*

3. “The health and safety committees are under a management appointed system and not a worker or union elected system.”

Just as the participants’ projects showed no trade union activity around OH&S in the workplaces and cases investigated, so they also revealed inactive health and safety structures in the workplaces:

- *No report of the incident was sent to the health and safety committee.*
- *Proper investigation could not happen because the health and safety reps do not have capacity or skills.*
- *The health and safety committees in the clinics hardly ever meet. We have taken the issue of occupational TB there but nothing happens.*
- *The role players are dominated by a management appointed system and not one for worker representation. The health and safety co-ordinator, the infection control sister, the health and safety trainer, the occupational nurse, the human resources officer – these are all management appointed positions.*
- *Management appoints the chair of the health and safety committee and then the chair asks for volunteers.*

We must start with the election of health and safety reps among the workers. And they must be give skills and capacity so that the can assist workers with their rights and the processes that have to be followed.

4. "I feel out of my depth...but I have made workers aware."

In carrying out their research/investigation projects participants were getting involved (as health workers and shop stewards) in real cases in their workplaces. This had a variety of impacts on themselves and others:

- *I felt out of my depth about the advice I was giving and whether to refer the worker to a specialist.*
- *I have made workers aware of their health and safety rights, especially around TB. We also discussed how we would be involved in the drafting of policy around HIV and AIDS and TB for the workplace. I also spoke to the health and safety rep about doing workplace inspections.*
- *There is now better communication with management around health and safety. Myself and other workers will now also be going on health and safety training. They are eager to learn and to change their views on health and safety.*
- *I spoke to the worker to get her permission to investigate. I then spoke to the facility manager to get more information on what had been done. I also spoke to the health and safety rep to see their involvement. I am still gathering information. The new facility manager will also now investigate the case further. The person came to me because I am a shop steward and asked me to assist. With my work so far the management has now come to realize that this might be a WCA case. No responses yet as we are currently stuck in a report jam, nothing appears to have been kept with regard to documentation.*

Another very important lesson is seeing how important it is to take a history and to have documentation when you are doing an investigation. Getting a report from our occupational doctor and why this case was never reported to Compensation Commissioner.



5. “If the medical practitioner does not do the proper reporting then the whole chain gets broken.”

The evidence brought to the workshops by the participants’ investigations revealed a number of cases where an incorrect diagnosis by a medical practitioner, the failure of the medical practitioner to make the occupational link, or the failure of the practitioner to submit the required reports, stopped a worker’s case dead in its tracks:

- *We must see the role played by the medical practitioner. If this person does not do the proper diagnosis and reporting then the whole chain gets broken. From diagnosis and making the occupation link, to completing the COID Act forms. And then submitting the forms to the Department of Labour and the employer. Its only with these steps that treatment and compensation become possible.*
- *We must make sure that occupational health doctors and nurses report all cases to the health and safety committees so that preventive measures can be developed.*

6. “With every case we see the same problems of ignorance of rights and the systems not working.”

All of the investigations carried out by participants confirmed that there is no effective functioning system of occupational health services available to health workers in the Cape Town metropole.

- *There are many role players and lots of activity around the 3 cases of occupational TB. But everything moves very slowly and there is hardly any progress. An investigation happened 5 months after the cases were diagnosed. We still haven’t received the report. And when the investigation was done the workers were not even interviewed.*
- *Reed Street Clinic is supposed to be an occupational health clinic for the metro district, in fact it is the only such clinic. But health workers don’t use it. They say that it is because they were not consulted about it. There is also a stigma because it was first set up as an HIV clinic for health workers, so people do not want to be seen to go there. Workers also say that it is inaccessible and many have not even heard of it.*
- *There is not much in the way of guidelines in place with regard to occupational TB, and there are some clinics that do not have any preventive measures.*
- *We got some unconfirmed statistics from someone in the provincial DOH that there are forty cases of occupational TB in the Western Cape. This is alarmingly high.*
- *She used her own sick leave and her own medical aid. Her case went through the GP, surgeon, psychiatrist, occupational therapist, and management. It had a huge impact on her home and family life. Only far down the line was the occupational ergonomic issue identified as the problem.*

We don’t know where to take cases. I keep discovering new role players in OH services who are relevant that I did not know existed. There are no proper svstems in place.

- *She was diagnosed with occupational TB and she followed all the compensation claim procedures. But there was no investigation. Only if there is an investigation can there be an improvement of the preventive measures.*

3.5 Building our collective capacity to engage with the OHS role players

Towards the end of the third and final workshop we made use of an adapted version of the Stepping Stones process in order to develop recommendations from the group of participants regarding how they envisage building the capacity of organized health workers to engage with the “authoritative” role players in the occupational health services – i.e. management, occupational health practitioners, and government authorities. Following the challenge from one of the participants that “**we must equip ourselves**”, participants were asked to identify the steps that health workers, shop stewards, and public health sector trade unions need to take to strengthen their capacity to intervene and shape OHS.

With regard to our trade unions:

1. There must be collaboration among the public health sector trade unions around occupational health and safety.
2. We must share information through networking among the unions so that each union is not having to reinvent the wheel.
3. Our trade union leaders and structures must get involved in OH&S issues and hold OH&S meetings for the members.
4. Unions and shop stewards must make union members aware of OH&S issues.
5. We must get our unions to enforce our rights to access to OH&S information in our workplaces.
6. We must develop appropriate trade union strategies for organizing around health and safety issues in our workplaces.

With regard to capacity development and skills training in OH&S

7. We need a Skills Development Plan where we can access Skills Development Funds for OH&S skills training.
8. We must ensure that those people who go for training in OH&S skills are committed to taking action on issues in the workplace.
9. We must develop the ability to critically review policies, protocols and legislation relating to OH&S.

With regard to cases of injury and illness in our workplaces:

10. OH&S representatives and officers must carry out investigations and give feedback and information to workers around workplace OH&S issues.
11. We must find and investigate cases in our workplaces.
12. We must make sure that our employer has a dedicated person responsible for administering compensation cases and this person must be accessible to health workers.

4. Participants' reflections on their learning experience

At the start of Workshop 2, the IHRG facilitator asked participants to share their understanding of the PRA approach for the benefit of newcomers. This **Reflective Brainstorming** provided us all with an opportunity to check in with what we were learning and to deepen our discussion and understanding of the value of the methodology we were using. This activity is reflected below:

"In most trainings and workshops everything is presented to you. With this PRA it is not all just given to you. In fact it is the participants who bring things in and it is us who decides on any action that we want to take."

"We come with our experiences from our workplaces. By coming here we can get a distance from it and see its reflection. We can reflect on this experience and analyse it. And then like Shabira says, we can decide and take action."

"I think that what is important about this approach is that it helps us understand that we learn by doing. The emphasis on learning through action. When somebody brings a case to you you learn as you go along."

"Here we are allowed to participate. We reflect on our issues. With participation we come up with action. This approach that IHRG uses in its training is a good one. The resolutions or answers that we come up with are actually based on problems that we experience at our workplaces. This is also why my management at Alexandra allows me to come here during working hours, because they know that this will help to solve the problems."

"Reflection is when we look in the mirror to identify a problem. It is also when we network with one another to examine an experience. It is also when we bring an experience from our workplace to a place outside and we can see it from a distance. Then we can analyse it and see what are the problems."

The evaluation carried out at the end of the third workshop of the project gave participants an opportunity to write down the main thing that they learned, what actions they plan to take following this learning, and what the main obstacles and challenges are that they face with regard to improving occupational health services for workers in the Cape Town area. What follows is a selection of comments made in the participants' written evaluation:

Our main learning:

- I have learned to network
- My experience is not isolated
- Health and safety is now a priority for me
- Investigating cases is an important way to learn
- I have found so many resources at my disposal
- Investigations are hard to solve, they open up new questions
- Workers must hear about cases in their workplaces
- Advice cases are very different. You need different approaches, but cases can be used to learn lessons.

Through this project we are seeing the gaps. All the things that are not in place that should be there.

The main obstacles and challenges we face

- The non existence of protocols
- Our lack of access to information
- We forget to network and share our experiences
- Shop stewards don't know about health and safety
- Management likes to isolate cases
- We must try to make OH&S a collective issue

What we can do

- I must seek out more skills training
- I will make more use of my union representatives
- We must find out about workers rights around health and safety
- We must develop skills to monitor management's compliance with the law
- We must facilitate the election of health and safety reps
- We must talk with other workers about health and safety issues and experiences



Following the written evaluation, participants took the opportunity to make final comments. Some spoke of how this PRA project experience has enabled them to make a difference in their workplaces:

- I have learned about the importance of health and safety. And also the importance of doing regular health and safety inspections in the clinic. There is now better communication with management around health and safety. Myself and other workers will now also be going on health and safety training. They are eager to learn and to change their views on health and safety.
- Management is starting to act now because they are aware that we are asking questions.
- I learned a lot. I have now also acted to improve communication in my workplace and to increase awareness. I am now also much more aware of OH&S issues. It was a very good project.
- I had training many years ago. Now with this I feel recommitted.

What was valuable for this PRA project was also the comments that participants made about the methods that were used in the workshop and research experience:



- I have really been through a lot of learning that is full of feeling. What I have learned here is not what I thought health and safety is. I thought it was just about injuries at work. I see that there is a lot of ignorance and lack of awareness among workers and shop stewards. We have to learn a lot in order to investigate. And when I started to investigate, I did not find so many answers as I found more and more questions. It is a can of worms.
- On previous training I get this big file and I don't even know how I must go through it. I just have it without knowing what to do with it. I liked the way everyone participated in the discussions. Now I am learning how to do things.
- This is extraordinary learning experience. It is a personal growth experience. Tremendous. Thank you. What was also important for me was that I came to the Denosa training course with IHRG in August last year. What has been important is the gap, and then coming back to this project. I could test out the theory and see what doesn't fit for me. It helps to have support.

5. Conclusions and the way forward

In the course of this short project, the case investigation work carried out by participants and the process of participatory collective reflection and learning of the workshop activity had several important outcomes. The facilitators from IHRG identified the following:

With regard to the project's findings on occupational health services:

1. The project “uncovered” at least 6 cases of occupationally acquired TB in a selection of public health workplaces in the Cape Town Metropole. The project has certainly highlighted occupational TB as an OH&S issue that needs urgent attention.
2. By investigating and analyzing the fate of these occupational illness cases, and others identified during the project (eg. trauma, upper limb injury), participants identified serious weaknesses and problems in the systems and processes that constitute occupational health services in the Cape Town Metropole.
3. Whatever systems and processes are in place, these are fragmented and disconnected.
4. Role players in the occupational health services are not properly carrying out their duties, and our project uncovered examples of management, medical practitioners and other authoritative role-players obstructing and frustrating basic legal processes with regard to workers occupational health and safety rights.
5. Management finds many ways of individualizing and isolating incidents of workplace injury and illness. We also heard stories of top level management bullying workers by suggesting that occupational disease is something they should accept in caring for patients and by suggesting that they look for other work if they are not happy.
6. One of the levers that management uses to dominate the culture of OH&S and to frustrate the efforts of individual case investigation and worker enquiry is its access to expertise and its control over information.
7. Management domination over a dysfunctional and ineffective system of occupational health services is facilitated by trade union lack of involvement and engagement with occupational health and safety issues.
8. An important question that arises from this project is that even where occupational services exist – such as the Reed Street clinic – workers are not making use of these services. This is one of a number of other ‘research questions’ that have arisen from the project.

With regard to the learning and capacity building process experienced by participants and with regard to IHRG's learning experience, we believe that the outcomes were positive:

9. Participants in the project all expressed strong appreciation for what they found to be a valuable and transformative learning experience. This was said explicitly in relation to the methods used in the project and also to the awakening that a number of participants experienced in relation to issues, struggles and rights regarding occupational health and safety.
10. This awakening is an indication of the value of this project as a contribution to the broader effort to build the skills, confidence, capacity, collective activity, and organisation of health workers around occupational health and safety. It is only this kind of initiative that seeks to build the knowledge and skills of workers in the workplace that can break the culture of silence amongst health workers. It is only by raising their voices, as a community needing proper health care in their provision of a public health service, that health workers can transform the dominant OH&S culture of neglect into a culture of prevention.
11. PRA tools and methods, within an overall collective capacity-building process, offer a means of integrating the process and experience of learning into the objective of capacity building and transformation. Participants set out to undertake activities that will bring change to their occupational health services. In doing this through a learning process informed by participatory, reflection and action methodologies they experience change in themselves and realize the connection between their own process of development and their desire to change circumstances around them.
12. Capacity building and skills development processes such as this project and such as the activities of the PHS Forum cannot substitute for the development of OH&S skills and capacity in the public sector trade unions. However, these participatory learning and research projects are an important tool for stimulating, building, and encouraging that growth inside trade unions. It is important to sustain these networking and learning activities in order to contribute to that organizational development.
13. For IHRG, this experience of piloting PRA methods and tools has been important in pushing us more consciously into developing and implementing action learning and participatory methods of OH&S capacity and skills.

In planning the third and last workshop it became clear to IHRG that we needed to facilitate a process that would provide a space and possibility for our connection with the participants and their learning process to continue. The final activity of the last workshop involved a discussion of how to ensure this continuity. The question we addressed was: **What are the needs, opportunities, and resources for continuing the case work, the networking, and the learning activities of this group?**

1. There is a strong need. This is about following and learning about case work and developing our skills for investigation.
2. There is also a need for OH&S skills training and for this kind of forum for networking and sharing.
3. We also need to discuss and engage with policy and protocol development – for example the TB protocol that exists for the province but that none of us know about.
4. The resources and opportunities that we can make use of are:
 - a. Our workplaces
 - b. Our OH&S meetings
 - c. Our union structures
 - d. The MDHS Labour Caucus meetings held monthly on last Friday
 - e. Contact with IHRG for case work advice
 - f. Possibility of OH&S training – for eg. With IHRG
 - g. PHS Forum meetings.
5. As an immediate step, IHRG is starting the monthly PHS Forum workshops again at the end of June. Funding for this activity is secure for the next six months.



Update

On June 27, 2006 IHRG convened a workshop of the PHS Forum. Fourteen health workers attended, 4 of whom had participated in the PRA Project (3 others had intended to come but were unable to make it). This workshop heard more stories of occupational TB amongst health care workers. The workshop decided that the PHS Forum should plan a programme on occupational TB that would integrate case investigation, with education and training, and possibly try to stimulate campaign work around this issue. Dates for monthly workshops were set for the following 6 months.

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As the facilitators of this project, we in IHRG hope that this report conveys the richness of the group experience and carries the voices of the participant health workers. We acknowledge the valuable participation and contributions of Shabira Adriaanse, Craig Appels, Patsy Collins, Elizanne Hanevil, Jocelyn Hartzenberg, Leonard Hoeane, Lena McKenzie, David Meyer, Duncan Pakati, Nawaal Prins, Katrina Reid, Freddie Sam, Daniel Vermeulen, and Beverley Wilcox. We also acknowledge the participants' trade union organisations Denosa, Hospersa, Nupsaw, Pawusa, Samwu, and Sadnu for supporting and facilitating their members' involvement.

This PRA project also needs to be recognised for its connection to wider programmes and processes. The project provided IHRG and its ongoing programme of capacity building, skills development and organisational development with health workers with an opportunity for a very valuable learning experience.

Further still, the PRA project has opened the door for IHRG and this emerging health worker occupational health and safety network to contribute towards EQUINET's purpose and activity of promoting equity and social justice in health in the Southern African region. The experiences, interests, and needs of the health worker community are important ingredients in developing quality health care for a people centred health system.

Acronyms

CHC	Community Health Centre
DENOSA	Democratic Nurses Organisation of South Africa
DOH	Department of Health
EQUINET	Regional Network for Equity in Health in East and Southern Africa
HOSPERSA	Hospital Personnel of South Africa
IDRC	International Development Research Centre
IHRG	Industrial Health Research Group
MDHS	Metro District Health Service
NUPSAW	National Union of Public Sector and Allied Workers
OH&S	Occupational Health and Safety
OHS	Occupational Health Services
PHS	Public Health Sector
PAWUSA	Public and Allied Workers Union of South Africa
PRA	Participatory, Reflection, and Action
SAMWU	South African Municipal Workers Union
SADNU	South African Democratic Nurses Union
TARSC	Training and Research Support Centre
UCT	University of Cape Town

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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