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WHO CARES FOR HEALTH CARE WORKERS?

The State of Occupational Health and Safety in Municipal Health Clinics in South Africa

by

Industrial Health Research Group
and the
South African Municipal Workers Union

Series Editors

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and Greg Ruiters

ABOUT THE PROJECT

The Municipal Services Project (MSP) is a multi-partner research, policy and educational initiative examining the restructuring of municipal services in Southern Africa. The Project's central research interests are the impacts of decentralisation, privatisation, cost recovery and community participation on the delivery of basic services to the rural and urban poor, and how these reforms impact on public, industrial and mental health.

The research has a participatory and capacity building focus in that it involves graduate students, labour groups, NGOs and community organizations in data gathering and analysis. The research also introduces critical methodologies such as 'public goods' assessments into more conventional cost-benefit analyses.

Research results are disseminated in the form of an occasional papers series, a project newsletter, academic articles/books, popular media, television documentaries and the internet.

Research partners are the International Labour Research and Information Group (Cape Town), Queen's University (Canada), Rhodes University (South Africa), the Human Sciences Research Council (Durban), Equinet (Harare), the South African Municipal Workers Union, and the Canadian Union of Public Employees. The Project is funded by the International Development Research Centre (IDRC) of Canada.

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The Industrial Health Research Group is based in the School of Public Health and Family Medicine at the University of Cape Town. It has provided occupational health and safety (OH&S) services to workers and their trade unions for the past 24 years. The IHRG's work involves capacity building through OH&S education and training for workers and elected health and safety representatives; resource development; conducting accident investigations and risk assessments; providing OH&S and compensation advice for workers with occupational injuries and diseases; and undertaking participatory research programmes.

Samwu, the largest municipal labour union in South Africa, is affiliated to the Congress of South African Trade Unions (Cosatu), the African National Congress-aligned trade union federation. Although open to all municipal workers, Samwu primarily represents manual and semi-skilled workers.

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Summary

After the 1994 elections the African National Congress (ANC) government of South Africa committed itself to developing a District Health System that would meet the health needs of local communities and allow them to give input into the management of their own primary health care. Almost a decade later, in 2003, the National Health Act was passed, which finally gave us an administrative framework for resolving the fragmentation, uncertainty, and insecurity that has historically characterised the implementation, governance and financing of primary health care delivery in our country.

The passing of the Act has meant the restructuring of the primary health care sector and new challenges for primary and municipal health workers, their employers and their trade unions regarding the work conditions that these workers face every day.

The central question of this paper is: "Who cares for health care workers?" To answer this question, we investigated municipal health clinics to explore the attitudes, experience, culture and practices of occupational health and safety (OH&S) there.

We gathered evidence on:

- The existence and functioning of workplace health and safety committees;
- The election of health and safety representatives;
- Workplace OH&S activities, such as incident investigations, hazard inspections and OH&S training; and
- The capacity of clinics to deal with the HIV/AIDS epidemic and to implement programmes to protect health workers from exposure to occupational HIV.

The findings of our research point to a situation of employer abuse and neglect of the health and well-being of health care workers, even though the health care profession publicly embraces the important ethics of service and sacrifice. There is a culture of reactivity and minimal compliance, so that OH&S is all too often reduced to the processing of compensation claims.

We did not find any proactive or preventive procedures in place for identifying hazards, evaluating risks, preventing workplace injury and illness, and maintaining a safe workplace. More significantly, we found that management did not actively engage with workers and ask for their input when developing health and safety practices in clinics.

The biggest health and safety hazard we face in South Africa is a critical shortage of staff, coupled with ever-growing queues of patients, especially those affected by the HIV epidemic. As a result, health workers become stressed and eventually burn out, which makes them more prone to infection and accidental injury. Another consequence is that the quality of the health service that they can provide to the public deteriorates.

Further problems include a lack of facilities, equipment and medicines, which frustrate health workers and add to the already existing tension between themselves and the communities they serve. We identified these problems as caused by negligent OH&S management. However, it is not that simple. The problem is a cultural one, a culture of neglect in the primary health care sector that is reinforced and reproduced by health workers themselves. The need for health workers to recognise this has been one of the most valuable findings of this research programme.

The inclination of the majority of health workers to accept appalling OH&S conditions, to isolate themselves and to individualise their workplace traumas, stress and exhaustion, presents an enormous challenge to the South African Municipal Workers Union (Samwu) and other unions organising in the public health sector. Our discussions during this research also led us to recognise that there will be no proper care for health care workers unless these workers collectively build a proactive, preventive culture and engage their employers about their responsibilities as employers.

Our research programme also helped to spark activism around the problems we were investigating. As activist investigators, the participant researchers in this programme not only explored the prevailing attitudes, behaviours, and practices of OH&S but, in doing so, also began to challenge the silence and neglect that characterises that culture.

Our research focused on:

- asking questions;
- identifying workplace hazards;
- documenting case studies of workplace injury and illness;
- interviewing management and workers in the clinics;
- sharing stories of needle-prick incidents;
- interrogating policy and protocols;
- challenging employers' non-compliance;
- discovering rights and responsibilities; and
- examining the representivity and functioning of health and safety committees.

The above activities constituted an organised effort to build an alternative vocal, assertive, and dynamic culture of OH&S.

However small and tentative, an important outcome of this programme has been the way in which participatory action research has transformed, and can transform further, the culture of OH&S in municipal health clinics. The research therefore presents exciting challenges to health sector unions in how to organise health workers in municipal clinics.

INTRODUCTION

Who Cares for Health Care Workers? is the outcome of an 18-month occupational health and safety training and research programme carried out in a partnership between the South African Municipal Workers Union (Samwu), the Municipal Services Project (MSP) and the Industrial Health Research Group (IHRG) at the University of Cape Town.

There were two broad objectives to the research programme:

- The first objective was to develop a picture of the state of occupational health and safety (OH&S) in the municipal health sector. Through a variety of research activities carried out by participants and through two substantial training/research workshops, the programme sought to gather information that could offer insight into the conditions, experiences, attitudes and behaviours that contribute to the present OH&S situation in the municipal health sector. The report presents a summary and analysis of these research findings by revealing the severe neglect that characterises the culture of occupational health and safety in the municipal health sector. The report also offers disturbing insights into the impact that HIV is having as an occupational hazard on health care workers, and consequently on the service that they provide.
- The second objective was to involve Samwu participants in an education, training and participatory research experience that contributed towards their own personal and collective empowerment. A team of 32 union members carried out research in 38 municipal health clinics. The participant researchers were provided with information and tools related to OH&S and the programme sought to build their capacity as OH&S investigators and union health and safety activists.

The report as the voice of a collaborative experience

In the methodology section of this report we explore the participatory nature of the research programme. One aspect of this collaboration that is important to highlight is the dialogue that developed between the activist-investigation work of the participants on the one hand and the documentation and interpretation of this experience and its findings by

IHRG on the other.

The process of constant research, feedback, training and documentation generated the rich and self-reflective data in this report, which characterises the programme as a whole. What is presented here is the most recent in a line of 'networking' communications amongst role-players and participants over the period from October 2003 to November 2004. This process is illustrated in *Figure 1*.

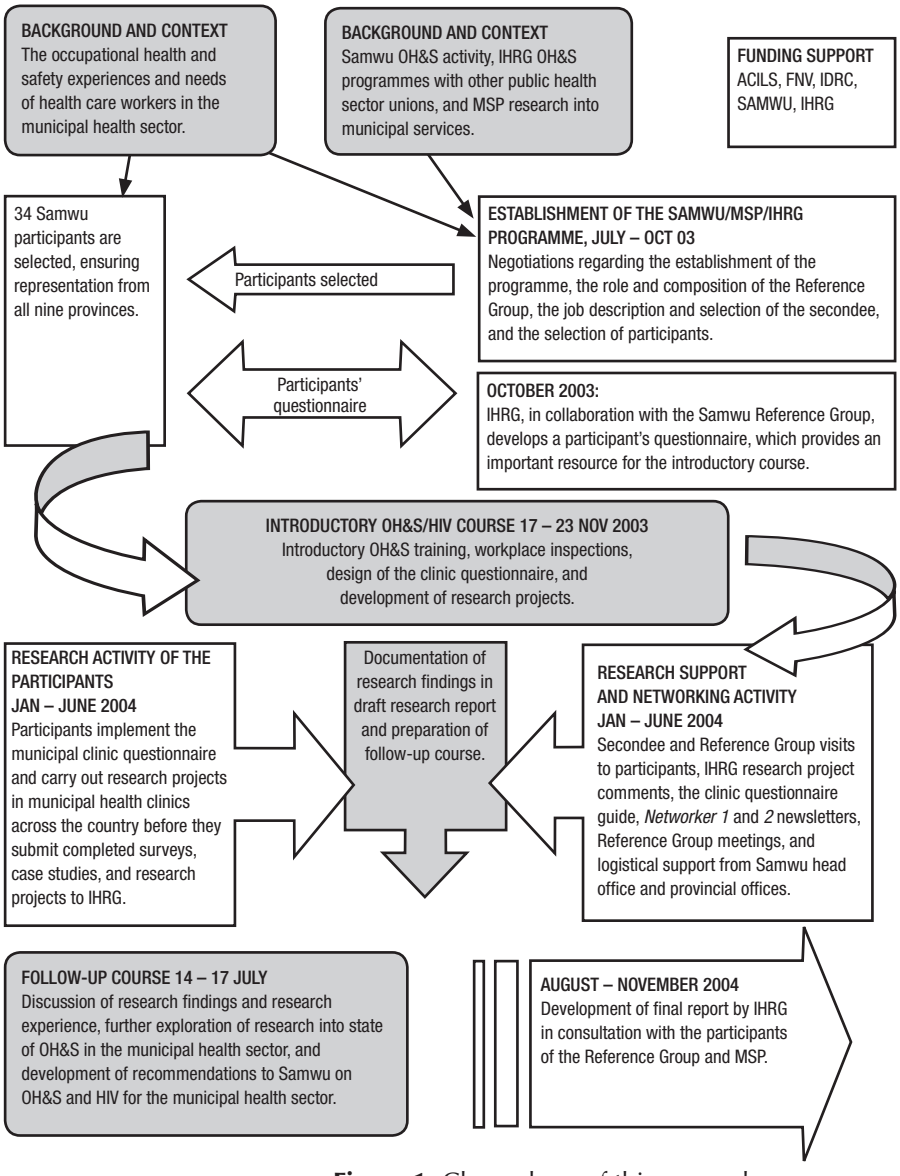

Figure 1: Chronology of this research programme

METHODOLOGY

The research findings of this programme were collected through participant questionnaires, clinic survey questionnaires, participants' case studies and a number of workshop discussions amongst participants. Members of Samwu carried out the research and IHRG documented their findings. The Reference Group that was co-ordinating the research and all the participants in the follow-up course further explored and analysed the findings. We set out to establish a picture of the state of OH&S in the municipal health sector in South Africa. Within this broad research objective, a particular concern of the programme was to explore the experiences, needs and recommendations of health care workers themselves.

Through our research activities we reached 252 workers (including 123 Samwu members), 38 municipal health clinics and 25 out of 284 municipalities across all nine provinces. For budgetary reasons we not able to investigate all municipalities, or all the clinics within a specific municipality, so our sample gives only some insights into a broad cross-section of municipal health clinics in the country. The data we gathered does not allow us to make conclusive generalisations in statistical terms, but it does offer important indications of OH&S trends and patterns in the municipal health sector and draws attention to some of the problems and concerns that affect a wide range of municipal health clinics in South Africa.

Financial restraints also meant we didn't have the resources to interview municipal employers, clinic patients or other stakeholders in order to systematically cross-check the information health workers gave us. Although some participants did engage with management during the implementation of their own clinic surveys, this was not feasible at all of the clinics surveyed.

Ultimately, the primary concern of our research was to explore the experiences, attitudes, behaviours, needs and recommendations of front-

line health care workers. Therefore, our methodology took the form of participatory action research.

Participatory action research

The research team for this report consisted of health workers, OH&S activists, union members and union officials. More specifically, they were environmental health officers, clerical workers, nurses and professional nurses, health support services managers, emergency medical services staff, nutritional advisors, librarians, sanitation workers, waste management officers, cleaners, and HIV/AIDS educators (see *Figure 2*).

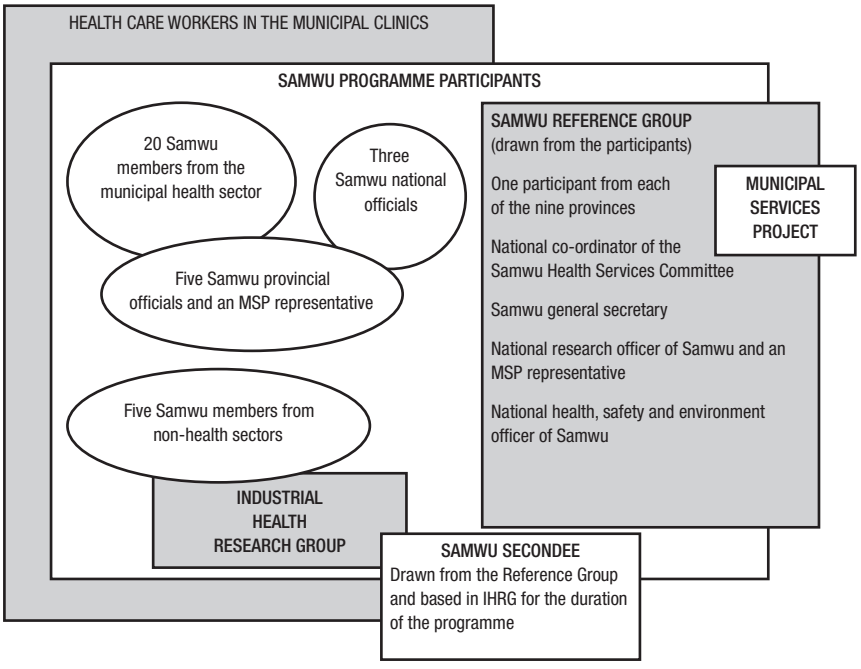

Figure 2: Participants in the research programme

In our research programme, we focused on the methodology of 'participatory action research'. Given that the research programme was investigating the conditions of OH&S in the municipal health sector, this meant that the participants were both the 'object' of their study, as well as the actual researchers. In other words, they were critically investigating themselves (as workers, health and safety activists, and union members) with regard to the behaviours, practices, attitudes, rights and responsibilities that make up the OH&S culture in the municipal health sector.

This organised 'self-research' offered participants an opportunity for critical reflection and, therefore, experiential learning. By encouraging the participants to explore their own experiences, needs and recommendations concerning OH&S, the programme sought to explore and test their individual and collective insights. This provided participant researchers with the foundation for learning and transformation.

Once we had selected participants in the programme, IHRG sent out a questionnaire that asked participants to provide information on themselves and their workplace, and to explore questions related to their occupational health and safety experiences, practices and knowledge. This initial process of 'self-examination' was an individual experience but in the course of the first meetings, participants found they shared many of the same difficult issues and experiences. Most notable here were the stories that workers told of needle stick injuries and the fear of possibly contracting HIV. By gathering and sharing stories, we not only exposed a range of issues related to OH&S and the impact of HIV on health workers, but also showed the empowering value of a participatory programme that allowed people to share stories like these for the first time.

> I have travelled a hard gravel road in my life. It is not the smooth road of the people with money. I am a mother of four children. Two of them are mine and two are adopted. I have also buried one child. I am also a grandmother. When I was a nurse at Baragwanath Hospital doing midwifery, we had to care for the youth injured in the 1976 uprising. I have been a member of a trade union since 1987 and a shop steward since 1993. In this programme it was the first time that I could share my experience of a needle-prick injury and the threat of HIV. I brought this experience so that I could help other health workers to report their needle injuries.
>
> **(Samwu secondee evaluation report)**

The process of reflection and learning made possible by self-research was not only individual. It was also collective, in two senses:

- The discipline and structure of the research allowed participants to engage in collective self-criticism – of themselves in their roles as workers in the workplace, as municipal health workers, as OH&S activists or as Samwu members.

> As health workers we hide the truth. When the Minister comes to visit we like to clean up the clinic and make it look nice. How can they know that we do not have computers if we go to the next place to borrow some? Health workers like to pretend as if they are okay to their superiors and that is why they are always forgotten. We like to hide the problems. Some are afraid to talk because they fear victimisation. Others feel that it is their duty to *provide* care but not to *get* care. Others, we want to shine and get a promotion even when things are not good on the ground. Now I want to go back to the health workers and help them to correct these things.
>
> **(Samwu secondee evaluation report)**

- The structure, discipline, safety, trust, intimacy and openness of a participatory programme encouraged and facilitated a dialogue between individual and collective learning. An important aspect of this participatory process is that it brought health workers and union OH&S activists together around common issues and needs. This allowed workers to see how their individual problems were part of the broader problem of OH&S negligence in the public health sector. Our discussions in the workshops also helped participants to link their personal and collective experiences to wider social, economic, and political realities (Sohng, 1995).

> Participant 1: This research experience has made me realise that I wasn't alone in the problems that I experienced.
> Participant 2: Sharing information has helped individuals to move away from their little boxes and see their common problems.
> Participant 3: We can see the common plights encountering our members – all the stories that I have heard hear today will remain with me. We are re-armed with each other's experiences.
> Participant 4: When I told my experience of contracting encephalitis at work participants became aware of how small, undetected hazards can lead to disease and permanent damage.
>
> **(Follow-up course record)**

To ensure that the research programme developed into a collective experience, we made deliberate efforts to build a communication network amongst the participants. The main instruments for this networking were:

- the visits by the Samwu secondee and the Reference Group members to the participant researchers; and

- the two issues of the Networker newsletter that IHRG produced to communicate provisional research findings back to the participants. (Refer to Figure 1).

As a collective project, the programme embraced a diversity of skills, experience and expertise. More specifically, we encountered:

- a variety of experience and expertise relating to trade unionism, work in the health sector, OH&S activism and research activity;
- unequal skills, experience, knowledge and confidence in the specialised areas of OH&S, training and research;
- different class, cultural and gender experiences, based on historical and social inequalities; and
- a range of personal and organisational energies, allegiances, relationships, capacities and interactions.

In the methodology for our programme, we sought to engage with these differences but inevitably the power differentials allowed certain voices to be heard above others. Although we could not solve this problem, the participatory practices of representative leadership, dialogue and networking encouraged and facilitated participation and experiential learning, and helped some people improve their own levels of learning and confidence.

> The majority of us feel that we were part of a collective project. We networked with IHRG, with other comrades, with other trade unions like Nehawu. We got information from everybody at the workplaces. We gave support to health care workers and to each other as participants.
>
> **(Follow-up course record)**

One of the primary objectives of the collaborative programme was to build the capacity of the participants as OH&S activists. We tried to achieve this in the following two ways:

- *Establishing representative union leadership over the programme:* At the outset a Samwu Reference Group was established as a union structure that would provide overall leadership to the programme. The Reference Group brought together Samwu's health sector, OH&S and research experts, as well as provincial representatives drawn from the participants. Its primary role was to represent the interests and needs of Samwu and its member-participants in the development and implementation of the programme through a

liaison with IHRG. It also offered an opportunity for the worker members of the Reference Group to develop their skills so that they would be able to lead a training and research programme in OH&S. Between July 2003 and November 2004, a total of five Reference Group meetings were held.

- *Building OH&S capacity in the union through a secondment:* A more intensive capacity-building project was undertaken with the election of a Samwu secondee from and by the Reference Group. The secondee worked full-time on the programme in the offices of IHRG. Her primary role was to visit all the participants during their clinic-based research and to provide them with a direct link to Samwu, the Reference Group and IHRG.

Experiential expertise and living knowledge

We have already explored the significance of the self-research methodologies we used in our research. The fact that we had health workers researching health workers was of further significance, especially for those people who were questioned and interviewed, and for the nature and quality of the findings that these interactions produced.

It is difficult to make generalisations about the significance of this fact because a range of factors could have determined the attitudes of those being researched:

- Was the researcher known to the staff of the clinic?
- How did different staff at the clinic (such as management, nursing staff and cleaners) relate to being interviewed by health workers?
- How was this affected by the fact that researchers were Samwu members?
- Did these factors allow for greater confidence and trust or did they discourage openness on the side of those being researched?
- What impact did these relationships and the interactions around the research have on the nature and quality of the findings?

For the most part our experience in the programme has been that having the research carried out by health workers instilled a quality of trust, familiarity, comradeship and sympathy that would not have been possible with outside researchers. As one participant observed, "One will never know what the health workers are feeling and experiencing except that we

can be in their boots" (Follow-up course record).

A result of the sympathetic connection between researcher and those being researched was that the findings were those of 'lived experience'. This is an important feature of participatory research as it generates living knowledge as expertise. This kind of knowledge is not easily surrendered to, or understood by, a researcher from the outside. On the contrary, living knowledge and experiential expertise are produced by people who are sharing experiential expertise and who have the interest and capacity to understand and transform their experiences.

> As researchers, the health workers bring knowledge and experience of health issues to this programme. They bring knowledge of primary health care. They know how the health systems work. They provide the key link between primary health care and OH&S. They have an understanding and experience of OH&S in the clinics.
>
> **(Follow-up course record)**

Consequently, one of the important ways in which participatory action research differs from more traditional research is that it does not claim to be 'neutral'. Traditional researchers pride themselves on being detached. They often claim to have no moral or social interest in what the findings of the research are or if the situation that they have researched needs to be changed.

Participatory action research is different. It is 'objective' in the sense that it can collect data in a non-judgemental, accurate and disciplined way, but it is also motivated by an explicit interest and purpose. One of the clearest purposes of participatory action research is to facilitate change in a way that serves the interests of those participating in the process (although what this 'change' is may only reveal itself during the course of the research).

To understand the transformative impact of the research it is necessary to appreciate the overall conclusion offered by our research findings on the state of OH&S in the Municipal health sector: "There is no care for health care workers". Not only do the conditions under which the majority of health care workers work present a variety of serious health and safety hazards, but there is little evidence of any systematic practice to identify, investigate, evaluate, monitor, remedy or prevent these conditions, their causes or the health impact that they have on municipal clinic employees and the service that they deliver to the community.

The activist-investigation experience of the programme participants

required them to access information, ask questions, conduct interviews, request protocols and policies, investigate accidents, collect stories, share their secret stories of needle stick injury, explore their OH&S rights in legislation, interrogate health and safety experts, conduct workplace inspections and write research reports. This stirring of an organised collective activity is the beginning of an alternative culture of OH&S for health care workers: a culture of caring for health care workers.

During the course of doing their research, Samwu participants constantly found themselves having to intervene, to educate fellow health workers and to engage with management on OH&S issues. As one participant remarked, "There is a relation between being a researcher and being an OH&S activist. When you discover hazards, you face the question whether or not to take this issue up with the management."

To emphasise the value of this research experience is not, however, to exaggerate the impact of this activity on the state of OH&S in the municipal health sector. We are talking of stirrings, only small beginnings. What is important is that we recognise that changing the conditions of OH&S in the clinics or building the OH&S activity of the union are things that have now already begun as a result of the research. The participants of the programme have already been doing both.

The challenge facing programme participants, health care workers and their unions is not to lose momentum, but to build it into greater organised activity.

Problems and difficulties

The collaborative experience of the participatory research programme was not without its difficulties. The following observations and comments emerged during the course of the programme and during programme evaluations:

- The programme felt the push and pull of conflictual relationships and currents within the union. At times this impacted negatively on relations among participants, between participants and the Reference Group, and on the secondee.
- The lack of co-ordination between Samwu's National Health Co-ordinator, Health, Safety and Environment Officer, Samwu's National Research Officer and the Reference Group impacted negatively on Samwu's creative leadership of the programme.
- The Reference Group did not fully develop its potential as a

leadership provider and did not stamp sufficient authority on the programme. Although some individuals in the Reference Group engaged with IHRG very actively, the Reference Group did not often take collective initiative.

- The secondee faced difficulties in her work due to a lack of support from some participants. She was also put under significant stress as a result of steps taken by her employer to dismiss her due to an earlier occupational needle-stick exposure.
- Although very valuable exchanges and communications happened during the research process amongst participants, and between participants and IHRG, the opportunities for networking were not fully made use of.
- Some participants experienced inadequate support from Samwu provincial offices for research access and time off for their research activity.
- Some participants struggled to implement what was a lengthy and quite complex clinic questionnaire. Participants also indicated that the health workers in the clinics should have been mobilised around the research before it was conducted.
- Participants were often not able to implement the research projects that they had planned to do. The problem most likely lay in the planning and preparation process carried out by IHRG in the introductory course.

The above problems are not necessarily obstacles to the collective process of participatory action research. They are in fact the stuff of that process: the realities that make the principles and methods of collective participatory programmes all the more valuable and necessary.

Despite these problems, the overwhelming experience of the participatory methodology was one of an incredible blossoming of individuals on their journeys of discovery and a rich experiential learning process for IHRG and Samwu.

> When I started I had a fear of the unknown. I have learned to write reports, to collect information from the health workers, to identify occupational health hazards and diseases, and to assist in inspections. I learned to network and to face the challenges of health workers. I shared my stories. I gave support to the participants in their research projects. I learned how to work in a team. I learned to have confidence in me.
>
> **(Samwu secondee evaluation report)**

Defining the 'workplace' and the 'health worker'

Finally, it is important to define the workplace that is being discussed in this report in order to identify the kinds of hazards that municipal health care workers may face. Through the participatory nature of the work the research participants themselves defined the workplace as follows: "Our workplace includes the clinics, the mobile clinics, the communities we serve, someone's home, public roads, the schools, taverns, shebeens, where our work requires us to go. We need to be creative in covering all situations in which we provide municipal health services. Some of us travel in our work, so we need a mobile approach to OH&S." (Follow-up course record)

Health care workers, in turn, were defined by the research participants as "those directly or indirectly rendering health services in the municipality and making it possible for health services to be implemented. This includes all levels of workers: medical doctors, nurses, pharmacists, radiographers, environmental health officers, environmental health promoters, emergency medical service workers, social workers, administrative support staff and general workers, including those responsible for clerical work, security, cleaning and medical waste disposal. It also includes sub-contracted staff and non-governmental organisation employees who provide services through the clinics and volunteers."

This broad definition of health care workers is important. It gives us the greatest room to explore who is exposed to which OH&S hazards, what the different work activities are that can expose these employees to hazards and who should be considered when OH&S training programmes, policies and protocols are developed. This expanded definition of health care workers is also important because many professional health workers are increasingly being forced to work outside their areas of expertise or job description due to staff shortages.

We note that the needle-stick protocol only addresses the professional staff. What about the other municipal health workers who are at risk of exposure to hepatitis and HIV? For example, there is the story of a clerical worker at the Ladismith clinic who was stuck with a needle while she was transporting used needles to the hospital for incineration.

(Follow-up course record)

THE STATE OF OH&S IN THE MUNICIPAL HEALTH CLINICS

Municipal clinics and the transformation of primary health care services

When the African National Congress (ANC) was elected to government in 1994 it inherited a primary health care system that was not only inadequate and discriminatory, but also fragmented and inefficient. Because the 1977 Health Act had allocated the provision of primary health care services to both provincial governments and local authorities, there was considerable duplication, overlap and confusion about authority, responsibility and expenditure. The newly elected ANC government committed itself to restructuring and transforming South Africa's health care service through a Primary Health Care (PHC) Approach[1] and through an organisational framework called a District Health System (DHS).

The DHS is regarded internationally as the best vehicle for delivering the PHC Approach. A DHS is defined as "self-contained segments of national health systems that deliver primary health care to communities,

[1] The PHC Approach is a philosophy and a conceptual model for an ideal health system. It formed the basis of the 1978 Declaration of Alma-Ata, which promotes essential health care base on practical, scientifically sound and socially acceptable methods and technology, made universally accessible and equitable at a cost that is affordable, with community participation. It includes social upliftment of the community as a whole through, amongst other things, the provision of clean water, household food security, a clean and safe physical environment and mental well-being. The PHC Approach is more than the provision of 'primary level services' that are typically provided in clinics and mobile services. It envisages a seamless referral system from the community all the way to the most sophisticated health care available (Health Systems Trust, 2002: 1)

thereby improving the ability of health systems to address needs at the local level, and promote grassroots input into their management" (Centre for Policy Studies, 2003: 5–6).

In 1994 the Department of Health began working on new national health legislation and policy. One aspect of this was to legislate for the establishment of a DHS. Initially, it was assumed that the Department of Health and the district health management structures would be part of a single national system of health administration. However, since 1994 this scenario has been dismantled through the devolution of certain health responsibilities to provincial and local government.

Until the passing of the National Health Act in 2003 there was considerable disagreement on exactly which decentralised level of government should administer and finance the DHS. This led to considerable confusion, anxiety and fatigue amongst primary health care providers. As we point out in our findings later in this section, this environment of uncertainty has caused insecurity and stress amongst front-line health workers.

The new National Health Act (Act 61 of 2003, Section 29) gives responsibility to provincial governments to establish, administer and finance the District Health System.[2] Provincial authorities are required to establish health districts (and sub-districts) that correspond to district and metropolitan municipal boundaries. The establishment of local level health service providers must take into account issues such as equity, access, the need to overcome fragmentation, local accountability, quality of service and sustainability (National Health Act No. 61 of 2003, Section 30).

As far as municipal clinics are concerned, the prescriptions of the 2003 National Health Act and the diverse situations that exist on the ground suggest a difficult period of transformation ahead. Historically, the municipal health clinics were directed to offer a core package of primary health care services. Their task, according to the 1977 Health Act (and subsequent amendments) was to focus on the prevention of communicable diseases, the promotion of community health, the capacity to offer very basic treatment for injury and disease, and the provision of essential medicines. Because of varying local and provincial circumstances,

[2] This Act was signed by president Thabo Mbeki in June 2004. There were more than a dozen drafts of the legislation, all of which indicated PHC as a municipal function. The shift in the final draft of the Act making PHC a provincial function was therefore a significant change.

municipalities were also obliged to "co-ordinate such services with due regard to similar services rendered by the Department of Health or the provincial administration of the province." The Minister of Health was empowered by the 1977 Health Act to also delegate additional service responsibilities to municipalities for which they would be refunded (Section 20).

Over time, however, municipal clinics have taken on additional services that have pushed them beyond their core function of health promotion and preventive services and into providing more and more curative services. This has happened as a result of communities using the municipal facilities that are most accessible to them, and often because of a lack of delivery on the part of provincial services. For the most part, this extension of services has not brought more funding or additional staff. As a result, municipal clinics have felt the strain of a higher workload and stretched resources (Reference group meeting record, November 3, 2004).

One of the most significant experiences of the division of services between provincial hospitals and municipal health clinics has been related to HIV/AIDS prevention, care and treatment. Given their focus on prevention and minor treatment, municipal clinics have provided voluntary counselling and testing (VCT), and treatment for the prevention of mother-to-child transmission (PMCTC) as well as for opportunistic infections. However, it is not the task of municipal clinics to provide ARV treatment – for which they must refer patients to provincial hospitals. Again, there is a problem of access and a fragmentation of services that an effective ARV rollout should seek to resolve (Reference group meeting record, November 3, 2004).[3]

How then does the new National Health Act of 2003 seek to address the challenge of integrating fragmented health services? The Act first states that local authorities are obliged to provide 'municipal health services' which relate to environmental health issues such as water quality, waste management, environmental pollution, air pollution, and communicable diseases. With regard to medical health services, the National Health Act directs the provinces to take over the primary health care services that have historically been offered by the municipal clinics. Services should become integrated and, where possible, offered by one facility, but the staff and the

[3] It is true that some municipal clinics are being used as test sites for ARV treatment – but this is mostly with donor funding.

facility should now become the responsibility of the provincial authority. Simply put, municipal health workers would then become employees of the province (Reference group meeting record, November 3, 2004).

The National Health Act of 2003 (Sections 1 and 32, following Section 156.4 of the Constitution) also allows provincial governments to delegate specified services to municipalities (at a metropolitan or district level) through 'service level agreements', if the local authority can provide the most effective form of delivery and if it has the capacity to deliver that service. Alternatively, the provincial authority can also outsource specific services to private providers.

The biggest challenge in this scenario is financial. For a long time, the larger municipalities have covered their own direct costs (staff and medicines) in their health clinics without being refunded by province. South Africa's six largest metropolitan areas (Johannesburg, Cape Town, Tshwane, Durban, Nelson Mandela and Ekurhuleni) presently contribute R700 million from their rates income to the R1 billion annual cost of primary health care.[4] Can the National Treasury fund the provinces to this extent to take over financial responsibility for delivering a primary health service without access to the tax base of the local authority? If municipalities continue to run the services, will they be funded directly by the Treasury or from municipal funds?

This overview is important because it outlines how municipal health services fit into a wider picture of transformation in primary health care delivery. But it also provides us with a context and background against which to consider at least three specific issues related to our study of OH&S in municipal clinics (each of which will be explored further in this report):

- Health workers felt a lot of frustration, uncertainty and insecurity regarding the transformation and restructuring of primary health care services.
- A substantial part of health workers' frustration arises from their not being informed about, or included in, the process of shaping the new primary health care dispensation. This raises questions about the involvement of public health sector trade unions and/or the extent to which these unions are drawing health workers into this process.

[4] *Business Day*, November 1, 2004

- One aspect of the vision of the DHS is its intention to facilitate engagement and communication between communities and the clinics that serve them through clinic committees or ward committees. Our research points to a serious lack of communication between health workers and the public.

The restructuring of primary health care services

The restructuring of primary health care services is an ongoing and widespread phenomenon. Almost half of the 38 clinics surveyed (47%) described existing and past experiences of restructuring, including freezing of posts, integration of provincial and municipal services, privatisation and the opening of new services. The remaining 53% identified real or rumoured changes in the pipeline.

These changes pointed primarily to the national plan to integrate the primary health care services of provincial and municipal authorities through the District Health System. While some respondents feared the loss of all municipal health services to a provincial service, others spoke of some services going to provinces and others remaining municipal. Most people were concerned that more posts would be frozen and that permanently employed staff would be shifted to contract posts.

> It is a burden, too heavy to carry as no one is coming with the true information of what is happening. It sounds like a forceful removal of service. There is too much uncertainty. We are uncertain as to what will happen with the staff – especially to temporary employees. Many workers are temporary and they are not sure about their job security or about benefits and conditions of service.
>
> **(Municipal clinic survey)**

The uncertainty around the devolution and integration process is clearly stressful for workers in primary health care services. The possibility (or actual experience) of changing conditions of employment, of relocation, and even of job loss, in the context of existing staff shortages and experiences of work overload, would appear to be impacting negatively on the well-being of health care workers.

More than 50% of the clinics surveyed indicated that Samwu had not been drawn into discussions around the reorganisation of the clinic services. This exclusion has clearly contributed to a lack of information, uncertainty and a feeling of powerlessness amongst health

service employees. As one participant commented: "It is frustrating and demoralising since workers are not involved at all and municipal health workers are not sure what will happen to their benefits. It is affecting workers. They are not happy because they were never consulted. The staff at the moment do not know where they stand. Nothing has been said officially to them from management." (Municipal clinic survey)

Another major restructuring concern relates to the privatisation and outsourcing of many municipal health clinic services, although our clinic survey revealed very different experiences and attitudes among municipal clinic staff regarding these developments. The services that have been most commonly outsourced are the Voluntary Counselling and Testing for HIV programmes (44% of the clinics surveyed), the collection and disposal of medical waste (41% of clinics), security (32% of clinics) and employee assistance programmes (13%).

While some clinic workers expressed misgivings about privatisation, others pointed out that private services were often new services and therefore were not being outsourced in the traditional sense of the term. Moreover, no clinic employees said that they felt OH&S conditions were being negatively affected by privatisation. The one exception to this was a suggestion by an interviewee that the Employee Assistance Programme was not used by municipal employees because it was inaccessible as a privatised service.

Interestingly, many workers expressed support for the privatisation of certain health care services because it relieved the work pressure facing clinic staff, as indicated in the following quotes from interviewees:

- "Privatisation does not impact negatively due to the fact that the clinic is understaffed."
- "The staff was also glad in a way because it took some pressure off them in their work."
- "[Privatisation] took some burden off the shoulders of staff – for example, counselling, testing, support and education around HIV/AIDS and STIs. This left the nurses to get on with medical treatment." (Municipal clinic survey)

Not all interviewees felt this way, however, with many sharing the sentiments of this participant: "Workers are concerned that if the services are privatised then they will lose their jobs and benefits, and the conditions of service will change." (Municipal clinic survey)

Whether they opposed, supported or were indifferent to privatisation and outsourcing, the overwhelming majority of health care workers expressed concern about the workload that they are carrying and the additional stress associated with the uncertainty surrounding restructuring.

The culture of OH&S in municipal health clinics is a culture of neglect

Through our research activity and discussions in the introductory and follow-up courses, we defined the role of 'occupational health and safety' as follows:

> The identification, anticipation, evaluation, monitoring, control, and elimination of all workplace hazards in order to prevent workplace injury and disease and to protect workers' rights. (Follow up course record)

Establishing this definition was important for the following reasons:

- It takes the prevention of injury and disease, and not remedy or compensation, as its primary objective.
- It asserts workers' occupational health and safety rights as a priority.
- It underscores the importance of employer responsibilities with regard to the health and safety of their employees.
- It provides a framework for organised activity in the workplace on the part of worker-elected representatives.
- It suggests a vigilant, proactive culture of prevention.
- It points to the need to identify workplace hazards.

However, our research showed that the actual practice or culture of OH&S in municipal health clinics comes nowhere close to this definition. In most cases it is the employer who is defining what health and safety means in the workplace and most OH&S systems appear to be reactionary rather than proactive, only responding to OH&S matters *after* an accident has happened. According to one participant, "There is low OH&S compliance by management. OH&S is not a priority or a problem. OH&S is an irritation. Municipal management…only take action if there is an accident and if workers are responsible. Management is not concerned and they are defining OH&S by failing to give OH&S any clear definition. In fact, OH&S is ignored!" (Follow-up course record)

This culture of 'not caring for the health care worker' is the dominant one in the clinics surveyed. As another programme participant explained, it is not just an absence or a silence, it is a culture of neglect, disrespect and exploitation that is led by employers' disregard for their OH&S responsibilities and for the OH&S rights of their employees.

The challenge for Samwu and other unions in the health sector is to address the fact that the prevailing culture of 'not caring for the caregiver' is deepened, reinforced and continually reproduced by the attitudes and behaviours of health care workers themselves.

Although 70% of our clinic questionnaires indicated that OH&S was regarded as a priority for clinic staff and, according to one interviewee, in most cases workers seemed "very ignorant of health and safety measures and did not know their rights or what procedures to follow". "Our mindsets are a hazard", said another participant, "When we interviewed health workers they said things like, "We are understaffed but we cope well. Patients wait the whole day but they are used to it'. These comments show that health care workers acceptance of poor conditions can make prevention difficult."(Municipal clinic survey)

Another participant commented that, "We are often too busy to complain or to even consider OH&S issues. We take bad conditions as normal. It is a culture of sacrifice and acceptance. All of us – management, HCW's, Samwu – are prepared to accept appalling, very bad conditions, as 'normal' and therefore acceptable. The community also accepts appalling conditions."(Follow-up course record)

This reflection included critical comments about the weakness of Samwu as a labour organisation and activity around OH&S in the municipal health sector: "All of us must take responsibility for not doing enough to address municipal workers' OH&S – the management, the workers and Samwu. Only Samwu can counter the management approach. No one is challenging the municipal management's OH&S culture. Unorganised health workers will remain suffering. Samwu must become involved in defining how we understand our OH&S culture." (Follow-up course record)

In a climate of job insecurity and in the absence of any collective tradition of asserting control over the conditions in which they work, health care workers take on and reproduce the culture of sacrifice and neglect.

One of the most important outcomes of our research programme in this regard was that our investigation became an act of intervention. We provided information about OH&S rights, identified hazards in the

workplaces, encouraged health workers to speak out and to ask questions, challenged management, and raised health workers' expectations of themselves, their unions and their employers around OH&S issues. By bringing OH&S to life through our participatory action research, we began to challenge and change the dominant culture of neglect.

> We raised health workers' awareness of their rights. There is a new willingness and there is a hope that things can change. Health workers want to know the outcomes. Even management wants to know if it can get a report. Our research has also caught the interest of municipal workers in other departments. The circle of organising around OH&S can start anywhere – with training, with research, with compensation problems, with recording case studies. This programme raises for us the challenge of building health workers' OH&S representation and activity in the clinics.
>
> **(Follow-up course record)**

The OH&S hazards that municipal health workers face

> What you find in many municipal clinics, especially in the rural areas, are two things – hazards and miracles.
>
> **(Reference group meeting record, November 3, 2004)**

There are number of potential hazards in most workplaces. A workplace 'hazard' is a condition, situation, product or process that can cause injury or illness to workers. Hazards can be divided into two categories:

- Safety hazards are those that can cause accidents and may result in injury and sometime even the death of a worker. Examples of safety hazards that we identified in the municipal clinics include violence, assault, rape, aggressive and angry patients, carrying heavy equipment, faulty electric plugs, broken chairs, flammable substances, inadequate security, inadequate procedures for disposing of sharps, lack of fire extinguishers, poor medical waste management, slippery floors, unsafe transport, unserviced machinery and broken equipment.
- Health hazards are those that can cause diseases or illness. These hazards can be slow to develop. By the time they are noticed a worker may have changed jobs several times and this makes it

difficult to prove what the conditions or circumstances were that produced the illness. It was not difficult, however, for participants to identify a range of health hazards that they experience at work, which we classified into five main groups: chemical, physical, biological, ergonomic and psycho-social hazards.

Any particular sector of work can experience certain categories of hazards quite intensely. In the case of health workers, the presence and risk of exposure to biological hazards and the subsequent psycho-social impact is prominent.

> My own experience in the clinic made my co-participants aware that one can contract any disease which is work-related because of the congestion and lack of sufficient fresh air. After explaining that I contracted encephalitis because of an outbreak of meningitis, people became aware that small undetected problems can lead to disease and permanent damage.
>
> **(Follow-up course record)**

Because their work involves coming into contact with people carrying infectious diseases, health workers are routinely exposed to dangerous pathogens, such as viruses, bacteria and parasites, which can be transmitted through the air or through body fluids. Participants cited encephalitis, TB, Hepatitis B, and HIV as communicable diseases that are significant workplace health hazards.

But a hazard is only a source of danger. We also need to evaluate the risk of being exposed to or affected by a particular hazard. For example, working with sharp instruments such as needles presents a hazard, but the risk of injury will depend on conditions such as how long the health worker has been on shift, how fast the worker is having to work, what assistance is being provided to the worker, what protective mechanisms are in place, what the lighting is like, whether the worker has access to retractable needles or not and what methods of disposal are available.

Our research revealed that conditions of overcrowding, bad ventilation, inadequate supply and use of personal protective equipment, negligent waste disposal methods, staff shortages and high patient loads, inadequate OH&S awareness amongst clinic staff, an absence of effective protocols and a culture of stigma around HIV/AIDS all increased the risks of workers being affected by these biological hazards.

> Nurses sometimes risk working without gloves because they do not have the gloves, other times because they feel uncomfortable. One nurse said she gets an allergic reaction to the gloves. Nurses felt that the gloves do not prevent needle pricks. Interviews revealed that nurses know that there were policies on needle pricks, HIV policies, evacuation procedures, Employment Assistance Programmes, etc, but that they have not seen these policies as they are in the management's office.
>
> **(Introductory course record, Nyanga Health Care Centre)**

Our research and our workshop discussions moved beyond the most obvious workplace hazards to recognise that hazards must include "all the conditions which affect our psychological, mental and emotional health. We must consider everything in our working conditions, including hours of work, rest periods, staff shortages, and increased workloads due to non-replacement of employees." (Follow-up course record)

Our definition of 'risk assessment' can also go further:

- How aware is a worker of her health and safety rights?
- What access does she have to safety procedures and protocols?
- What OH&S training has she had?
- Does she have representation on any workplace health and safety structure?

All of these circumstances and conditions either impact directly on the health, safety, and well-being of health workers or else they contribute to the risk of workers' exposure to hazards.

The impact of staff shortages

> I would like to share what I have seen at Freedom Square Clinic with Minister Manto Tshabalala because they are up there and they don't see what is happening down here. Nurses are traumatised because of the situation they work in with staff shortages, long queues of patients, and the HIV epidemic. It is very sad at this time of ten years of democracy
>
> **(Networker newsletter 2)**

In its 2003 National Survey of Primary Health Care Facilities, the Health Care Trust reported that there were shortages of health care staff and community health workers in certain categories and that there was an inequitable distribution of PHC personnel across the nine provinces. The survey indicated that there were 33.2 full time equivalents of professional nurses for every 100,000 people in the community (Health Care Trust, 2003: ix).

One of the most important findings of our research was the significance of staff shortages and patient load as an important cause of anger and frustration amongst municipal health workers. Clinic staff identified this as a major factor impacting negatively on their health, safety, well-being and job satisfaction.

Specific examples include the following:

- At Red Hill Clinic, in the Ethekwini municipality (Durban) there are supposed to be six professional nurses seeing 240 patients per day but there are only four. "The clinic staff are always complaining about patient loads. Posts are frozen. Staff on sick leave are not replaced. Staff are overworked and highly stressed."(Municipal clinic survey)
- At Mzamahle Clinic, in Nyanga in Cape Town, there are five professional nurses seeing between 300 and 450 patients per day. "We don't have enough staff. It is too much for us. We cannot cope. It is worse now that we are having afternoon sessions. This is the only clinic in the whole area." (Municipal clinic survey)
- At the Buite Street Clinic in Polokwane, Limpopo, there are eight nurses who see up to 300 patients per day. "The sisters have to attend to many patients at a go. The influx of patients from all over causes stress and exposure to dangerous illnesses." (Municipal clinic survey)

These figures represent a nurse/patient ratio ranging from 1:40 to 1:90, well above what research participants considered to be a norm of 1:35. The pressure and stress caused by these staff shortages therefore needs to be seen as a health hazard having its own direct health effect (i.e. burnout) as well as a condition that increases the risk of workers being exposed to other health and safety hazards, such as preventable needle stick injuries resulting from fatigue or the rush to see patients.

> It was on that day at about 12:30 when I gave a client an injection that I had a needle prick on my left thumb. It was because I worked under the pressure of the many clients that I have to attend to. I was angry because of the shortage of staff. We are usually two working in the family planning unit. But often I am working alone and the queue is long. This is because they freeze posts when the health workers leave and they don't fill them.
>
> **(Networker newsletter 1)**

In our discussions at the follow-up course we saw that there is an interplay of a range of factors that are contributing to the problem of staff shortages and increased workload experienced by health care workers. These include the growth of communities being serviced by clinics, the migration of people from rural to urban areas, the impact of HIV/AIDS, health workers leaving the public health sector, absenteeism, the freezing of posts, public preference for municipal clinics over other primary health care services (most likely due to their relative proximity), and mobile services taking staff away from the clinics.

> HIV in the community creates great stress and demands on the clinic staff. But it is not HIV and AIDS that is driving nurses out of the public health sector. It is rather the work load and insufficient staff and supply of medicine.
>
> **(Municipal clinic survey)**

Apart from the increased health and safety risks caused by a high workload, there is the direct negative impact that high patient numbers have on the physical, psychological, and emotional health and well-being of health workers. The common symptoms of this overwork are burn out, low morale, apathy, demoralisation, stress and depression. In the absence of any effective occupational health service that could help workers deal with these issues, clinic staff tend to use their leave as a way of managing their stress. A lack of energy, absenteeism and resignations from overworked staff further deplete the number of clinic staff and their capacity to do the work.

It is also important to appreciate that other pressures and grievances get added into the mix, such as the following:

- One feature of the present staff shortage is that the remaining overworked staff are being faced with the trauma and stress of increasing numbers of HIV/AIDS patients – a challenge which puts the resources of the clinics and the clinic staff under added strain.

"HIV has increased the workload in the clinic. It has caused low morale and stress. It causes unfinished work in the clinic as there is a staff shortage. It causes daily stress for all – the general assistants, nurses, clerks, drivers, and counsellors. It ends up affecting their families and their health."(Municipal clinic survey)

- A second feature of the staff shortage is that many clinic workers are being forced to work outside their job descriptions – often without appropriate training or remuneration. Our research found cases of nurses working as pharmacists, nurses working as senior sisters without being paid an extra allowance, and nurses being expected to counsel patients who come for HIV tests without having had any counselling training.

  We heard a story of a clinic administrative clerk having to do the job of transporting medical waste and suffering a needle stick injury in the process. Probably the most embarrassing impact of staff shortage came from the Freedom Square clinic near Bloemfontein, where patients are required to clean the clinic before they are attended to because there is no cleaning staff at the facility.

- A third aspect to the negative health impact of a high workload on health workers is the pressure to provide care regardless of the circumstances. As one participant explained, "It is policy not to turn patients back and nurses can be reprimanded for turning patients away. So nurses try to see as many patients as possible. This can result in them making a mistake. If they make a mistake then they can face a disciplinary hearing. This is stressful for the nurses because either way they are wrong."(Municipal clinic survey)

The neglect that characterises the culture of OH&S in primary health care facilities cannot be considered part of the ethic of sacrifice and commitment to serving the community. On the contrary, the findings of our research indicate that one of the consequences of the neglect of OH&S rights of health care workers has been a *decline* in the quality of the health care that they are able to provide to the communities they serve.

Participants related a range of stories to illustrate their awareness of the inadequate service they were providing. For example, the high infant mortality rate in South Africa due to HIV, diarrhoea and pneumonia is an important indicator of an inadequate delivery of primary health care services. While staff shortages seem to lie at the heart of this inadequacy, we also need to recognise a range of other service delivery problems.

For example, the National Primary Health Care Facilities Survey of 2003 reported that 70% of facilities required structural repairs and 58% had inadequate security. While most clinics had water and electricity supplies, many experienced disruptions to these services, as well as inadequate communication infrastructure. A large number of primary health care facilities experienced a shortage of key equipment items such as thermometers, stethoscopes and blood pressure apparatus. Less than 10% of clinics have the full complement of the 25 drugs on the essential drug list. The survey also reported that the safe disposal of medical waste has declined since an earlier survey in 2000 (Health Care Trust, 2003: ix-x).

A remarkable number of clinics did not even have such basic supplies as soap. Although all had wall-mounted dispensers, many – including a brand-new clinic with an NGO attached to it conducting hygiene education – did not have soap in the dispensers (and in the case of the new facility, the soap has never been supplied). This is a matter of concern for any public institution, but for a health care facility it is totally unacceptable.

Inadequate facilities and equipment shortages clearly contribute to an unsafe and stressful working environment. Furthermore, participants and interviewees in our research expressed resentment about the fact that the patients that they serve see health workers as responsible for the inadequate services they receive. Being the target of community anger not only creates stress and anxiety amongst clinic staff, but sometimes constitutes a safety hazard as well.

Participant 1: The community do not understand that the nurses do not make decisions and are not responsible for the shortage of staff. There is even an instance where a clinic was burned down because of dissatisfaction of the community.

Participant 2: It is hazardous for health workers to be on the frontline and to have to deliver health services under these conditions.

Participant 3: Patients talk to each other about the health services and often there can be anger because there is only one sister on duty. The anger is directed at the clinic staff due to a lack of service.

(Follow-up course record)

Health workers felt particular frustration in cases where their municipal employers made promises about health service delivery to the public that the clinics were unable to fulfil, or where municipal councillors sided with angry communities against inadequate delivery from health workers. In one

case it was reported that a councillor "was marching with the community against the nurses in the clinic, complaining about the poor health services and blaming the health workers. This is the same employer who is not taking responsibility for municipal health workers conditions of service. Our working circumstances and management control are resulting in negative communication between health care workers and the community."

During the follow-up course it became apparent that the unions must also take up this challenge and address the lack of communication between health care workers and communities on this issue:

- "We are not involving the communities in seeing how our OH&S and working conditions affect their health needs. Samwu lacks strategy at a national level to address municipal health services problem of staff shortages and the impact that this has on the poor health service delivery to the poor areas."
- "The challenge to Samwu is to identify what are the barriers to allocating resources to the municipal health clinics. Samwu must address community feelings about the health services in the clinics. We must organise for all health workers to send one message to the community and get the patients to understand. Samwu must seek support from the community to fight to improve the conditions of OH&S in the clinics."
- "Samwu must be represented in the health forums and clinic committees where management, clinic staff and the community can communicate."

The state of OH&S structures and activities

An important indicator of the culture and practice of OH&S in a workplace is the existence, constitution, representivity, activity and vitality of its health and safety structures. Through our municipal clinic survey we uncovered a picture of mixed legal compliance on the part of municipal employers with key aspects of the Occupational Health and Safety Act and the Regulations for Hazardous Biological Agents (RSA 1993, 2001). Where there was compliance we found little investment on the part of clinic management, health workers or Samwu in active and informed worker representation or in effective functioning of workplace or district-level OH&S structures.

Of the clinics surveyed, 59% indicated that the clinic was serviced by a health and safety committee. Our questionnaires gathered a variety of responses to questions around how often meetings were held and whether

minutes were made available to staff. Of the clinics that had committees, 63% of them (37% of the total surveyed) said that committee meetings dealt with substantial matters such as inspection reports, workplace hazards, accident investigations, occupational TB, HIV as a hazard, PTSD as a health outcome and preventive measures.

Only in a minority of cases (21%) did the committee or an elected health and safety representative hold meetings with employees in the workplace. In seven of the 38 clinics surveyed, clinic staff felt that their committee was non-functional: "Health and safety committees might be legally there, but they are not functioning. Workers feel that it is not necessary for such a committee because they do not benefit anything out of it."

A similar picture emerged around health and safety representatives. While 60% of the surveyed clinics indicated that they had health and safety reps, only half of these were elected. The rest were appointed by management or were volunteers. In only 15% of the clinics surveyed did Samwu play an active role in the election of health and safety reps. In just under 50% of the clinics we surveyed, the health and safety reps had undergone some kind of OH&S training. This training varied widely in terms of duration, quality, frequency, its contents and who the service provider was.

With this uneven picture of the existence and functioning of OH&S structures in the municipal health clinics, it is not surprising that we found a variety of experiences of access to information and decision-making. Both in the workplaces of the programme participants and in the clinics that we researched there is irregular communication to staff on health and safety issues. In only half of the clinics surveyed did health workers say that they received information on hazards in the workplace and on the health effects of exposure to these hazards. Almost half of our questionnaires indicated that management (or a senior sister) effectively takes decisions on OH&S matters unilaterally.

A clear message coming through from the research is that municipal clinic management tends to regard OH&S as a priority only when a problem emerges, such as a workplace accident or a compensation claim. This attitude is part of a culture of reaction and neglect. It does not see the importance of building a proactive culture of OH&S that seeks to prevent workplace injury and illness.

A more proactive culture would involve workplace health and safety inspections before accidents happen, regular risk assessments, fuller incident investigations, the development of preventive and control

measures, the development of workplace policies and protocols (in consultation with workers), the implementation of an employee assistance programme (EAP), the development and implementation of OH&S training programmes and the proper administration of compensation claims.

Some clinics do undertake statutory workplace inspections but these are generally inadequate. Of the clinics covered in our survey, 56% carried out inspections but only 25% were conducted monthly and only 31% produced reports. Only 22% of the clinics did inspections that covered exposure to health hazards such as HIV and TB. Elected health and safety representatives were involved in only about half of these investigations.

With regard to compensation claims made since 2002, of the 18 claims identified in the questionnaires, 12 were cases of needle stick injury. Various people had responsibility for administering compensation claims, such as occupational health officers, clinic managers, health and safety reps, private doctors, sisters in charge, municipality human resource departments and clerks at the district office. Twenty-two percent of the returned questionnaires indicated that clinic staff do not know who is responsible for administering compensation claims. We discovered a number of cases where health workers have used their own medical aid and their own sick leave for an occupational injury or illness.

Half of the clinics surveyed reported that they do not have access to the employee assistance programme (EAP). This service, which is usually provided by a local authority but in some cases has been privatised, offers psychological counselling, stress management, support and advice around family problems and alcohol and drug abuse, and a system of referral to specialists.

Even where the EAP is accessible to health workers, many expressed reservations about confidentiality and the capacity of the EAP to adequately explore and follow up workers' problems. Clinic workers were also negative because they felt that the EAP could not solve or prevent the problems they face. In our workshop discussions we also recognised that the EAP tends to deal with work stress as an individual's problem and does not facilitate a collective approach to health and safety issues.

Clearly there is important OH&S activity happening in many of the municipal health clinics. But much of this appears to be erratic, shallow, and lacking vitality. Municipal management needs to be compelled to act on the principle that OH&S is no less a priority than any other aspect of its public service. Without informed and elected worker representation, without the participation of employees in OH&S activity and decision-

making, and without a consistent programme of OH&S training and capacity building, a vigilant and creative proactive culture of preventive OH&S is not possible.

The role of Samwu

An important part of our research was to investigate the role of Samwu with regard to the interests and needs of health workers. As indicated above, the findings point to some serious problems. Samwu is simply not a strong organising force around OH&S in the municipal health sector. As one participant put it, "Samwu is not visible to workers on OH&S". Another argued that "Samwu is trying but is wanting due to lack of capacity".

Whether it is a problem of neglect or of capacity (or both), it is clear that Samwu has not played the kind of proactive role it could and should play when it comes to health care workers' OH&S.

We explored this issue in different ways during the course of the programme:

- We asked questions in the participants' questionnaire at the beginning of the programme.
- We discussed the issue at the introductory course.
- We explored the issue with health workers in the clinics through the municipal clinic questionnaire.
- We revisited the question during the follow-up course – especially in formulating challenges and recommendations to put to the union.

Space constraints make it impossible to present all the comments, challenges and recommendations with regard to Samwu that the programme generated. Instead we offer broad areas of concern expressed by health workers (with supporting comments) in order to guide the further exploration and development of recommendations in the union.[5]

What can Samwu do to establish a stronger presence amongst health workers in the clinics?

"Samwu must try to convene meetings with workers at the clinic because it is not easy for them to attend at other venues. We must also get feedback from other Samwu meetings. Samwu should embark on a serious

[5] A fuller report on these findings was sent to the Samwu Central Executive Committee for consideration.

awareness campaign and educate workers about their rights and about how to claim compensation. We must also use this research and follow up with action."

What is Samwu's role in providing education and training, and developing workers' awareness of OH&S?

"Samwu must provide training to members and raise awareness of their OH&S rights. It must give education and advice programmes and workshops on OH&S Act and on negotiating health and safety agreements and policies."

What is Samwu's role in representing workers and ensuring employers' compliance with health and safety laws and regulations?

"Samwu must champion the formulation of OH&S policies in workplaces. Samwu must see that the employer is not complying and it must strategise how it is going to enforce workers' OH&S rights. Samwu must interact with the management on OH&S affecting workers and it must challenge management to comply with the OH&S Act. It needs to play a role at the Local Labour Forum, at the Community Forums, and at the Ward Committees."

What is Samwu's role with regard to building OH&S structures in the workplace and building OH&S systems, policies and practices?

"Samwu must develop a programme for visiting workplaces to assist with setting up OH&S structures and systems. It must help to ensure that there is OH&S Reps and committees. It is also a challenge for Samwu to help to define the role of the reps and the committees. It must empower the members to challenge employers with knowledge and confidence."

How can Samwu facilitate a linking and networking between health workers and other municipal employees around OH&S?

"It is imperative that the programme be extended to all Samwu members in other departments of the municipalities and other sectors of the union since that would be the foundation for Samwu to build on, as there is currently no concrete tool for the union to use as its original weapon to force compliance from municipalities. Concrete recommendations in this regard should be formulated and forwarded to the relevant authorities or structures."

THE IMPACT OF HIV/AIDS

We turn now to a closer look at the impact of OH&S matters as they relate to HIV and AIDS. As the community that takes primary responsibility for the treatment, management and prevention of disease in our society, public sector health workers are at the forefront of the fight against the HIV/AIDS epidemic. Like everyone else, health workers face the risk of exposure to HIV from their sexual partners if they are exposed to their body fluids, and if they are assaulted or raped. Like everyone else, health workers have family members, friends or neighbours who are HIV positive or living with AIDS. Some health workers are themselves HIV positive.

The big difference between health workers and the wider population is that health workers provide health care to people who are HIV positive. This means they are exposed to HIV/AIDS as an occupational health and safety hazard. They are not only in danger of physical infection by the virus but are exposed to a wide range of psychological and emotional stresses associated with the disease.

Being at the front line of treating people infected with HIV gives health workers an unusual opportunity and responsibility to develop a culture of care that is free from fear, denial, stigma and discrimination. This can only happen if health workers are confident that they are protected from exposure at work – ie., if vigilant preventive measures become integrated into an active culture of OH&S.

For that to happen, health workers need to be active agents in shaping those workplace protocols, policies and programmes that are directed towards preventing HIV exposure and infection and towards engaging with the multiple psychological, social and cultural aspects of the disease. By building a culture of care for themselves, health workers can better provide care for others.

> We do not want to disclose our HIV status but we expect patients to disclose it. We expect patients to accept if they are HIV positive but we don't accept it for ourselves. We are trying to provide care for other people but who is taking care of the caregiver?
>
> **(Follow-up course record)**

It is within this framework of seeking to build an active and preventive culture of OH&S – of caring for health care workers – that we used our research programme to explore the impact of HIV as an occupational hazard on the health and well-being of municipal health workers and on the health service that they offer to the public.

When we interviewed municipal health workers about HIV in the communities that their facilities serve, the vast majority of responses pointed to negative experiences. Health workers reported high rates of infection (particularly amongst young people), increasing deaths and an escalation of opportunistic illnesses. Families are falling apart and grandmothers and children have become heads of households. Poverty is increasing, as breadwinners die or become too sick to work. Stigma is rife and people who are infected are often disowned by their families.

There are high levels of mistrust, shame, denial and fear. People are blaming one another and sometimes there are even accusations of witchcraft. Women are especially vulnerable due to the high level of rape and gender discrimination. There are many funerals.

We had some discussion in the follow-up course about the problem of getting access to social grants if you are HIV positive. In some provinces people can only get access to the grant for nutritional food when they are in Stage 4 of the disease (in which case they are very sick with a very low CD4 count, like a "living corpse"). It would be better if patients could access a grant *before* they become so sick. Health workers can also advise on this because they know the patients. It is also very important that people have greater access to clean fresh water if they are sick with HIV/AIDS.

We did not only hear stories of tragedy in our research. Some people have been touched with awareness around HIV/AIDS. In some communities, increasing numbers of people have become confident about their rights and less concerned about stigmatisation. They come for testing or to seek out counselling. Support groups have been established and NGOs with volunteers have set up networks for home-based care. Lay counsellors are being trained and are sometimes working in the clinics. Even in some rural areas where people do not usually discuss sex issues, there appears to have been some progress.

The impact of HIV on workloads in the clinics

The growing HIV epidemic is impacting hard on the clinics that offer primary health care. While municipal clinics are not responsible for the provision of anti-retroviral (ARV) treatment[6], they are responsible for preventive programmes, voluntary counselling and testing, prevention of mother-to-child transmission, and for the treatment of opportunistic infections.

The impact of these responsibilities is felt first of all in an increase in workload on facilities that are already suffering from a shortage of staff. The heavy workload creates stress amongst health workers. Health workers are also feeling the emotional and psychological impact of dealing with the trauma and despair and suffering that accompanies an epidemic of an incurable disease.

Most severe as an OH&S issue is the frequency of incidents where health workers are potentially exposed to infection with HIV. The problem is not just the presence of the virus as a hazard. More problematic is the high degree of risk of being exposed to the virus due to the poor OH&S conditions in which most health workers work. The risk is increased by the pressure created by long queues, inadequate training and awareness around HIV, and the absence of needle stick protocols and HIV workplace policies.

> The HIV rate is very high in the community. This means that there is an overload of patients for the clinic and morale is very low. It taxes the health workers psychologically because we deal with these patients daily and there is a shortage of the medication that we are able to supply. The stigma is also bad and there is often discrimination. The workload leads to burnout syndrome and to more sick leave and depression. Because there are special rooms for VCT and PMCT there is no confidentiality.
>
> **(Municipal clinic survey)**

One clinic reported that the number of patients had tripled due to HIV while another said that five out of every seven patients attending their clinic were HIV positive. This increased workload meant that staff were working longer hours or else they were rushing each consultation so they

[6] With the exception of some municipal clinics that are being used as test sites for ARV treatment.

could get through the queue. While one clinic reported that the only way they could deal with this was to refer HIV cases to the provincial hospital, another clinic said that their heavy load was due to the fact that HIV patients were no longer being taken by the hospitals.

There were a few clinics where health workers are saying that they are not feeling the impact of HIV. In the follow-up course we explored this and asked how it could be that some parts of the country are not affected by the epidemic. One of the explanations was that in some rural communities, people are not aware of the impact of HIV because sufferers are hiding their status. It may also be due to the fact that the VCT services are not well established in rural areas, so there is no way of telling who has HIV/AIDS. One participant told how community members who have HIV visit her at home and not at the clinic because they do not want other people to see them.

In addition to the stress caused by an increased workload on a shrinking staff is the emotional and psychological trauma and distress experienced by those who are dealing with the devastation of HIV/AIDS every day. One of the serious problems that health workers can experience with a killer epidemic disease is that the grief just piles up. They do not have time to come to terms with one death before another one happens. This can lead to ongoing grief that prevents health workers from processing their experiences and feelings. They start to deny their experience, express anger and become depressed.

Another emotional problem that health workers expressed is one of powerlessness when they are confronted with the helplessness of many patients' situations: their illness, their medical treatment needs, their financial problems, their isolation and rejection by family and community, and their struggles to accept their condition.

> It is painful. You see all the stages of HIV and you feel helpless. Patients are very sick and people are dying. Health workers develop low morale as they see patients deteriorate. It taxes them emotionally and psychologically. They want to do more for the patients. Sometimes we have to counsel HIV positive patients and they can get very distressed and even aggressive._
>
> **(Municipal clinic survey)**

Interviewee 1: I am counselling but no one is counselling me. I take my stress home and misplace it on my family.

Interviewee 2: There was one day when a 22-year-old girl came for the results and the sister had to tell her she was positive. The girl collapsed in the room with her mother outside who did not even know that her daughter was coming for results. The sister did not know what to do because she was not trained as a counsellor. Really, this situation of staff shortage is hurting._

(Municipal clinic survey)

A particular emotional and psychological aspect of HIV/AIDS that affects the community and health workers alike is stigma. Stigma is a mark of social disgrace that is put on someone who is thought to have done something culturally or morally wrong. People fear HIV so they try to deny that it can happen to them. The easiest way to do this is to pretend that it only affects "other kinds of people".

Stigma prevents people from talking openly about HIV. It creates a silence that is an obstruction to awareness and education. Stigma prevents people from seeking testing or counselling. It prevents people from revealing their status. It even prevents people from taking preventive measures, since these may appear to be an admission of positive HIV status. Stigma isolates and victimises HIV positive people. It can tear families and communities apart.

Our research indicates that the problem of stigma works in a number ways in primary health care facilities:

- There is the stigma that HIV positive people feel coming from the community and which prevents them from being tested or seeking treatment.
- There is the stigma that HIV positive patients feel coming from health workers who are discriminatory or aggressive.
- And there is also the stigma that clinic staff feel coming from one another in the workplace.

All three types of stigma contribute towards a mistrust that is a major obstacle to the development of effective HIV treatment, management and prevention programmes.

Participant 1: Health workers often distance themselves from patients who are HIV positive because they don't want to be drawn into all their problems. But it is also stigmatisation. And they break confidentiality because they talk about those patients amongst each other.

Participant 2: To avoid the stigma some patients will travel many kilometres instead of using the closest clinic in their community.

Participant 3: Some staff still discuss their patients during lunch breaks. The HIV/AIDS counselling is done only in two rooms in the clinic. Everybody who visits those rooms is identified as HIV positive. It is not healthy because it prevents people from coming for testing.

Participant 4: Due to the stigma, patients take longer to come to the clinic for HIV tests and then when they come it is very late in the disease.

(Follow-up course record)

Stigma creates a tension and a silence in the clinics that is contrary to an open and vigilant culture of health and safety. In our research we experienced a powerful challenge to this culture of silence. A significant number of participants and health workers broke their silence about their experiences of needle stick injuries and the trauma of being in danger of testing positive for HIV. One participant even told us how she had tested herself secretly after a needle stick injury so that nobody would know.

Clearly stigma plays a huge role in pushing health workers to keep these experiences a secret. And yet, providing health workers with the confidence to share such experiences can have an enormously important effect in building an active OH&S awareness and practice around HIV as a workplace hazard.

I was not aware that a needle stick is an 'injury on duty'. I was not aware that my employer was supposed to pay my hospital fee and also that I did not have to use my own sick leave for this occupational injury. I did not get the proper counselling that could prepare me for the outcome or that could help me disclose to my family what had happened. It was a bad experience. Now I want to give advice to other health workers so that they can be aware of the dangers and their rights around the needle prick.

(Follow-up course record)

In the course of the research programme we heard nine stories of needle stick injuries amongst workers. While none of these people tested

positive, they each tell a tale of incredible trauma and distress. With a concern for the OH&S conditions surrounding these incidents we offer the following extracts:

Worker 1: In 1998 while I was transporting sharps containers to the Ladysmith provincial hospital for incineration, I was pricked by a used needle. Back then sharps containers were made of cardboard boxes.

(Municipal clinic survey)

Worker 2: It was such a frightening experience. I was suturing an episiotomy when I felt something on my hand. I inspected it and found that the middle finger on my left hand was covered in blood under the glove. The glove was faulty and the blood had leaked in. I had open cuticles on my hands._

(Municipal clinic survey)

Worker 3: In September 1999 I visited the rural areas in a 4×4 vehicle with medical equipment to provide TB care to patients living there. The vehicle had a 500ml sharps container for disposing of sharps, like needles. The sharps container had been removed to empty and had not been returned. A patient I was attending to pulled away as I was preparing to inject him so I decided to recap the needle. That was when I pricked myself. I was stunned and did not tell the patient._

(Introductory course record)

Stigma also plays a role in shaping the way that community members are treated in the clinics. One of the most difficult stories we heard during the course of the research programme was a presentation given by an activist from the Treatment Action Campaign about her experience of neglect and abuse at a municipal clinic in 2002: "No services are offered for the HIV positive patients. The sister said to me 'I told you the sexually transmitted infection places you at risk of HIV. Now you have contracted HIV. There is no grant for you. You must get a job and fend for yourself.'

"After I found that I was HIV positive, I cut myself and was too scared to go to the clinic for treatment from this sister. I went to the office of the AIDS Council where the lady treated my cut and asked me why I had come to her and not to the clinic. The health workers in the clinic mix their personal feelings. The patients' clinic cards are pink and have an M stamped on them for the HIV positive patients. There is stigma and discrimi nation."(Introductory course record)_

Measures in place to prevent the spread of occupational HIV in the municipal health clinics[7]

In our survey of clinics we gathered information on needle stick protocols, statistics on reported needle stick incidents and HIV/AIDS workplace policies in order to get some picture of the kinds of measures being taken to prevent exposure to occupational HIV amongst health workers. Our findings showed that only a small majority of clinics had measures in place. Moreover, what is in place is not part of any active, vital or informed practice of OH&S.

Most importantly, the HIV procedures and policies that are in place are typically reactive and not preventive. This is characteristic of the prevailing passive and negligent culture of OH&S.

> The municipality set up is such that management only think of HIV/AIDS as a problem when workers have already developed AIDS. Our study of the policies in Ekurhuleni show that they are mainly concerned with compensation and the issues of workers who are already infected. They do not address issues of education and awareness and preventive measures. The guidelines on needle stick injuries at work also deal with the protocol to be followed to deal with an incident. But it does not cover the education of the workforce in how to avoid being pricked by a sharp object.
>
> **(Municipal clinic survey)**

A second typical feature is that the procedures and polices that are in place tend to be inaccessible to many of the workers: "Management in the clinic tend to create an impression that only nurses can be pricked by needles. But they forget that it is often the cleaners who have to deal with spillages and with the disposal of sharps. The policies are written in English and in a sophisticated style that is inaccessible to the general workers. Sometimes these policies are even stored away in the management office so that workers do not have access to them."

Eighty-three percent of the clinics surveyed said that they have a protocol in place in the event of a health worker being exposed to HIV in the workplace. In most cases staff said that they were aware of the contents of the protocol and that staff do feel confident enough to report an incident. However, we also gathered many expressions of caution and

[7] It is anticipated that the HIV/AIDS Framework Agreement that Samwu is seeking to establish with Salga will address many of the issues raised in this section of the report.

doubt on this issue. As one participant observed, "Staff will not report [their HIV test results] because they are afraid of the results being known by management and that they might be fired. We are scared of the stigma if we test positive. Others would not be prepared to know their status. There is not much emphasis on reporting needle stick injuries and there is no confidentiality among the clinic staff. We are afraid of disclosing. They are afraid to be tested in case they are positive. Some staff members do not know that they should. Some are confused and scared and don't report due to the trauma they go through."

Most of the submitted clinic questionnaires indicated that statistics for needle stick injuries were available, although one participant from the Western Cape is still being obstructed in her efforts to get statistics from the Director of Health in the City of Cape Town. The statistics that we obtained from 12 clinics reported 30 needle stick injuries in the period 2000 to 2004. In only 20% of clinics that have protocols were workers and/or their unions involved in developing the HIV protocol.[8]

With regard to HIV/AIDS workplace policies, 64% of the 38 clinics surveyed said that they had a policy. In 18 clinics, workers know about the policy and in 15 clinics workers know the content of the policy. Unions were involved in developing the policy in 12 clinics. The main issues covered by these policies include counselling, testing, AZT treatment, discrimination and confidentiality, prevention programmes, needle stick and rape incidents, accidental exposure procedure, guidelines on how to handle HIV positive patients, awareness education and exposure risk profiles. Six participants submitted copies of clinic HIV workplace policies as part of their research projects.

When clinic staff were asked what they thought about the HIV/AIDS policies in their workplaces, some gave positive responses. However, the majority of responses indicated problems of accessibility and application: "It is there but it is not properly popularised. The document is somewhere in the cupboard and on the notice boards. They need workshops and participation. Workers want to amend the policy so as to be worker friendly but most of them are not even aware of the policy. We think it is good because it protects workers, although when it comes to practicality the occupational benefit is not done. Health workers cannot comment on

[8] Reference group members questioned this finding, however, arguing that the protocols that have been applied to the clinics have simply been handed down by the national Department of Health and could not have been negotiated by workers and their unions (Minutes of Reference Group meeting, November 3, 2004).

it because they do not know the content. Although the staff were left out of decision-making they trust that the union took extra caution around issues related to the members on the ground".

The predominant picture that emerges from the survey is that the efforts of the employer with regard to preventive HIV measures are haphazard and inconsistent. Some initiatives have been taken but many remain on paper. If there are HIV/AIDS workplace policies, they tend to be centralised in the municipalities. This means that they are very general and are not directed at the specific conditions and needs of different departments or clinics. Where policies exist, staff are not familiar with the contents. This is either because they were not involved in drawing them up or there was no education taking place.

From the side of the health workers, participants argued that clinic staff do not do enough collectively to address the impact of HIV on themselves in their workplace. They tend to handle the difficulties individually or only respond when there is an incident. They say that they would like to organise themselves to change this situation but are simply too busy with the heavy patient load.

CONCLUSION

An important aspect of the research programme was the dialogue that we developed between OH&S expertise and the experiential knowledge of the participants and the health workers we engaged. This enabled us to develop and sharpen our OH&S investigative tools in the process of exploring the experiences and needs of municipal clinic staff around OH&S.

One result of this learning experience was that we were able to develop flexible and broad definitions of what our workplace is, who health workers are, what hazards they face, what kinds of factors should be considered in assessing the risks that these hazards present, and what sort of preventive measures are appropriate. This pushed us beyond a narrow health and safety perspective that simply concerns itself with reactive procedures, compensation claims and minimal compliance with the law.

While our research indicated that OH&S structures, functions, services, policies and protocols are often in place in the municipal clinics, these are not invested with the kind of energy and activity required to develop an effective preventive OH&S culture. What prevails in the municipal health sector is for the most part a culture of neglect and disregard. A central feature of this passivity is the exclusion and inactivity of clinic staff in the activities and structures of health and safety.

Our research findings indicate that what is consistently missing in almost all aspects of OH&S in the municipal health clinics is a creative dialogue between management responsibility, workers' health and safety rights, and patients' health care needs, in the development of a healthy and safe workplace environment that can facilitate the delivery of a high-quality health care service.

While the focus of this research has been to explore the responsibility and capacity of health care workers and their union in developing an active preventive culture of OH&S, it is very important not to leave the employer out of the picture. Above all, it must be stressed that the legal

responsibility for health and safety rests solely with the employer (and with the national Department of Labour, which has the power to enforce OH&S legislation). Trade unions need to be actively engaged in matters of health and safety but they have no legal obligations.

With this in mind, our research has shown that local authority employers have been at best negligent and at worst abusive in their disregard for the occupational health and safety of municipal health workers. Just as workers need to give life to their OH&S rights, so employers need to take their responsibilities seriously.

With our broader perspective on OH&S we can move beyond a routine list of problems and solutions. We can identify staff shortages, HIV stigma, and uncertainty around the future role of the municipal health clinics as health and safety hazards. By listening to workers' experiences we can understand that it is not just nurses who need to be considered in needle stick protocols, and we can gain insight into some of the emotional and psychological consequences of caring for HIV positive patients.

These kinds of discoveries are only possible through a creative, vigilant and ongoing investigation of the experiences of health workers as the basis for developing a preventive culture of OH&S. Equally important is that the activities of investigation, assessment, monitoring and evaluation that are required in a preventive approach to OH&S are carried out by health workers themselves. For this to be possible, organisation and training are necessary.

This training and participatory research programme offers a model for Samwu and other public health sector unions to work with. An important outcome has been the challenge that it presents to Samwu. A training and research programme can easily be regarded as an activity that is separate from real trade union work. Workshop experiences too often live on only in the certificates awarded to individual participants. But implicit in the experience of participatory action research is the suggestion that the research and learning process is not just "preparation for something else". It is itself the organised collective activity of research, learning, and intervention. Samwu needs to explore not only how it can take forward the recommendations around OH&S that have come from this research, but also how the union can integrate this kind of participatory research and learning experience into its union activities.

In returning to our question of 'Who cares for health care workers?' it is important to highlight the perspective and conclusion that we developed through this programme. The law may offer workers occupational health and

safety rights and employers indeed have duties towards their employees, but these can only be effective when workers breathe life into paper regulations. A vigilant occupational health and safety culture also needs to be built and maintained by the conscious activity of workers. This is how health workers can ensure that the employers take their responsibilities regarding OH&S seriously and that the unions meet the challenge to enforce workers' OH&S rights.

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