A Multi-sectorial Committee in Directing HIV/AIDS-Specific Interventions in the Occupational Setting: An Example from South Africa


ABSTRACT

We present a descriptive analysis of a mechanism to coordinate and implement human immunodeficiency virus (HIV) prevention and care in the occupational setting. The mechanism we describe is a multidisciplinary committee composed of stakeholders in the occupational health environment including unions, management, medical researchers, and medical personnel. The site chosen for the analysis was a South African sugar mill in rural KwaZulu-Natal. The factory is situated in an area of high HIV seroprevalence and has a workforce of 400 employees. The committee was initiated to coordinate a combined prevention-care initiative. The issues that were important in the formation of the committee included confidentiality, trust, and the traditional roles of the stakeholder relationships. When these points were addressed through the focus on a common goal, the committee was able to function in its role as a coordinating body. Central to this success was the inclusion of all stakeholders in the process, including those with traditionally opposing interests and legitimacy conferred by the stakeholders. This committee was functionally effective and demonstrated the benefit of a freestanding committee dedicated to addressing HIV/acquired immune deficiency syndrome (AIDS) issues. We describe the implementation and feasibility of a multisectoral committee in directing HIV/AIDS initiatives in the occupational setting in rural South Africa.

INTRODUCTION

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) is probably the greatest challenge to public health in sub-Saharan Africa today. The situation in South Africa is one of the most dire. The need for a coordinated community intervention is apparent from the increasing seroprevalence demonstrated on antenatal surveys in this country. In 1998 in KwaZulu-Natal, the most populous province, almost 30% of women were HIV positive compared with 1.9% in 1991. Although action is urgently needed on a large scale, one avenue that has been advocated and not fully utilized is the occupational health setting. This setting allows an entry point for HIV prevention, therapeutics, and education.

1Division of Infectious Diseases, University of British Columbia, Vancouver, Canada.
2Southern Australia Center for Rural and Remote Health, University of Adelaide and the University of South Australia, Whyalla Norrie and Adelaide, Australia.
3Columbia University School of Public Health, Columbia University, New York, New York.
4Illovo Sugar Limited, Durban, South Africa.
For the occupational environment to be utilized, it requires cooperation and coordination of all the stakeholders in that environment. Traditionally, these include labor unions as representatives of workers, management, and occupational health care personnel. We demonstrate a way of achieving coordination and direction in tackling HIV/AIDS issues in an occupational setting with the establishment of a committee comprising representatives of all these stakeholders.

We show that it is feasible and beneficial to establish such a committee in this environment. Although some difficulties can be anticipated, a positive outcome was achieved by creating a dedicated committee to address these issues. With this committee structure the response to HIV in the workplace and related issues can be dealt with on a regular basis with multisectoral input.

The occupational setting and HIV infection has been the subject of much conjecture but not extensive published work.\(^6,7\) Established interventions such as peer educators, condom promotion, and improved voluntary counseling and testing are obvious choices that have been studied and proven useful.\(^8–10\) However, the control and coordination of these programs within the occupational setting has not been analyzed or dealt with to any extent. One study in South Africa showed that the majority of HIV/AIDS prevention activities were managed and run by occupational health nurses, while union representatives were not involved in either of these activities.\(^11\) In a follow-up study in the Western Cape, only 2% of HIV/AIDS prevention programs had worker or union participation and only 6% of these programs had management initiative behind them.\(^12\) Mechanisms to utilize the unique stakeholder relationship in these settings have not been established. We proposed a model of stakeholder participation utilizing a dedicated committee, meeting at regular intervals, as a means to initiate and sustain workplace interventions to establish a dialogue about HIV/AIDS in this setting. We will describe the process of initiating this model and the issues and difficulties that were faced.

**SETTING**

The project took place in a rural sugar mill in Mtubatuba, South Africa. It was part of a larger coordinated package of care for provision of preventative and therapeutic care for HIV/AIDS to the sugar mill workforce. The mill employs 400 people. Three unions have a presence at the mill and an on-site medical cen-
tre provides medical care staffed by nurse practitioners and part-time contracted physicians.

RESULTS

The committee structure is outlined in Fig. 1. Outcomes measured included the sustainability of the committee structure and effectiveness. Measures of effect were related to the functions of the committee completed and implementation of programs initiated at the mill (see Table 1).

DESCRIPTION OF THE COMMITTEE

The committee was made up of representatives of the major unions (three), senior management (including the human resources manager), representatives of the occupational health care team (both a nurse practitioner and physician) and a medical researcher. Initially, the committee met on a biweekly basis and monthly thereafter.

DISCUSSION

In the formulation and implementation of this committee, several important themes became evident that related to its sustainability and relevance. These included the requirement of validation and legitimacy conferred from other power structures within the occupational environment, the establishment of a common goal to bring conflicting interests into concordance, and a well-defined delineated area of influence. In our setting the committee consisted of the following:

- The three unions present at the sugar mill had equal representation;
- The human resources manager or assistant human resources manager represented management;
- The occupational health care team supplied two members, the senior nursing sister and a clinic physician;
- The medical research staff provided one member.

The function of the committee was to deal with all the issues relating to HIV/AIDS in the workplace. It was to provide direction and feedback on prevention and educational programs initiated by the medical researcher, to facilitate implementation and planning of these programs, and to establish a forum for dialogue between stakeholders about the disease itself and the local response and reaction to it. Key to its ability to achieve these goals was that it be sustainable, provide an environment conducive to dialogue about HIV/AIDS, bring forth locally generated ideas, and see these into practice.

As in establishing any new power structure that is to be effective, the initial cooperation necessary to allow a committee to be formed, must come from a sufficiently influential force within the management structure of the company and unions to give validity and political weight to its establishment. In our case we experienced this benefit frequently and without it many things would not have been possible. We accomplished this mainly through thorough preliminary meetings between stakeholders where we were seen as an impartial

<table>
<thead>
<tr>
<th>Table 1. Outcomes of Establishment and Functioning of Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustainability</strong></td>
</tr>
<tr>
<td>Committee meeting 2 years after inception on monthly basis</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
</tr>
<tr>
<td>Implementation of planned initiative—Mass educational meetings organized and at 6-month intervals, drop-in educational center in workplace developed, peer educator program established.</td>
</tr>
<tr>
<td>New initiatives generated by committee—New AIDS day events planned and executed, incorporation of other members into the committee structure with peer educators now part of committee structure, union representatives trained in provincial AIDS education program.</td>
</tr>
<tr>
<td>Administration of HIV interventions—Drop-in center and peer educator program administered through committee.</td>
</tr>
<tr>
<td>Feedback on concerns of workers incorporated into educational efforts—Incorporation of psychological aspect of HIV care into education program initiative.</td>
</tr>
<tr>
<td>Feedback of medical care providers incorporated into practice—Use of vitamin supplementation by workers, debate over alternative therapies.</td>
</tr>
<tr>
<td>Conflict resolution—Worker confidentiality, drug access issues.</td>
</tr>
</tbody>
</table>
group with no vested interest. The direct involvement of the Group Medical Consultant of Illovo Sugar greatly enhanced the committee’s effectiveness, as did the openness of senior management to the issue of HIV/AIDS. The credibility and neutrality of the research organization also played a role in the initial establishment of the committee.

The issues that came to the fore in the preliminary meetings of the committee revolved around confidentiality, trust and traditional relationships between the stakeholders, e.g., the traditional role, as in any union management pairing had been one of conflicting interests. This conflict of traditional roles was bridged by a sense of shared interest in the welfare of workers. The effective implementation of the HIV/AIDS preventive program was attractive to management, not only from a social benefit but also from an economic aspect. The union’s incentive was benefits accrued from an access to health care not otherwise available as well as being able to share concerns and suggestions outside the framework of traditional union and management relations.

Once established, defining the bounds of the committee was an important facet of the sustainability of the committee and needed careful attention. The committee bounds were closely defined in terms of the issue of HIV/AIDS, so that other disputes did not become its raison d'être. This was made explicit in advance so that the focus was clear even in preliminary discussions. The bounds of the committee meetings were scrupulously adhered to and other non-HIV issues were not discussed.

The issue of confidentiality was extremely important and the committee allowed a forum for these concerns to be raised in an atmosphere of informed discussion. Here the medical researcher was able to facilitate the discussion with scientific information that was relevant. Assurances were directly conveyed to union representatives and reinforced over time with consistent direct responses from management. Another outcome of this open process of dialogue was that the stigma associated with HIV/AIDS was addressed and amicably resolved by stakeholders. Here the union representatives contributed to opening dialogue about the disease and demonstrating leadership including undergoing training in HIV education. This led to an increase in trust from the workforce, which impacted on their concerns about confidentiality and allowed them to be more open about the disease.

The further benefits of a committee involved in a sustained dialogue about HIV/AIDS in the workplace allowed problems arising from the implementation of the prevention and education initiative to be resolved. The workers’ needs such as the contents of education program, access to sites for promotion within the workplace, allocation of resources, and feedback from workers through the union are examples of some of these benefits.

One of the deficiencies of such a committee was the lack of direct feedback to employees except through a “union” filter. True representation may not naturally occur from the union so care must be taken to allow some mechanism for nonfiltered feedback on programs, content, and confidentiality in practice. This was achieved in these circumstances by community meetings at which all workers were present for question-and-answer forums. These forums were complemented by feedback sessions held with peer educators biweekly in the factory canteen in small groups or singly. Another response to this problem came from within the committee itself, when representatives from peer educators were asked to participate in the committee meetings. This allowed additional input from the workers that was not linked to union activities or policy.

Although difficult to measure empirically, the committee has been sustainable and has had qualitative success. The sustainability of this mechanism was demonstrated over a 2-year period with continued direct participation from all stakeholders in the committee. The effectiveness of the committee can be descriptively identified as the achievement of the tasks it was given to accomplish. This was manifest as completion of the package of care intervention for HIV that depended on the committee to implement, administer, and provide feedback for this project. This included several specific activities that the committee has undertaken over this 2-year period and com-
completed successfully. Coordinating 6-month mass meetings on HIV/AIDS topics in the mill workplace was one of these tasks. The content of these meetings has been derived from consensus among committee members in response to the needs expressed by the various participants. In addition, the committee is charged with the yearly World AIDS Day coordination, which it has successfully accomplished. A drop-in center for HIV/AIDS education opened and is administered by the committee and staffed by peer educators. Feedback has been provided by both workers and medical staff which prompted action. Issues that were raised by workers and unions has been the psychological effects of HIV on individuals in the workplace and a psychologist trained in this area was invited and participated in a meeting with workers at the mill site. The medical care provider on the committee brought the issue of vitamin supplementation to the committee and this was relayed through this mechanism to management and was instituted as policy.

In terms of conflict resolution, the two issues that have been defused have been the aforementioned confidentiality question and most recently access to antiretroviral medications. This latter issue being of considerable popular interest over the time course this committee has been in place. The response of the committee to the workers, union, and medical communities queries was both informative and compelling. The committee was able defuse misunderstandings and provide a platform for idea generation on this question. Over several meetings this issue was central to discussion and with input from all sectors allowed the committee to formulate a draft idea for cooperation on medication co-payment. Although not implemented as yet the cooperation and good will shown in this process demonstrate its effectiveness.

In summary, we describe a mechanism for the implementation and sustainability of an HIV/AIDS education and prevention program in the occupational setting. This involves the formation of a committee comprising stakeholders in the workplace. With this approach, coordination of activities, implementation and institutional response to HIV/AIDS were all improved over a 2-year period. This mechanism may be important in other settings and warrants follow-up and further study.

ACKNOWLEDGMENTS

The authors are grateful for the support of: Centre for Epidemiological Research, Medical Research Council of South Africa, and Columbia University.

Special thanks to the medical staff at Illovo Sugar Limited’s Umfolozi Medical Centre for their help in this study.

REFERENCES

11. Bentley ME, Spratt K, Shepard ME, Gangakhedkar


Address reprint requests to:
Chester N. Morris
Heather Pavilion, Room 452D
Vancouver General Hospital
2733 Heather St.
Vancouver, B.C. V5Y 3J5, Canada

E-mail: cmorris@cw.bc.ca