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Dlamini, T.T.T.

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CHAPTER 5

Task Shifting in Motion: Relationship Dynamics amongst Expert Clients in Healthcare Settings in Swaziland, creating, sustaining or severing Bonds?

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Abstract

Most research on the involvement of expert clients in health care in sub-Saharan Africa highlights the effectiveness and challenges of grafting this non-biomedical cadre onto the delivery of care in medical institutions. Research has also focused on the tensions and conflicts that arise between experienced, core health workers and the newly established cadre of expert clients. This paper goes a step further by illuminating how expert clients navigate the conflicts and tensions they encounter within highly contested work environments, and how they cope with the challenges that result from their engagement in the delivery of care as volunteers. The article argues that relationship building and bonding are key coping strategies, and documents how such relationships are negotiated, sustained, and severed.

Introduction

Although expert clients do many things in many different settings, the consensus among most practitioners, policy makers, and researchers is that expert clients are lay personnel with varying degrees of expertise, who are positioned between credentialed health personnel and patients (Callaghan, Ford, and Schneider 2010; Wilson 2001). They are also sometimes called ‘expert patients,’ ‘peer mentors,’ or ‘peer counsellors’. Expert clients have performed important and high-quality advocacy and care work as part of HIV/AIDS clinical treatment since the beginning of the epidemic all over the world (Zachariah et al. 2010; Kielman and Cataldo 2010). For example, in a context of widespread discrimination in the United States in the 1980s, American AIDS activists advocated on behalf of people with AIDS in health care settings and made demands on policy makers and health care administrators for better, less stigmatizing services (Advisory Committee of the People with AIDS 1983). American AIDS activists documented practices and circulated knowledge regarding the advantages of having people with AIDS actively involved at all levels of AIDS care and treatment (Epstein 1996).

On the eve of the new millennium, in 1999, the United Nations (UN) incorporated a ‘greater involvement of people with AIDS’ (GIPA) policy, which formalized the engagement of people living with HIV (PLHIV) in service delivery. Before the UN’s GIPA policy, the involvement of PLHIV had largely entailed consultations and participation in policy and processes related to HIV. In 2006, the UN formally adopted GIPA as a strategy to augment the expansion of HIV treatment in low- and middle-income countries in response to human resource shortages (Zachariah et al. 2010; Callaghan, Ford, and Schneider 2010). From the perspective of the World Health Organization (2006), shifting some aspects of care to PLHIV as expert clients was meant to build bridges between health facilities and the communities, and to create local jobs and new opportunities for PLHIV. It was also theorized that involving

PLHIV could lead to greater patient satisfaction and better health outcomes (Rogers et al. 2008). Countries in the global South consequently adopted GIPA as a task-shifting strategy in a context of limited human resources, and PLHIV became a core cadre responsible for delivering psychosocial and physical care within clinic-based HIV services. In this way, PLHIV entered health care institutions as expert clients, often as part of short-term donor-funded initiatives, and often with little understanding of what exactly they would do in the institutional settings where they were placed.

The UN's efforts to promote the involvement of PLHIV in the expansion of treatment did not mean that their presence was easily accepted by health care professionals and hospital administrators. But over time, health care workers came to accept PLHIV as service providers. The lack of acceptance was partly driven by stigma and fear, as many workers did not want to care for dying patients who could infect them with a deadly virus. In America in the 1980s, many of those who were HIV positive and fell sick – homosexuals, drug users, prostitutes – were alienated from their families and there was no one to provide care for them, creating a need for expert clients from the outset of the epidemic. In Africa, most of this early care work was carried out in the home by families and community-based institutions (Simbaya and Moyer 2013; Seeley 2014). Since antiretroviral treatment (ART) has now become more widely available in Africa, care responsibilities outside the clinic seem to be shifting to the PLHIV and their immediate family members, such as parents and children (Moyer and Kageha Igonya 2013; Meinert 2014).

The utilization of expert clients in HIV care in sub-Saharan Africa has been the focus of numerous studies. Several studies highlighted the benefits of expert client programs, patients receive essential information and support from expert clients (Lees et al. 2012; Cataldo et al. 2012). It has also been demonstrated that expert clients contribute to improved quality of care

and expanded treatment access (Morris et al. 2009), and to reduced HIV incidence through direct and pragmatic counselling services (Simbaya and Moyer 2013: 7). Likewise, challenges were documented: Rasmussen (2013) shows that expert clients are overwhelmed and suffer burnout due to many tasks they assume, while Njeru et al. (2009) suggests that expert clients compromise the quality of services, and that counselling has become more coercive. Research shows that counselling focuses on regulating the sexual behaviour of clients, specifically, who clients could have sex with (stick to one partner), how to have safe sex (prevent transmission), and when to have children (Simbaya and Moyer 2013). Another group of scholars have documented power conflicts between expert patients and professionals, showing how power is contested, negotiated, or lost, and how expert patients are alienated within the clinical space (Kyakuwa, 2009; Dapaah and Moyer 2013; Lees et al. 2012; Cataldo et al. 2012; Kyakuwa, Hardon and Goldstein 2012).

These previous studies were situated within service delivery and focused on power dynamics. But these did not examine how frictions between nurses and expert clients, and resulting power contests, affect the practices that are valued by PLHIV or the relationships among expert clients. There is a paucity of research on how expert clients navigate the challenges of their job, as a cadre of workers not fully recognized as staff in the health facilities, and how the challenges they encounter in their work affect existing relationships and practices. If expert clients work in extremely challenging conditions, what propels them to keep doing the work and remain productive, despite the challenges? Understanding how expert clients deal with the power dynamics and alienation they encounter is necessary. This article addresses this gap by examining how expert clients – sharing both infection and work challenges – navigate highly controlled and contested workspaces. In addition, it focuses on the various support systems formed to provide solace and refuge from the harsh environment of the work, as well as the consequences of the alliances made. The paper is an example of

travelling concepts and policies (Hardon and Dilger 2011), the baggageⁱⁱ that accompanies both, and how such baggage can potentially harm or constrain existing local practices.

In rich countries the US and UK, it was discovered that expert patient programs promote self-care for sufferers of chronic diseases. Improving the quality of life of patients with long-term conditions was associated with developing self-management skills and increasing patients' confidence and motivation to take control of their lives and support other sufferers of chronic illnesses (Rogers et al. 2008). In the Sub Saharan Africa, the primary rationale for involving PLHIV was their ability to model the efficacy of ART, their input in patient compliance and the benefit of regaining a long healthy life (Kielman and Cataldo 2010). Involvement of PLHIV in delivery of healthcare was promoted by the UN through endorsement of greater involvement of people living with AIDS (GIPA principle) (source). Expert clients are a local form of GIPA. In the process, PLHIV gained experiential knowledge of living with HIV, and became adept in taking treatment, counselling PLHIV to understand the value of ART treatment, resolve challenges of living with the disease and life with ART (Kyakuwa, Hardon and Goldstein 2012). As PLHIV became increasingly involved in the delivery of care in Swaziland, not only were human resource shortages within health facilities addressed, but relationships and norms were reconfigured among health care workers and expert patients. This paper illustrates the different practices and relationships that spring up when expert clients are on the frontlines of care.

Methods

This research was carried out under the auspices of a larger study, the aim of which was to provide insight into the trajectory of patients who fell out of care after HIV diagnosis despite the availability of decentralized HIV services in Swaziland. During the course of fieldwork, expert clients were found to be in the frontline of delivery of care within clinics yet engaged

as volunteers and performed manifold duties. The status quo stimulated the need to examine how expert clients managed to perform their duties effectively and manoeuvred challenges encountered given the difficult circumstances they worked in. The article documents the experiences of expert client working under these conditions and how they navigated the constraints.

The research was conducted in eight clinics in Swaziland, included observation, informal talks, and in-depth interviews over 20 months of fieldwork between September 2012 and July 2014. Eight expert clients were interviewed multiple times, for a total of 17 in-depth interviews. The purpose of the interviews was to gather information about four main areas: the scope of expert client work and how it had evolved over the years; power relations in the different clinic spaces and how they were negotiated; how expert clients managed their many clients; and the high degree of motivation displayed by expert clients. In addition, many informal and more intimate conversations with expert clients during the course of the research were held.

Additionally, eight focus group discussions (FGDs) were conducted with 21 expert clients recruited the clinics. The purpose of the discussions was to compare experiences of expert clients across the clinics. Thus, the questions asked were similar to those asked during in-depth interviews with the eight expert clients: what their jobs entailed, how their work had evolved over the years since they had become expert clients, what challenges they faced in the job, and what strategies they had adopted to manage them.

In total, 21 expert clients participated in the study, five were men and 16 were women. Fourteen were married, seven unmarried. Ten held a high school certificate, the highest level of education among participants, whilst 11 did not. All expert clients were unemployed before becoming ECs. All had known their HIV status for more than five years. Sixteen had

been expert clients for five years or more whilst five had worked for less than five years. Their age ranged from 28-45 years.

The author collected all the data and spent eight months across the clinics doing active observation, conducting interviews and having informal conversations. In-depth interviews and FGDs were conducted in SiSwati (the local language) by the author. All interviews were recorded with permission of the participants. The author also transcribed and translated the interviews into English prior to analysis. Content analysis was done with assistance of NVIVO to code data and identify recurring themes.

Exclusion Criteria

Clinics hired expert clients for specific tasks, ANC or ART. ANC focused expert clients were recruited by Mothers2Mothers and were not part of the study. The study focused on expert clients doing ART related duties.

Ethics

Ethics approval of the research was granted by the National Health Research Review Board in Swaziland.

Study setting

In Swaziland, community clinics are located at the grassroots, as part of decentralization efforts to meet universal access to health. The community has a role in the running of the clinic and form part of a health committee, made of community leaders and clinic staff. The committee safeguards the welfare of clinic staff, and ensure smooth operations at the clinic. The committee collects a nominal fee from patients to pay a security guard, an orderly, and sometimes a grounds man. Expert clients in all eight clinics lived in the same community where the clinic was. While expert clients are largely recruited by nurses and vetted by the committee. All but ART staff at the clinic is government employees. ART staff (doctors,

phlebotomist and all counsellors) is recruited directly and remunerated through funding agencies.

All of the eight clinics were part of the MaxART project,ⁱⁱⁱ which aimed to use ART to prevent new HIV infections, and the clinics thus shared common interventions. The project's primary goal was to achieve universal access to testing and treatment in Swaziland by addressing the barriers to care faced by individuals in need of HIV treatment. The second goal was to understand the needs and realities of people living with HIV and to assess if the ambitious expansion of HIV treatment was carried out within a human rights framework. Lastly, the program aimed to test the 'treatment as prevention' model by initiating ART for all PLHIV, regardless of CD4 count.

In 2011, when MaxART activities were first implemented, all eight clinics started expanding the scope of their services. In two months, the clinics transitioned from providing basic HIV services such as HIV testing and counselling and antenatal care (ANC) to managing mini-labs for point-of-care diagnostics, enrolling patients into chronic care and initiating ART, tracking patients, monitoring adherence, and dealing with donors to report results. In short, the tasks of expert clients began to swell. The clinics in the study served a catchment area of up to 20,000 people.

Findings

Expert clients in Swaziland

In Swaziland, the quest for treatment expansion was stifled by human resources crisis. PLHIV could close the gap considering that they were already involved in the response. The expert client programme started operating in 2006. Funding partners that utilize expert clients in their programs in Swaziland include the International Center for AIDS Care and Treatment Programs (ICAP), the Swaziland National AIDS Programme (SNAP), the Clinton Health Access Initiative (CHAI), World Vision, Médecins Sans Frontières (MSF), the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), and the Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA). They developed a manual for training^{iv}of expert clients, each partner focusing on its strengths and expertise (Ministry of Health, 2007). Expert clients, regardless of the program in which they work, are trained together on a quarterly basis on new or evolving information on ART/HIV, in order to equip them for counselling. Once hired, expert clients are prepared for their role in HIV service delivery through a training of six and one-half days, followed by two days spent in a care and treatment site as a practicum.

Expert clients received a monthly stipend (approximately US \$ 90 at the time of study), which is \$ 30 more than the gazetted income for domestic workers. The stipend is paid by one of the funding partners, ICAP, SNAP, or Global Fund, depending on the mandate of each organization. In each clinic, there were five expert clients; two based within the clinic and paid by Global Fund, SNAP or ICAP; one community-based expert client whose main role was to track clients and two expert clients paid by Mothers2Mothers, a USAID-funded project, they were exclusive for antenatal care of HIV-positive mothers. World Vision paid the stipends for the community-based expert client as part of strengthening the community and health linkages.

According to the official job description from the Ministry of Health, an expert client should be a person living with HIV and is on ART, who models high adherence level to ART, motivates other PLHIV to live a normal life with HIV, and is comfortable to disclose their status and encourage other PLHIV to take ART (Ministry of Health 2007). Becoming an expert client in Swaziland is in two forms: sending an application after adverts are placed in clinics or through a nurse recommendation of a client that has a good record of taking ART. The latter was more common at the start of the program, but in recent years the first approach is more widely used.

Interviews with expert clients indicate that the early days of the program were less competitive, probably since fewer people were willing to publicly disclose their status, let alone share experiences of living with a disease considered fatal. Education level was not a priority so long as one could read and write in English. However, current vacancy announcements for expert clients include a high school certificate as a requirement. Other requirements include good communication, listening, and interpersonal skills; having a non-judgmental attitude; demonstrating care, compassion, and respect for people affected by HIV/AIDS; being self-motivated and committed to working with HIV; and being of good repute in the community (Ministry of Health, 2007). The job requirements applied to all expert client positions, regardless of the particular tasks or funding agency.

Expert clients' primary task is to counsel patients in preparation for ART initiation. Over time, their role expanded, as the scope of HIV services at the clinics increased. As the workload increased, expert clients assumed other tasks either assigned by nurses, or performed voluntarily as a way of learning additional skills. Expert clients in the study sites were different from other lay volunteers. Their scope of work was bigger, they worked as nurse assistants and did technical jobs, operating HIV equipments, and interpreting technical

information such as CD4 information to patients. Also, they are full-time health workers; they work 8 hours a day, 5 days a week like permanent staff. In a typical definition of volunteerism, such are not traits of volunteers.

The life of an expert client: relationship amongst and with other staff

Although the expert clients interviewed for this study offered rich descriptions of their work lives, additional insight into the context, scope and conditions of their work were made through daily observations. Their diligence, dedication and love for their jobs were manifest, but less positive experiences were also witnessed, including expert clients who felt alienated and overworked. Through these observations, many intimate details of their lives, both inside and outside of work became privy, as everyday conversations and daily farewells were routinely exchanged. Expert clients displayed great endurance in carrying out their work and managing difficult work environments. Both frustration and exhilarating moments of the job were witnessed, and I learned how tenacity and despair, diligence and reverence of superiors sometimes led to manipulation.

There was a greater degree of closeness amongst expert clients than any other groups of staff in the clinic. Expert clients used the common term '*bahlobobetfu*' when referring to their peers, which was a way to show affection towards one another. In SiSwati, it means someone you can always count on, especially during challenging times. The connotation of the term is pleasant, signifying a certain bond and a reciprocal relationship. Usually this term is used by two people who share similar circumstances, often the basis for their connection. For this reason, expert clients would not refer to nurses as *bahlobobetfu*, rather as *umphatsi* (the boss), a term that both shows reverence and implies that they are not in the same class or status. However, in a few settings in which expert clients were well integrated and nurses treated them like the rest of the staff, expert clients would refer to nurses as *bahlobobetfu*.

Subservient Workers

We are told to do all these duties by our supervisor. Although we know some of the things we are told to do are outside our scope of work, there is nothing we can do once she has told us – she is the boss, we cannot question her. It is also normal to be sent by the nurse for private errands during duty time and we cannot refuse because she is the boss. Doing the private errands shows respect and allegiance to your boss. (FGD with expert clients, June 2014)

In general, expert clients did not question the exercise of power by nurses or others they considered their superiors. Swazi cultural norms, place a high premium on overt expressions toward social superiors and elders. A key aspect of performing respect is being silent when one disagrees. A Swazi is expected to perform respect everywhere – workplace, family, marriage, church – or risk being labelled disrespectful. This partly explains why expert clients most often did as they were told without challenging nurses when given extra tasks. Also, expert clients feared challenging a nurse as it could result to dismissal on grounds of insubordination, thus coercing expert clients to execute instructions for fear of retribution.

Beyond, power imbalance and overt expressions, it is worth noting that expert clients are an extremely vulnerable cadre of health workers. They are hired and qualified through a stigmatised disease within highly contested spaces. Furthermore, patients were more comfortable with expert clients as expert clients are pros in experiential expertise over their trained biomedical bosses yet least qualified. This possibly created a tiff between the two. In addition, nurses hire expert clients directly and determined their contract renewal. All the expert clients in the study were unemployed prior, therefore having the job was the only source of livelihood to be safeguarded. A combination of these factors potentially made expert clients docile towards their bosses.

Relationships in the clinic

In a quest to understand relationship dynamics in the clinics, expert clients were asked to share their experiences working with other staff. The findings suggest an on-going subtle feud between expert clients and other support staff, especially orderlies. In all FGDs, expert clients accused orderlies of maltreatment in one way or another, including stigmatization and exclusion.

With teary eyes, Fundzi, a female expert client of six years, recounted her experience. When she began working as an expert client, she was destitute, and could not afford buying her own cutlery. She explained;

I used to cry all the time, [because] I couldn't use the utensils and cups provided by the clinic. I could not even afford to buy myself a teacup. I would not sit in the kitchen anymore because the orderly told me that nurses could not share the utensils with me. She said to my face that I shouldn't use the teacups. As such I hid all the time when I ate because they all watched what I was using. I felt stigmatized (FGD, June 2014)

Nana, a female expert client of four years, also related her experiences with an orderly: 'The orderly in our clinic refused to clean our workstations and she said she was hired to clean offices for government staff. ... She said she didn't understand why we couldn't do it ourselves because we are uneducated like her that is what uneducated people do'. The treatment expert clients received from orderlies seemed to be motivated by resentment, in part because they shared the same space in the clinic, but also perhaps because they had similar social statuses (minus being HIV infected). It seemed that being full-time government staff made orderlies feel superior to the expert clients who only had temporary contracts. These acts served to remind expert clients that they occupied the rank lowest in the hierarchy of the clinic. One might also interpret the friction between orderlies and expert clients as a

manifestation of the fact that orderlies are generally overlooked by HIV workplace programmes, which sensitize workers about HIV and discourage HIV-related discrimination. It is possible that the orderlies viewed expert clients as likely to infect them with HIV.

Expert clients also experienced conflict with nurses. The following excerpt shows sycophancy by subordinates towards superiors. Zama an expert client of seven years, explained to me:

One needs to be patient every time when working with nurses as I am not as educated. There are instances when you are trying to do something then they tell you to start doing another thing. You need the help of God to have patience. For example I will be counselling a client and they tell me to off-load the boxes from the truck and pack boxes in the storeroom. As you are doing that, they tell me that the pills are finished and we need to re-pack them into small containers. They may also tell me to call the stores and make ARV orders. All this happens, whilst I have a lot of clients waiting for me to weigh, issue files, do pill counts and counsel them. (Interview, June 2013)

Expert clients often appeared sullen in the face of such treatment by nurses. However, they did not openly share their sentiments with the nurses. They executed all tasks demanded by the nurses, though grudgingly, did as they were told and appeared content with their bosses' requests. Though expressing their feelings to the nurses was difficult, they had little problem venting their frustrations with me, a stranger.

Some patterns were observed regarding the relationship between expert clients and nurses and the rest of the staff. In clinics where nurses were reportedly hostile, expert clients complained of harsh treatment from orderlies too, suggesting that other staff emulated the nurses' behaviour towards expert clients. In these clinics, where nurses were less supportive and implicated in condoning maltreatment, expert clients were less enthusiastic and complained more about the scope of the work.

The reverse was also true: where nurses were supportive, expert clients did not report any maltreatment from orderlies and or other staff. Expert clients had healthier relations with all staff. Expert clients were also less likely to complain about their work, except for a common grievance about being paid a small wage, though the expansion of tasks was characteristic to all clinics. In addition, in clinics where expert clients were treated well, they were likely to be friendly to the patients too.

In three of the clinics, the head nurses demonstrated leadership by not instigating division among regular staff and expert clients and were supportive of expert clients. Expert clients in those clinics reported that when the orderlies showed hostility towards them, nurses dealt swiftly with it. During a FGD, an expert client explained that:

In our clinic, we are like one big family. We often hear colleagues [expert clients from other clinics] complaining about maltreatment from nurses or other staff but not in our clinic. We always have meetings to discuss issues and *Umphatsi* [our boss] makes sure that if there are complaints or any issues of concern from any staff, not only expert clients, the perpetrators are subjected to a disciplinary hearing. (FGD, July 2014)

All clinics are supposed to have multi-disciplinary team (MDT) meetings and in-service trainings where issues affecting delivery of services in the clinic are discussed and resolved. In-service trainings are supposed to be held once a week, and MDTs are held when there is a need. The effectiveness of these structures varied from clinic to clinic; in the clinics where these structures were regularly implemented, expert clients generally reported better working conditions compared to clinics where they were not. Four clinics had active in-service trainings and a functional MDT, only one in-service training or MDT took place in a year.

It was not clear why these important procedures were not implemented. However, observations suggested a lack of commitment to resolve issues and sometimes a general lack

of time for such processes, which would leave patients waiting. The expert client coordinator in the Ministry of Health was the only administrator above the clinic level to which expert clients could report concerns at work. Even so, expert clients noted that ‘sometimes we just report to the EC coordinator to let off steam [*kutihhamula nje*], and no action is taken because some issues are above her power’. Issues above her power would include complaints about too much work or issues pertaining to contracts. In fact, there were very few instances where the expert client coordinator had power to intervene successfully.

Coping at work

In the absence of a structure to relay grievances and complaints in the workplace, expert clients found a potent way to cope with the stress of their job: supporting each other during challenging times. Linda’s story illustrates one of the ways expert clients manage.

One time the nurse-in-charge called me to her office and said she received a complaint about me, that I did not give good treatment to a client. She scolded me and she was judgmental without asking to hear my side. What hurt the most was that I was not even the one the client was complaining about – it was the expert client with whom she was friends. I was very angry, but there was nothing I could do. The only thing I did was to tell Muhle [referring to another expert client]; she consoled me. She was really a great support in dealing with it. In fact, as expert clients, we are each other’s support system. When one of us is not ok, we encourage each other. We are like a family (FGD, April, 2014).

Another expert client added during a FGD: ‘When we have problems we share it amongst the three of us. We cry and comfort each other, then we get back to work’. Instead of voicing concerns to superiors, expert clients opted to seek solace from each other. Consequently, expert clients were generally close to each other compared to other staff in the clinic.

The majority of those interviewed reported similar supportive benefits from fellow expert clients; those working in the same clinic seemed to be especially close-knit. All expert clients

concurred that the shared infection made their ties stronger, as Thandi explained:

Being the known HIV-positive staff in the clinic creates bonds and solidarity amongst us. Our HIV connects us because we are the only people in the facility who got a job through disease and this fact brings us together and we are each other's keeper. (FGD, April 2014)

They also supported one another when they had an emergency that required them to miss work or leave work early, as Thandi further said: 'We simply ask *bahlobobetu* (peers) to cover our back or help finish an additional task'. The trust and connection established was like a buddy system, not only for work challenges but for issues in their private lives. One expert client said during a FGD, '[If] I come with a problem from home, before we start working I call *bahlobobami*^v [peers] and we talk about it and I feel better afterwards'.

The closeness shared by expert clients and the support they gave each other was also used to reprimand colleagues who strayed and to mediate conflict between peers. 'We remind each other why we are in the clinic [to help other PLHIV] and that we need not fight each other otherwise the other staff will laugh at us,' said an expert client during a FGD. This support network was not utilized by everyone, however, as some expert clients resorted to other means to cope with challenges encountered at work.

Solidarity under threat

While many expert clients appreciated the shared bonds and supportive peer relationships, there were exceptions, as there were frictions amongst themselves. Some separated from their close-knit co-workers, and were seen as renegades because they perpetrated division. These included those who were allies with nurses or with fulltime staff, and thus were considered 'sell-outs' and not part of the expert client group. While expert clients did not actively discourage their peers from having relationships with other staff, it was an implicit expectation that they should be loyal to their peers. Those who did form relationships with

other staff were not considered trustworthy, and their allegiance doubtful. Beyond considered disloyal, they were also accused of being slothful in their duties and diligent towards the bosses' requests. Expert clients alleged that the renegades' major duties were the nurses' private errands, and that the nurses reciprocated by bailing them out when needs arise.

Furthermore, the fact that expert clients were given different stipends was the source of friction among expert clients, thus exacerbating division among them. To elucidate this, the following are excerpts from different conversations that transpired during a group discussion:

Vuma: It could be better if all expert clients could get the same stipend amount.

Phinda: In fact, we do much more work compared to expert clients from other programmes. We see ANC clients, and TB patients are enrolled to be cared for by us.

Sethu: We possess similar skills and education – why the variation in the stipend amount?

Expert clients were displeased by the variations in the scope of their work and the difference in stipends. The pay inequality contributed immensely to expanding the division among expert clients.

The involvement of different implementing agencies also contributed to rifts amongst expert clients, sometimes with subtle undertones. Expert clients competed and bragged about belonging to a donor considered rich. A 'rich donor'^{vi} was considered one that pays expert clients a higher stipend, has the most expensive cars and buys or donates assets to the clinic. Sindi an expert client, confirmed this observation during one of our informal conversations: 'Sometimes we can even quarrel over stationery or furniture – imagine what happens if your donor is the poorer one' (February 2013). Expert clients positioned themselves as custodians over their donor's assets. For example, if one asked to borrow a pen or a chair, the expert client whose donor donated the stationery might respond by saying, 'Ask your donor to buy it

for you'. Expert clients whose stipend was paid by a rich donor seemed to enjoy having more power over their peers. The power display and territorialism over donor assets, termed 'donorization,' indicated that relationships were becoming unstable, or that cohesion was declining within the group and schism setting in. Needless to say, expert clients were worried when these traits emerged among them, challenging the effectiveness and solidarity once enjoyed by all.

Discussion

When expert client programmes are implemented locally, they leave far more complex imprints beyond programmatic outcomes and challenges, as shown by various scholars (Kyakuwa, Hardon and Goldstein 2012; Morris et al. 2009; Tenthani et al. 2012). Scholars have studied volunteers to understand motivations for volunteerism. Sometimes, it is motivated by economic gain (Takasugi and Lee, 2012), whilst in other cases it provides a chance for personal development or recognition in the society. Meas and Kalofonos (2013) report that in Ethiopia and Mozambique socio-moral values motivate people to become a volunteer. Other studies focused on relationship dynamics between expert clients and nurses (Dapaah and Moyer 2013; Lees et al. 2012).

This paper goes a step further, demonstrating that not only do expert clients deal with external alienation and encounter friction within biomedical spaces but also experience alienation and friction among themselves (Qureshi, 2014). What is novel in this article is the undercurrent of feud and division amongst PLHIV yet for the longest time, PLHIV are represented as a community that through shared infection and collective efforts, enjoyed solidarity which has led to achievement of great milestones globally (Robins, 2006; Biehl, 2004). This research provides an additional lens to understand the complex resonances and dissonances of PLHIV in service delivery. It relates various ways in which expert clients

cope with power imbalances and alienation within the clinic and relationship dynamics among their peers, finding ways to navigate around these challenges as they execute their duties.

Both shared infection and shared circumstances connect expert clients; they are the only cadre at the clinics hired because of their health status. This facilitated the creation of a mutual bond and support mechanisms amongst them, seen in their fond reference to each other as *bahlobobetfu*. Sharing in suffering – infection, job challenges, social class and status – strengthened the bond amongst expert clients, helping them cope with friction and alienation in the workplace.

The leadership and attitudes of nurses were central in determining relationships amongst staff within the clinic. If a nurse had good leadership and management skills, expert clients were generally motivated and there was less conflict between expert clients and other staff. Where nurses were a source of division, the rest of the staff, followed suit. Where nurses did not model good relationships with expert clients, expert clients were grumpier, less motivated, and had poor relationships with other staff. Where the stipulated procedures for operating a clinic such as the MDTs for conflict resolution and in-service training were not followed, the relations were generally poor with expert clients. Clinics that made an effort to use existing structures to deal with discord such as MDTs had motivated expert clients, while in clinics that did not use such procedures to deal with discord, poor relations among expert clients and other staff prevailed. The correlation repeated itself in reverse: expert clients also emulated the behaviour of the nurses towards the patients. Where nurses were disrespectful towards expert clients, expert clients were in turn likely to be unpleasant to patients. In this equation, one fact shines brightest; nurses are gatekeepers, determining whether the use of expert clients in service delivery is both programmatically effective and favourable for all staff

within the clinics.

The study shows clearly that clinics with functioning staff welfare systems had motivated staff. Albeit the demonstrated benefit, it is often difficult as health workers rarely had time to attend to their welfare needs. Consequent to the expansion of treatment and clinic tasks swelling, staff welfare is endangered and at a risk of being deprioritized over the welfare of patients. Therefore, it is recommended that staff welfare initiatives are kept functional within the clinic structures alongside treatment expansion targets as human resource are the engine to achieve the anticipated ART coverage goals. Good performing clinics on staff welfare need to be recognised in order to spur all clinics to improve staff welfare. Also, there is a need for on-going professional development and mentoring to motivate staff and ease tensions stimulated by treatment expansion.

Though some expert clients enjoyed the refuge their support network created, others split from the close-knit group. Various circumstances facilitated friction amongst them. First, external funding of the expert client programme led to the creation of different types of contracts. Due to lack of state funds, external actors had influence over the programme's administration, which diminished the state's role in governing the healthcare of its citizens (Wilson 2001). Territorialism and competition over funders' assets, given the term 'donorization' also threatened existing solidarity, creating anxieties that corroded the mutual support that expert clients once enjoyed. Togetherness was replaced with a quest for individual gain and power over others.

This is the risk and baggage brought by global policies (Hardon and Dilger 2011), to the locale as they are implemented. Notwithstanding the benefits of travelling policies, which can also facilitate greater connection and closer ties among expert clients, GIPA initiatives can instigate conflict and friction among staff. This paper shows how the increasing involvement

of PLHIV in service delivery also injures solidarity, a key coping mechanism PLHIV rely upon to deal with conflict in the highly contested clinic space.

Whilst there is no doubt that this initiative is effective on the biomedical paradigm, clearly it also triggers dysfunctional, long-standing norms amongst PLHIV. As a result of organized campaigns, PLHIV have seats in powerful global platforms (Global Fund, UN) that steer the agenda of HIV globally. PLHIV have influenced the administration of ART and have ensured that their input is included in shaping policies that concern them (Mallouris, Caswell, and Bernard 2010). HIV strategies, guidelines and policy in every country cannot be completed without PLHIV involvement and approval (Morolake, Stephens and Wilbourn 2009). Donors stipulate conditions that call for PLHIV involvement as a condition for granting funds (Davis 2014). The efforts of PLHIV, and their biosociality have shaped the outlook of PLHIV globally. Though the shared infection of PLHIV has accomplished strides at a global level, at the local level we see different effects as GIPA is implemented. This is a foretaste of a new form of self-care, and the way that self-care models of patient empowerment are evolving in the resource-poor settings.

Conclusion

The expert client programme is a playing field on which agency is exercised and constrained, solidarity is created and challenged, and new norms of self-care are displayed. It is an intersection where the desperation to end AIDS (involving patients as a solution), conflates and conflicts with professionalism, culture and politics. The seemingly insurmountable challenge of the acute shortage of health workers was instantaneously resolved by GIPA as a magic bullet for service delivery. These were drastic and radical measures adopted to expand treatment in the hardest hit, resource-poor settings of the world. Most expert clients navigated this new landscape, managing to cope with difficult workplace environments and

demands by initiating supportive peer relationships, whilst others severed ties and built alliances with the powerful.

The relevance and efficiency of task shifting needs to be explored beyond the binary perspectives of whether it is effective or what challenges arise. The laissez-faire approach to its implementation calls for a curious enquiry into the resonances and dissonances of patient involvement in delivery of care. The impact of globally derived policies, task shifting or GIPA do not end at the confines of the clinic to augment treatment coverage, avert acute human resource shortage (Tenthani et al, 2012), enrich positive experiences of patients (Morris et al. 2009), but instead goes beyond to have larger social ramifications. The call to utilize services of PLHIV by global health proponents makes HIV to become a form of capital and exploited as an economy. Prince (2012) reported that HIV infection became a conduit for economic and material gain by PLHIV in East Africa. This calls for enquiries to understand how global policies for treatment expansion may invade a society, how they can hamper, alter or configure new practices, shape norms and meanings and affect social processes.