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Understanding the culture of care: An ethnographic study of how healthcare workers in a Mental Health Centre negotiate care in Windhoek, Namibia.

A Dissertation

Submitted to the Department of Anthropology of the

Faculty of Humanities

at the

University of the Western Cape

by

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In Fulfilment of the Requirements

for the Degree of

MASTERS IN MEDICAL ANTHROPOLOGY

November 2023

Western Cape, South Africa

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ABSTRACT

This study was aimed at exploring the culture of care that healthcare workers at a Namibian Mental Health Centre have cultivated, their lived experiences and how they use their agency to deliver the service of care. a qualitative research approach to conduct the study. Convenience sampling was used to select a sample of healthcare workers at this Mental Health Centre, based on availability and presence at the Mental Health Centre. Data was collected through the use of participant observations and semi-structured interviews. The findings showed that the Mental Health Centre at Windhoek Central Hospital functions like a 'total institution', however, it is under-equipped, understaffed and lacking the capacity to accommodate all patients. Furthermore, it was established that healthcareworkers at the centre have cultivated for themselves a culture of care that is centered on patients feeling and looking better than when they were admitted. Care that involves allowing patients to express themselves in their most comfortable language to make the treatment process smoother was the order of the day. Aweekly routine at the centre was found to help both the healthcare workers and the hospital run smoothly. The study also found that the healthcare workers were significantly desensitized to the violence in the workplace that they considered it tobe a part of the package of working in a Mental Health Centre. These healthcare workers used their agency to care for both inpatients and outpatients, improvising is second nature for them. This study highlights how agency plays an important role in the provision of care as well as recommends government intervention especially through financial and human capital support to help lead to more effective care at this facility.

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Keywords: Namibia, Mental Health Centre, Structure, Agency, Care.

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ACKNOWLEDGEMENTS

All glory to God because all is possible through him and in him.

I am grateful for my biggest support system, my sweet and supportive mother. You have always believed in every dream of mine, and you have always supported me in everything I have pursued. Thank you for always showing up for me, for stressing with me when I was stressed and for crying with me when I cried. I would like to thank my little sister, who is not so little anymore for believing in me and being my biggest cheerleader.

I would like to thank my supervisor, Professor Sakhumzi Mfecane for guiding me throughout the entire process of writing this dissertation. Thank you, Prof. for your patience and most especially constructive criticism.

I would also like to thank Bishop Joseph Shikongo and Fr. Luis Malama for their support went a long way.

To my friend Mulela Chindo, thank you for all your support and spirit of cheering me on especially on the days my mental health was hanging on by a thin thread.

Deep gratitude to Amarachukwu Odo, my friend, for your kind words and encouragement on days I felt like I could not complete this thesis.

Immense gratitude to the Carl Schlettwein Foundation for their financial support went towards the completion of my studies.

I extend my gratitude to the Ministry of Health and Social Services for the permission granted to me to carry out this research and the brave healthcare workers at the Mental Health Centre who played a pivotal role in this study.

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ACRONYMS AND ABBREVIATIONS

BP Machine - Blood Pressure Machine

MoHSS - Ministry of Health and Social Services

OPD - Out Patient Department

Ward A and B - Male Wards

Ward C - Female Ward

Ward D - Acute/Depression Ward

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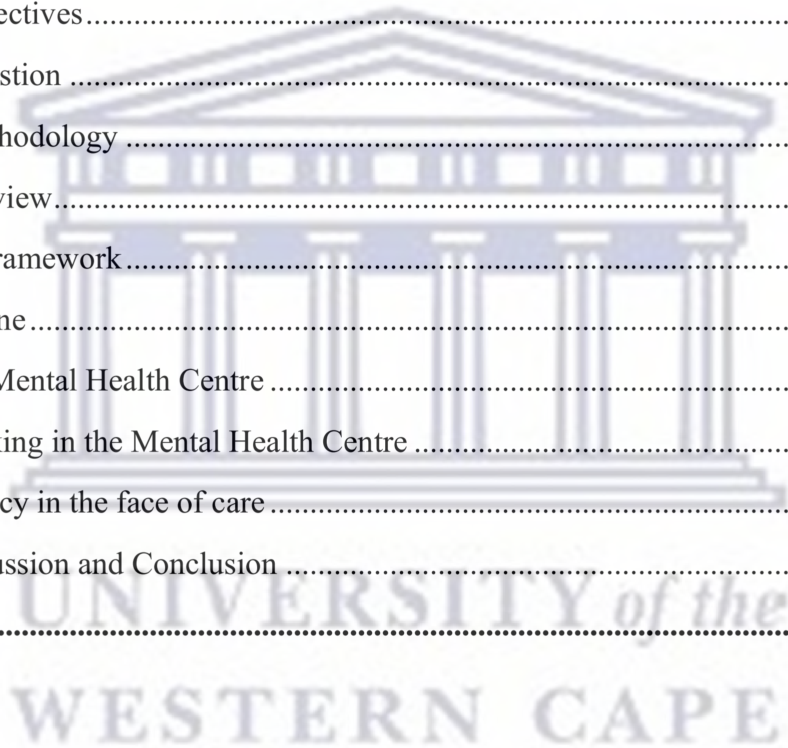

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CHAPTER 1

INTRODUCTION

1.1 Background

What started as a concentration camp turned out to be the only Mental Health Centre in Namibia way before the country gained its freedom from Germany in 1990. The Mental Health Centre was built in the year 1903 accommodating black people who had mental illnesses. Over the years it has home to every citizen who battles mental illness and needs the States' care. Thirty-three years after independence, the Namibian government has managed to add what is referred to as the Forensic Unit and the Out-Patient Department but has ignored the urgency to build more mental health institutions for a country that records 26,000 cases and more of mental illnesses annually.

Mental health care is at the bottom of the budget for the Namibian government. In the past five years the Ministry of Health and Social Services has been allocated a sum ranging between 6.9 billion and 9.7 billion, however, the question on how much of this was allocated to mental health care is not an amount that the ministry has been transparent about. The head of the Mental Health Centre simply shared how little of the funds are allocated to mental health care but failed to give any numerical figures. Researchshows that as much as psychological distress is not an unfamiliar thing in Southern African countries, it still happens to be of low priority in these parts of the world therefore remaining underfunded (Bird et al., 2011). This is the reality of mental health services and a depiction of its relationship with the government of Namibia.

The Republic of Namibia still uses the mental health legislation of South Africa that was imported during the apartheid era as the legal guidelines to oversee mental health in Namibia (MoHSS, 2005). The health sector is one of the sectors that the government cannot seem to steer in the right direction, from the oldest and biggest state hospitals in the country falling apart and now barely having its clutches on mental health care. Even with such little support, this Mental Health Centre manages to keep its doors open to all.

The vision of the Mental Health Centre is to provide quality care to the mentally ill and raise awareness of mental health in Namibia. It also tries to play the role of assisting individuals so that their mental illness does not deteriorate. The head of the Mental Health Centre, Dr. Nene, who also happens to be one of the psychiatrists, elaborated that the latter is something that they have

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failed to achieve because they do not have people representing them at ground level in the communities. The Mental Health Centre was supposed to throw itself at the front of raising awareness around mental illness but because of a lack of support and limited funds, Dr. Nene shares that it has been almost impossible for the Mental Health Centre to achieve this because there is little to minimal support in terms of resources.

The personnel at the centre include psychiatrists, medical officers, psychologists, social workers and nurses. The nurses however have extra training in psychiatry compared to the nurses one would find at a general hospital. Dr. Nene shared that the wide range of personnel with each one of them having their specialization makes the Mental Health Centre a multi-disciplinary psychiatry unit. Each of them plays their part in making sure the needs of the patient are met while in their care. Dr. Nene pointed out the obvious fact that there are not enough hands to share the load of work with because working at the Mental Health Centre is not a very popular thing amongst healthcare workers. She pointed out that the main reason is because there is no clear information on it out there for everyone to access and the misconceptions that people who work closely with those mentally ill, will sooner or later be mentally ill too. A misconception that some of the nurses working in the wards shared with because they had heard other nurses say it way too many times.

Furthermore, she shared that her experience of working at the management level instead of just being another psychiatrist at the Mental Health Centre has been a challenging one. Having different departments within the Centre that report to her, she stated that there is a delay in meeting deadlines because some departments may be a bit slower than others may. There is also the issue of some of the staff members feeling like she only represents and advocates for the doctors instead of all the employees because she happens to be a doctor.

The Ministry of Health and Social Services (MoHSS) (2005) has stated that 12-13% of Namibians battle with psychological distress. This may sound trivial but for a country with such a small population of 2 664 609 million, it is the exact opposite. It is alarming because the only Mental Health Centre in the country fails to accommodate all the patients comfortably.

1.2 Problem Statement

The Mental Health Centre is stretched beyond its capacity as it is designed to accommodate 200 patients. Nashuuta (2018) found that it was accommodating close to 600 patients with two nurses

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taking care of all the in-patients and out-patients at the Centre. Furthermore, it has three clinical psychologists who are responsible for providing psychotherapy, psychometric tests and diagnosis services.

Moreover, not only is the Mental Health Nursing division understaffed but also the shortage of psychiatrists has left the staff frustrated as they have to work twice as much to assist patients. The patients are sometimes waitlisted and this takes up to a week or sometimes a month before they can be assessed by a psychiatrist (Nashuuta, 2018). According to the World Health Organisation, about 1.79 psychologists, 0.34 psychiatrists, 0.17 social workers and 5.32 nurses per 100,000 of the Namibian population work in the mental health services department in the country (WHO, 2014). The WHO standard and international standard is a 1:1000 doctor/patient ratio, which means 10,000 inhabitants in a population annually. This means the health professionals in the mental health care services of Namibia can barely cater to the part of the population that needs this service. The high number of patients and understaffed healthcare workers make it impossible to provide effective and quality healthcare. The most defining factor of quality healthcare services is an adequate number of healthcare workers.

1.3 Research Objectives

The 1:1000 doctor/patient ratio that sets a global blueprint and standard of health care is a standard that is unattainable and maybe a little unrealistic for Namibia. That is not to say the health care system in Namibia is in shambles, it just means what is on paper and the reality are two different things. Especially for a developing country still struggling to manage the country's resources for the good of all. Even so, that does not justify the neglect of mental health care and it is for that reason that this study aimed at drawing more attention to the reality of mental health care in Namibia also highlighting the work that the healthcare workers are doing with the little support they have to deliver quality care to their patients.

Mental health care still being at the bottom of the budget is completely unacceptable, especially for a country that keeps recording alarming numbers of cases every year. Other than adding to

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emerging literature, this study aimed at highlighting the consequences of a neglectful government. Most importantly, it aimed at bringing to light how the healthcare workers in this MentalHealth Centre keep going beyond the oath they took to simply take care of the part of the population that battles with their mental health.

This Mental Health Centre is carrying the future of mental health care in Namibia on its back. Aside from private Mental Health Centres that the average Namibian cannot possibly afford, this Mental Health Centre is at times home to patients that these private psychiatric clinics can no longer accommodate due to various reasons. Delivering care should not be as hard, exhausting, scary and draining as it is in this Mental Health Centre.

1.4 Research Question

This study sought to answer the following question: How do the healthcare workers in the Namibian Mental Health Centre that overflows with patients, conceptualize and operationalize care? The majoraims were to investigate the culture of care that exists within an understaffed and overflowing psychiatric ward as well as the lived experiences of healthcare workers concerning their work conditions and how they can be improved for better healthcare delivery.

1.5 Research methodology

This study was a hospital ethnography, this refers to a researcher positioning oneself in a hospital setting because the hospital or clinic turns into a field site (Long, Hunter and van der Geest, 2008). I immersed myself in the Mental Health Centre to truly grasp and understand the experiences and interactions in this mental health care facility. I was stationed at the Mental Health Centre for two months, both on weekdays and weekends and I rotated between day and night shifts. Moreover, I spent two weeks in each ward, familiarizing myself with the nurses and the ward and getting to know the rhythm of every ward.

I showed up to the wards as a researcher and gave a helping hand when the healthcare workers needed it. I conducted informal interviews with the healthcare workers every chance I got while working with them, in the wards, during lunch, at the tuck shop and in the corridors. Semi-structured interviews were also conducted later with eleven healthcare workers representing the different disciplines. I mostly relied on participant observation, which involves being in a social situation in which you then observe individuals but instead of observing from the sideline you get involved in their activities (Spradley, 2016). This enabled me to gain an in-depth

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understanding of experiences and interactions as the healthcare workers always involved me in the activities of the ward. I did whatever was needed whether it is being on my feet or sitting in on consultation sessions with patients, therefore making myself available for anything that the healthcare workers, especially the nurses neededme to help with. This also involved putting away the belongings of the patients at the duty station, rinsing the cups patients used for their medication, closing medication cabinets in case they forgot to close them, and unlocking and locking the padlocks that gave them access to the patients sleeping quarters. If they needed me to help them carry a file, I would also assist, even including making sure the interns carried out their tasks as informed by the nurses.

I have always been passionate about healthcare workers and the conditions of their work environment and resources. Furthermore, I have always tried to stay up-to-date but nothing could have preparedme for what I was walked into. My first day in the Mental Health Centre brought to the researcher's attentionthe reality of the healthcare workers in this clinic, the resources at their disposal and what could count as care. There were not a lot of helping hands around apart from the intern doctors, social workers, occupational therapists and at times student nurses and yet this Mental Health Centre stillopens its doors to patients even when the standard of care does not meet that recommended by theWorld Health Organization.

1.6 Literature Review

Medical officers in this Mental Health Centre see 50 to 60 patients in a day which is an equivalent of 1800 patients in a month. This surpasses the recommended doctor: patient ratio by the World Health Organization which is 1: 1000 and as one of the medical officers expressed in a situation like this where healthcare workers see more patients than they should because of the work environment they find themselves in, it is likely that the standard of care drops. Care seems to be an unstable concept because it covers so much ground concerning day-to-day practices, biomedicine, affective states, different practices of moral obligation and ultimately the relation between all the things mentioned above (Buch, 2015). The healthcare workers' understanding in this Mental Health Centre of what care is very much revolves around their everyday practice of caring for their patients. Caregiving is a moral practice that can make both the caregiver and care receiver feel more human because there is a sense of presence from both parties (Kleinman, 2009).

When caregiving is a daily practice like it is for these healthcare workers, it easily turns into an expertise that they embody (Mol, 2008).

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According to Buch (2015), the practice of care entails three things, namely, the caretakers, and the role of the institutions and policies because they happen to shape the dynamics of care. The interest of this study was largely in healthcare workers. The World Health Organization acknowledges healthcare workersas valuable resources for people`s health. A Healthcare worker is defined as:

> One who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians, or even medical waste handlers (Joseph and Joseph 2016, p.71).

Berger (2007) defines healthcare workers as encompassing three categories: Personnel, referring to all the people working in the health service sector; Providers – these are individuals who provide some sort of health service in line with the law; and Health workers which includes every person that plays a role in making sure a patient receives care (for example emergency medical workers). Scholars highlight that the experiences of healthcare workers shed light on how they operationalize and understand care, which involves moral distress, violence, trauma and professional vulnerability. Moral distress is commonly known as a dilemma of one's morals, it is a result of an individual being caught between doing what they know to be the right thing and the constraints of the institution that hinder the pursuit of the right action (Jameton, 1984). I witnessed too many healthcare workers batting with this dilemma daily especially when it involved how long they had to keep patients in the seclusion room.

The standard should be for an hour or two but they are forced to keep patients in there for as long as two weeks or however long it takes for the patient to show signs of being calm. This is as a result of there not being better resources available for hostile patients other than the seclusion room. A lot ofthe healthcare workers, especially the nurses who spent more time in the wards with the in-patients, expressed how they were aware that keeping them in the seclusion rooms for weeks was ethically unacceptable but their hands were tied. This dilemma is known to be very common in healthcare practices. Nurses in psychiatric institutions are prone to moral distress and this is usually a result of staff resources and the poor quality of care that they are forced to provide (Deady and McCarthy2010).

Furthermore, Deady and McCarthy (2010) recorded that the healthcare workers seemed to have ascribed their moral distress to three aspects: professional and legal conflict, which involves scenarios in which doctors' opinions are considered over the nurse's because of their status in

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mental health care. This undermines the fact that the nurses spend more time with the patients and their insight into the decision-making process of a patient's future should be considered as well. Nurses at the Mental Health Centre were rarely consulted on how to proceed with a patient's treatment. The psychiatrists, medical officers and at times intern doctors would have the final say on the treatment of a patient and nurses were simply there to assist. The only time doctors would ask for the nurses' opinions was when they wanted to enquire about the patient's behaviour in the ward, their response to medication and vitals.

The second one is professional autonomy and the scope of practice, in which they argue that nurses' moral distress is a result of them turning to non-medical measures when medical interventions are insufficient; and them having to watch a patient's mental health get worse and not have their colleagues close for moral support (Deady and McCarthy 2010). The third aspect is standards of care and client autonomy, in which moral distress is a result of the nurses working in an institution that is under-resourced and having to watch clients settle for few alternatives of treatments and also is a result of client's autonomy being restricted because doctors view it as a patient trying to harm him/herself (Deady and McCarthy 2010). They believe these highlighted aspects present difficulties in decision-making for healthcare workers.

Furthermore, Ohnishi et al. (2010) found that healthcare workers in a Japanese psychiatric institution believed that not only does it play a role in their decision-making but also that moral distress had an effect on their exhaustion. However, it also gave them a sense of responsibility. This sense of responsibility seemed to drive their sense of agency in making sure that they found a way to work around their limited resources and deliver care. Although, Austin et al. (2005) believe that healthcare workers ought to be equipped with strategies to help them to identify and act on their experiences of moral distress.

Violence in the workplace, also commonly known as occupational violence, refers to verbal and physical aggression that one is subjected to in their work environment or in the process of performing work-related activities (Driscol et al., 1999). According to Altinbaş et al. (2011), healthcare workers in psychiatric institutions experience verbal and physical assaults from the first time they start working This claim is supported by a study carried out in a Turkish psychiatric institution.

Furthermore, 71% of their participants had experienced verbal or physical assaults and 50% of the healthcare workers noted that they believe violence to be a part of the job (Altinbaş et al., 2011).

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The healthcare workers in this Mental Health Centre shared that being on the receiving end of violence is a part of the job. I observed nurses being at the receiving end of verbal and physical abuse, some of them had scars to show for it. Medical officers and psychiatrists would usually be atthe receiving end of verbal abuse. At the end of the day, any individual who looked close to resembling authority was subjected to verbal abuse by the patients. The nurses in the wards would always inform the me that at some point one gets used to it.

Gascon et al. (2013), who conducted a study in three primary hospitals in Spain, found that healthcare workers experience some form of violence in their workplace. The study reports that 11% of health workers are reported to have been physically attacked at least once and 34.4% reported to have been victims of threats and intimidation while 36.6% had received insults from the patients. This is in line with a study by Chan, Khong and Wang (2017) asserting that healthcare workers are second victims of violence and aremost likely to be traumatized.

Scholars seem to believe that healthcare workers in psychiatric institutions are prone to violent incidences in comparison with healthcare workers in other sections of healthcare. Bimenyimana et al. (2009) shed light on the experiences of nurses in a Gauteng psychiatric institution. They found high levels of violence and aggression, with staff shortage, lack of support and the mental condition of the patients as the contributing factors. They add that this violence and aggression leaves the nurses with feelings of frustration, fear and sometimes the need to be absent from work. Furthermore, a study by Kennedy and Julie (2013) in Western Cape, South Africa found that healthcare workers experience violence daily and they have normalized it as being a part of the job.

Vulnerability in this context refers to proneness to threat and assault (Styles and Gottdank, 1976), which happens to be a common phenomenon amongst healthcare workers. Healthcare workers experience vulnerability in mental health institutions because of the tension between the healthcare system and their convictions about their practice as healthcare workers (Bachmann, Michaelsen

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and Vatne, 2019). The scholars assert that this vulnerability is also a result of the threat of unpredictable events in their workplace.

In Namibia, there is scant research on mental illness or mental health services. The few studies include the work of Shirungu and Cheikhyoussef (2018), Fumanti (2018) and Feinstein (2002). These studies provided pioneering work on the research of mental illness in Namibia with the addition of an analytical study on mental health services conducted by Dhaka and Musese (2019). The latter study revealed that mental health services such as psychotherapy and counselling are not readily available to community members. The work of Amukugo and Nangombe (2017) asserts that health care workers are concerned with providing quality care yet their work environments work against them achieving the quality standard of care. However, there is not sufficient empirical literature that can help in truly grasping how the healthcare workers in Namibia provide care in anenvironment that is not ideal for the provision of quality healthcare.

This study sought to address this knowledge gap and add to this emerging literature, with a specific focus on healthcare workers and their experiences within the mental healthcare section of the Namibia hospital. The thesis narrated the real-life experiences of the healthcare workers at the Namibian Mental Health Centre. It explored the cultures of care that they have had to create because of the lack of resources and support; their ability to use their agency more than anything to get the job done; their ability to improvise in whatever situation they find themselves in because they cannot afford to stop caring for their patients; the sheer commitment to not only their oath but to every patient that walks through the doors of the Mental Health Centre.

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1.7 Theoretical Framework

This study rested on the dimensions of Giddens' structuration theory as its theoretical base. The structuration theory strengthens the argument on how the structure (mental health centre) has empowered agents (healthcare workers) to create a culture of care (institutional culture) that revolves around agency and improvising. Structure refers to the rules and resources that play a role in the production and reproduction of social systems (Giddens, 1984). It exists because of the presence of agents who partake in this reproduction of social life through their daily activities; this is inclusive of the physical environment and social relations that may exist in this environment (Dyck and Kearns, 2006).

According to Dyck and Kearns (2006), structure has the power to either restrain or empower the

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agent. This Mental health Centre and its structure/agency dynamic is a clear depiction of the statement above. The agency that the healthcare workers exhibit in this centre as thoroughly discussed in this study is at its core the result of the structure in which they find themselves (e.g. institutional rules, systems and practices). Structure informs the practices of human agents and social practices such as allocating resources and the code of conduct individuals may adopt (Rwafa-Ponela, Goudge and Christofides, 2021).

Agency refers to an act where an individual takes a certain course of action when he/she could have acted differently (Giddens, 1984). Furthermore, this act is usually intentional on the part of the individual, without intention, it is just another mere response to a situation. Agency also involves the agent or said individual being able to make some sort of difference with their course of action (Giddens, 1984). The work of these healthcare workers circles around agency and improvisation, I might even go as far as to say that improvisation were an example of their agency atplay. Some scholars have suggested that agency consists of certain features which they classify into three categories. Firstly, iteration which relies on past patterns of thought and action; second, projectivity which involves creatively coming up with a thought of action that can be applied in the future and thirdly, practical evaluation involves having a possibility of options and having theability to choose a practical course of action (Emirbayer and Mische, 1998).

Agency can also be referred to as the capacity that an individual has to make changes in the social and cultural structures that they exist in (Buckser, 2009). He further argued that the structure of institutions influences how individuals express their agency. The lack of resources and minimal support from the government has made the healthcare workers in this Mental Health Centre rely mostly on their agency to get the job done. They have found creative ways to care for their patients, they go the extra mile because this is the pressure that their work environment placed on them. Arguably all institutions allowed for some form of agency to take place; what is critical here is that the agency is exercised as a way to deliver care in situations that are not ideal and is done for the benefit of patients.

Agency may be understood as the ability to adapt, being hopeful and at times as an act of free will (Kockelman, 2007). He further adds that an individual can be flexible when working towards an end. Various scholars have highlighted different aspects that constitute as agency but the one

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common factor is that agency involves the exercise of free will by the actor. The healthcare workers in this Mental Health Centre can care for their patients in the best way they can because they rely on their sense of free will. Structures shape the physical setting that agency plays out in, especially when these social relationships exist in physical spaces, for example, institutions. This involves agents having to take on social roles that are assigned to them because of the environment they find themselves in and for them to reinforce these roles they rely on their agency (Buckser, 2009). Healthcare workers in this Mental Health Centre are forced into extra roles when caring for their patients because of their work environment. They take on whatever role they can for the sake of delivering care to a patient the best way they know how. By free will I do not mean that they could do as they please, rather they freely partook in whatever situation they found themselves in.

Namibia being a culturally diverse society was an interesting place to explore these dynamics of structure, agency, culture and care. The structure/agency theory enabled me to scrutinize the Mental Health Centre by looking at how individual health workers negotiate structure (institutional culture, local culture, etc.) with their own lived experiences to maximize the delivery of health services, as well as transform these structures. To understand what care essentially is in this centre, the concept of structure and agency was the lens that guided this research.

1.8 Chapter Outline

Chapter 2: The Mental Health Centre

Chapter two gives a depiction of the Mental Health Centre and insight into the different wards. Additionally, it highlights the weekly routine they have adopted to maximize care for inpatients and outpatients. I discuss the weekly routine in-depth and how all the healthcare workers fit into it. Furthermore, it discusses the structure being the Mental Health Centre and how this has shaped the agents, in this case, the health care workers. It concludes by giving insight into my experience while conductingmy research in the Mental Health Centre.

Chapter 3: Working in the Mental Health Centre

This chapter is a depiction of the experiences of the healthcare workers in their everyday work in the centre. I discussed the risks they experienced, the workplace conflicts, their hours of work and overall how they maneuvered working in the Mental Health Centre. I briefly touched on their

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sense of agency about caregiving. The findings suggest that these experiences influence how these healthcare workers provide care for the patients. Their understanding of care and how they executeit whilst being aware of their limitations is what was further discussed further in Chapter Four.

Chapter 4: Agency in the face of care

Chapter four discusses agency and care in detail. This chapter entails the healthcare workers' understanding of care, how they executed it, what their limitations are and how they work their way around these limitations. I discuss the different ways that they improvise to care for the patients. The findings depict how agency is a part of care delivery, especially in this Mental Health Centre. The chapter further discusses how and why the agency in this Mental Health Centre is important in the face of care and the delivery of it. Especially because this Mental Health Centre caters mostly to the have-nots of Namibia who cannot afford private mental health care services and the government seems to haveturned a blind eye to it.

Chapter 5: Discussion and Conclusion

This chapter entails a discussion and summary of the key findings of the study.

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CHAPTER 2:
THE MENTAL HEALTH CENTRE

Introduction

Improvisation is highly a part of health care institutions in Africa. Healthcare workers use the knowledge of biomedicine and tailor it to suit their unique situation within the space of healthcare (Livingston, 2012). In this chapter, gave a description of the Mental Health Centre and the routine that it utilises to make sure it runs smoothly. Moreover, I also highlighted the different wards and how each of them fits into the routine that they implement to provide care to their patients and still be able to attend to the administrative part of healthcare. This weekday routine seems to work for the Mental Health Centre and it is a great example of the direct influence of structure on agentic behaviour. Itplays a role in how healthcare workers operationalise and conceptualise care. It offers them a senseof order and prepares them for what each day may entail, but at the end of the day, whether the healthcare workers have to improvise and prioritise in the name of care, all depends on the day athand and the patients. This is the reality of what biomedicine looks like for the individuals who have to execute it and apply it (Street, 2014).

Scholars argue that instead of viewing hospitals as islands, we should view them as a big part of the mainland (van der Geest and Finkler, 2004). They add that life in hospitals is highly shaped by everyday life in society and thus should not be viewed in contrast to the other. The Mental Health Centre has walls with improvised broken bottles where barbed wires should ideally be placed, to discourage patients from escaping. It has doors that are locked at all times and specific persons who have the keys and access to the keys and high walls in the forensic unit with barbed wires. This may give the illusion of it being isolated but in reality, it is simply another part of the biggerhospital.

However, other scholars argue that hospitals are islands because patients experience a different regime; they are expected to dress differently and take on different roles (Long, Hunter and van der Geest, 2008). In this Mental Health Centre, patients have to adjust to a different way of living and their outside roles are almost invisible because they are merely viewed as patients. These scholars add that hospitals are spaces in which people are taken away from their everyday lives into a space where they are diagnosed and treated (Long, Hunter and van der Geest, 2008). This

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speaks to the nature of this Mental Health Centre as diagnosis and treatment may at times involve being admitted voluntarily and at times involuntarily. The difference between one's day-to-day life and hospital life is that there is an intensified sense of urgency in the hospital setting (Long, Hunterand van deer Geest, 2008).

Institutions are greatly responsible for the form and shape that social relationships take and the different types of agentic behaviour that may arise (Buckser, 2009). Furthermore, Institutions give individuals social roles as they give them physical positions in the institution that then fit into the world of the institution. This Mental Health Centre is a great depiction of this, the agentic behaviours observed are linked to the structure/institution which comes to life in the shared experiences of the healthcare workers shared in interviews and the study observations. Biomedicine and hospitals are at their core institutions in which values and beliefs are made new (van der Geest and Finkler, 2004). This assertion is made on the notion that they both strive to reinforce certain social and cultural processes of whatever given society biomedicine is being implemented.

Street and Coleman (2012) argue that hospitals appear to be "isolated islands" with biomedical regulations but at the same time uphold the reflections of what occurs on the "mainland" in terms of social interactions. The Mental Health Centre is in proximity to one of the country's biggest state hospitals, yet isolated at the same time. It is situated at the Far East end of the premises and the hospital is right in the centre of the premises. The Mental Health Centre has its routine and rhythm separate from the state hospital. The atmosphere in the Mental Health Centre is very different from that of the world or what scholars refer to as the mainland, making it an Island.

I conducted a qualitative study, a hospital ethnography. An ethical clearance was obtained from the ethical committee at the University of the Western Cape with further permission being obtained from the Ministry of Health and Social Services in Namibia to access what was the field site where I carried out my research. I sought to be fully immersed in the Mental Health Centre to truly grasp the interactions between the healthcare workers and patients in the face of care. Which in the field meant being quick on my feet, following the healthcare workers and closely observing them in their interaction with the patients.

I also aimed at developing an understanding of the culture of care that the healthcare workers uphold in this Mental Health Centre. Thus, I relied a lot on participant observation to build close

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acquaintances with the workers. I did not have an exact number of healthcare workers that I wanted to interview because of knowledge the that the Mental Health Centre was understaffed so there had to be reliance on participant observation to gatherdata including informal and formal interviews. I initially had significant reservations about which spaces in theMental Health Centre the study would be permitted to be conducted in. I however made use of the permission letter received from theMinistry of Health and Social Services to access the Mental Health Centre. The first person I met was the head of the Centre who then invited me to their weekly morning meetings where introductions were done with the doctors and interns. The head of the Mental Health Centre grantedme access to every part of the Mental Health Centre, provided I was always in the company of thehealthcare workers. This allowed me to truly observe the dynamics in this Mental Health Centre for the two months the study was being conducted at the facility.

The Mental Health Centre is situated at one of the big state hospitals, Windhoek Central Hospital. As soon as the gates are opened up for you, it is not hard to spot the sign and arrow that directs you to the mental health centre. The centre is isolated from the whole hospital, with its limited parking lot being the first thing one sees as soon as they drive up or walk up to it. The entrance is relatively narrow, with a tap on the left side for patients and visitors to wash their hands because it is operating during a pandemic (fieldwork was conducted during the peak of the COVID-19 epidemic). The brown bricks give the centre its unique look, making it distinct from anything else in close proximity.

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Once you were through the entrance, your temperature was recorded and you were required to jot downyour details on the COVID-19 tracing list before you can proceed further. The Out-Patient Department (OPD), which is what you walk into once you are through the entrance is very green. The walls are painted green because this is a colour associated with mental health, which is information that was obtained from one of the nurses upon inquiring.. The duty station and reception are all on the right side, with white burglars around the counter and the pharmacy on the left. Between the duty station and pharmacy are a few rows of benches made out of cement and tiles, where the patients are instructed to sit andwait. On the far corner on your right, is a corridor that leads you to some of the offices that belong to the medical officer consultants and nursing supervisors.

Right after the pharmacy are two corridors in opposite directions each that also holds offices that belong to the medical officers, psychologists and a conference room in which their morning

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meetings are held and toilets. Each corridor has an exit door that leads to the other departments of the Mental Health Centre. There is a tuck shop and car wash right in the centre and an occupational therapy department facing the tuck shop in an opposite direction.

The rest of the wards are located towards the ends of the Mental Health Centre, with the acute ward also referred to as WARD D and WARD A & B on the left side; and WARD E and C on the right side. WARD E being a ward under construction had no patients in it at the time of the study. At the far left side of the Mental Health Centre is what they refer to as the Forensic Unit, it houses patients who happento be mentally ill and have committed serious crimes. It comprises the ground floor A and B, first-floor wards A, rehabilitation ward and maximum security ward where the different patients reside.

The Mental Health Centre has a routine of the week that helps things run smoothly as explained by an occupational therapist. Mondays and Wednesdays are for the Outpatients who show up at OPD. Tuesdays and Thursdays are what they call doctors' rounds, for the in-patients at the wards. Fridays before the pandemic were for sports activities that they would let patients indulge in and the weekends were simply for attending to all patients with needs by the on-call which is quite busy in the mental health centre. The doctors start the day with a presentation meeting by the interns, which turns into a learning process. The nursing centre holds meetings every Monday morning, to discussshifts and all matters concerning nurses.

The administration block, also referred to as the Out-Patient Department tends to be quite crowded with patients coming in for their medication and follow-ups. The notice board is bombarded with a lotof posters about health but only one small poster sheds light on suicide. The counters, where the administrative work is executed are on the right, they have burglar bars that further draw the distancebetween the staff and the patients. The pharmacy is on the left once you walk into the Out-Patientdepartment. Taking into consideration that there is a pandemic, there is always a nurse taking the temperature of everyone walking in and making sure they jot their name down on the COVID-19 tracing list. The corridor with one of the medical officers' consultation room, right after the pharmacy is filled with small bins on either side, a little hard not to notice. The interns use these same corridors and conference room to hold sessions with the outpatients because of the lack of sufficient consultation rooms. Before the clock even hits 10H00 there are close to 60 patients insideand outside simply waiting to be attended to.

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Right after the Out-Patient Department, the emptiness of the Psychiatry Department attracts ones attention. The offices had no names indicating who the office belonged to, except one that belonged to a clinical psychologist. The head of the Mental Health Centre's office has no information on the door, the staff and student nurses simply referred to it as 'the office in the corner on your right'. This applied to the nursing centre as well, a bunch of offices with no names or information on them. Its notice board is also bombarded with posters touching on 'child welfare grants, understanding schizophrenia' and so forth. The one thing that also draws one's attention is the 'NO SMOKING' signs pasted on the walls and windows of almost every building within the vicinity of the Mental Health Centre.

Right after the administration block is the Occupational therapy building on the right and the forensic unit on the far left, with a tuck shop and car wash in the middle but also faces the front of the Occupational Therapy Building. The forensic unit is secluded from the rest of the Mental Health Centre because according to an occupational therapist, "this is the one department where mental illness and the law meet". The occupational therapy department is lively, the setting is welcoming. There are posters of positive messages on the wall and notice boards. Right after the Occupational Therapy Department, there are wards on each side: Ward D and E. Ward D is also referred to as the Acute Ward, which has patients who are diagnosed with depression. The striking thing in this department is the information board that has posters on schizophrenia and bipolar mood disorder, which is convenient because the Ministry has classified them to be amongst the most frequently recorded mental illnesses in Namibia.

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Each room in Ward D has cameras, and the nurses have access to all these cameras through a screen built protectively at the administrative counter. When I enquired about the cameras in their rooms, a student nurse made it clear that this was because nurses got relatively occupied with other duties and the cameras allow them the convenience to monitor the patients and work at the same time. She further clarified that they do however check on them physically after every two hours. The ward is very well structured, and nurses are on high alert as this is the ward with suicidal patients and they need extra care. It also has what they call seclusion rooms for patients who are suicidal, the females and males sleep on different sides of the ward. It has a courtyard, bathrooms,television room and dining room for the patients.

Right after Ward D, the Mental Health Centre stretches out to Wards A and B which are the male wards. The one thing that stands out in Ward A is the box of condoms on the counter at the duty

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station, the luggage that belongs to patients right below the cabinets under the counter, the broken windows and the single nurse working at the duty station. This ward accommodates patients with psychotic disorders. Ward B on the other hand seems to accommodate substance abusers. The ward is not designed differently from Ward A, all its windows have rails. The registered nurse is gone for hours from his duty station and leaves the duty station with student nurses. This duty station has a camera like all the others and all the male wards' key cabinets are situated far from the burglar door where patients stand and interact with the nurses and so is the box of condoms and for some reason this box of condoms is only present in the male wards.

Right next to these two is the female ward, referred to as Ward C. When one walks to these wards, the male wards are on the left and the female ward is on the right. The first thing that stands out is the two nurses at the duty station. The belongings of the patients are under the counter just as observed in the male ward and the camera at the duty station. The female ward is very lively; it has a lot of colourful drawings on the wall with bright colours. These drawings are in figures and some words. It has four consultation rooms, two for the doctors and the other two for the social workers and psychologists. The one consultation room, gives you access to the camera feed of the different spaces that patients at times occupy except for the bedrooms and doctors' consultation rooms are distinguished by the two main tags "white firm and green firm", this helps doctors identify which patients have been admitted longer and which ones have not. The notice board in the female ward is filled with posters on anger management, it is the first thing you see on your right before heading into the corridor that leads to the female ward.

It is barely mid-day and the female ward gets pretty busy, a nurse attends to the family members of a patient as she processes the discharge of the patient; she reminds them to pick up the patient's medication at the Out-Patient department (OPD) and that she should always show up with her medical card and book. The Mental Health Centre is packed with student nurses and medical interns, more student nurses of course; that have been divided into groups for the different civil wards.

On Tuesdays, the civil wards are the busiest, especially the female ward (Ward C). Nurses make sure the patients have their morning showers and breakfast. The student nurses may be doing their rounds but they seem to be a helping hand for the nurses. Once a registered nurse instructs them on how to dispense the medication to the patients, they took over as the nurse supervised close by. The medication was stored in a medicine cart that had a lock and key, student nurses had

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access to it. It became apparent that as much as the Mental Health Centre caters to patients, it also makes room for being what the head of the department had referred to as a 'teaching hospital.' The ward had a broken window at the duty station that the nurses used as the spot from where they dispense medication to the patients. The window still had its rails, which represented protection for the nurse,just no glass.

The lady responsible for cleaning Ward C walked in around 8 AM and at this time the patients had been let out into the courtyard and locked out so they cannot have access to their sleeping quarters while she cleans. One of the registered nurses illustrated to the student nurses, how they are to give medication to patients who need extra attention. Whilst the nurses were busy with dispensing medication, a man walked in who happened to be a social worker, with no name badge or lab coat like the medical officers and interns. One of the nurses informed me who he was. The staff of course knew each other and this was probably why there was no need for name badges, as the nurses in the ward did not have any on them either.

Whilst some of the students were dispensing medication, one of the nurses took a few students with her to the courtyard to take down the vitals of patients, especially the ones who had a chronic illness such as hypertension. All these had to be done before the doctors made their way to the wards for their rounds. One of the students was sent to the pharmacy with the medication box, which had a list of the medication that the ward had run out of and medication that had expired. Once every patient had their chance to take their medication, the medicine cart was rolled back into the storeroom and the cups that were used to dispense medication were washed off and dried. A nurse made it a priority to fill out a laundry list for the laundry man who would then pick it up.

The two male wards were also pretty busy too, as they too were expecting doctors to show up for their rounds. As they had pretty much-done everything, one of the nurses decided to teach a few student nurses how to take the blood pressure of a patient, the male wards were not as noisy as the female ward.

Wednesdays are OPD days, hence the wards were not as busy. The acute ward also referred to as Ward D, was so quiet one could almost hear themselves breathing. The sound from the television took s up more space than the voices of the patients and healthcare workers. There were two nurses at the duty station and a few student nurses. The student nurses were dusting off the

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counter and store room. One of the nurses was busy with a diet sheet review and the other with dispensing medication to the patients. The nurse busy with the diet sheet pointed out the youngest patient in the ward whowas sitting with them at the duty station "He misses his mother, so we are letting him sit by the phone, to answer the calls because he believes his mother will call eventually." She said to me. She further explained that the patients were not allowed to keep their phones with them in the ward, they communicated with their families through the telephone at the duty station.

When a patient received a phone call, the nurse called out for her and she stood on the other side ofthe duty station and attended to her phone call right in front of whoever happened to be at the duty station. A truck that belonged to a catering company parked right in front of the ward and two women rolled in a cart with wrapped food. Patients drank their medication before they had breakfast which is served at around 8 AM and by this time the patients has already taken their morning shower. All the wards seemed to have their own "NO MASK, NO ENTRY" sign only at the duty station and a poster that instructed patients not to remove their identification bracelets. One of the nurses explained to me that patients took their medication at the duty station because then they could monitor them and make sure they swallow their tablets. The cleaning lady arrived at 09 AM to clean up the ward, aspatients relaxed in the courtyard.

The cleaning lady in Ward C seemed to have started cleaning around about the same time as the lady in Ward D. The morning was pretty slow in Ward C, patients were in the courtyard and there seemed to be no rush in dispensing medication. A doctor walked in to follow up on medication that was changed for the patient during the doctors' rounds. Since Wednesdays are OPD days, the department is full. Close to 60 patients were in the waiting area and more sitting outside as they could not be inside because of COVID-19 regulations. The medical officers and interns worked hand in hand to attend to the patients, and interns were forced to see patients in the corridors due to the lack of consultation rooms that would provide privacy.

It was the afternoon and it looked like the nurses had time to spare to sort out paperwork and do theadministrative work in the ward. The ward was oddly quiet, some of the patients were napping and the others were in the courtyard barely chatting. "We have sedated the noisy and verbally abusive ones, hence the bit of peace in the ward." The senior nurse said to me. Although the medical officers were busy with patients at OPD, one of them showed up to the wards for a consultation with an in-patient.

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The ward had a new patient to admit after a consultation with one of the doctors at OPD, one of the nurses administered the admission and demonstrated to the student nurses at the same time. The patient took the stuff she needed from her bag and left her bag at the duty station for the nurse to put away. I had at this time only spent a few days in Ward C and it was apparent that the nurses did notonly make sure they work but also made it a priority to teach, their consistency was admirable. Paperwork and new admissions seemed to be the highlight of the day in the wards. A social worker popped in to help a patient run some errands and returned her to the ward after a few hours. During lunch hour, the ward was pretty quiet except for the excited patient who was watching the television through the burglars, eating her lunch and engaging the nurses in conversation. A few family members walked into the ward to drop off some snacks and drinks for a patient, which a nurse put in the small fridge at the duty station. The fridge seemed too small to accommodate every patient'sfood, but it looked like they manage it just fine.

Thursdays were a slow day for the Out-Patient Department but the same thing could not be said for the wards. The two male wards were lively, with the student nurses interacting with the patients. After a few days of wondering who the condoms in the wards are for, one of the male nurses informed me after questioning them that they were for the visitors and not for the patients. Around 08 AM, all the patients had been let out into the courtyard and rooms await to be cleaned. Although the two wards are next to each other, male Ward A looked a bit tidier than male Ward B. Unlike the femaleward and Ward D, the two male wards were cleaned by men. The male nurses seemed a bit more relaxed for a day that doctors would show up for their rounds, unlike the female ward nurses who busied themselves with making sure everything was top-notch before the doctors showed up.

There was a distinction with how medication was dispensed in the male wards, the patients received their medication through the main burglar door that led to their rooms and not a broken windowlike in the female ward. The nurse instructed a student nurse to feed a blind patient, who seemed to be one of their permanent patients. Each ward had at least one patient whose stay at the Mental Health Centre was permanent, for various reasons.

Ward C was busy, the cleaning lady was doing her part and a nurse was dispensing medication through the window, like they did every morning. A student nurse from the male wards had been sent to theward, to get the BP machine and the nurse informed me that the wards shared the machine. The senior nurse indulged me in conversation about how the patients are not allowed to

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have pens with them because of an incident that occurred a few years back in one of the wards. Before she could give me all the details, there were interruptions and she had to attend to a patient. The patient board showed that the total number of patients in the ward had reduced within the past few days because of the discharge of patients.

One of the nurses was playing the role of a teacher and correcting a student nurse on her patient diagnosis notes. A family member walked in with bags, she has brought stuff for one of the patients and the senior nurse cleared the bags out to examine the contents. "It is simply a routine, that I make sure I examine everything in the bag." She said to me when she noticed that I was looking at her. Ward D on the other hand was pretty quiet, patients were in the courtyard. There were two nurses at the duty station doing paperwork, as they wait for the doctors to show up. By the time I got to the ward, it is squeaky clean and the cleaning lady had left.

One of the nurses invited me into their doctor's round sessions. The aim of course during these sessions was to attend to the needs of a patient and analyse their recovery process. At the same time, doctors made sure to turn it into a learning process for the intern doctors. The medical officers let the interns do the follow-up questions and take notes, they simply jumped in when they saw the interns were stuck. Once the patient left, the medical officers, interns and nurses discussed their different opinions on the patient's recovery process.

Fridays during the pandemic were pretty slow, both in the wards and OPD. The patients were entertained by the student nurses since they could not do sports activities with them. The Mental Health Centre is lively on Fridays because nurses get to wear their casual clothing and not their uniforms as they do from Mondays - Thursdays and the weekends. Student nurses interacted with patients in the courtyard, under the supervision of the nurses of course. It gave the nurses time to get through some paperwork and arrange their medicine carts and cabinets. Fridays were not as hectic,medical officers on call showed up to the wards to see if their services were needed. Social workers, occupational therapists and psychologists showed up to the wards for private sessions with the inpatients. If any patients showed up at OPD, the interns and medical officers on call, attended to them.

The routine had its drawbacks on the Mental Health Centre's ability to deliver the best care but it allowed them some room to then still care for their patients. On OPD days, patients grew wearyand tired at the fact that they had to wait on the medical officers and interns who usually spent two to

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three hours in the conference having their morning meeting, which at times turned into a learning session for the interns. All in all, this weekday routine seemed to work for the Mental Health Centre and it was a great example of the direct influence of structure on agentic behaviour. It played a role in how they operationalise and conceptualise care. It offered them a sense of order and prepared them for what each day entailed, but at the end of the day, whether the healthcare workers had to improvise and prioritise in the name of care, all depended on the day at hand and the patients. This capacity to attend to many human needs by using a sense of social organisation categorises this Mental Health Centre as a Total Institution (Goffman, 1961).

Goffman (1961) argued that what makes up an institution centres around the interest of members, the creation of a world for these people and encompassing tendencies. This is also what he referred to as total institutions. The Mental Health Centre had walls with improvised broken glass bottles where barbed wires should be, to discourage patients from escaping. Furthermore, it had doors that were locked at all times and specific persons who had the keys and access to the keys, high walls for the forensic unit with barbed wires which speaks to what he referred to as a total institution and what other scholars refer to as an island. Total institutions are places that are put in place with the assumption of taking care of individuals who are not deemed fit to take care of themselves and possibly a threat to the rest of the community (Goffman, 1961). This speaks to the nature of this Mental Health Centre and the service it provides to the Namibian citizens. The individuals in this Centre take on the role of patients when admitted, they are introduced to a whole different social setting with different rules.

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The Mental Health Centre Entrance

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This is a board present in all the different wards at the Mental Health Centre.

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A notice board in the Out-Patient Department.

A notice board in the corridor separates Wards A and B.

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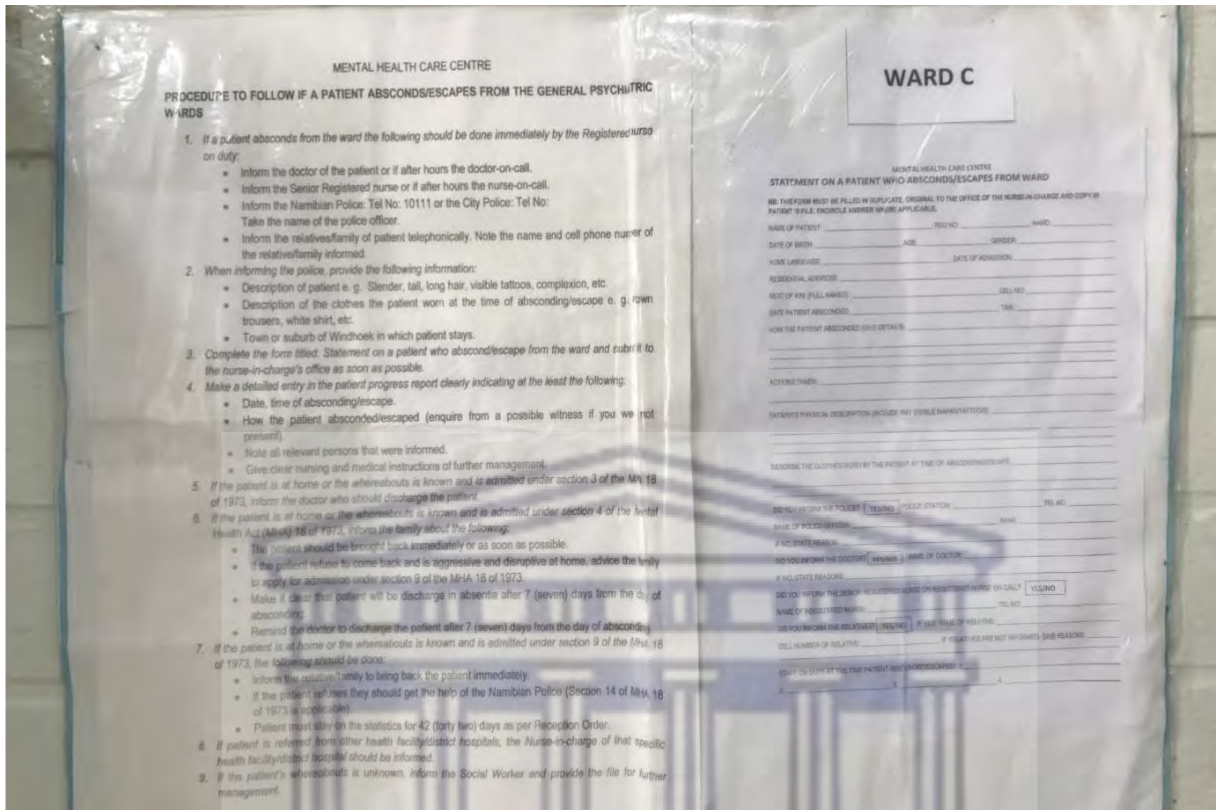


MENTAL HEALTH CARE CENTRE

PROCEDURE TO FOLLOW IF A PATIENT ABSCONDS/ESCAPES FROM THE GENERAL PSYCHIATRIC WARDS

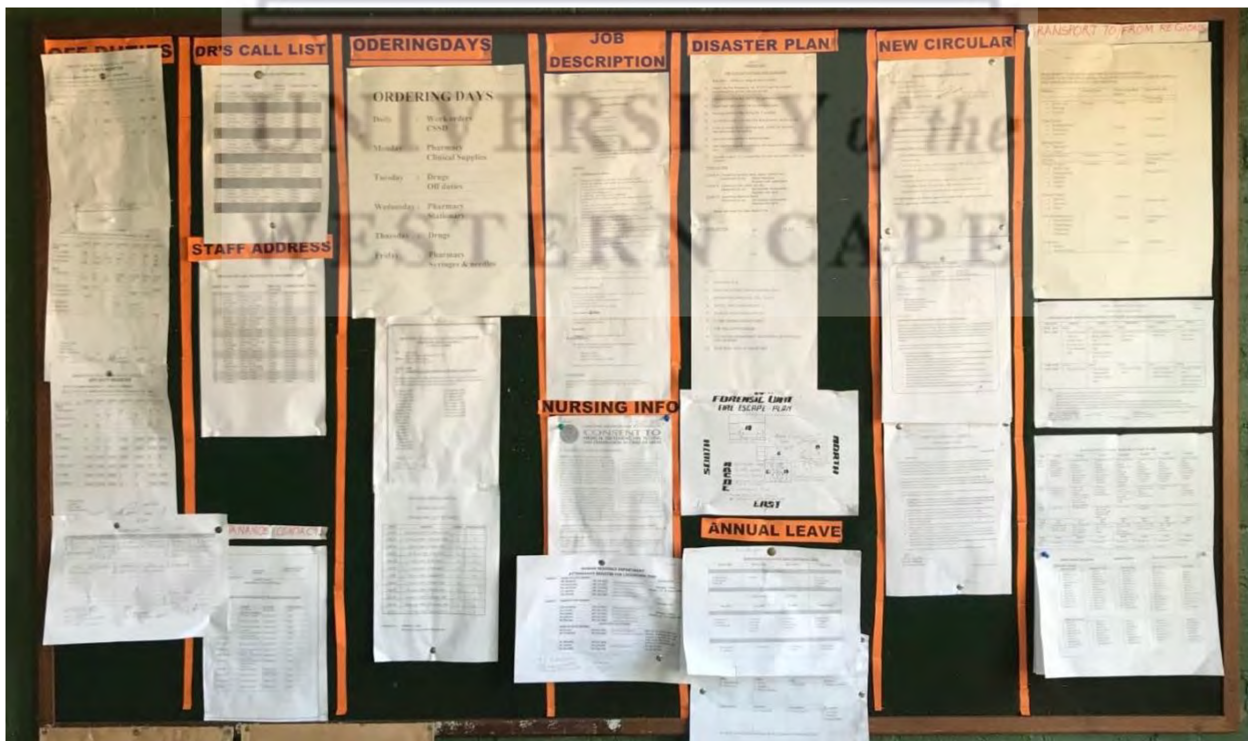
1. *If a patient absconds from the ward the following should be done immediately by the Registered nurse on duty:*
   - Inform the doctor of the patient or if after hours the doctor-on-call.
   - Inform the Senior Registered nurse or if after hours the nurse-on-call.
   - Inform the Namibian Police: Tel No: 10111 or the City Police: Tel No: Take the name of the police officer.
   - Inform the relatives/family of patient telephonically. Note the name and cell phone number of the relative/family informed.
2. *When informing the police, provide the following information:*
   - Description of patient e. g. Slender, tall, long hair, visible tattoos, complexion, etc.
   - Description of the clothes the patient worn at the time of absconding/escape e. g. brown trousers, white shirt, etc.
   - Town or suburb of Windhoek in which patient stays.
3. *Complete the form titled: Statement on a patient who abscond/escape from the ward and submit it to the nurse-in-charge's office as soon as possible.*
4. *Make a detailed entry in the patient progress report clearly indicating at the least the following:*
   - Date, time of absconding/escape.
   - How the patient absconded/escaped (enquire from a possible witness if you were not present).
   - Note all relevant persons that were informed.
   - Give clear nursing and medical instructions of further management.
5. *If the patient is at home or the whereabouts is known and is admitted under section 3 of the MHA 18 of 1973, inform the doctor who should discharge the patient.*
6. *If the patient is at home or the whereabouts is known and is admitted under section 4 of the Mental Health Act (MHA) 18 of 1973, inform the family about the following:*
   - The patient should be brought back immediately or as soon as possible.
   - If the patient refuse to come back and is aggressive and disruptive at home, advice the family to apply for admission under section 9 of the MHA 18 of 1973.
   - Make it clear that patient will be discharge in absentia after 7 (seven) days from the day of absconding.
   - Remind the doctor to discharge the patient after 7 (seven) days from the day of absconding.
7. *If the patient is at home or the whereabouts is known and is admitted under section 9 of the MHA 18 of 1973, the following should be done:*
   - Inform the relative/family to bring back the patient immediately.
   - If the patient refuses they should get the help of the Namibian Police (Section 14 of MHA 18 of 1973 is applicable).
   - Patient must stay on the statistics for 42 (forty two) days as per Reception Order.
8. *If patient is referred from other health facility/district hospitals, the Nurse-in-charge of that specific health facility/district hospital should be informed.*
9. *If the patient's whereabouts is unknown, inform the Social Worker and provide the file for further management.*

WARD C

MENTAL HEALTH CARE CENTRE

STATEMENT ON A PATIENT WHO ABSCONDS/ESCAPES FROM WARD

A list of procedures is pasted on a wall in Ward C and a notice board in the forensic unit below.



A notice board in the rehabilitation ward of the Forensic Unit

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Doing fieldwork at the Mental Health Centre

I was born in Windhoek and partly raised there, before my family moved to Kavango East. I studied at the University of Namibia which is based in Windhoek and had not once stepped foot at this Mental Health Centre at the Windhoek Central Hospital before my fieldwork. Once I received the letter from the Ministry of Health and Social Services that permitted me to conduct the research, I went to meet up with the head of the Mental Health Centre, Dr. Nene. She invited me to join the doctors and interns' morning meeting that they had weekly. She introduced me to the doctors and interns and allowed me to tell them a bit about what the study was all about. After the meeting, she instructed one of the interns to give me a tour of the Mental Health Centre. The intern gave me a tour around the Centre and introduced me to the nurses that were on duty in the different wards and I further informed them about being a researcher. Once the intern shared the weekly routine at the Centre, I drew up a schedule to help manoeuvre the Mental HealthCentre.

The mornings at the Mental Health Centre were quite interesting. I would sit in on the morning meetings to observe and listen to the interns diagnose a patient and wait on the psychiatrists who played the role of mentor to correct them or confirm their diagnosis. The doctors felt at ease to let me sit in on the meetings because of my clinical psychology background which Dr. Nene shared with them during her introduction of me. It was always a learning process for everyone in the room, although at times I practiced restraint because of being an Industrial psychology graduate with exposure to clinical psychology and at times they were temptations to want to join the conversation but had to reminded that the purpose for being there was as a researcher only. My psychology background made the doctors trust me enough to allow sit ins during consultation sessions with the in-patients in the civil wards. The permission letter from the ministry and psychology background enabled me to have access to every part of the Mental Health Centre under the instruction that when in these different wards, I had to always stay close to the doctors and nurses and never be alone.

Moving between the different wards was nerve-wracking because each ward had a different atmosphere. Each ward required me to practice different levels of restraint. The female ward, Ward C was the hardest to maneuver. The patients always got excited at the sight of anyone other than the nurses walking into the ward. They would engage me in conversation and I would indulge them but always had to stop the conversation the minute they confused me for being a medical officer or intern. This was one of my biggest ethical dilemmas, I could not ignore the patients when

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they wouldwant to indulge in conversation but also had to always make sure they understood that I was not a doctor. This pushed me to introduce myself and inform them that I was simply a researcher, which the patients did not seem to grasp because it felt like every time they saw me I had to reintroduce myself. None of the staff bothered to introduce me to the patients, they allowed me to do it myself. This said a lot about how the patients are not visible beyond the status of being mere patients, that are to be taken care of and medicated and nothing more. The nurses at times would intervene when the patients would show too much excitement from seeing them walk into the ward. I spent two weeks in each of the wards, and the patients eventually got accustomed to seeing me in the ward, which made practicing the restraint of interacting a little hard for them. Some patients would of course get verbally aggressive and I could not defend myself, however such behaviour was not taken personally. The nurses would always inform me to shrug it off and made assurances that it was a norm of behaviourwith the patients.

The nurses in the wards at times would indulge in a verbal exchange with the patients and as much as I wanted to advise them to be the better person, the best decision was to just sit and observe. The nurses at timeshad to be rough with the patients because they believed this was the way they get the job done. Itmade me feel uncomfortable not defending the patients or even attempting to put a stop to it but it seemed I was the only one that viewed the patients as humans before anything because this was a norm for these nurses. It was as if these patients were invisible when viewed beyond their status as patients in this Mental Health Centre. I did not want to have a hostile relationship with the nurses because that was going to make the fieldwork harder than it had to be. I had to stay on thegood side of the nurses to do the fieldwork with ease and fought the side of me that wanted to correct them and question some of their ways of executing their roles.

Many times I had to sit in the same room with nurses who felt like I was violating their privacy, simply by being present in the same ward as they were. On a few occasions, the observation process had been interrupted by them asking too many questions to see if there were justifiable reasons for my presence in the wards. One of the nurses tried to get into an argument with me because she was not happy with having a 'stranger' in the ward. She believed me to be a spy for the Ministry of Health and Social Services. I always had to keep calm and make it clear time and time again whatmy purpose was for being at the Mental Health Centre and always carried the permission letter with me in case a nurse demanded to see it. The tension with some of the nurses was because when I first made my introductions in the different wards on the first day, some of

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them were not on duty. I had to approach the head of the nursing staff at some point, to kindly request that he spread the news to the rest of the nurses about my presence at the Mental Health Centre. He seemed to not be aware of my presence because Dr. Nene had failed to mention it to him and it was highlighted to me that communication channels were flawed in this Mental Health Centre.

The medical officers and psychiatrists were easy to interact with. The intern doctors resented me for not attending to patients with them, although I wore a lab coat that was embroidered that I was a researcher. The nurses always wanted me to explain my presence at the Mental Health Centre although most of them were welcoming and the others not so much. The patients seemed to confuse the lab coat for the status of a doctor, which meant always having to reintroduce myself. Those who would confuse me for a doctor would always plead with me to discharge them, which felt awkward all the time because I was simply in the wards to gather data and somehow they had managed to magnify my role. As much as I tried to blend into the point that the staff and patients would forget I was even there, the curious patients always made it impossible because they always acknowledged my presence.

Doing research in a Mental Health Centre of course involved risks. Every time I walked into the male wards and the forensic unit, there was a fear related tomy safety instantly. Nurses always made it their job to remind me to be vigilant, to always choose outfits for each day correctly and avoid drawing unnecessary attention to myself. The latter was the hardest, my presence in the wards was something new for the patients of course that would spark their interest. I tried to mitigate the situation by always situating myself in the ward in places where I could observe without them noticing me. The forensic unit was the scariest to manoeuvre, nurses 'could not stay by my side all the time. If they had errands to run outside of the forensic unit, I had to stay put and carry on with my observations. Sometimes I would be all alone at the station duty and patients would roam around, some making their way to their rooms or at times to the toilet. Some would pop up at the duty station asking for the nurses. It would help when the correctional officers were close by, I would feel a little at ease. The correctional officers wore their civilian clothing most of the time, which made it hard to distinguish between them from some of the patients that they would let roam free in the open courtyard. Some of the patients would sit and chit-chat with the patients. Patients in the entire Mental Health Centre wore their clothing brought in from home, they had no uniform clothing distinguishing them from the employees of the state.

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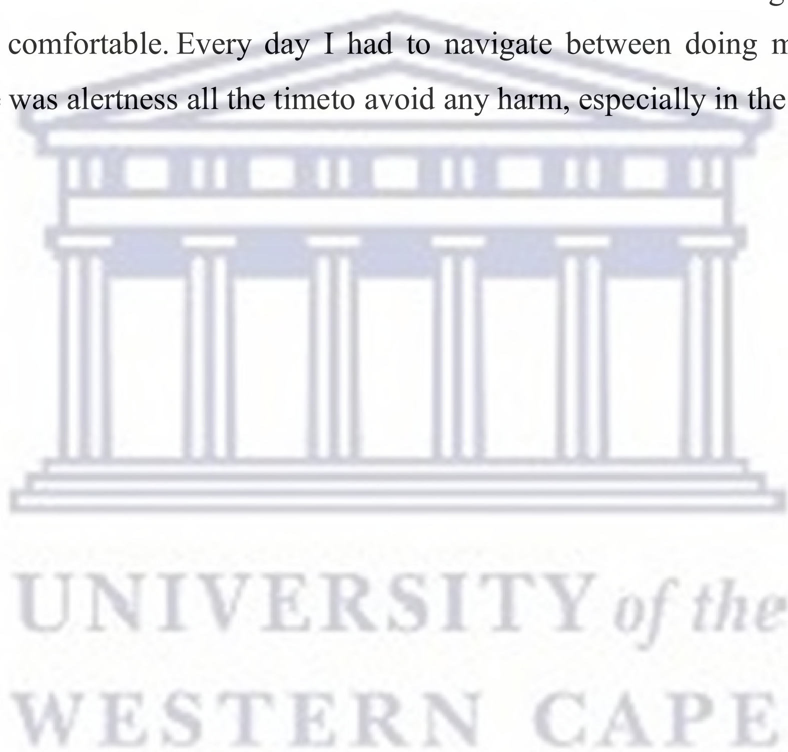
So navigating the forensic unit madethings slightly harder. I did not know which corner to stand in and observe and feel safe at the sametime. It was not their place to tell the correctional officers to show up to work in their uniforms, although the head of the forensic unit shared with me that he always advised them to.

In the end, I always managed to sway myself in the direction of quietly observing, assisting when asked to and asking questions whenever possible. I hid my fear as much as possible so that the focus was not on me but on their daily work. There was a sense of gratefulness for being allowed into every space of the MentalHealth Centre and had healthcare workers so eager to assist me and make sure I was comfortable. Every day I had to navigate between doing my field work and making sure there was alertness all the timeto avoid any harm, especially in the wards.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CHAPTER 3:

WORKING IN THE MENTAL HEALTH CENTRE

The pursuit of biomedicine involves modifying its practice and knowledge in order for it to fit into one's reality especially where caregiving is involved (Livingston, 2012). The way these healthcare workers executed their roles is highly subjective to their work environment and their access to resources. In this findings chapter, the study discussed how healthcare workers make it a priority to executetheir work in an environment that is not entirely designed to support them. I depicted the everyday work of these healthcare workers as a collective because they present themselves as a multi- disciplinary Mental Health Centre.

The practice of biomedicine in countries that battle with poverty is not executed the same way it is in the developed world. Institutions that are rigged with medical uncertainty and institutional instability have forced healthcare workers to strive for ways in which they make biomedicine work for their conditions (Street, 2014). In this mental health centre, the healthcare workers have managed to come up with a schedule that works for them. The limits that exist, mean biomedicine is constantly reinvented and imagined like clockwork to curb the reality of a shortage of resources and an institution that is technologically challenged (Street, 2014). The work that these healthcare workers engaged in daily rests on improvising with what they have. It is a mere reflection of what the physical world of biomedicine looks like in a developing country with an almost non-existentbudget for mental health care services.

The healthcare workers all worked within the Monday to Friday schedule. I spent most of the time in the civil wards because other than the Out-Patient Department, they were the busiest at the MentalHealth Centre. The mornings were busier any day of the week but most especially on the doctor's rounds days. The nurses made sure everything was done before the doctors showed up to the wards. They looked at any reports about the patients that the nurses who were on the night shift might had left. After that, they wait for all the patients to gather in the courtyard before dispensingmedication. Once they complete dispensing medication, they took assessments of each patient. This entailed clearly defining how the patient was feeling, the patient's vitals and their general moodfor the day.

Work and boundaries were clearly defined by the healthcare workers. They all knew what part to play in making sure that this Mental Health Centre's schedule for care moves smoothly. The

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medical officers and psychiatrists held meetings every morning to discuss and help interns reach the right diagnosis. They then attended to the patients at the Out-Patient Department depending on the day of the week that it was. They did follow-up consultations with in-patients at the wards and made decisions on discharges and recommendations to psychologists, social workers and occupational therapists.

Accommodating patients is a shared role of care. Once the intern doctors and medical officers decide that a patient should be admitted, the next step is to have the patient escorted to the wards. Institutions where a shortage in personnel then pushes doctors and nurses to establish connections between staff and patients that are close to resembling kinship as a resource (Street, 2014). At times an intern doctor took the patient to the wards and other times it was nurses in the Out-Patient Department that did it. Once the patient was in one of the wards, a nurse at the duty station filled out the admission form before allowing the patient to join other patients. In the case where the patient's blood pressure and so forth had not been assessed, the nurses made sure to do it.

When a patient was discharged, the medical officer made it clear during a consultation meeting with the patient and nurses. The nurses filled up the paperwork before a patient was discharged, they also made sure the patients had a prescription of medication that they had been taking in the ward. Patients were to collect the medication at the pharmacy, they confirmed this before letting the patient out of their site, and the patient's vitals were also recorded. If everything looked fine and they had their medication and there was a relative to collect them or an ambulance set up with the social worker to take the patient home, then the discharge process proceeded smoothly.

Medical officers were given the status of medical doctors in this Mental Health Centre. Nurses referred patients to the medical officers and at times to the intern doctors. Together they played the role of diagnosing the patients. Medical officers had the liberty of diagnosing patients and prescribing medication for both in-patients and out-patients. Interns on the other hand, once they were diagnosedhad to run it by the medical officers and psychiatrists before the diagnosis can be made certain, especially in the case where a patient had been admitted. I picked this up during observations, the interns presented the case of a patient they admitted the following day at the morning meetings and the psychiatrists then gave the final diagnosis of the said patient.

However, the case was different with regular out-patients who showed up for a refill of their medication or a simple check-up. The interns consulted the medical officers in instances where

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they could not carefully figure out the prescribed medication and dosage and when they were stuck on how to further assist the patient. Interns accompanied by medical officers held consultation sessions together during the Doctor's rounds. Some medical officers took the lead and let the interns learn from them, other medical officers let the interns take the lead and correct them when they needed to. After all, these sessions were supposed to be a part of their learning experience as this was also a teaching psychiatric clinic.

Psychiatrists in the Mental Health Centre worked closely with the inpatients, especially those who were referred to as forensic state patients. They are state psychiatrists, therefore were tasked with evaluating a patient to determine whether he or she is fit for trial. They also determine whether at the time the crime was executed he/she had a mental illness. These patients were then housed in the forensic unit, referred to as a ward with the aim of treatment and rehabilitation. Psychiatrists worked closely with these patients because at the end of it all they determine whether a patient can be discharged and released back into society under the certainty that he/she is not a threat to society anymore. One of the nurses shared the following:

> "*We are just the nurses; we take care of them in the wards but the psychiatrists are the ones that can authorize the patient to be discharged because they monitor the rehabilitation process of a patient. They are the ones that give assurance to the courts on patients being released back into society".*

Psychologists, in this case clinical psychologists played the role of assisting patients with a treatmentplan that had been set. They worked hand in hand with the psychiatrists who played the role of prescribing medication for the patient which also played a role in the success of the treatment plan. Psychologists had follow-up sessions with the in-patients usually on the referrals of a medical officer. They attended to outpatients based on referrals as one of the clinical psychologists shared that they were a referral clinic.

Social workers played the role of helping the patient navigate the social world. They also played the role of mediator between a patient and family members and at times members of the community. This belief stemmed from one of the challenges the Mental Health Centre faces that involved patients relapsing and being returned to the psychiatric clinic. They relapsed almost immediately because they did not have a supportive environment. One of the social workers shared that most family members would rather just drop off their relative at the Mental Health

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Centre rather than have to care for them at home. This was highlighted as follows:

> *"Some of these patients are dumped at the Centre by their relatives, they claim that they are hard to deal with. Especially during the festive season, the relatives of some patients would rather just leave them here instead of spending some timewith them".*

Social workers also visited the homes of the patients to determine whether they were fit for patients and try and reach an understanding of how supportive the environment is or could be. All of these factors helped with coming up with a treatment goal and how effective it could be. The social workers also played the role of accompanying patients who had no one to rely on with regards to purchasing a few personal things they may need from the outside during their stay at the Mental Health Centre. This was echoed as follows:

> *"Sometimes, like you saw me the other day. We take some of the patients, especially senior citizens to town to help them get a few personal things like toiletries, we also help them get their money at the ATM or the bank because theirrelatives are unwilling to help with all this".*

Occupational therapists were the last step for patients, especially for the patients being rehabilitatedat the forensic ward. The occupational therapists were the last step in the process of a patient's treatment while in the care of the Mental Health Centre. They indulged patients in activities that help them stay active and learn skills to incorporate before returning to work and simply how to carry on living after a traumatic episode. The healthcare workers in this Mental Health Centre took a holistic approach to care, each of them played a role in attending to the needs of a patient. The security personnel were responsible for helping the healthcare workers quickly deal with an event where a patient got aggressive, refused to take their medication or needed to be locked up in a seclusion room for the safety of other patients, the patient and the healthcare workers.

The work of these healthcare workers in the Mental Health Centre varied. It all depended on the ward one found themselves in and the type of patients in the ward. The female ward was the busiest compared to all the others and because it had no security men at the door or male nurses in the ward, the nurses in this ward depended on the security men from the forensic ward. Healthcare workers in psychiatric institutions are normally exposed to risk as they work in settings where they have to attend to patients with unpredictable behaviour (Fernandes and Marziale,

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2014). All the civil wards did not have any security men on sight for assistance with aggressive patients. The security men stationed at the forensic ward then played the role of moving to the civil wards to assistwhen things were out of hand.

This was the main risk that these healthcare workers who spend their time in the wards faced daily. Healthcare workers in psychiatric institutions were always exposed to risks when they had to administer injectable drugs to patients (Fernandes and Marziale, 2014). For example, Ward C on one of the days had an aggressive patient who had refused to take her medication for fear of getting hurt and the nurses called for help. Once the help arrived, they managed to sedate her and move her to the isolation room. Once they all emerged from the bed area of the patients and locked the burglar door, Sister Rose complained to the other nurses about being kicked in the abdomen. Once the ward settled down, the nurses got back to the order of the day, as if they had not just had a pretty dramatic and eventful morning. The nurses made it clear to me that since it was mostly female nurses that work in Ward C, they always had to rely on the assistance of the group of security men to sedate highly aggressive patients. This was emphasized as follows:

> *"My dear, this is how it is sometimes with these patients. You want to take care ofthem and they can hurt you in the process because you are forcing them to take their medication. At least in cases like this, we can call the security men fromforensic unit and sometimes the male nurses from Wards A and B to help us".*

The risk that healthcare workers in the female ward may concern themselves with was not the concern for the healthcare workers in male wards. The latter's concern was that patients at times may try and fight them or injure them to abscond, the absence of security personnel at these civil wards was then felt differently depending on which ward one found themselves in. The two male wards had more cases of patients who absconded and in their capacity as healthcare workers, they put the patients who showed signs of wanting to escape from the facility in the seclusion room because they were prone to being violent with the nurses in the ward and to the other patients. The healthcare workers then tried to collectively work together to explain and make sure the patient understood why he could not leave the facility just yet. I witnessed it too many times, at times patients would get tired of waiting to be discharged and the other patients would help them climb over the wall. Oncethat happens all the nurses would hope for is that the family return the patient and they can attendto him and start his recovery process all over again.

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The acute ward, also at times referred to as ward D, houses patients who suffered from depression and was built a little differently from the other wards. The main door to the ward is always locked and the nurses in the ward kept it with them at all times. When someone outside wanted to access the ward, one of them got up from the duty station and walked to unlock the door. This system they had set up in this ward allowed them to have control over patients who may have wanted to abscond. The nurses who worked in Ward D believed that there was not much risk compared to the other wards which they had worked in. This was because, at times, they rotated the nurses. This ward just like the civil wards had no security men for their protection. When faced with a difficult patients, the nurses then called on the security men who were stationed at the forensic unit.

The civil wards exposed the healthcare workers to risks but the security personnel resided in a different part of the centre. The forensic ward which was home to convicts who had been declaredmentally ill posed the biggest threat in this Mental Health Centre which was why this was the only wardwhere I found both security personnel and correctional officers. As a nurse working in forensic psychiatry, it was a must that one is on guard, as one could find oneself in a life-threatening situation (Hammarström et al., 2019). The nurses in these Mental Health Centres shared that they always had to be on guard when working at the forensic unit rather than at any other ward.

The sub-wards in this forensic ward all had either one or two nurses at the duty station. The correctional officers and security personnel hung right outside the wards and sometimes in the courtyard interacting with the patients. This put the nurses at high risk because at times some of the patients lingered around in the ward, and some watched television in the ward instead of going outto the courtyard. The nurses usually spent time alone in the wards, especially because they had to always make sure the patients took their medication. The offices of the correctional officers were far from the wards which only put the nurses and the other healthcare workers who stopped by for consultations at risk of getting hurt by the patients.

The two sub-wards that housed the most volatile patients barely had any security personnel close by for the protection or defense of the nurses at the wards. The maximum security sub-ward had two male nurses at the duty station, one man from the security personnel and the main door into the ward that had been broken for years. The head of the correctional officers, who happened to be in charge of the forensic unit could not give any definite answer on when the door would get

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fixed. The following is what he said:

> *"This door has been like this for a long time now. I reported on it butI don't know when it will be fixed, so we just manage with it".*

Taking care of patients with mental disorders does expose healthcare workers to physical and verbal abuse (Sousa, Gonçalves, Silva et al., 2018). Risk was almost a familiar thing at the Mental Health Centre and everyone who worked in these wards had simply found ways to stay vigilant and made sure they were not a victim of violence while doing their job. The biggest risk that the healthcare workers were faced with was physical injury at the hands of the patients and this was a risk they had made clear they would never be compensated for.

Even with all that in mind, the nurses still looked out for the interns. There was an instance in Ward A, one of the male's wards were an intern doctor decided to have a session with a patient she had admitted the previous night. She went ahead and decided to evaluate the patient, without asking for assistance from the male nurses who were on shift in the ward at the time. The patient threw atantrum that made the nurses rush to the consultation room to help control the scene and bail out the intern doctor from a situation that would have caused her harm. One of the nurses explained that what she had done had been so risky because the patient could have hurt her or worse, he stressed the point that the interns should always make sure a nurse is around when evaluating a patient.

The wards may be risky environments to work in and conflicts between patients and the healthcare workers may be an everyday thing but conflicts amongst the healthcare workers were a part of the culture in this centre. Healthcare workers had conflict because at times they were all trying to findnew ways to care for patients in psychiatry (Silva, Terra, Leite et al., 2015). Nurses clashed amongstthemselves, they clashed with medical officers and the intern doctors. These conflicts rose from differences in how to care for a patient, with the limited resources they all had at their disposal itcreated a stressful environment for all.

For example, nurses in Ward C struggled to reach an agreement because of a patient who was experiencing a manic episode. She had not slept at night and kept them up all through the night with her antics. Some of the nurses were trying to be gentle with her so they could convince her to get sedated but the other nurses were not having it. They simply wanted to call for the assistance of the security men at the forensic ward, so they could sedate her against her will. Sympathy and

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empathy may be at the forefront of guiding their approach to care but they each have a preferred way they operationalise it. This often led to healthcare workers having conflicts. For example, the nurses got upset about how the intern doctors would make decisions regarding the patient's treatment without getting their opinion. They felt that they spent more time with the patients therefore their opinion should be considered. This was highlighted as follows:

> *"These doctors sometimes switch up the medication that they give the patients without even asking us for our observation of the patient in the ward, like their mood when they take certain medications. Some patients' appetite for food and overall mood changes from the switch-up of their medication. We should also have a say in these things"*.

At times conflict would arise from the unavoidable battle of power and authority, especially in the wards. Nurses always had a lot to say after the doctor's rounds and it would be about being talked down to, undermined and disrespected. This battle of authority in the presence of intern doctors and student nurses led to tensions amongst some of the nurses, medical officers and psychiatrists. Intern doctors always try and steer clear of conflicts with the nurses because they believe this would lead to them having to repeat their internship period as punishment. They shared how it has happened to so many interns in the past. A lot of them then made sure to please the nurses and medical officers to avoid the threat and likely probability of failing. This did not seem to botheranyone as it was a clear part of the culture in this Mental Health Centre.

Conflicts were frequent between older and young nurses. The older nurses who had more experience at times tried to impose their way of executing their duties. The younger nurses felt entitled to find their way of executing their duties and refused to listen to the nurses who had been working longer than they have. Nurses who had been working at the Mental Health Centre for a long time got very territorial about the wards they worked in. On a few occasions, I had clashes with some of the older nurses because of just being present in areas they were territorial about in the wards.

Conflicts among the nurses in wards were common among female nurses and rarely occurred among males. There was always a noticeable competition for authority that stemmed from their work experienceamongst female nurses. The head of the Mental Health Centre made it clear that

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all the healthcare workers were subject to fair disciplinary hearings based on the Labour Act in Namibia. Male nurses and female nurses did clash here and there, especially when they find each other in their different wards. They all had different ways of executing the daily tasks of the ward in their respective wards and so at times failed to reach an agreement when forced to work together.

Conflicts did not only occur between healthcare workers, at times they involve patients. How one reacted to a patient initiating an argument or throwing insults at a nurse all depended on the different personalities these healthcare workers had. Some of the nurses would indulge in verbal fights with patients and others would simply ignore them. Medical officers did not have it easy during doctor's rounds because patients fought to be discharged from the Mental Health Centre with the medical officers and psychiatrists. Once they found out that they were not being discharged, they verbally attack them. The healthcare worker then had to calm the patient down and de-escalate a potentially violent scene.

All the wards had shifted rosters on their notice boards, as they worked for 40 hours a week and anything over that was then considered overtime. The head of the nursing committee did their part in making sure hours worked in the week and during shifts were as they should be. The day shift is divided into two parts, such that each nurse worked for two shifts that covered 07H00 to 19H00 and three shifts that covered 07H00 to 12H00. The night shift meant a nurse covers 12 hours, working from 19H00 to 07H00; the nurse would have three nights on and three nights off to cover all 40 hours of the total week.

Their work schedules at times inconvenienced their colleagues but the nurses deserved rest especially if they had been working a lot of night shifts. There was an instance where one of the nurses in the male wards had a day off. It was a doctor's round day and the two male nurses had a lot on their plate. This is what one of them stated:

> *"Look, there should be three of us on duty but it's just the two of us because our colleague has a day off to rest. Now it is doctor's rounds, I do not like this day because it is so much work but we have to do it. We owe it to these In-patients".*

The two nurses had to each be in charge of one of the male wards, with some assistance from the student nurses they were able to get the job done.

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The rest of the healthcare workers worked from 08H00 to 17H00 and covered extra hours if they were on call, especially for the medical officers. The nurses who worked at the Out-Patient Department also covered 40 hours a week, they worked from 07H00 to 16H00 for five days a week. I spent a lot oftime in the civil wards and nurses would always look out for each other if a colleague ran late and covered an extra 15 to 30 minutes until the colleague showed up. They would never leave the ward unattended even if their shift was over for the day or night.

Except this only applied in the civil wards, the nurses at the forensic ward would leave as soon as they fulfilled their hours for the day. One of the nurses shared that the forensic sub-wards had no nurses working at night as they all knocked off at 18H00 at times 19H00. This was all fear of patients' violence, being alone in the ward with patients, the knowledge that there was no risk allowance andthe fact that every nurse who had been physically hurt by a patient had never been compensated.

Conclusion

The findings in this chapter spoke to the fact that the healthcare workers in this Mental Health Centre took an approach to work like a multi-disciplinary unit. Each of them knew their role and although some of them overstepped and conflict arose, they did understand that what matters most was caring for a patient. These healthcare workers 'did not manoeuvre the same wards daily as they had to attend to all the patients in different wards and when they did, they adjusted accordingly. This findings chapter was simply about the work, what it entailed and the precise details of it. The findings in this chapter provided insight into the different entities involved in the services of providing care in this Mental Health Centre. It also gave insight into their different roles, the risksthat these healthcare workers are exposed to, their interpersonal relations and these related to their work, their experiences and how they embodied being healthcare professionals in this Centre. The next chapter illustrates the agency and agentic behaviour of these healthcare workersin the Mental Health Centre.

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CHAPTER 4:

AGENCY IN THE FACE OF CARE

In studying the culture of care, one had to take note that the practices of biomedicine are usually moulded to fit the reality of health care on the ground (Livingston, 2012), it was important to keep in mind that improvisation and the sense of agency in these structures was almost inevitable. In this chapter on findings, I discussed how healthcare workers made it a priority to deliver care in an environment that was not entirely designed to support them. The chapter depicted the lived experiences of healthcare workers in the different wards, especially the nurses with regards to providing care and provided a depiction of their agency in this Mental Health Centre.

The dynamics of the logic of care, the role of culture and the act of improvising itself were best explained by the structuration theory. Pleasants (2019) referred to agency as defined by the course of action an individual chooses knowing fully well they could have acted differently. He emphasized that the sense of free will which gives the individual the ability to choose from a range of alternatives. Agency is the ability that individuals possess that allows them to act and work their way through cultural structures that exist and rely on past experiences (Buckser, 2009). Individuals then can rethink the practices that exist in the structures they find themselves in. The practices of care are greatly rooted in both social and institutional contexts (Buch, 2015).

This is to say that healthcare workers who found themselves in this overcrowded and understaffed Mental Health Centre made use of their agency to improvise with what they had available and to deliver care to their patients. What distinguishes the practice of care is that it does not only involve upholding its basic principles but also finding ways to negotiate different ways that care can be achieved (Buch, 2015). The healthcare workers in this Mental Health Centre can delivered care at times simply because of their agency but at times this exercise of agency may look like stretching the limits of what care was in this structure.

Care is a process with no set boundaries in the sense that it is an ongoing process between the caregiver and patient, an interaction that is defined by time (Mol, 2008). Whether the process is short-lived or prolonged depends on the back-and-forth interaction between the patient and caregiver. Care in its essence is active and aims at improving one's life (Mol, Moser and Pols, 2010). There are various ways in which people define care and although the explanations for it

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may have common objectives, the understanding and practice of it seems to be very subjective. These healthcare workers at the mental health centre were able to make it clear to me what care means in this centre and were able to describe the practice of it.

The health care workers in the Mental Health Centre for the most part explained their understanding of care with their patients using the Monday – Friday routine in mind. Apart from the weekly routine, the nurses especially highlighted how the assessments they carry out, dispensingmedication and recording the patients' vitals daily also counted as care. In one of the informal interviews conducted with a male nurse from wards A and B, Mr. Mac elaborated that care in wards A and B was applied when the patient was admitted and extended to the day the patient is discharged. His colleague, added that care was "to fulfil the needs of the patient and making sure that the patients areswallowing their medication." The act of the patients swallowing their medication was something I had witnessed the entire time at the Mental Health Centre. A lot of the nurses emphasised itbecause they had observed over the past years patients who seem to deteriorate while supposedly taking their medication, and many times they found that it was because they do not swallow the tablets and not because the medication is not doing its intended job. Sister Mayble on the other hand added that care was "the willingness to put in extra effort to help someone who is unable to help themselves for whatever reason." This was something the nurses especially practice in the wards, from going the extra mile to making sure the patient swallows their medication, making sure the patients took a shower every morning, assisting those that cannot bathe themselves, always making sure each patient had every one of their meals and assisting those that could not feed themselves.

The health care workers at the Mental Health Centre at times referred to it as a multi-disciplinary hospital, because there are different disciplines in which a lot of them had acquired the knowledge and expertise to help the patients. They took a holistic approach to caring for the patients. Mr. Jeff, one of the social workers summarised care from the approach that the social workers implement totake care of the patients in the following manner:

> *"For us, we tackle the social issues. So this can be from a personal level, like maybe the person is stressed about something, maybe the person is struggling to adhere to their medication or the person doesn't understand why they have to take the medicine. They maybe stigmatized at work, family is stigmatizing them on the family level. Also, the community at large, trying to just raise awareness of the*

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different and various mental conditions".

Although the social workers may not have been there to do their part of always making sure the patient swallowed their medication, they did assist the nurses by explaining to the patient why they needed to take the medication. They also made it their objective to assist patients who struggled with taking their medication. Aside from the nurses and social workers, psychologists, medical officers and psychiatrists also played a role in delivering care. Dr. Eve, one of the psychologists shared insight into the role psychologists played in caregiving through the following statement:

> *"Care would be basically to see them, attend to them, and make sure that whatever their presenting problem is, is dealt with according to their treatment goals. So usually if a client comes in and they have an issue that they bring up, we come up with treatment goals. Once the treatment goals are met the sessions can be terminated. So that's our care, so the psychological needs of the individual need to be met for me to say that I have cared for this particular patient".*

She further elaborated that the medical officers were usually first in line with the nurses when caring for a patient. Once they had diagnosed the patient and were of the understanding that the patient needed the assistance of a psychologist to complete their recovery process, then that is when they referred patients to the psychologist. These formal interviews with the healthcare workers reveal a lot of things that coincided with what I had observed which is that there is a holistic approach to the treatment process of a patient.

This holistic approach to care was not without challenges seeing as these healthcare workers had to practice care in a health facility with little to no resources and were short on personnel. The healthcare workers revealed a lot of things that hinder their ability to provide care but managed to shed light on how they worked their way around it to deliver the best care that they could. A clear depiction of how they use their agency to thrive and uphold care in this Mental Health Centre. The healthcare workers shed light on how the environment besides the lack of sufficient resources played a major role in their ability to deliver care, as referred by one of them the best care:

> *"The environment things not being up to date, the building is old and sometimes lack of medicine that is not available and the structure, some of the*

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things are broken and you request for it to be repaired and they take so long or don't do it at all. That is a problem".

A lot of the nurses shared the sentiment above from one of the nurses. An irregular supply of medication weakens the interventions healthcare workers have come up with to treat patients (Raja, Wood and Reich, 2015). Nurses shared that a lot of the wards share medicinal equipment which they expressed as an inconvenience because it slows them down. According to the World Health Organisation, the limited availability of the necessary medication somewhat was responsiblefor the mental health gap in most African countries (WHO, 2001). Mr. Mac revealed that they sharedblood pressure machines, thermometers and so forth and that all four wards shared this essential equipment. I had seen the blood pressure machine moved from one ward to another and witnessed nurses having disagreements about where it should be kept. Other than sharing equipment it became clear during the observations that the civil wards shared security personnel with the forensicward. The distance between the forensic ward and the civil wards then made it difficult for the security personnel to get to a civil ward on time when there was a patient out of control. This was the type of support that the nurses at the civil wards need but had made it clear it was not sufficient.

The lack of personnel to prescribe and dispense medication is a clear obstacle to accessing medicines that are necessary for healthcare systems (Raja, Wood and Reich, 2015). One of the medical officers shared with me that the lack of support from seniors and the management also hindered their ability to provide care. He further elaborated there was no room for keeping up to datewith medication and new research and using that information to help patients:

"During my ward rounds, I always stress this part, like anti-psychotics for example, you know. Literature says that if you give haloperidol for example and whether the patient is improving or not. There is a specific wait time, the time that you wait before you alter the medication and that is, you can go as far as four to six weeks but you see, sometimes you notice that there is deviation from literature, you know but it's not quite justified for us who have to execute it. You know, it's a bit difficult to get it right because it looks like sometimes when it is conducive, we do bush medicine. So there's that grey area, so in that regard, knowledge base and research we need some support".

The medical officers were the first in line with interns where diagnosing a patient and admitting

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them is concerned. Dr. Sam's sentiments on what limited his ability to provide care beyond what hemanages were right within his scope. The medical officers were the ones that decided on the prescription of the patient, and the dose the patient should take for the medication and he believedwithout the Mental Health Centre staying up-to-date, he feared he was not doing his best for the patients.

However, as intimidating as the environment and lack of resources and support may have been the healthcare workers, relied on their agency to make sure their patients' needs were met. They acknowledged that there was a shortage of staff and had all found a way to attend to the patients that were at times a lot to handle for three to four nurses on duty. The nurses in the wards shared thatthey prioritised their patients, between the ones who had urgent needs and those who were fit to tend to themselves. Even so, they made sure to monitor the progress of every patient; they simply started with the patients they classified as more vulnerable than the others. The nurses made it clear that not all the civil wards overflow with patients. Ward D, as one of the registered nurses shared with me, did not overflow with patients but she summarised the duty of every nurse that works in this ward as follows:

> *"It depends also on our roles. I am an RN (registered nurse) on top of nursing I have management roles. So, for example in the morning if we are only two. I have duties that I have to carry out like dispensing medication, and doctors' orders. Those are things that I have to do and for the EN (enrolled nurse) patients being bathed, a patient being fed, that's her scope of practice. So it depends, it's not really to say that it's five each, it's just who canassist right now based on what the problem is. Who can best assist right now?"*

The nurses who found themselves in the forensic ward had it a little different. Most of the patientswere fit to tend to themselves except for the patients on the first-floor Ward A. The nurses who worked on that floor attended to the patients a little differently. This was highlighted as follows:

> *"What we do is, in the morning, with the help of the security and the prison officers. We take them to bath, each one has to bath; from bathing we have to help them you know, to apply lotion, then what and then with their clothes and so on and after that; they come to the duty station one by one then we have to give*

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them medication, asking if they have any problem. You have to see the physical condition of the patient. How is the patient appearing, does he look sick, does he look down, does he look aggressive and so on? Afterthey take their medication, after a while breakfast is served, you have also to be there to observe, how they are eating and so on after they are done with breakfast they are used to going outside in the courtyard and being guarded by the security and the prison officers".

One of the nurses, Sister Shelly who was stationed at the forensic ward shared with me in a semi-structured interview. Highlighting how the nurses negotiated care in this Mental Health Centre differently, depending on where one founds themselves in the centre. The medical officers, psychiatrists, psychologists and social workers seemed to negotiate care a little differently from the nurses. Apart from attending to the inpatients, they also attended to the outpatients. One of the social workers shared with me that he drew up a working schedule that helped him navigate between the inpatients and outpatients. Although the number of outpatients he had to attend to depended on howmany showed up. He then had no choice but to attend to all of them before they left because with the inpatients it all depended on whether there was a referral from the doctors for the patient to be seenby a social worker. The medical officers and psychologists attended to the patients as they showed up. Dr. Eve, a psychologist gave her insight on negotiating care when patients were overflowing in theMental Health Centre. She stayed that *"It's your work, so once a patient is referred you make time. Evenif you are going to leave later in the afternoon, you would leave later and make sure that all the clients are attended to."* The healthcare workers clearly understood what role they wanted to play incare and by all means tried and upheld it.

Dr. Sam, a medical officer on the other hand, felt differently about care when the Mental Health Centre was overflowing with patients. This is what he had to say:

"Obviously, in that instance, care has to drop, the standard has to drop. Specifically becauseyou know the doctor-patient ratio increases at that point and usually instinct-wise, people start work faster and sometimes ignore important details. That's why I am saying in that instance, I have seen it, care can quite drop".

Although he did add that, having interns around helped them attend to patients better as they

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worked together to make sure all the patients were attended to. Nurses at the Out-Patient department also had it a little differently, as one of the nurses shared with the researcher that the main thing was to prioritise senior citizens who showed p as patients. At times they had to prioritise patients who were dropped off with referrals from the Katutura State Hospital as emergency cases and have them attended to immediately and admitted. He clarified that it all depended on the category the patients fit into whenthey showed up at the Out-Patient Department.

The practice of care was something the healthcare workers were able to exhibit in their actions whenI observed them daily and being an institution that has its guidelines and a routine that helped things run smoothly, all this fitted into the culture of care in this Mental Health Centre. The healthcare workers understood that there was a routine and they each had a role to play but the dynamics regarding this culture of care depended on which ward one found themselves working in.

The civil wards had it all pretty figured out, from dusting the duty station, dispensing medication, doing two evaluations of the patients daily, assisting the medical officers during doctor's rounds, and attending to all the needs of the patient. Although one of the medical officers shed more light on the culture of care stating the following:

> *"There is a general scope as a doctor you can do A, B, and C but I think each department needs to have like what is expected so you can also know that okay I think now I am aboutto exhaust my limit, I have to get in a third party. It also depends on your personality, thereare specific things that we do when a patient comes, the patient registers, the files of the patients are set on the space allocated at the duty station, we take them from the order of first come, first serve but there is no specific criteria like 'if a patient comes this is what you need to do, this is how you treat them, this is how you talk to them'; this is just sort of left to depend on who you are. If you are a bad person, you start to shout around at people, if you are, you know, otherwise, then you are easygoing. So in that regard care does not adhere to the standard".*

Dr Sam then, highlighted that as much as there is a routine with which they all work in collectively, at the end of the day the practice of care is very subjective. This draws down the culture of care to the main objectivity, which is putting the needs of the patient first. How one

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executed all this does fall under the culture of care but had a lot to do with individual agency. The healthcare workers knew and understood what their roles and responsibilities were but because the structure does not give them room to maximize care, the healthcare workers then resulted in improvising in the name of care. The best example of this is what one of the psychologists explained to me:

> *"We have a WhatsApp group and we always inform each other of our patients, so we let each other know that there are three new patients, or there's this one's follow-up or that one's follow-up. So that way we are conscious of the fact that I am busy with someone now but I have got two follow-ups waiting for me. So, I need to make sure that my sessions are not extended so that I can attend to the cases that are being presented. So we do have an open communication system amongst ourselves. To make sure that we do cover the workload and also with assessments, we have a booking system where we book clients, especially for the assessments. People can't just walk in for assessments, they have to be booked as well so that we know at this time, this person is coming and is going to be seen by this psychologist for this type of assessment".*

The psychologists knew their role in this Mental Health Centre and took it upon themselves to come up with a system that helped them maximize the care they could provide to the patients. Since the institution had not created a system for them to work with, other than the routine that applied to every healthcare worker in Mental Health Centre; they used their agency to make sure that they were not just existing within this culture of care but actively living through it by finding ways to attend to all their patients.

The culture of care and agency in the wards

Sometimes agency and care in this Mental Health Centre did not look like how one would imagine it but was greatly subject to the environment and resources in this Centre. Being one of the busiest wards, Ward C healthcare workers at times found themselves in arguments with the patients. The frequent subject that resulted in an argument is the patient demanding aggressively to be discharged. This was an almost everyday demand from the patients but the nurses are only human and at times could get annoyed with having to listen to the same demand every other day.

Apart from nurses always finding themselves in arguments with the patients, they had to attend

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to aggressive patients. In Ward C in particular, when having to restrain an aggressive patient, the nurses called for help from the security men who worked at the Forensic unit. On one occasion, when the men arrived, they managed to sedate the patient and moved her to the isolation room. Once theyall emerged from the bed area of the patients and locked the burglar door, Sister Rose complainedto the other nurses about being kicked in the abdomen by the patient. The nurses got back to the order of the day as if they had not just had a pretty dramatic and eventful morning. The nurses made it clear to me that since only female nurses work in Ward C, they always have to rely on theassistance of the group of security men to sedate aggressive patients. Some patients have both mental illness and aggression coexisting in them (Wessely and Taylor, 1991). Nurses endured patients throwing shoes at them and being cursed at and this aggression usually came from newlyadmitted patients. The process involved calming the patient down, sedating the patient and placingher in the isolation room at times also referred to as the seclusion room. Episodes where patients take out their frustrations on the nurses were in abundance in the wards but the nurses were so accustomed to it that, at times they did not even flinch but focused more on taking care of the patient the best way they could.

The seclusion room was used for so many things in this Mental Health Centre. Sometimes nurses wereforced to place a patient in a seclusion room if there war a possibility that the patient may want to abscond. I use the term necessity because this was out of necessity in this Mental Health Centre, thiswas in line with what Muir-Cochrane, Baird and McCain (2015) found in their study that the lack ofaccess to alternative measures of restraint makes the health care workers resort to using seclusionrooms in this way. It may seem like a harsh decision because of the state of the seclusion rooms but this is their only option. Mr. Mac shares:

> *"Look, the thing is when a patient absconds it slows their recovery process and their familymembers look at us like we are negligent but these patients help each other escape. They climb over that wall in the courtyard with the help of the others".*

They kept the patients in the seclusion rooms longer than they should because they 'did not have anyother measures in place that would stop the patients from absconding. This is sort of the last resort when trying to take care of the patient (Muir-Cochrane, Baird and McCain, 2015). Especially in wards A and B, the male patients were always trying to leave the facility and because the nurses alsofeared being overpowered they always resort to locking up the patients in

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the seclusion rooms. In thelong run, it did pay off and the patient started9 responding positively to the treatment.

Ward C was the busiest ward in this Mental Health Centre and being such a busy ward improvising was like second nature for these nurses. For example, a patient once stood at the burglar doors askingthe nurses for what they call linen savers and instructing them to cut them into the sizes of pads, because she had run out of pads. The nurses informed me that the state does not offer these patientsa basic need such as pads, or at least has not in years.

Sometimes care looks like nurses working collectively to inject a patient who refuses to take her medication orally. Collectively because the patient is bound to resist and at times react aggressively. At times it did not only fall on the nurses to provide care in the wards. They collectively worked with medical officers at times if not all the time. Some situations required the assistance of medical officers, for example, a medical officer stepped in to attend to the cries of anew patient who had a court appearance in the next 24 hours, to seek out a solution. They finally agreed to let her family members pick up a letter that the doctor was going to draft and have it delivered to the court.

Some healthcare workers went the extra mile to make sure that they could provide care to the best of their abilities. Healthcare workers tended to speak about the extra effort they put into tailoring the practice of care for their patients (Buch, 2013). One of the senior nurses in Ward C was bilingual and fluent in many of the vernacular languages. When asked what motivated her to learn these languages, she replied saying:

> *"We get a lot of patients here, from the different ethnic groups of our country. I believe patients freely express themselves about their condition in their vernacular and I want to be able to understand every patient".*

A great example of agentic behaviour and quite admirable since it was not required of her and neitherwas it in her job description.

Having spent fairly enough time in each of the wards, I noticed that nurses going the extra mile in the face of care was another part of the culture of care in this psychiatric clinic. In one of the wards,nurses had to fight a losing battle with a patient, who had not slept in 36 hours, according to theirestimation. She kept roaming in the hallway and courtyard, looking tired but still fighting the urgeto sleep. The nurses pled with her through the window where they dispense medication,

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begging her to get some sleep. They did not want to sedate her because they felt like it was unnecessary butthe patient did finally sleep, so that was a win in the end.

Delegation was part of the culture of care in this Mental Health Centre because it was unrealistic to think that these already understaffed healthcare workers could get everything done, and attend to every patient's needs without some assistance. At times nurses needed to escort patients who may have had other ailments that 'were not psychological to one of the big state hospitals in the country. On one occasion I observed a student nurse escort a patient to her sonar appointment and once she returned she gave the nurses feedback. The senior nurses updated this information and sonar visit on the patient board in the ward.

Every morning I would walk into a ward, the first thing that would always grab my attention was the patient board. Each ward had a patient board and on it, they write down the total number of patients in the ward, those who were having sessions with the occupational therapy department, thenumber of patients who had absconded and anything about the patients that everyone working inthe ward should known about.

The busiest civil wards A, B and C were always overcrowded with five to ten extra patients in the ward. These patient boards not only gave you insight into the progress of patients in the wards but also whether the ward was overcrowded and an idea of how long the nurses had to monitor patients in an overcrowded ward in my quest to find out how the patients in these overcrowded wards slept,one of the nurses explained as follows:

> *"My dear, some of them sleep on the floor and the others share beds since they are veryfamiliar with each other. The ward barely has any mattresses because the patients have destroyed a lot of them and we have not received new ones from the Ministry for quitesome time now".*

I simply noted the head at this information, the entire situation was out of the nurses' control and they did their best they could under the circumstances. The patients who slept on the floor were provided with linen to minimise the discomfort of the hard and cold floor. To paint a picture of how the environment in this case infrastructure failed the healthcare workers, nurses sat at the duty station and openly discussed a patient's HIV status while discussing the medication that she took because of her mental illness. I felt quite uncomfortable because she should not have heard any of it, but since there was not much private room in this ward as the duty station was where

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they do all their work and it probably seemed like a private space for them to discuss patients' medical histories.

Medical officers, medical students, clinical psychologists and social workers had resorted to holding consultations with their patients in the closest place that looks close to resembling a sense of privacy. This could have been an unoccupied corner in a conference room, a corridor that was not used frequently by the staff and an empty courtyard in a ward. They improvised with what they could evenif the infrastructure was working against them.

The healthcare workers' agentic behaviour was easy to pick up on during the night shifts. For example, during one of the night shifts one of the nurses ignored the instructions of the doctor on the dose to give to a patient. Her colleagues reminded her to break the tablet in two give the patient half of the tablet and keep the other one for the next day. She ignored them and proceeded to give the patient the full tablet. The night shifts were not as busy as the day shifts and once the patients had taken their medication, the nurses relaxed. When there was a patient in one of the seclusion rooms, the nurses took turns watching the patient on the screen that had a live feed of the activities in the seclusion room. Although they were not supposed to give the patients in the seclusion rooms linen because there is always a risk of them attempting suicide, they practiced their agentic behavior and gave the patients linen. The heated floors in the seclusion rooms had not worked for years and this forced the hand of the nurses to provide the patients with linen when in seclusion because it could get really cold at night.

The nurses switched off the lights at the duty station and went to sit in one of the consultation rooms. They made sure to take turns to watch the live feed only if there was a patient in the seclusion room. Once all the patients had gone to sleep, the nurses sat in the chosen consultation room and discussed problematic patients and the medication that the ward had run out of. Once the clock hit 23H00, the ward was pretty quiet. *"Don't be fooled by this silence, some patients fight their sleep and keep us on our toes all night."* One of the nurses said to me. Some of the nurses however engaged with some of the patients that had not fallen asleep yet.

The nurses kept themselves busy with their phones. I noticed that every time I showed up for the night shift, it made some of the nurses pretty uncomfortable. They also managed to take light naps once all the patients were asleep, converse amongst themselves to shorten the night and made sure to answer any calls that may come in. Some of them spread some linen over the tables

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and benchesto rest on once all the patients had fallen asleep.

The dire situation of the Mental Health Centre being understaffed at times forced the interns to start with the doctors' rounds on their own without the supervision of a medical officer. The medical officers at times made the forensic ward patients a priority and once they were done with them, they head over to the civil wards. I watched the interns anxiously try and do follow-up consultations with the patients and since some of them were new at it, it showed and the patient either grew frustrated because they too realised this was only a student. One could argue that interns at times did most of the work, especially attending to outpatients. Which at times put them in positions where their agentic behaviour clashes with that of the nurses in the wards. For example, one afternoon an intern walked into Ward A and directed a patient to the duty station. He looked for admission forms at the duty station and when he did not find any, he left the duty station and headed back to the Out-Patient department to get one. He left the patient, who seemed agitated without informing the nurses of the ward who were seated outside. The patient shouted to try and get attention from anyone and I called the nurses to calm him down and explain to him where he was. The nurses exchanged looks of disappointment when the intern returned to the ward because they believed the intern did not handle that well. The intern oblivious to the disappointment instructed the patient to join him in one of the consultation rooms in Ward A.

One of the nurses voiced his disappointment saying:

> *"See? This is the nonsense I am always complaining about. What if the patient would haveturned out to be violent? The intern did not even inform any of us that he had left a patient at the duty station. This happens too many times and they don't seem to care".*

I simply nodded my head due to being a bit shaken up by the fear and thought that the patient was goingto get violent before I had called out for the nurses. Out of curiosity, I would always watch the feed now and then to observe what happens in the parts of the ward that are not so obvious when you walk in. I alerted a nurse on one occasion to two patients smoking in the corridor and sharinga cigarette with one of the patients in the seclusion rooms. He brushed it off saying *"I am not evensurprised."* There is no doubt that he has seen it so many times that he did not even bother to reprimand the patients.

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Sometimes care in this Mental Health Centre looked like a psychologist having a patient who is not fluent in English and when she finds out the patient speaks a vernacular language different from hers; she asks for help. She looked for a nurse that spoke the same language as the patient, for translation. Another aspect of the culture of care in the wards is the practice of trust that the healthcare workers try and cultivate with the patients. For example, some of the patients that they assessed and believed were taking their treatment seriously were rewarded with a weekend leave. It was a practice that was common in Ward D, also referred to as the Depression ward. *"One of our patients was on weekend leave."* Says Sister Rachel when she notices me looking at the patient board.

> *"We let patients go home for the weekend to stay with their families but return once the weekend is over. It's a bit of a risk though because the patient might decide not to return".*

The mere practice of trusting a patient not to jeopardize his/her treatment when granted a weekend leave away from the psychiatric clinic is a part of the culture of care. Some days care did not require much but looked like a nurse waiting for the patients to finish eating breakfast so she can give each of them their medication. I noticed sister Rachel was noticeably pregnant and was instantly worried on her behalf because of witnessing how violent patients can get. The notice board at the duty station had a 'leave planning' list, giving each nurse a chance to take leave without neglecting the ward. She could have been on leave but she wanted to work.

These healthcare workers' jobs were all connected and if one of them did not perform their duty it affected the rest of the healthcare workers and their duties. Which in turn forced them at times to rely on their agency instead of protocol, especially when a patient was involved. For example, there was an incident in Ward D. A patient was discharged, and a NAMPOL officer showed up to pick up the patient but the patient could not leave the centre because she had not been seen by a social worker. *"The patient cannot leave because she has to be evaluated by a social worker before she can leave and since they are short-staffed the patient suffers for it."* Sister Mable said to me. This had me thinking, this is such an inconvenience to the patient and she looked so annoyed sitting in the waiting area as the nurse explains to her why there was a delay.

After Sister Mable made a few phone calls to the medical officer (referred to as doctors in this centre), she showed up at the ward and had a conversation with the NAMPOL officer who seemed

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very reluctant to take the patient with him. *"I feel like; she will just relapse if I take her back to her aunt's place here in Windhoek."* He said to Dr. Hilda, *"We'll have her take a trip back to Angola then."* She replied and he pointed out how this was going be a problem because we were in a pandemic and things were a bit strict at the Angolan border. The doctor had a private conversation with the patient and authorised her discharge, and the patient seemed relieved as she had been waiting all morning to go home. The culture of care then can at times be as simple as making sure a patient who had been discharged manages to leave the mental health centre even if one of the healthcare workers had not executed his/her duty in making sure the process goes smoothly for the patient. At times the nurses went the extra mile and arranged transport for discharged patients who may not live in Windhoek and residedin other parts of the country.

Some of the wards had what they referred to as permanent patients. The patient either had no living relatives or because of the condition the patient had. The patient was confined to live the rest of his/her life in this Mental Health Centre. The depression ward had a patient who is bedridden dueto paralysis. The nurses took turns feeding, bathing and clothing her. Sister Mable said to me:

> *"You know what makes it so hard, is the fact that she is not an easy patient. She is very demanding and on top of that likes to throw racist comments".*

She stated this while washing her hands before she could head to the patient's room to feed her. She emphasised how the important thing was to take care of her and make sure she was comfortable. Everything else like her cussing at the nurses, and spitting at them are things they had to overlookto care for her.

The male ward had a permanent patient who was blind, so the nurses helped him with everything. Theybathed him, clothed him and fed him. They did not let him mix with the other patients, they used whatused to be a conference room as his sleeping place and they had made it as comfortable as possible for him. At times the nurses delegated the student nurses to attend to his needs and keep him a littleentertained by reading him a book or simply chatting to him.

Having sat in too many sessions during the doctor's rounds, I can confidently say medical officers and psychiatrists rely on their agency during their consultations with patients. The student nurses and medical students usually followed the lead of the medical officers, psychiatrists and nurses. I once had to sit through consultations where the patients were teenagers. The medical students

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simply took down notes and let the psychiatrist take charge. These consultations in particular were a little emotional, once the psychiatrist was updated on the patient's mood and presence in the ward; she would either scold the patient or praise the patient. The psychiatrist would scold and advise the patients in the same breath, she would go from taking on the role of a doctor to that of a parent to the patients.

At times care in this Mental Health Centre looked like healthcare workers being exhausted and yetstill pushing themselves to do their work. I witnessed on a lot of occasions social workers that hadto move between different wards complain about their exhaustion and still proceed to attend to thepatients that were awaiting them in the different wards. This did not apply to social workers only but to all healthcare workers. The nurses tried as much as possible not to overwork themselves when they could. They let those that needed to take naps, take them. Especially a nurse who was pregnant at the time, the other nurses were kind enough to understand she may need to be on her feet less. They divided the workload in some cases to keep her at the duty station doing administrative work, which kept her in a chair and they resorted to attending to the patients and their needs.

In the Depression ward, nurses went the extra mile trying to keep the young patients a little entertained so they did not get frustrated out of boredom. I watched one of the nurses, Sister Mable promise to get the youngest patient they had in the ward a colouring book and crayons. Once she managed to convince patients, she complained to me about the ward not having resources that patients could use to keep themselves busy.

> *"Since they usually have nothing to do, once they all gather in the courtyard, I join them and initiate conversations around general knowledge just so that they are not bored out of theirminds staying in here".*

At times nurses had to play the role of the villain to care for a patient. To paint a picture, there was an incidence in which a nurse denied one patient painkillers. This was because the patient had been admitted to the Mental Health Centre for having overdosed on painkillers. She explained to her why she could not give her the painkillers even when the patient did not completely understand it and seemed to be in discomfort. The nurse's explanation seemed to be the only type of comfort she could provide the patient with.

Care in the male wards looked a little different from the one observed in the other wards. Since

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the male wards always had patients in their seclusion rooms, nurses spent a lot of time in the seclusion rooms during hours that the patients had to eat. They had to make sure the patients in the seclusion rooms were fed. Having spent a couple of weeks in the male wards, I noticed that thepatients always stood at one of the broken windows of the ward to ask for water whenever they werein the courtyard. Which I found strange since there was a tap in the courtyard. When I tried to confirmwhether it worked or not this was what one of the male nurses said:

> *"It works just fine. These patients just love to be seen, they love the attention. So, we do what we can to pamper them here and there".*

Right after saying this, he handed another patient a cup of water through the broken window. Howwas not tired or feeling tedious about it all was baffling to me, because he had been doing it for thepast two to three hours. The nurses walked from the window to the medical supplies room to get the water and back. This was a daily activity for these nurses and I never heard them complain; neither did they scold the patients to simply get water from the tap in the courtyard.

The broken windows were a part of the infrastructure in this psychiatric clinic, especially in both the female ward and male wards. The nurses seemed to have improvised with the fault in their infrastructure because, in the female ward, they used the broken windows to dispense medication to the patients once the patients were in the courtyard. In the male wards, they used the broken windows as access points where they could consult the patients, dispense medication and assist patients with water when they queued up for it. These broken windows were not designed to be a gateway through which the healthcare workers and patients should communicate but it looks like they made do with what they had. They improvised with them instead of pointing out how they needed to be fixed. Although at times when there were a lot of patients to assess. Some of the other nurses with the help of student nurses headed into the courtyard to assess patients, there 'were not enough broken windows from which to assess patients and have full-on conversations with them to get an idea of their mood and feelings. The courtyard of the male wards was bigger than Ward C's courtyardand the patients made great use of it.

A practice in all the wards was that they did allow the non-hostile patients to have visitors. This was a part of the culture of care. The Mental Health Centre had to limit visitation because we were in the middle of a pandemic (COVID-19 pandemic). So many times, visitors would simply drop off the belongings they had brought for the patient. Sometimes the nurses would allow some of the patients to sit at the benches outside of the wards for some privacy and a chat with their

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relatives. At times that is all care looks like, in these wards, nurses assisted family members in seeing a patientthat is a relative of theirs.

Nurses in the male wards allowed the low-risk patients at times to have access to a small radio that belonged to the ward. Patients were not allowed any electronics and since the patients spent a lot of time in the courtyard, the nurses let them have a radio that they could listen to music on. I had observed how it lifts the mood in the courtyard. The patients were required to return the radio to nurses on duty before they return to their sleeping quarters. Care in wards A and B also involved nurses having conversations with their patients over anything. There was not much for them to do in the courtyard, so the nurses accommodated them if they 'did not have a lot of paperwork for the day. These conversations varied depending on the patient and their progress with their treatment plan butthe nurses made sure to accommodate them all.

The two male wards that the nurses ran like one ward at times had only two nurses attending to the needs of the patients, with the help of student nurses. Caring for patients in these two wards most times meant the nurses working through their exhaustion to maintain a standard of care they each upheld. Nurses made sure to give the patients in the isolation rooms their food and medication. At times care looked like a nurse allowing a family to see their loved one even after visiting hours, a lot of the nurses in wards A and B practiced their agency more visibly.

Every ward housed patients who refuse to take their medication. The strategy applied in wards A and B was to let the patient be and eventually, he would take his medication instead of forcing him. The same could not be said for the other wards, a clear example of how nurses tapped into their agency when faced with an unwilling patient.

I watched nurses in the male wards treat a patient's ankle that he had injured himself in the process of attempting to abscond from the ward over the wall in the courtyard. Nurses carried him from the courtyard and treated his ankle without any scolding. They quietly treated his ankle, like they had dealt with so many patients who try and abscond and get hurt. Then again that was their reality in these wards. The patient board in both these wards always had two or more patients listed for having absconded. One of the nurses expresses his frustrations over it stating the following:

> *"Listen, when you scold them try and try and remind them why they're here. It's like all yousay falls on deaf ears".*

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This explained exactly why they do not even bother stopping the patients from absconding because at the end of the day, the patients do not succeed and when they do, their relatives bring them back. Wards A and B are home to so many aggressive patients who always find ways to abscond. The male nurses tried their best to deliver care but there was only so much they could do and control. As two wards are built in the same building, it was falling apart with regards to effectively caring for patientsand avoiding relapses while they were at the mental health centre.

The dynamic of care in the biggest ward at this psychiatric ward was slightly different from what they referred to as the civil wards. The forensic unit was considered the biggest ward because it was structured like another version of a psychiatry clinic that housed convicts. This ward did not onlyhave nurses present at all times but, a team of security men, correctional officers and social workers.

Care looked a little different in this ward because the nurses 'did not have close contact with patients like the nurses in the civil wards did. Nurses attended to the needs of the patients such as giving them their medication and noting down any complaint that was health-related. Medical officers and psychiatrists spent more time in this ward than they did in the civil wards. The sub-wards all had one or two nurses and a correctional officer close by in case a patient got aggressive.

The forensic ward was not foreign to nurses sharing equipment like a BP machine. On days that oneward did not have a BP machine, the wards had to share it. A nurse instructed a patient to go gethis BP checked in another ward and return to the nurse with a paper that the other nurse had recorded it on. This ward housed patients but at the same time, these patients were going through a rehabilitation program. The patients who were at an advanced stage in their treatment were part of programs initiated by the occupational therapy department. There was a mini car wash and tuck shop where the patients that were progressing through their treatment better than the other patients worked. This was a part of their rehabilitation program and this was how they prepared the patients for the outside world before they were discharged from the psychiatric clinic.

All the nurses had to do was make sure the patients were taking their medication, had their breakfastand were physically well. Patients spent their afternoons in the main courtyard, the low-risk patients that were medium-risk and high-risk patients were never let out of the small courtyards behind their sleeping quarters. Some of the correctional officers and security men

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lingered around in the courtyardjust to be close by in case patients got into fights.

The routine was the same one used in the civil wards. The patients had breakfast early in the morning and after that, took their medication at the duty station in front of the nurses. Patients spent most of their time in the courtyard and the other patients were part of a rehabilitation program with the occupational therapy department. A part of care in the forensic unit involved the nurses getting themselves busy since they had to get through a lot of paperwork, patient files and prescription notes. They also had to update their medical supply cabinet and take a medication box out to the pharmacy for medication that the ward did not have. Besides nurses making sure the patients had their breakfast, they also had to make sure they had their lunch and dinner. They also let the patients watch television and listen to music on the radio. Care in the forensic unit looked like nurses making sure patients stayed on top of their rehabilitation program.

Nurses made sure to provide care even in the face of risks, which were more frequent in this part ofthe psychiatric clinic. For example, one morning in the forensic unit, in the two wards that accommodated the patients considered to be a medium risk, the patients grew impatient and subjected the nurses to verbal slurs. This was all because the security personnel were in a morning meeting that was running late and that meant that the patients could not be let out of their rooms. It was past their time for breakfast and taking their medication. The nurse could feel that the patients were getting impatient. She took it upon herself to walk from door to door to inform the patients that there was a slight delay but assured them about them having their breakfast and taking their medication. She asked them to be patient and apologised to them for the delay. The potential risk here was that if she attempted to let the patients out all by herself, she may have been overpowered and attacked by the patients because they tended to get out of hand when the security personnel and correctional officers were not close by. She however decided to unlock for the female patients, she trusted not to be aggressive. The nurse said a prayer joined by the patients and I joinedher. After the prayer, the patients were served their breakfast, they ate quietly and only respondedwhen the nurse asked how they had slept. Once the female patients finished with their breakfast, they headed to the duty station to take their medication.

Once the security personnel wrapped up their meeting an hour and thirty minutes later they immediately opened up for the patients and they headed out to take their medication at the duty station and then headed straight to the dining area to eat breakfast. Once all the patients had

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breakfast, they headed out to the courtyard. There were two courtyards, one for the males and the other for the females. The security personnel and correctional officers liked to join the patients in the courtyard. They sat under the shade provided by a big tree in the courtyard and observe the patients as they chat amongst themselves.

There was a sub-ward in this forensic unit called the first-floor ward A and it was home to patients whowere considered the most vulnerable. It had its duty station and a nurse who attended to these patients. Care in this ward meant not letting the patients mingle with the other patients because they could harm them or worse. The ground floor wards housed patients who were considered medium-risk patients, and a nurse explained to me that they were the most unpredictable patients and one could neverbe too careful around them.

Some days care in the ground floor wards A and B looked like, keeping the female patients busy with knitting and sewing face masks as part of their rehabilitation with the occupational therapy department. They sew in a room, made just for that on the first floor of Forensic Ward A. The forensic unit was the highly risky part of the Mental Health Centre but the healthcare workers did their best to provide care.

The routine in the outpatient department was different from the civil wards and forensic unit. This department accommodated the outpatients of the Mental Health Centre. It was also home to medical officers, medical interns, student nurses, psychiatrists, psychologists, social workers, pharmacistsand nurses. Patients from all parts of Windhoek visited the Out-Patient Department. Since patients came and left in this part of the Mental Health Centre, care was highly centred on making sure a patient had a consultation and had been given medication at the pharmacy before he/she left. OPD was very busy in the mornings, it could have over 70 patients simply waiting to be seen by doctors, psychologists and social workers.

The nurses at the duty station sort out their patient cards in the order of 'first come, first serve'. The waiting area filled up because the morning meetings took as long as the number of cases that the intern doctors had to present. The longer the meeting went on, the more the patients in the waiting area increased. Care in this department looked like the nurses noticing that the patients were getting agitated and aggressive from waiting to be attended to and delegating the student nurses to take the blood pressure of the patients and slipping the recorded BP into their patient cards. A tactic that nurses improvised with to keep the patients a little busy and made them feel cared for while they waited.

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Although these morning meetings took quite a while, once the morning meetings ended the medical officers and intern doctors got straight to seeing the patients. When these meetings usually ended, the waiting area was so full some of the patients queued outside by the door. The healthcare workers each picked up a patient card and read out the name on the card, waited for the patient to stand up and follow them to where they would have the consultation. For the medical officers, these consultationstook place in their offices but as for the medical interns, they had these consultations in the corridors and corners of the conference room where the meetings were usually held.

Psychologists and social workers walked from their offices to the duty station and back to check if there were any patients referred to them. Some of the psychologists had offices in which they could have private consultations with their patients. Some of the social worker interns took their patientsall the way to ward D for consultation because they did not have offices.

Once the queue at the waiting area reduced, the queue at the pharmacy increased. There was only onepharmacist at the pharmacy, who was usually assisted by an intern but that still did not make the queue shorten faster. At midday, the queue in the waiting area was short, some of the interns were taking their lunch while the others worked. They gave each other turns, and the medical officers tooktheir lunch and let the interns help the remaining patients. The pharmacist did not go on lunch until she made sure every patient had received their medication. She only got time to eat when OPD has no remaining patient and that was essentially her role in providing care.

On days that were for the in-patients, OPD was fairly empty. The few patients who did show up were seen by the interns since all the medical officers and psychiatrists were busy at the wards. Nurses shared that OPD was usually fully packed beyond capacity after public holidays because all the patients flocked to the hospital. The health care workers were forced to stretch themselves thin to caterto the patients. Especially if a lot of patients showed up on days dedicated to doctors doing their rounds in the wards. Healthcare workers had to then attend to both the in-patients and out-patients.On one occasion, I watched patients pile up at OPD after a public holiday.

Patients waited up to five hours before one of the medical officers showed up at the duty station and asked the nurses to screen the patients who simply needed to get medication. For those who needed a consultation, he politely asked them to remain patient. The rest of the interns and medical officers returned to the department to see the outpatients, once they completed their rounds for the

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day. OPD always has patients showing up and the healthcare workers simply try and work fast enoughto attend to both the out-patients and in-patients. The priority simply depends on whether it was an outpatient day or doctors' rounds at the wards.

Conclusion

This findings chapter was a depiction of the reality of the healthcare workers' sense of agency and how they negotiated care in this Mental Health Centre. The female ward, Ward C waa the busiest ward in the Mental Health Centre with aggressive patients and no security personnel to assist the nurses working in hostile situations and this did not stop the healthcare workers, especially the nurses from providing care to the best of their abilities. The nurses were so accustomed to the patients' verbally abusing them and at times physically abusing them, yet they did their best to provide care. The forensic unit seemed to have it all together from the outside view until one spends a day in it. The nurses barely had any support, they worked with the most risky patients and spent time alone at the duty station almost all the time. The nurses were overworked and always had to stretch themselves to get the work done.

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CHAPTER 5:

DISCUSSION & CONCLUSION

This study set out to explore how the healthcare workers in this Mental Health Centre conceptualised and operationalised care, by investigating their culture of care, their lived experiences in this centre and how all this can be improved for better healthcare services. The findings of this study depicted that the implementation of care and its conceptualisation in this Mental Health Centrelied heavily on agency. The creativity of these healthcare workers was what had kept the doors of this Centre open for so long and was also what helped them care for the overlooked mentally ill citizensof the Republic of Namibia.

I have used three chapters to provide insight into how the findings answer the research question. Chapter 2 gave insight into the Mental Health Centre and its dynamics. I used this chapter to paint the picture of this Centre, and the routine used to keep it open and even went further to refer to it as an island. This was to further push the argument that the Mental Health Centre is an institution with its own culture and way of doing things separate from the hospital that it shares grounds with. In Chapter 3, I discussed the work of these healthcare workers and discussed in depth what working in the Centre was like for these healthcare workers, their working hours, their interpersonal relations,risks that came with the job and how they mitigated all of it. This was the first findings chapter in which I attempted to provide clear insight into the dynamics in this Mental Health Centre amongstthe health care workers, how they worked as a collective to care for the patients, the conflicts they found themselves in and how all these factors played a role in how they cared for their patients.

I went on further to discuss their lived experiences in the second findings chapter 4, discussed how they apply their understanding of what care is in this Mental Health Centre. This chapteralso gave insight not only into how they executed caring for the patients but also their understandingof it in this healthcare facility. I shared based on the observations made and interviews on how they creatively improvised in an under-equipped and understaffed health facility to care for their patients in the best way possible. I used the two findings chapters to clearly show how these healthcare workers embodied being health professionals in this Mental Health Centre and the different ways they hadcreatively managed to draw from their agency to care for patients and their understanding of care.

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This study set out to understand care, and how the healthcare workers conceptualised and operationalised it. The findings shed light on this and more because out of the findings stemmed the evidence that these healthcare workers relied on their creativity to get the job done in this Mental Health Centre. The findings shed light on the different aspects of the Mental Health Centre from it being an island, workplace aggression and risks, culture of care, agency and improvisation.

This Mental Health Centre is what scholars refer to as an island (Long, Hunter and van der Geest, 2008). Being situated on the east side of the grounds that it shares with one of the country's largest state hospitals, physically put some distance between it and the rest of the world. Mental hospitals are closed-off cultural institutions that influence the way the patients identify themselves (Goffman, 1961). The patients in this Mental Health Centre were stripped of their outside roles, in this Centre they were merely patients who had to live through the routine of their different wards. Healthcare facilities are institutions that may contribute to the reproduction of a society but they are different from the societies they are part of (Parsons, 1951). It was a whole new world when one is manoeuvring the hallways and wards of the Centre, from the nurses in uniform, the patients in the courtyards, the student nurses and interns roaming the different wards, the security personnel and the constant need to stay alert when at the forensic unit is a constant reminder you are in a different reality.

Healthcare professionals who work in mental health experience violence in one way or the other (Nolan, Dallender, Soares et al., 1999). Nurses were frequently on the receiving end of verbal aggression and physical aggression in this Mental Health Centre. This was not to say other healthcareworkers did not experience aggression from the patients, it is just because nurses spent more time with these patients in the wards. Nurses in mental health were usually on the receiving end of aggression during their daily practice (Jonker, Goossenes, Steenhuis et al., 2008). This is the biggest risk for these health care workers in this Centre because there was always potential for patients to act aggressively. All the risks that came with working in this Mental Health Centre did not seem to deter these healthcare workers from caring for their patients. The culture of care in this Mental Health Centre is in line with what Mol (2008: 97) asserts:

> *"…articulating 'good care' is not a way of describing the facts, of talking about the world as it is. Nor is it an evaluation, a (positive) judgement of care practices. Instead, it is an intervention. Articulating the logic of care is an*

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attempt to contribute to improving healthcare on its terms, in its language".

These healthcare workers managed to craft their version of care, one that was inclusive of all their patients. The basis of it was to always be sympathetic and work towards the good of the patient.It may deviate a little from the global standard but still carried with it the blueprint of care, it worked for this Centre and helped patients get better. The weekly routine in this Centre made room for both in-patients and out-patients, the working shifts and hours were set up in a way that made sure the health professionals were not burnout. When individuals complained about bad healthcare, they tended to lean towards the argument of not being given a choice but more often they talked about the neglect from healthcare workers as an indication of bad healthcare services (Mol, 2008). No patient in this Mental Health Centre could claim that the healthcare workers did not prioritise their wellbeing and recovery process. The lives of the healthcare workers inside the walls of this Centre revolved around the patients, from the ones they had to feed, bathe and give medication to and to the ones who simply wanted to chat with the nurses. One of the male nurses referred to the patients as "big babies" because they always wanted the attention and affection of the health care workers. Patients shared that a little more interaction and attention to their needs made them feel cared for (Mol, 2008).

Kleinman (2009) argued that care is a moral practice that involves empathy, responsibility and solidarity for those who are in need. These healthcare workers used their creativity to imagine different ways they could care for their patients, it is almost as if it was their moral duty to do right by their patients. Livingston (2012), assertet that caregiving in its sense is a morally pressing act. There are instances where they were forced to use restraints but all this was out of necessity because, in the long run, it was for the good of the patient. Restraining patients was not an easy task for healthcare workers because they feel conflicted about it (Muir-Cochrane, Baird and McCann, 2015). Every act of care that these health professionals got involved in was to make sure they could care for the patient in the best way possible. They were not in the most desirable mental health facility but they made it work, by tapping into their creativity and improvising. This ability for human beings to be creative and imaginative allowed for individuals to go beyond whatever situation they may be facing and the conditions that caused it (Rapport and Overing, 2000). This spoke to the nature of the health professionals in this Mental Health Centre.

This sense of creativity or agency stemmed out of nowhere but necessity because these healthcare workers found themselves care-giving in an environment that was under-equipped and

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understaffed, this agency was intersubjective and interdependent (Nyamnjoh, 2002). In the determination to care for the patients that access this Mental Health Centre, the health care workers did not simply indulgein agentic behaviour that empowered them but at the core helped the patients in a great way. Agency should go beyond empowering individuals and fulfilling individuals who happen to share the sameinterests (Nyamnjoh, 2002). He further adds that there is a sense of freedom that comes with being in pursuit of the same goals, as it allows for both individual creativity and fulfilment; this is whathe terms "domesticated agency" and subjectivity. The culture of care that these healthcare workershad refined, may have rose out of the necessity to take care of their patients in the structure theywork in but it was highly fulfilling for them as well. They all had the understanding to care for theirpatients and not exhaust and endanger themselves while doing it.

Domesticated agency and subjectivity involve individuals collectively sharing both the consequences of failing and the perks of success which makes it easy for an individual to strive to do more (Nyamnjoh, 2002). One of the nurses in this Mental Health Centre, took it upon herself to learn the different vernacular languages in Namibia just so she could be able to give each patient the room to freely express themselves in their preferred language. There was no extra payment addedto her salary for this; it all just stemmed from her domesticated agency. The health care workers tended to go the extra mile in pleasing these patients in an attempt to minimise any discomfort they may have experienced from having to live inside the walls of this Mental Health Centre. This culture of care may have been a result of their creativity and ability to improvise but it is a very selfless act on their part and that is what Nyamnjoh (2002) says is the defining distinction between domesticated agency and undomesticated agency. Domesticated agency is not fueled by greed, it does not involve sacrificing one party or the other but thrives in working together towards a shared goal and interdependence (Nyamnjoh, 2002). In an attempt to find out how these healthcare workers negotiated care in this Mental Health Centre, I found that they had managed to hone a practice ofcare that stemmed from their creativity but was very well along the lines of the practice of biomedicine.A practice of care that prioritized the patients, nurtured them, catered to their needs, and strived for their safety amid adversity.

This study was a hospital ethnography that used Giddens's structuration theory as a lens for the structure and agency dynamic that exists in this Mental Health Centre. In the first chapter, I gave the background of the Mental Health Centre and painted a picture of the dire situation in the centre

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and the state of mental health care services in Namibia. I gave a brief introduction to care in this mental health centre and discussed the literature and the theoretical framework that this study rested on. In Chapter 2, I described the Mental Health Centre and the routine they adopted to maximize on care and efficiency. I highlighted the Mental Health Centre as the structure in this study, and depicted how it enabled and empowered these healthcare workers. The healthcare workers made it their sole mission to thrive in their work environment, as unsuitable as it may have been anddeliver care to the best of their abilities.

In Chapter 3, I discussed the Mental Health Centre further, with all its dynamics. The role of the different healthcare workers, the risks involved, the work hours and the conflict these healthcare workers experienced. I gave different examples as observed in the different wards to paint a clearerpicture of the experiences of these healthcare workers. The Mental Health Centre had both civil wards and the forensic unit which had its fair number of wards. The same culture of care applied in all these wards even if one side of the Mental Health Centre was riskier for the healthcare workersto maneuver in.

In Chapter 4, I discussed agency and care in depth and incorporated the different interviews I had with the different healthcare workers. This is the chapter that broadly depicts the structure and agency dynamic and what role it played in the face of care. I shared the different experiences of these healthcare workers and how they embodied care in this Mental Health Centre. Moreover, I demonstrated the agency of these healthcare workers and how their structure (Mental Health Centre) played a big role in their need to improvise and use their agency. In as much as these healthcare workers used their agency, they knew not to cross the boundaries of mental health care. Their agency was not about rebellion but one directed towards a common goal which involves caring for their patients the bestway they could, one that Nyamnjoh (2002) referred to as domesticated agency. The culture of care depicted in this study was subject to this Mental Health Centre, it did not speak for the culture of care that may exist in other mental health care facilities in Namibia.

The pressure of this one Mental Health Centre to take care of the mentally ill can be mitigated by the development of more mental health facilities being provided by the state. Namibia has less than ten private hospitals that provide mental health care services and that accounts for the haves of the country. The have-nots on the other end rely on the services from the state and they deserve betterthan what they are getting at the moment. The Mental Health Centre had all these missions

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and core values that are supposed to guide it, but the main limitation like most of the healthcare workers shared in not too many words was the financial support from the Government of Namibia. Governments should consider scaling up the resources dedicated to mental health care, especially where evidence of effectiveness is clear (Patel et al., 2007). Most of the resources that were lacking in the Mental Health Centre could be solved if only mental health care services are prioritized.

Prioritizing mental health care services would entail relying on research based scaling up mental health care interventions, and working with non-governmental institutions that are far ahead in creating models that would set the groundwork for improving mental health care services (Patel et al., 2007). This would be the Namibian government's social responsibility because investing in mental health care services is a social investment and not a dent in the national health budget.

Strengthening the human rights factor in global mental health would help in addressing the inequalities that exist at the root of the global mental health dilemma (Clark, 2014). She further adds that healthcare workers could rely on their influence to further boost the advocacy for the protection of people who battle mental illnesses and their human rights. The health care services in Namibia 'are not exactly ideal for the average person and the reluctance from those in positions to fix this is quite alarming. I hope this study's findings add to the gap of research knowledge on mental health care in the Republic of Namibia and someday play a role in the betterment of mentalhealth care services.

Limitations

This study did not have too many limitations, the permission letter from the Ministry of Health and Social Services granted me access to every part of the Mental Health Centre. Although, I could not be in the forensic wards at night for safety reasons. This applied to the male wards as well, the male nurses were always anxious about my presence there during the night shift. I would observe at night but not for long because for some reason they all worried for my safety. Since this study was limited to the Mental Health Centre, the findings could not be generalized to other state mental health wards/facilities across the country. Interviews were conducted in the official language of Namibia, English and this may have made it difficult for the interviewees to freely express themselves.

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