PROFESSIONAL HEALTH CARE WORKERS'
EXPERIENCES OF CARE AT TWO COMMUNITY DAY CLINICS
ON THE CAPE FLATS

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ABSTRACT

Primary Health Care (PHC) is the cornerstone of health care globally, nationally and locally and, therefore, should be regarded as the foundation of health care provision. In South Africa, Community Day Clinics (CDCs) are part of the bouquet of services that is being offered at a PHC level. There are various factors that generate inconsistency in the provision of care to people accessing these CDCs. The purpose of this study was to identify and explore how these factors impact on the care practices that health care professionals provide.

Research suggests that the majority of health care workers are women, who play a double role as carers in their professional and private lives. Therefore, the political ethics of care, a feminist theoretical approach, was utilised to understand care practices in these health settings. The aim of the study was to develop an in-depth understanding of the care practices of health care workers at two CDC facilities on the Cape Flats.

A qualitative research methodology was used to explore and identify the phenomenon under study. The research project followed an explorative and descriptive research design, as the researcher sought to understand the care practices of health care workers and how their values and ethics further influenced care practices at these two CDC settings. The data was gathered using semi-structured one-on-one interviews, and later analysed using qualitative thematic analysis.

The research findings were grouped in terms of the values entrenched in the political ethics of care, which are attentiveness, responsibility, competence, responsiveness and trust. The research findings identified various aspects that, either negatively or positively, impact on these values. Finally, recommendations were made to management, as well as care workers. These recommendations were in terms of implementing care services that are attentive to service-users and care-workers; providing a service that takes into consideration the value of responsibility; the provision of competent services; and finally creating trusting relationships within the CDC.

KEYWORDS

Care

Ethics

Values

Professional Health Care Workers

Community Day Clinics

Primary Health Care

ACRONYMS

CDC   Community Day Clinic

PHC   Primary Health Care

DoH   Department of Health

WHO   World Health Organisation

**C²AIR² Club**   Caring, Competence, Attentiveness, Integrity, Respest, Responsivenss

DECLARATION

I declare that the study, *Professional Health Care Workers' experiences of care at two community Day Clinics on the Cape Flats,* is my original work and that it has not been submitted for any degree or examination at any other University. All the sources used or quoted in this study have been indicated and acknowledged by complete references.

Full name: Asma Achmat

Date: November, 2015

Signed: …………………………………
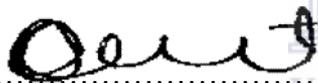
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CHAPTER ONE

INTRODUCTION AND ORIENTATION TO STUDY

"Healthy societies and healthy communities will foster healthy individuals and families, enabling societies and individuals to reach their full potential." (Coulson, Goldstein & Ntuli, 1998: 1).

1.1. Introduction

According to South Africa's Minister for Health, Aaron Motsoaledi (2010), health care facilities are locations where the public are supposed to receive quality care. However, he expressed concerns in a speech delivered at the University of Cape Town graduation in 2010:

> *"The quality of care in our hospitals is extremely worrying. Every day we hear sad stories of people not being well-taken-care-of in our hospitals. Once established, this office will ensure that all our healthcare facilities comply with a set of standards around quality, so that our hospitals become places where people find love and compassion"*. (Motsoaledi, 2010)
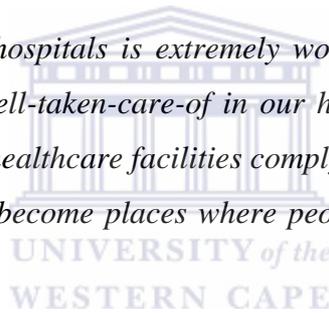
The researcher is employed as a social worker at two of the Community Day Clinics (CDC) Facilities that form part of a comprehensive Primary Health Care (PHC) service (for the purposes of this report, PHC and CDC will be used interchangeably) offered by the Provincial Health Department. The researcher agrees with these sentiments expressed by the Minister of Health and has often wondered about the health professionals' understanding of being care-givers, as well as their implementation of quality of care in health-care settings.

While engaging with colleagues and service providers, the researcher observed a mixed response by care workers towards service users, while in the process of caring for them. On occasion, care workers' approach to users would be abrupt and unprofessional manner, at other times, they would respond in an empathic and caring manner. It is, therefore, these sentiments and observations that triggered the researcher's interest to '*explore health care workers' experiences of caring for service users at two CDC facilities on the Cape Flats*'.

1.2. Context of the Study

This study was conducted at two Community Day Clinics located in Heideveld and Hanover Park, on the Cape Flats. The Cape Flats planning district is located in the Southern part of Cape Town, and includes the areas of Hanover Park and Heideveld, amongst others (Statistics South Africa, 2011, Census). The City of Cape Town statistics, according to the 2011 census, reflects that approximately 185 000 people live in the catchment area, where these two facilities are based, and include the suburbs/townships of Hanover Park, Heideveld, Manenberg, Phillipi and a part of Gugulethu. A deeper analysis of these statistics indicates that over 60% of the people, residing in these suburbs/townships, receive a household income that is below R3500 (Statistics South Africa, 2011, Census). It is, therefore, the assumption that over 60% of the people, living in this catchment area, could potentially access the CDC facilities of Heideveld and Hanover Park areas. According to the daily head-count at one facility, the average number of people accessing the clinic, per day, for the months of April-September, 2015, is as follows:

Table 1.1: Head count at one facility for the months of April-September, 2015

April	May	June	July	August	September
212	248	242	209	233	242

(Heideveld Community Day Clinic, 2015)

Both these areas are characterised by high incidences of crime and violence, which is the working context that the health care workers are, at times, exposed to. A recent newspaper article concurs by stating that:

> *"Numerous incidents have been reported, including staff being hijacked or threatened by gang members, rival gangs clashing inside facilities, or constant shooting in the area surrounding clinics in Hanover Park and Manenberg..." (Cape Times, April, 2015).*

Considering the statistics above, it is quite evident that high volumes of people are accessing the service, and the volatile conditions that health care workers are exposed to could potentially impact on their interactions with service users.

These two CDC facilities form part of the Mitchell's Plain/Klipfontein Substructure in the Cape Metropole. A Western Cape research study proposed that the district health system is a

relatively new structure and many district, sub-district and facility-level managers are still in the process of being appointed, which causes challenges, such as poor leadership and governance (Mash, Govender, Isaacs, De Sa & Schlemmer, 2013: 459). There is yet another challenge that workers have to contend with; when management and governance is poor, the possibility exists that this poor functioning could filter down to the health care worker.

The Department of Health in South Africa has developed 'National Core Standards' that provide a framework for the provision of quality service to patients and users of health services (South Africa, 2011). It is therefore, expected that all health care professionals should be implementing these standards, as part of their practice, towards the provision of quality care. Mash et al. (2013), however, states that 'primary health care workers are expected to be caring and compassionate at the coalface, and yet becoming patient centred and improving the quality of care in this context is a challenge'. Research in South Africa also indicate that the morale among health professionals in PHC clinics are low, as a result of the unavailability of resources, poor salaries, staff shortages, increased workload, exposure to infections and large numbers of clients, due to the vastness of the catchment areas (Manongi, Marchant & Bygbjerg, 2006; Loevinsohn, 2014; Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw & Ditlopo, 2008; Lehman, 2008; Zeitz, Salami, Burnham, Goings, Tijani & Morrow, 1993; Haines, Sanders, Lehman, Rowe, Lawn, Jan & Bhutta, 2007). It has also been suggested that within PHC, relationships in the organisation are undermined by a culture of blame and manipulation (Mash et al., 2013: 464).

These two facilities are also situated in previously disadvantaged communities and as a result are characterised by limited and/or poor resources. These conditions could have an impact on the vision to provide person-centred quality care which is in agreement with what Healthcare 2030 is proposing. The Department of Health launched the Health Care Plan for 2030 in June 2011, which focuses on the steps required to address the burden of disease, increase the wellness of communities, and ensure patient-centred quality care (Healthcare, 2030). This plan proposes that all health care professionals should endeavour to implement the care values of caring, competence, accountability, integrity, responsiveness and respect, but the challenge currently is how to make these values a living reality (Healthcare, 2030).

When one considers the context that health care workers are exposed to on the Cape Flats there are questions as to whether these aspects, among others, could be impacting on the quality of care in these hospitals.

1.3. Context of Care

The Department of Health in Healthcare 2030 proposed that all health care professionals should adopt the core values of the department which is caring, competence, attentiveness, integrity, respect and responsiveness (Healthcare, 2030). These values are to an extent, in synergy with the political ethics of care (Tronto, 2010) that was used as the theoretical framework for this research. As the research explores care experiences of health care-workers it is important to consider the context of care. Tronto (2010: 167) outlined that it is imperative for the carer to experience caring as rewarding on both a personal and financial level, in order for them not to be too concerned about the 'opportunity cost of caring'. Additionally, Tronto (2010: 160) proposes, from a political ethic of care perspective that 'care processes are affected by power relations and inconsistencies about the nature of good care'. Besides, when one applies the ethics of care to an analysis of care work, it requires a focus, not only on what care-workers do, but also, on the circumstances in which they do it, both, in terms of their relationships with those to whom they provide care, as well as their position as workers in agencies, responsible for taking care (Barnes, 2012: 61).

This current research therefore, endeavoured to explore the professional health care worker's role, as well as the power associated with it, and how all this impacts on the caring process. In contrast as a social worker at these hospitals, the researcher often witnessed how service-users took care for granted, and placed unwarranted demands on health professionals, resulting in some of the care-workers treating the service-users with contempt and disrespect. As a health professional the researcher wondered whether this could also be a reason for health professionals reacting to service-users with a lack of respect and care.

Care theorists also argue that a core for good care practices is a trusting relationship (Tronto, 2010; Gilson, 2003). A lack of trust could lead to care-workers adopting a harsh and uncaring attitude towards particular patient groups, who are demeaning, and who undermine the quality of patient interaction with the health care system (Gilson, 2003). Similarly, care could also face two dangers, namely *paternalism*, in which the care-workers perceive that they know better than the care-receivers or clients, and *parochialism,* in which care-workers develop preferences for care-receivers/clients, who are closer to them (Tronto, 1993). These are also aspects that the researcher explored as well as how these aspects impacted on the care processes.

In response to the values entrenched in the Healthcare 2030 (Healthcare, 2030), a programme termed the C²AIR² club challenge was initiated (Cape Winelands Health Systems Strengthening Workshop, 2014). This is a relatively new concept and still needs evaluation and monitoring. This might be the start towards encouraging CDC staff to adopt these core values. These complex dynamics around care formed the basis of this research. The researcher, therefore, explored the experiences of professional health care workers' ethics of care, in their interaction with clients, and in their community.

1.4. Rationale for the Study

The Department of Public Services, in the *Batho Pele – "People First":* White Paper on Transforming Public Service Delivery (1997) outlined 8 principles that would guide and transform all Public Service Departments (Government Gazette of South Africa, 1997). The Batho Pele principles are as follows:
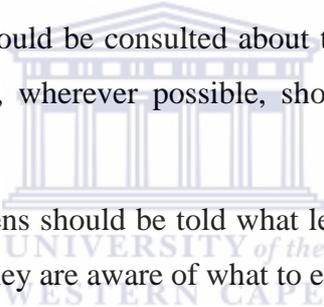
a) **Consultation:** Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.

b) **Service Standards:** Citizens should be told what level and quality of public services they will receive, so that they are aware of what to expect.

c) **Access:** All citizens should have equal access to the services to which they are entitled.

d) **Courtesy:** Citizens should be treated with courtesy and consideration.

e) **Information:** Citizens should be given full, accurate information about the public services they are entitled to receive.

f) **Openness and transparency:** Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.

g) **Redress:** If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.

h) **Value for money:** Public services should be provided economically and efficiently in order to give citizens the best possible value for money (Government Gazette of South Africa, 1997).

These principles guide all state officials and health care workers at state hospitals in particular, around service delivery, as well as the manner in which they should conduct themselves and offer a service to the people accessing any government department. The findings of study by Khoza & Du Toit (2011) indicated that the *Batho Pele Principles* were not implemented effectively at the particular public hospital, where their study was conducted. The researcher has also observed that, at the facilities under study, some staff attempt to practice the *Batho Pele Principles*, while others are challenged in that regard.

In addition, at these CDC's under study the health care workers including social workers, medical practitioners, physiotherapists, occupational therapists, nursing staff and pharmaceutical staff are guided by various professional bodies that subscribe to a Code of Ethics. It is argued that these professional ethics prescribe that health professionals have a moral obligation to provide ethical health services to the community (Rowe & Moodley, 2013). Despite the fact that professional health care workers are bound by guidelines pertaining to their conduct, and have a moral obligation, there is often a disparity in their interaction and conduct towards service-users. This disparity is not only noted among health care professionals, but also in other departments in the clinics especially the administration department, where service-users are treated with disregard. It is also noted that at times service-users would react to the disregard, which often led to confrontations. A significant number of research studies have been conducted on the service-user's experiences of receiving patient-centred quality services, yet the individuals, who are supposed to offer the services, are not competent, despite the moral values and guidelines that are intended to guide them.

1.5. Problem Statement

The research problem is 'an intellectual stimulus calling for a response in the scientific inquiry' (Frankfort-Nachmias & Nachmias, 1996, cited in Henn, Weinstein & Foard, 2009: 53). Some professional health care workers' caring for service-users at the CDC's are inconsistent with the value they place on care and the manner in which they interact with clients. The political ethic of care theorists argue that one needs to focus on the particularities of the interactions and the need for care to be given and received in particular to circumstances and context (Almond, 2005; Barnes, 2012; Hankivsky, 2004; Sevenhuijsen, 1998; Tronto, 2010). Working within the context of the PHC, where the focus is on quality of

care and specific targets for each month, the primary focus is not on the broader context of the health care worker's situation, which is problematic. Within the South African context, the literature specifically suggests that there are many challenges at the PHC level, influencing the care offered by health professionals. The context would include inadequate supervision, staff shortages, lack of motivation of health professionals, to name but a few. As most of the caring activities are performed by women, there is also a strong element of rejection and marginalization of these professionals, within the profession. These factors combined with the external factors, such as gangsterism, drug abuse, unemployment and poverty, could be influencing the kind of care that is demonstrated in the two hospitals. Women service providers are also care-givers at home, and are not always supported by their partners, when it comes to debriefing or engaging in stress relief. This research therefore seeks to explore what the experiences of health care workers are, as they engage in care practices at the two CDC's. Their care experiences at home were also taken into account.

1.6. Research Question

What are the experiences of professional health care workers, while providing care at two Community Day Clinics?

1.7. Aim of the Study

The aim of the study is to develop an in-depth understanding of the care practices of health-care workers at two CDC facilities on the Cape Flats.

1.8. Objectives

The objectives of the study are:

- To explore and describe the care practices of health care workers at two CDC facilities on the Cape Flats.

- To explore and describe how health care workers' values and ethics are influencing their care practices at two CDC's facilities on the Cape Flats.

1.9. Methodology

Babbie & Mouton (2001: 207) propose that, when studying 'human action', one should always study it from the 'social actors' perspective, as the primary goal would be to describe

and understand what people think and feel. The researcher used a qualitative methodology to conduct this study. The reason for choosing qualitative research, as opposed to quantitative research, is stated in the following quote: 'quantitative studies focus on the systemic control of the theoretical variables influencing it' (Henn, Weinstein & Foard, 2009: 134), whereas qualitative research, however, is 'developing an appreciation of the underlying motivations that people have for doing what they do, or the meaning that people have of their world' (Henn et al., 2001; Creswell, 2013). The one-on-one interviews are conducive to explore the meaning that participants attach to their caring practices'. Qualitative research is a process, through which the researcher makes sense of the feelings, experiences, social situations or phenomena, as they occur in their natural setting (Terreblanche & Durrheim, 2006). Besides a qualitative approach is interpretive and naturalistic, which implies that the researcher will conduct the study in a natural setting, attempting to make sense of, or interpret observable facts, in terms of the meanings that people bring to them (Denzin & Lincoln, 2005). Using this approach it allowed the researcher to understand how the health care professionals constructed an understanding of their experiences of care, while working with service-users in the health facility. The researcher, therefore also acquired individual and different perspectives and interpretations of care, as well as a richer understanding and insight into the issue.
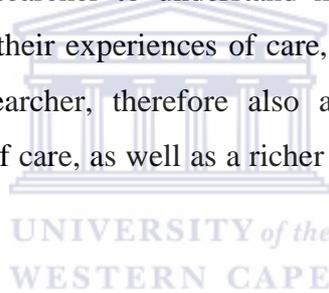
1.10. Research Design

Flick (2009: 128) proposes that there are several steps that contribute to a research design namely 'the aims of the study, theoretical framework, the research question, selection of empirical material, methodical procedures, degree of consistency and control, and generalization of goals'. According to Babbie & Mouton (2001), an exploratory study explores a topic and, in addition, is also appropriate when a phenomenon is persistent. The exploratory design was appropriate for this study as observations, prior to the research was that health care workers' experiences of care were inconsistent, which phenomenon was persistently experienced.

The research design used was an explorative and descriptive design. Using these designs enabled the researcher to provide a 'description of participants' experiences, and the context that they form part of' (Geertz, 2000, cited in Terreblanche et al., 2006). Descriptive research offers a richer meaning and intends to present a more accurate account of exactly *what* the

participants experience in their daily lives (Rubin & Babbie, 2001). 'Explorative research focuses on the *why* questions' (De Vaus & De Vaus, 2001: 2). In this manner the researcher explored potential *why* and *what* questions for health care workers in order to persuade them to speak openly about their experiences of caring for service-users who were accessing services at the two CDC's under study.

1.11. Population & Sampling

A population can be described as 'the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned' (De Vos, Strydom, Fouché & Delport, 2002). The population for the purpose of this study was health care workers at health care facilities (CDCs) in the Cape Metropole. These workers included professional nurses, staff nurses, medical officers, social workers and physiotherapists.

Sampling is viewed as the process of selecting participants for the study (Babbie & Mouton, 2007). The sampling process to be utilised was initially non-probability purposive sampling. With purposive sampling the researcher would rely on his/her experience and expertise to deliberately obtain the sample (Welman, Kruger & Mitchell, 2005). The experience of working within the PHC clinic, allowed the researcher to choose the appropriate participants for the sample. The researcher eventually used convenience or opportunistic sampling. Convenience or opportunistic sampling is the process 'where the researcher uses opportunities to ask people, who might be useful for the study, easy to access and whose ideas or experiences will help achieve the goal' (Holloway & Wheeler, 2010: 141). This sampling procedure is only adopted when 'the researcher finds it difficult to recruit people', which was the case of this study. The researcher obtained permission from participants who agreed to voluntarily participate in the research. A decision initially was made to choose 10 professional health care workers. However, there were challenges with recruiting the participants, which impacted on the sampling process. Chapter Three will provide a detailed discussion of these challenges.

A pilot study was implemented before conducting the main research. The data gathering instruments should be piloted as it could test the length of time to complete the interview and check whether questions are clear, allowing for preliminary analysis, to ascertain whether the

questions present any difficulty, when the data is analysed (Bell, 2007). The pilot was conducted with one participant in order to get guidance with regards to the above-mentioned.

1.12. Data Collection

With regards to data collection in-depth, semi-structured, individual interviews were conducted with the participants. Johnson (2001: 104) proposes that 'in-depth interviews develop and build intimacy; in this respect as they resemble the forms of talking one finds among close friends'. The semi-structured interview guide allowed for flexibility in the discussions. Fontana and Frey (2005) suggest that unstructured (or semi-structured) questioning, in contrast to structured questions, is particularly relevant to in-depth interviewing.

The individual interviews with the participants were recorded on a voice recorder. Their permission was firstly obtained before proceeding with the research. The recorded data allowed verbatim reporting on the participants' accounts of their experiences. The research was initially planned to be conducted in a quiet and confidential area; however, there were times that the interview process was interrupted, due to interruptions, with people walking into the room. One interview was also conducted at a participant's home, which gave some insight into care practices that she experienced at home.

1.13. Data Analysis

This research adopted an interpretive approach to analysing the data. The purpose of interpretive analysis is to provide a thorough description of the characteristics, processes, transactions and context that the participants constitute of, which are the 'thick descriptions' (Geertz, 2000, cited in Terreblanche & Durrheim, 2006). In addition this approach acknowledges that research is an interactive process, which is shaped by the researcher, as well as the participant's own personal history, biography, gender, social class and ethnicity (Denzin & Lincoln, 2005). The researcher was therefore, constantly aware of the experiences as a social worker in a hospital setting, and how it impacted on the analysis of the data.

According to Terreblanche et al. (2006), there are 5 steps in the process to analyse the data. For the purpose of this study the following steps were proposed:

Step1:   Familiarisation and immersion (organising and preparing the data, getting to know the data by going through the transcripts, field notes and interview transcriptions).The interviews were transcribed verbatim and the transcripts were subsequently read through, in order to become familiar with the data gathered.

Step 2:   Involved inducing themes that naturally arise from the data, as was deducted from the research questions. Themes and sub-themes were identified and were included within the values entrenched in the political ethics of care.

Step 3:   The data was coded by using different colours, to identify the themes that emerged.

Step 4:   During this step the themes that emerged were elaborated on and the sub-themes were explored.

Step 5:   The research was finally interpreted, data was checked and linked with theory and research collected and discussed in the literature review, which ultimately resulted in the research findings and the interpretation of these.

1.14. Trustworthiness

Trustworthiness essentially implies that the findings are credible, accurate in its representation and authority of the researcher (Babbie & Mouton, 2001). Similarly it will indicate whether the results proven, are a true reflection of participants' experiences and phenomena (Welman, Kruger & Mitchell, 2005). Lincoln & Guba's (1985, cited in Shenton, 2004) model was implemented to ensure that the results were trustworthy. The basic concepts for the model are credibility, transferability, dependability and confirmability (Shenton, 2004; Leitz & Zayas, 2010). In order to achieve *credibility,* only the original data collected during the research was used. To ensure *transferability,* the research findings fitted into a context other than that of the study, but which had some degree of similarity, as identified in the literature review. To obtain *dependability,* one should be able to conduct a study using the same participants, in a similar context, and still obtain the same results. *Confirmability* is the ability to confirm or corroborate the results (Shenton, 2004). This will however be explained in detail in Chapter Three.

1.15. Limitations

- The research was conducted with certain health professionals as it did not include the other professional team members, such as pharmacists, dieticians and occupational therapists.

- Interviews with management could also have added another dimension to the study as one could have explored the challenges with management that participants identified. This could have given a deeper understanding of management issues and at the same time also policy issues, which were key aspects identified in the research.

1.16. Self Reflexivity

The researcher was familiar with some of the participants as they were colleagues. The researcher was also fully aware of the potential bias during the interviews. In consultation with the researcher's supervisor, the researcher reflected on these aspects and was guided on how to limit personal biases with regards to colleagues, in order not to influence the analysis process. The researcher was also guided by the Code of Ethics which identifies that social workers should inform the participants that they could withdraw their participation at any stage of the research, without prejudice. The researcher also had to be aware of the interaction with the participants, post the interviews, on a professional and personal level, in order that these did not influence the research process.

At times the periods between interviews were drawn out due to the participants cancelling appointments, and momentum was lost. The researcher had to constantly revisit the interview guide in order to become familiar again with the flow of the interview.

1.17. Ethics Considerations

The essential purpose of research ethics is to protect the dignity and welfare of the research participants (Terreblanche et al., 2006). The participants were allowed to participate in the research voluntarily and therefore, had a choice to participate or not. They were requested to complete and sign consent forms and were informed that their personal details and responses would be kept confidential and anonymous. Wheeler (2003) argues that consent forms should be used to reframe the researcher-subject paradigm, in order to be more inclusive and participatory.

Before conducting the research the participants had to give their permission to use the voice recorder to record the interviews. The researcher informed the participants about their *right to withdraw* from participating at any stage in the research process, as highlighted above. The researcher also maintained a sense of *confidentiality* and *anonymity,* by informing the participants that the information they shared would be kept strictly confidential. At the end of the interviews the participants were asked whether they were in need of debriefing or a referral to a therapist. This was done to manage the possible risks related to participation in the study.

Permission to conduct the research was obtained from the UWC Senate Ethics Committee, the Department of Health Research Department and the facility managers at the respective CDCs. As a social worker, the researcher was bound by the Social Work Code of Ethics, as prescribed by the South African Council for Social Service Professionals (SACSSP), which implied that any research undertaken must be done within the bounds of confidentiality and informed consent.

1.18. Chapter Overview

Chapter 1 provides a general introduction and covers the context of the study and the context of care. The chapter further provides a rationale for the study, as well as the problem statement. The research question, aim and objectives of the study are highlighted, as well as the research approach and design. The population, the sampling process, data collection and analysis, as well as the trustworthiness of the study are discussed in the methodology. The issues of ethics and self reflexivity are identified. Finally the chapter also highlights the limitations of the study.

Chapter 2 sketches a landscape for understanding Health Care, particularly, Primary Health Care (PHC) clinics, policies and plans that guide care practices, and, finally, explore literature that expands on women in health care. This research study is expounded from the theoretical framework of the political ethics of care; therefore, this chapter also discusses how it relates to the study.

Chapter 3 explains the research methods and processes that are used when this qualitative study was conducted at the two CDC's. It discusses the population and sampling strategies, as well as the research design. The data collection tool which is the in-depth, individual interview guide, and the processes of data analysis are also discussed. Importantly the process

of verifying data, or in this case, the trustworthiness of the study, is clarified. In addition, it will also highlight the challenges that the researcher experienced while implementing the methodology.

Chapter 4 presents the outcome of the study and gives a detailed explanation of the research findings. The data analysis process is discussed and the themes and sub-themes that emerged, as a result of the analysis, are presented. The research findings are supported by direct quotes from the verbatim transcripts. The research findings are controlled by relevant literature, as highlighted in the review.

Chapter 5 provides the conclusions and limitations of the study, and the study concludes by making recommendations for future research.

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CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter explores the perception of the health care landscape as outlined in literature, including Primary Health Care (PHC) policies, contextual issues and plans that guide care practices, as well as literature that will elaborate on women in health care. The latter is important, as the research question originates from a feminist perspective of understanding care in two PHCs. The research is conducted from a political ethic of care perspective, which is the theoretical framework utilized. This framework will also be discussed and linked to the health sector.

2.2. Historical Milestones of Health-Care

Various international and national historical breakthroughs have contributed towards the implementation of policies and care practices within the health care setting. One international health breakthrough that guided the World Health Organisation (WHO) towards effective implementation of Health Care is the Alma Atta Declaration (Van Niekerk, 2009). According to the Alma-Ata Declaration (1978), access to basic health services is acknowledged as a fundamental human right and, therefore, it is the governments' responsibility to ensure that these services are provided (Hall & Taylor, 2003; Magnussen, Ehiri, Jolly, 2004; Rowe & Moodley, 2013). In response to this declaration, it was expected that all signatories take responsibility to provide Primary Health Care (PHC) services to citizens of their country. PHC is seen as the cornerstone of health service systems in the developed countries, such as the United Kingdom, and developing countries, such as South Africa. The Alma Declaration proposed that PHC should have the following: easy access for health care needs; long term person/client focused care; comprehensive care and the coordination of services offered (Starfield, 2009; Starfield, Shi & Macinko, 2005).

Subsequent to the Alma Ata Declaration, other Charters on health and health promotion also guided health care, particularly PHC. These included: the Ottawa Charter for health promotion in 1986; the Jakarta declaration of 1997 (Coulson, Goldstein & Ntuli, 1998); and

further declarations of Mexico City in 2000, and Bangkok in 2005, which called for strengthening the commitment of stakeholders, towards achieving health for all (Onya, 2007). The adoption of the WHO Rio political declaration on social determinants of health in 2011, is also seen as a historical milestone, as this took cognisance of the changing economic and political climates, globally, that has contributed to health inequalities within and between countries (World Health Organisation. 2011). This is of particular significance for South Africa, with its historical background of Apartheid that adopted inequality and discrimination, which impacted on the unequal distribution and provision of health services.

2.3. Factors influencing Health and Health Promotion

It should be noted that health and health promotion is influenced by global and national contextual factors, therefore, these were considered when conducting and understanding the context of health. 'A central tenet of the Alma-Ata Declaration (1978) is that progress in health depends on many factors, namely, economics, education, nutrition, the health system, and culture, and is closely linked to governance, social justice, and changes in other sectors' (Rohde, Cousens, Chopra, Tangcharoensatien, Black, Bhutta, Lawn, 2008: 950). These factors, therefore, influenced policies and procedures in the health setting, which, in turn, affected the health care professionals' working/practising context. Cockcroft, Milne, Oelofse, Karrim & Andersson (2011), through their study on the health services reform in Bangladesh, concur and also add that work progression and bad behaviour of clients towards service providers, negatively affects the morale of staff. Other researchers also agree that the context can influence the provision of health (Atun, Kyratsis, Jelic, Rados-Malicbegovic & Gurol-Urganci, 2007). Another key aspect also identified, was the retention of health care workers, as well as what financial and non-financial incentives should be put in place, to ensure health care workers' motivation and retention (Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw & Ditlopo, 2008). This aspect needs to be addressed as it could lead to an exodus of health care professionals, out of public health care, which potentially results in staff shortages.

France has a pluralistic health care system, and a study by Rodwin (2003) suggests that, when consumer satisfaction is high, customers have a choice of deciding on a service provider. South Africa also has a pluralistic health care system, with both private and public health services. However, a significant percentage of people use the public sector and, therefore, do not have that same privilege.

The South African legislative environment has changed with the promulgation of the Consumer Protection Act (2008) and the proposed amendments to the National Health Act that will view consumers from a legal perspective (The Consumer Protection Act, 2003, as cited in the National Health Act [No16 of 2003]). This has various implications for health care systems, health care providers and the doctor-patient relationship (Rowe & Moodley, 2013). Patients are seen as customers, who have the rights of choice and self determination. The Dutch health care system concurs with this, as it 'highlights the centrality of care as a normative concept, around which policy is built, concluding that choice is conceptualised as a shield against the coordinated need for care' (Barnes, 2012: 150).

In developing countries, the bulk of primary health care is provided by subsidised government services and, therefore, 'changes in financing health services, like budget cuts, resulted in the introduction of user fees' (Reerink & Sauerborn, 1996: 133). With budget cuts and changes in finances, other challenges arise, which are particularly relevant to the health-care situation in South Africa at this time. This is not only a challenge in South Africa, but has impacted on other countries, as mentioned in a study conducted by Mayosi, Lawn, Van Niekerk, Bradshaw, Karim, Coovadia & Lancet South Africa team (2012), which suggested that the Structural Adjustment Policy and globalisation, with its economic and political challenges, impacted negatively on health care in Bangladesh. Therefore, it should be noted that these political and economic changes, not only affect developing countries, but also developed countries, and should be seen as a global challenge.

A positive proposal from the Alma-Ata International Conference on Primary Health Care is the principle of communities playing a role in developing policies and programmes that affect their health, which simultaneously promotes citizenship (De Vos, De Ceukelaire, Malaise, Pérez, Lefèvr & Van der Stuyft, 2009). This principle of citizenship, therefore, promoted the notion of starting up health committees at the various PHC facilities. These committees would, hopefully, contribute to the improvement of social, economic and political conditions that affect community health. The desired result of this community participation and promotion of citizenship was for services to become more responsive to the care needs of the people accessing the facilities. Barnes (2012), as care theorist, proposes a 'participative mode of policy making', as this will ensure a moral sensibility among policy makers.

2.4. State of the Health Sector Worldwide

The state of the health sector, as noted, was definitely influenced by the context, nationally, as well as globally. It ultimately impacts on health care workers' and management's attentiveness and responsibility towards people accessing health services.

Numerous studies, internationally, as well as nationally, propose that the morale within the health care system, PHC clinics in particular, is very low (Laschinger, Finegan, Shamian, & Casier, 2000; Ayranci, Yenilmez, Balci & Kaptanoglu, 2006; Chopra, Lawn, Sanders, Barron, Karim & Bradshaw, 2009; Harries, Cooper, Myer, Bracken, Zweigenthal & Orner, 2007). The reasons for the low morale include a range of factors, such as the availability of resources, poor salaries, staff shortages, increased workload, exposure to infections and the large numbers of clients, due to the vastness of the catchment areas (Manongi, Marchant & Bygbjerg, 2006; Loevinsohn, 2014; Willis-Shattuck et al., 2008; Lehman 2008; Zeitz et al., 1993; Haines, Saunders & Lehman, 2007). In addition to the low morale, a research study suggested that within the health care sector, poor supervision and support structures for health care workers, is of concern (Chopra, Munro, Lavis, Vist & Bennett, 2008: 668).

Additionally, national and provincial management should articulate a clear vision and plan of action for health care workers to have a 'real sense of mission and personal fulfilment' (Harrison, 2009). This would, ultimately, influence health care workers to become more responsive to the needs of service-users. The Healthcare 2030 policy document in South Africa, however, is envisaged to provide that clear vision and plan of action (Healthcare, 2030).

When considering leadership, it is suggested that the leader brings tasks, expertise, abilities and attitudes to the team, which influence the group design and norm (Hackmann, 1990; 1992; 2002, cited in West, Borrill, Dawson, Brodbeck, Shapiro & Haward, 2003), and through monitoring and coaching, develops these processes that enable teams to achieve their tasks (McIntyre & Salas, 1995). When considering leadership in PHC, Moosa and Gibbs (2014) suggest that, addressing management capacity at the district health level, instead of in the hospitals, should be more of a focus, as leadership within these structures, is more of a challenge. The question, however, is whether management is providing the necessary vision,

monitoring and coaching for health care workers to become attentive towards the care needs of people accessing these services.

A cross-sectional study of trauma centre social workers in the United States identified that 'occupational stresses, namely, lack of group support, role ambiguity and, *again*, poor supervision, interferes with their ability to meet their own needs (including self-care) and leads to feelings of emotional depletion and being overwhelmed' (Badger, Royes & Craig, 2008:65). A study conducted by Magnussen et al. (2004: 147) outlined that, in order to ensure the effectiveness of the Alma Ata Declaration, it should include 'coherent human resource development plans and strategies for the retention of health professionals'. A number of studies in health, internationally and nationally, identified that the challenges in the health sector are as follows: structured and supportive supervision from managers; and an improved transparency in career development opportunities (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009; Hall & Taylor, 2003; Kautzky & Tollman, 2008; Manongi et al., 2006; Magnussen et al., 2004; Rowe & Moodley, 2013). These challenges are reinforced in Africa, and in particular, South Africa. If these support structures and training opportunities are lacking, how can health care workers provide a competent caring service? This is observed in the facilities, especially with allied workers, who have to compete with nurses, in order be exposed to appropriate training opportunities.

It was also noted that 'within the public health care sector, the motivation to work as a team is not uniform between medical officers, nurses and allied workers' (Franco, Bennet & Kanfer, 2002: 1265). Xyrichis & Lowton (2008:140) concur and state 'although it is widely accepted that no single discipline can provide complete care for patients with a long term condition, in practice, inter-professional working is not always achieved'. In addition, Moosa and Gibbs (2014:152) suggest that serious power issues are evident in PHC, where senior managers believed that nurses were the 'backbone of the primary health Care (PHC) service'. These power issues could hamper the implementation of effective multi-disciplinary team work. A study conducted by Atwal & Caldwell (2005: 272) suggests that, if members in a multi-disciplinary team do not communicate effectively, and if each team fails to value their contribution in the team, it will hamper efficacy and efficiency. This lack of communication could potentially impact on the effective performance of a multi-disciplinary team in the PHC clinics, which ultimately impacts on the caring process within primary health care.

Violence in the workplace is common in the South African health sector, as health professionals have direct contact with people, who are in distress (Di Martino, 2002). Due to high levels of violence and trauma, more health care workers are suffering from symptoms of post-traumatic stress disorder (Rippon, 2000). The impact of this development could, potentially, also lead to burn-out among health care workers. A study by Felton (1998) suggests that burn-out is quite evident among medical officers, nurses, dentists, carers in oncology, AIDS patient care personnel and emergency staff, to mention but a few. It is suggested that severe burn-out occurs, as a result of high working hours, as well as conflicts in the facilities (Embriaco, Papazian, Kentish-Barnes, Pochard & Azoulay, 2007). Even though the CDCs are 8 hour facilities, often professionals work later than the expected hours and, at times, also during lunch and tea breaks, in order to serve the volumes of service-users. When considering the political ethics of care, these factors become a challenge, as it impacts on the health care workers' commitment to care.

2.5. South African Context

Considering care in South Africa, the concept of 'ubuntu' is promoted. There is a relational view that is inherent in the concept of 'ubuntu', which literally means 'people are people through people'. The principle of caring for each other's well-being and the spirit of mutual support, implies that each individual's humanity is ideally expressed through his/her relationship with others, and through a recognition of the individual's humanity (Barnes, 2012: 16). In addition, the values of 'ubuntu' projects are: equality, sharing, empathy, respect, compassion, harmony, tolerance and redistribution, to name but a few (Broodryk, 2006). This concept of 'ubuntu' is also reflected in the 1997 White Paper on Transforming the Public Service (Rowe & Moodley, 2013). However, in the health facilities, the concept of 'ubuntu' often appears to be absent when health care professionals interact and care for clients, as some appear to be intolerant, disrespectful, and show very little compassion. This research, however, endeavoured to explore whether this was the case in the two clinics under study.

The service delivery changes in the public service advocated that the culture in all public services should be more responsive to putting people first. This led to the introduction and adoption of the Batho Pele principles, which guide health care professionals on care practices (Government Gazette of South Africa, 1997). A study by Khoza & Du Toit (2011) indicated

that the Batho Pele Principles were not implemented effectively, at the particular public hospital, where they conducted their study. A further study concurs that, even though there were posters on walls reminding health professionals about the ethical principles of Batho Pele, they indicated that their high workload, the environment they have to work in and the patients' attitudes, prevent them from implementing these principles (Fassin, 2008: 267). The question is, however, whether this is the case at most hospitals, especially the ones in PHC.

In South Africa, the public sector is the main service provider of public health care, as it serves 80% of the population, who cannot afford private health care (Ward, 2006: 2). This is the main reason for the high numbers of people accessing PHC facilities. In addition, while exploring the state of health care in South Africa in 2003, the World Health Organisation (WHO) found 'that more than 60% of health care institutions in South Africa struggled to fill vacant posts, which results in a shortage of trained health personnel and hampers the process of implementing a district-based health system' (Kautzky & Tollman, 2008: 24).

Furthermore, Holdt and Murphy (2007: 315) concur that public hospitals are highly stressed institutions, due to staff shortages, unmanageable workloads, which ultimately lead to negative public health outcomes. Working at a primary health care facility, there are often rumours of staff shortages being circulated, with management being forced to employ locum nurses, medical officers and pharmacists, which could have an impact on the stress levels of existing staff in the facility. In addition, management within PHC also need to consider the implications that these appointments have on budgets, and how it impacts on the care offered to service users.

According to Labonté & Schrecker (2006), the conditions that people live and work under, affect their health, and are termed the social determinants of health. It is proposed that racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities, and the extreme violence have all formed part of South Africa's past, and have inevitably affected health and health services (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). These social determinants mentioned, inevitably, impact on the conditions under which people in South Africa live and their prospects of leading a healthy life.

This is quite evident at PHC facilities, as health care workers in Hanover Park and Heideveld areas are often exposed to violence, racial and gender discrimination, as well as having to deal with clients from poor economic backgrounds. In addition, it should also be considered that the health care workers' could be concerned about their own health, when working with people suffering from communicable diseases, such as HIV/AIDS and Tuberculosis. A study conducted in South Africa by Lehman (2008) suggests that health workers are not always sufficiently protected from infection risks, particularly from TB and HIV, which could lead to illness and death. The Department of Health, however, provides masks and recommends that health care workers wear masks, as a means of protection against these conditions, but it is, ultimately, the health care workers' responsibility to ensure that they protect themselves. Harrison (2009: 2) asserts that the Department of Health achieved substantial improvements in terms of access, rationalisation of health management and equitable health expenditure, however, it is greatly 'eroded' due to the increased burden of disease, related to HIV/AIDS, which has resulted in weak health systems management and low staff morale that impacts on quality of care, especially in PHC, as it is the cornerstone of the health care system

There has been a number of media reports on the lack of competence of staff at some hospitals in South Africa (particularly in the Eastern Cape), which has led to cot deaths and other fatalities. This is probably due to the lack of training and supervision, as well as inadequate resources. A study by Jewkes, Abrahams & Mvo (1998: 1794) also posit that in 'parts of South Africa, the public health system is, at times, characterised by conflict, clinical neglect, verbal and physical abuse'. The following question, therefore, arises: 'How are health care workers able to be responsive to the needs of the care-receivers, if they are guilty of the above unprofessional conduct?'. This research, however, endeavoured to explore health care workers' experiences of supervision at the two CDCs under study.

2.6. South African Health Care Policies impacting on Care Practices

The health care system is impacted by different structures and policies that guide and ensure the management and implementation of accessible health care for all South African citizens. The National Health Care Act of 2003 proposes the establishment of the District Health systems where the boundaries of the health district coincide with the district and metropolitan district (National Health Act [No16 of 2003]). In response to the values entrenched in the 2030 healthcare plan (Healthcare, 2030), a programme named the C²AIR² club challenge was

initiated (Cape Winelands Health Systems Strengthening Workshop, 2014). The C²AIR² club challenge appears to be the start towards monitoring the Healthcare 2030 process. This monitoring tool was introduced recently; therefore, not much literature is available in this regard. It was launched in the various districts and has filtered to other levels in the health care system. Healthcare 2030 further suggests that targets should be set for health care that will be guided by the Millenium Development Goals. As a result, it is suggested that a strong culture, and a system, of monitoring, evaluation and learning, should be embedded at all levels of the department (Health Care 2030). In addition, Healthcare 2030 clearly proposes that a priority of the DoH should be the delivery of quality services. It also proposes that these services should be aligned with the Batho Pele Principles of consultation, setting service standards, increasing access, ensuring courtesy, providing information, openness and transparency, redress and value for money (Health Care 2030). Health care workers are ideally expected to use these acts and policies as guiding principles to conduct their practice and interact with service-users at all levels in the health system, including PHC.

The DoH developed a National Core Standards for Health establishments in South Africa, which promotes 'quality care for patients' (National Core Standards for Health Establishments, 2011). This policy articulated that there should be a common definition of quality care in all health establishments in South Africa and these standards should be a guide to the public, managers and staff at all levels. The Department also plans to, simultaneously, build sustainable commitment to continuous improvement in patient-centred experience (PCE) and quality. Additionally, the public health management policy proposed that, in order to respond to effective and efficient quality health care, services should include 'quasi markets with separated service markets to compete for resources' (Manning, 2001: 297). It is, therefore, evident that care is impacted on both a macro and micro level, and should, therefore, be viewed from a political perspective.

2.7. Primary Health Care (PHC)

It should be noted, firstly, that PHC is person-focused, as it recognises health related problems and the needs of patients and populations (Starfield, 2009). In addition, Lehmann (2008) proposes that PHC services should provide an integration of preventive, promotive, curative and rehabilitation services to communities accessing the health service. PHC in South Africa, is structured by using the District Health System, where care services are

decentralised into districts. In addition, all role players, such as NGO's, civil society and the service-user, are all responsible for the planning, managing, implementing and monitoring of the Primary Health Care Package, community needs, and national priorities (Peton, 2009). The district health system is a relatively new structure, and as such, many facility managers are still being appointed. This could be an indication that leadership and governance are challenges faced the new health districts that manage PHC (Mash, Govender, Isaacs, De Sa & Schlemmer, 2013: 459). Kautzky & Tolman (2008) also suggest that PHC is over-bureaucratised and rigid, therefore, they propose the development of innovative health systems designs and integrated district-based health worker training initiatives. This research attempts to unpack those challenges in leadership, as well as the processes that, not only guide health professionals to be, but also hamper them from being, responsive to the health needs of service-users.

As part of the Departments National Health Strategy, it proposes that PHC should emphasise community participation and empowerment, inter-sectoral collaboration and cost-effective care (Lehmann, 2008). This strategy is also aligned with the Alma Ata Declaration, 1978. While working in the facility, the researcher noticed that there was a drive towards inter-sectoral work, as the health promoters and social workers often collaborated with other sectors, such as the NGO's, other government departments and civil society organisations. It should also be noted that at the two facilities under study, there are health committees, members of the community, who serve on this structure, which further encourages collaboration and partnership.

The National Health Amendment Act (2013) presented the National Core Standards that provide a legislative framework of compliance to service delivery. These standards will ensure that the quality of health service standards are met, which, ultimately, also relates to PHC services. Within these core standards, the provision of quality care is entrenched, the kind of care that PHC should provide (Department of Health, 2007: 9-10). 'Quality of health care depends on policies to ensure that health workers, who are capable of delivering such care, are available in sufficient numbers' (Chopra et al., 2009: 668). This again suggests that if there is shortage of staff, the provision of quality care is impacted, at the expense of the health professional. As quality of care is a primary focus of service delivery in PHC, research is often focused on assessing care within these constraints. Quality of care infers that the service-users should receive good care, but it does not take into consideration, the service

provider or health care worker, or the conditions under which they have to provide the quality of care, especially with massive staff shortages. According to the Department of Health, primary healthcare workers are expected to be caring and compassionate at the coalface, however, becoming patient-centred and improving the quality of care in this context, is a challenge (Mash et al., 2013: 459). The challenges that health care workers often experience include high patient loads, violence in the workplace and conflict with service-users, yet they are still expected to provide a quality service. According to Mash et al. (2013), 'the strength of the PHC is that staff work together to make a difference in the communities it serve, the weakness, however, is that there are rigid and restricted internal structures, which reduce the organisations ability to adapt, transform and build internal cohesion'.

2.8. Women as Health Professionals

When one considers care work in health, it is quite evident that the majority of the care-workers are women (Poissonnet & Véron, 2000; Lund, 2010). These women care-workers are predominantly employed in low status jobs. Feminist theory, from a socialization perspective, argues that caring is seen as a 'woman's job', which has impacted on the status of the caring profession, as it was undervalued in terms of salaries and status (Parton, 2003; Tronto, 1995, cited in Sevenhuijsen, 1998). One should also consider that these women play a double role; as professional health care workers and carers in their homes. Ward-Griffin, Brown, Vandervoort, McNair & Dashnay (2005) suggest that this should be seen as and termed the 'double-duty care-giving'. McDowell (2004: 151) states that 'the labour force and workforce are part of an interconnected system, which would also include the home, and the one impacts on the other'. At the clinic where the researcher is based, the women professional health workers are mothers, wives, and maybe even caring for an elderly parent. It should, therefore, be considered that these varied roles, which include care in the private and public domain, could potentially impact on the care of themselves. This research, therefore, explored how these varied roles could impact on care-workers' care practices. Sevenhuijsen (1998: 4) proposes that care should be viewed from a political point of view and, as a result, should also have an impact on policy.

As a leading feminist, Tronto (2012) proposes the concept of privileged irresponsibility, which allows men to forego the caring within the community. As a result of this, women often take on the role of being the carer, instead of men, which is often reflected in the

nursing and social work sectors of the health profession. This is further evident in many clinics and health care facilities and, in particular, the clinics where the researcher is based, where the majority of the care-workers are women.

Ward-Griffin et al. (2005) argue that despite the use of a variety of strategies to manage double-duty care-giving demands, many women experience a dramatic blurring or erosion of boundaries between professional and private care, which results in feelings of isolation, tension and extreme physical and mental exhaustion. Women, who can multi-task, often willingly take on these roles, but it is likely that burnout can occur over time. There are a number of consequences that impact on women health workers. Research conducted by Di Martino also suggests that nurses are three times more likely, on average, to experience violence in the workplace (Di Martino, 2002). Another consequence is that women health professionals are at greater risk of burnout, because of unsatisfying working conditions, large caseloads, scarce income and the lack of opportunities for professional development (Acker, 2004). These are just two of the consequences that women working in the health care setting have to contend with, besides their challenges of being double-duty carers.

In response to increasing and on-going caring demands, it was suggested that employed women professionals must continually make adjustments in their lives in order to achieve 'equilibrium' (Guberman & Maheu, 1999, cited in Ward-Griffin et al., 2005: 382). This research will, therefore, explore whether health care workers' work experiences impact on their private caring roles.

2.9. Political Ethics of Care

Having sketched the landscape of health, as well as its impact on women health professionals, the political ethics of care and its impact on care practices, need to be explored (Sevenhuijsen 1998). After considering the health policy and identifying the Healthcare 2030 plan (Health Care 2030), it was evident that the values of caring, competence, attentiveness, integrity, responsiveness and respect are, to some extent, in synergy with one another. Literature on the political ethics of care, and how it could relate to care practices in PHC, therefore, needs to be explored. This perspective stems from feminist theory, since feminists were against the traditional understanding of this notion of care, and suggested that this should be challenged, as care is situated in terms of power and politics (Cloyes, 2002; Sevenhuijsen, 1998; Tronto,

2010). These theorists proposed that care should rather be seen as an integral part of society, and should not be marginalised. The question, therefore, is raised: What value do health care workers attach to their engagements of care with the clients accessing the services that the PHC clinics offer.

From a political ethics of care perspective, Tronto identified four phases of caring which are: a) caring about, b) taking care of, c) care-giving and d) care-receiving (Tronto, 1993; Tronto, 2005, cited in Barnes, 2012). The author further proposes that within these phases there are four elements/values of care that will guide care practices. These ethical elements/values are a) attentiveness, b) responsiveness, c) responsibility and d) competence to care (Tronto, 2005). There are other theorists who also added respect and trust as extra elements/values (Barnes, 2012). The reason for adding these elements is that it is assumed that in a caring relationship, there can be an element of inequality and vulnerability present, which requires that the care-receiver trusts that the care giver is acting in his/her best interest (Sevenhuijsen, 2003: 157). The theory also makes the assumption that relationships are bound by mutual inter-dependence, and its practice involves the values, as identified previously (Fisher & Tronto, 1990; Barnes, 2012; Sevenhuijsen, 1998). Razavi (2007, cited in Reddy, Meyer & Shefer, 2014: 398) suggests that the care system should be viewed as a 'care diamond', with its four corners; the households, markets, the public sector, and the not-for-profit sector, which indicate the different strategies, institution and practices involved in the 'design, funding and delivery of care'. This research will attempt to ascertain how these four corners relate to each other and how they impact on one another.

When considering care policies and practices, the everyday experience of, and the struggle over care, can be seen as a political struggle – 'the personal is the political', which implies that we need to think about the relationship between how people are able to live their lives, and the sorts of political values that dominate' (Barnes, 2012: 173). This is important in the health sector, as often decisions are made on a political level, not taking into cognisance the impact it would have on other spheres of care.

2.9.1. Attentiveness to care

The first phase of care is that of *caring-about*, which requires that the carer be attentive to his/her own perceived needs together with others (Tronto, 2010). There is the assumption that due to 'misfortune there is the need for care'. This, however, is just an

assumption, and can impact on how attentive, care practices are (Tronto, 2010). In addition, it also implies that the care-worker needs to understand what is necessary, to ensure that the basic human needs of clients are being met (Engster, 2005). As this research is from a feminist perspective, Reddy et al. (2014:3) asserts that, when one considers the 'care diamond', the amount of time women spend on unpaid work, is at least double to that of men. As health care workers are predominantly women, one should, therefore, consider how their care at home impacts on their care practices at work. Barnes (2012) proposes that it is important to be self reflexive about our own needs for care, and to ensure that the self is not subsumed in the caring, which is especially important for health professionals working in PHC.

In primary health care there are various policies and practices that are influenced by power and politics. This research will hopefully ascertain which factors influence policy, as well health care professionals to become attentive to the needs of the users accessing services at the two PHC facilities under study. Barnes (2012: 70) proposes that 'managerial practices should include practices that concentrate on developing systems, procedure and rules'.

2.9.2. Responsibility to care

The second phase, as proposed by **c**are theorists, is *caring-for*, which implies that someone assumes responsibility to meet a need that has been identified (Barnes, 2012; Engster, 2005; Tronto, 1995, cited in Sevenhuijsen, 1998). The political implication of the inclusion of responsibility in the ethics of care is that governments should take responsibility for ensuring the care for its citizens (Barnes, 2012). The issue of power in the caring relationship is also outlined by what care theorists refer to as privileged irresponsibility. This implies that care-receivers exercise their power and see it as a position of privilege and therefore treat care-givers unjustly or inhumanely (Zembylas et al., 2014). Barnes (2012: 61) also adds 'that the status associated with the role as health care worker and the extent to which they are recognised as professionals, could impact on responsibility within health care and how they are respected socially'. Therefore, the issues of status and roles of health care professionals should, therefore, be understood in terms of power relations between the care-receiver and care-giver, as well as its impact on the responsibility to care.

Care institutions need to have 'formal practices in place that will create the space for evaluating and reviewing how well the institution meets its caring obligations by being highly explicit about its pursuit of purposes, how it copes with particularity, and how power is used within the organization' (Tronto, 2010: 160). It is not clear, in South Africa, how this is operating as an autocratic leadership style appears to be most prevalent. The state takes the responsibility to provide PHC, but this responsibility is influenced by the care-workers' context, the attitudes of the care-receiver and community dynamics. The researcher explored these factors while conducting this research study.

2.9.3. Competence to provide care

The third phase is *care-giving,* which, from an ethics of care perspective, requires an element of competence (Engster, 2005; Tronto, 1998). Tronto (1998) proposes that care-giving requires individuals and organizations to perform the necessary caring tasks, as well as to have the necessary knowledge about how to care. In addition to knowledge acquisition, the care-worker also needs to have the necessary resources to do a good job (Zembylas, Bozalek & Shefer, 2014).

Theorists also suggest that a lack of competence is also described when care-givers lack the attentiveness to consider the consequences of policy implementation, as reported by care-receivers (Barnes, 2012: 162). Due to the increased work-loads, lack of attentiveness is highly probable in community day clinics, considering that competency in caring can be a challenge, when care-givers see organizational requirements as hindrances, rather than supports for care practices (Tronto, 2010).

2.9.4 Responsiveness to care

The fourth phase is *care-receiving*, which involves the response of the client to the care given. It questions whether the client's needs have been met or not, and whether the care-giving was successful or not (Barnes, 2012; Tronto, 1998). In the care-receiving phase, the care-giver engages with clients in order to determine the nature of their need and to monitor their responses to the care being offered (Engster, 2005). The lack of monitoring and evaluation is prevalent at community day clinics, due to inefficient management and implementation of policies.

In order to ensure responsiveness, the theory proposes that care institutions need to have formal practices in place that will create the space to evaluate and review how well the institution is meeting its caring obligations (Tronto, 2010). By putting these measures in place, they become 'highly explicit about its pursuit of purposes, how it copes with particularity and how power is used within the organization' (Tronto, 2010: 160). However, care-giving and care-receiving is a subjective process and, therefore, the care-givers' understanding of their responsiveness, might be in conflict to that of the care-receiver (Reddy et al., 2014). This research also attempts to identify how care-receivers' interaction with professional health care workers impact on the care process.

The value of responsiveness is related to the care-receiver's response to care, however, this research primarily involved care-givers (health professionals) and attempted to explore whether there were measures in place at the facility that address this value.

2.9.5. Trust in the care process

Caring with trust is the fifth phase of care, which Tronto has recently added. It refers to 'the reiteration of the process of care, where habits and patterns of care emerge through time and where the moral qualities of trust and solidarity are developed' (Tronto, 2010). The theory also proposes that the conditions of trust are created where 'reliance can be developed through the caring practices of others' (Zembylas et al., 2014: 205). Trust within the health setting is very important because people, who are acutely ill or vulnerable to suffering, can 'lose their opportunities in life and lack power', hence their need for care and reliance on health care workers (Dorr Goold, 2001: 26).

In conclusion, Tronto (2010: 165) proposes that 'if care is just narrowed to care-giving, rather than understanding the full process of care, which includes attentiveness to needs and the allocation of responsibility, it can challenge the full care process'. It is important to consider that, when the needs of care-givers are taken for granted within the organization, it indicates that the professional expert differs from the care-receiver, relative to what is needed, and care-giving can, therefore, become a challenge. Finally professionals might have their own agendas in determining others' needs, which might conflict with those of the care-receiver" (Tronto, 2010). This raises the issue of discrepancies between the different professional statuses in the health care sector, namely, a medical officer's, nurse', social worker's, occupational- and

physiotherapist's status. The value of work, therefore, also varies, as well as how all these discrepancies impact on the care being offered.

2.10. Conclusion

This chapter highlighted the policies that influenced health on a global, as well as national level. It became clear that macro factors influence the health care system and ultimately the work experiences of health care workers. These factors are changes in economic policies and political decisions. The review, in addition, explicitly highlights the consequences that the former mentioned factors have on health care professionals, which, amongst others, are shortage of staff, low morale, burn-out and stress.

The researcher also identified specific policies and contextual issues that have an impact on PHC, as well as their snowball effect on the care practices of professional health care workers. As this research embraces a Feminist perspective, it was important to explore women as health care workers and to consider the double role that they perform.

Finally, the chapter posits this study in the political ethics of care theoretical perspective and identifies and describes the values guiding the theory. By using this theory, the researcher will explore how the circumstances that professional health care workers are exposed to, could impact on their values, as identified by the theory.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

Methodology for a research study is defined as the 'logic in the decision making process' (Mouton & Marais, 1996:16). The research methodology will include the research tasks required to conduct the study, such as data collection through semi-structured interviews, sampling, data verification and data analysis (Babbie & Mouton, 2001). These will be fully discussed later in the chapter.

The research was conducted from a feminist methodology perspective as the theoretical perspective, political ethics of care, is based on a feminist frame of reference. According to Punch (2011: 136) feminist methodology is identified by five common features which are:

- the rejection of positivism;

- the pervasive influence of gender relations;

- the value-ladenness of science;

- the adoption of a liberation methodology; and

- the pursuit of non-hierarchical research relationships.

This feminist methodology guided the literature review process. It also identified the methods to be adopted, while conducting the research, as the researcher and the participants' relationships were non-hierarchical, meaning; their interactions were on an equal level. During the data analysis process, a critical view of care was identified, where care was seen from a gendered perspective. This chapter will also explain the research methods and processes that were followed, when this qualitative study was conducted at the two PHC clinics under study. In addition, the challenges that the researcher experienced, while implementing the methodology, will also be highlighted.

3.2. Research Question

According to Thomas (2011), a research question will emerge from your interest and observations about the study that you aim to investigate or explore. In addition, the answer to the research question will present the perceptions of the participants or what the study meant to them (Creswell 2009: 129). Babbie and Mouton (2007: 73) also explains that a research question guides the research design used in the study. A good research question should be '*clear, specific, answerable and interconnected*' (Punch, 2011: 46). It is, therefore, important that the research question be formulated correctly, in order to ensure that the most suitable method and design is used. The research question was as follows:

- What are the experiences of professional health care workers providing care at two CDC clinics on the Cape Flats?

3.3. The Aim of the Study

The aim of qualitative research is geared towards exploration, understanding and description of participant's experiences and their life world (Holloway & Wheeler, 2010: 10). The aim of this study was to understand the phenomenon of care practices from the health care workers' perspective. Therefore the aim of the study was as follows:

- To develop an in-depth understanding of the care practices of health-care workers, at two CDC's.

3.4. Research Objectives

Holloway (1998) encourages the researcher to set objectives that will guide the process to answer the research question. Research objectives are viewed as steps to be taken, in order to reach the aim of the study, and in the same process, answer the research question. The following were the objectives as mentioned in Chapter One:

- To explore and describe the care practices of health care workers at two CDC Facilities on the Cape Flats

- To explore and describe how health care workers values and ethics are influencing their care practices at two CDC Facilities on the Cape Flats.

3.5. Research Approach

Considering the approach to research, Holloway and Wheeler (2010:14) assert that it is 'dependent on the intentions of the researcher and the aims of the inquiry'. Punch (2011: 3) concurs by stating that, when an approach is chosen for research, it should focus on 'what we are trying to find out in the research, and then to fit the methods in with that'. Creswell (2009) proposes that there are three approaches to social research, namely, qualitative, quantitative and mixed method. The key features of a quantitative approach are 'quantitative measurement of the phenomena studied and the systemic control of the theoretical variables influencing it' (Henn, Weinstein & Foard, 2009: 134). Qualitative research, alternatively, is 'to develop an appreciation of the underlying motivations that people have for doing what they do, or the meaning that people have of their world' (Creswell, 2013). A mixed method approach is a combination of qualitative and quantitative approaches (Creswell, 2013).

This research was conducted with a qualitative approach, as it intended to understand the meanings that health professionals attach to their care-work, as well as the motivation for adopting ethical caring practices. By adopting this approach, the researcher was able to understand the context that the participants are exposed to and contextualise it within the community and the two hospitals under study.

Holloway et al. (2010: 11) also propose that qualitative research adopts a person centred and holistic perspective, to understand human experiences, which are important for health care workers, who focus on caring, communication and interaction. This current research, therefore, explored these aspects with the participants in their work and private lives. As health care workers, they adopt various roles, and have different relationships in society. These roles and relations impact on them in their private and personal realm; therefore, by adopting the qualitative research approach, the researcher was able to explore the participants' experiences, holistically. The ethics of care theorists also concur and state that 'understanding different types of relationships and the characteristics of relationships, in which [there is a] giving and receiving of care, contributes to nurturing growth and well-being' (Barnes, 2012: 85). Qualitative research is also the appropriate approach to use when adopting the political ethics of care as a theoretical framework.

3.6. Research Design

Flick (2009: 128) proposes that there are several steps that contribute to a research design, namely, 'the aims of the study, theoretical framework, the research question, selection of empirical material, methodical procedures, degree of consistency and control and generalization of goals'. It is obvious, therefore, that the design guides the researcher through the entire research process. According to (Babbie & Mouton, 2007), social research has three common purposes for investigating, namely, exploratory, descriptive and explanatory. Creswell (2009: 3) states that a research design is specifically chosen for its applicability to use in the problem or issue to be researched. According to Babbie & Mouton (2001), an exploratory study is exploring a topic, which is also appropriate, when a phenomenon is persistent. The exploratory design was appropriate for this study, as prior to the research, health care workers' experiences of care were perceived as inconsistent, which phenomenon was persistently experienced.

This study was explorative in nature, as the topic indicates, but, in addition, the objective was also to describe health care workers experiences of their care practices. De Vos et al. (2011: 96) propose that explorative and descriptive research might 'blend in practice'. Exploratory research is aimed at examining an interest/phenomenon and a descriptive study is aimed at describing what was observed or investigated (Babbie & Mouton, 2007). A descriptive design will therefore 'ask the *how* questions which are fundamental, as it gives a detailed depiction of the situation, the setting and the connections involved' (De Vos et al., 2011: 96). The exploratory study will attempt to extract health care worker's experiences, and ask the *why* and *how* questions. The research design was, therefore, an explorative and descriptive study of health care worker experiences of caring in two CDC settings under study, and asks questions about the way in which, they implemented their care practices.

3.7. Population and Sample of the Study

A population can be described as the group of people, from whom the researcher could draw conclusions (Babbie & Mouton, 2007). Punch (2011: 101) concurs by stating that the population is the total target group that the researcher is aiming to 'say something about'. The population for this study was all the female professional health care workers at two CDCs under study. The population included female social workers, medical officers, professional nurses, physiotherapists and clinical nurse practitioners, from whom the sample was drawn.

3.7.1. Sample & Sample size

According to Punch (2011:101) sampling is necessary for research, as it is not possible to study 'everyone, everywhere, doing everything'. Babbie & Mouton (2001) also propose that sampling is the procedure used by the researcher to select participants for the study. Sampling should, therefore, be viewed as the 'purposeful selection of a part of the whole population to obtain data' (Holloway et al., 2010: 137). Punch (2011) concurs, but also adds that the researcher analyses the data collected from the sample and makes statements about the whole population group.

The sample was therefore a selection of female health care professionals at the two facilities, a multi-disciplinary group, including; a doctor, nurses, physiotherapists and social workers. For this study the researcher chose eight (8) women health care professionals. The plan initially was to choose ten (10), however due to operational needs the researcher was not able to recruit the additional two (2). Holloway et al. (2010: 145) posit that the sample may be small or large, depending on the research question, material and time resources, as well as the number of researchers. As the researcher was alone and the time was limited to recruit participants, it impacted on the process. Holloway et al. (2010: 146) however propose that 'a sample size does not necessarily determine the importance of the study or the quality of the data'.

3.7.2. Sampling procedure

The researcher used convenience or opportunistic sampling to start the research process. During convenience or opportunistic sampling, the researcher uses opportunities to recruit participants, who might be useful for the study, easy to access and whose ideas or experiences will help achieve the goal/s (Holloway et al., 2010: 141). This sampling procedure is only adopted when the researcher experiences difficulties with recruiting participants, which was the case in this study. On numerous occasions the researcher tried to negotiate with the managers of the hospitals, but meetings that were set up, never materialised. This hampered the research process, as well as the time-frames, however it appeared to be the norm in PHC settings, as often meetings were planned, but never conducted. Moosa and Gibbs (2014) state that leadership within PHC structures are more of a challenge, than in other health sectors. Barnes (2012: 70), however, proposes that 'managerial practices should include

practices that concentrate on developing systems and procedure and rules'. This is often lacking at these PHC clinics and was also evident when the researcher tried to arrange meetings for the purposes of conducting the research and choosing participants for the sample. The researcher therefore recruited participants, who were willing to participate in the study. The steps that the researcher followed were as follows:

- The researcher is a social worker in the multi-professional team at a CDC and, based on the experience of working in a team, was able to identify women health care workers, who would be a representative of the population.

- The participants were approached during opportunities, when the researcher either engaged with them on duty, or during lunch and tea breaks.

- The participants were informed about the research and asked whether they were willing to participate in the study.

- When they agreed to participate, appointments were set up to conduct the interviews.

The criteria for being included in the study were:

- The participant had to be actively employed at one of the two CDC's.

- The participant had to be a woman professional health care worker.

- The participant had to be fluent in either English or Afrikaans, as no translator was going to be available.

- The participant should have signed the consent form before participation in the study. The researcher stressed the importance of voluntary participation and the right to withdraw from the study at any time during the process of data collection without prejudice. Before the participants signed the consent forms they were also informed about the confidentiality of their discussions in the research.

The sample was eight (8) female participants, made up of different health professionals employed at the CDC facilities under study. All the participants agreed to participate in the process. Initially, there were ten (10) participants who consented, however, the

interviews with two participants never materialised as appointments were set up and participants always cancelled before the interviews.

3.8. The Research Site selection

The research should be carried out in 'real life settings' to build up an understanding of how people experience the world around them, and to identify what informs their behaviour (Henn et al., 2009: 176). It is suggested that qualitative research involves gaining permission to access a particular site and to collect the data (Holloway et al., 2010: 151).

The research was conducted at two CDC facilities on the Cape Flats. Prior to contacting the facilities the researcher had to apply to the University Senate Ethics committee for approval to conduct the research. Thereafter an application had to be made to the Department of Health's ethics committee. This process was tedious as the Department at the time had transitioned to electronic submissions of research requests, which delayed the approval process. When the application was approved, the researcher informed the managers at the facilities about the study in order to attain their permission to conduct the research. The participants were then approached individually, as Henn et al. (2009) warn that if one uses gatekeepers; one could lose control over the sampling strategy. The managers might choose participants who view the facility in a positive light, and therefore, one could potentially obtain a false reflection of what the experiences are at the facility. The participants were given a verbal explanation of the study and once they consented to participate were given a consent form to sign, agreeing to participation.

Agreements were made with the participants to conduct the interviews. There were often challenges with setting up the interviews, as operational needs impacted on interview times, which resulted in interviews having to be re-scheduled. The interviews were mostly conducted in the afternoons, when participants were not too busy, and operational needs did not demand their presence and attention.

3.9. Instrumentation

According to Holloway & Wheeler (2010: 9), 'the researcher is the main research instrument as they decide what constitute data and where the focus should be located, analyse the data and determine how to shed light on the phenomenon under study'. Therefore the instruments for the study were the researcher, the interview guide and a digital recorder.

There are different types of interviewing; the one-on-one interview, the focus group discussion and narrative interviews (Holloway et al., 2010). For the purposes of this study, the researcher chose the one-on-one semi-structured individual interview type. A semi-structured interview is when the 'questions are contained in an interview guide with a focus on the topic areas to be covered and the lines of inquiry to be followed' (Holloway et al., 2010: 89). According to Rubin and Rubin (2005, cited in Holloway et al., 2010: 88), the researcher and the informant become 'conversational partners', however, the interview only has some of the characteristics of a conversation. The sequencing of the questions is not the same for every participant, as it 'depends on the process for the interview and the responses of each individual'. This was evident when conducting the interviews, as the participants, at times, highlighted certain issues that were not in the sequence of the interview schedule. This was, however, allowed as it provided an opportunity for a natural conversation to ensue. Holloway et al. (2010) propose that 'warm up and simple questions are asked first' and in this study, it was the demographic questions and aspects of their qualifications.

According to Babbie (2007: 306), a qualitative individual interview is an interaction between an interviewer and a respondent, in which the interviewer has a general plan of inquiry. The intention of the in-depth interview is to allow the participants to describe the phenomenon from their own point of reference, which, in turn, allows the researcher to understand it from the participants' point of view and not their own (Henn et al., 2009: 186). Punch (2011: 172) proposes that, when one plans an unstructured individual interview, there are certain aspects that need to be considered, namely, accessing the setting, understanding the language and culture of the organisation, how to represent oneself, locating and informant, gaining trust, establishing rapport and collecting empirical materials. During this period the guidance from the supervisor was very crucial, as the researcher was guided on how to probe, in order to get 'thick description', which is an important feature of qualitative research. Punch (2011: 172) proposes that the skill in conducting semi-structured individual interviews 'does not come

naturally, and most of us need specific training to develop that skill'. During the pilot interview, as a test for the main study, there were certain questions that were unclear, which questions the researcher had to adjust and clarify, in order for the participants to understand and respond.

3.10. The Pilot Study

Welman and Kruger (2005) propose that a pilot study is effective, as it will highlight any errors that may occur in the measuring procedure, as well as identify any ambiguities in the interviewing process. The pilot study was done with one participant to assess the data collecting tool and the time allocated for the interview. The pilot interview lasted 30 minutes and was discussed with the researcher's supervisor, who felt the responses to the questions were very superficial. As a result, the researcher had to do more probing in order to gain more information and richer descriptions. The researcher was guided on how to clarify certain questions. Some questions had to be adjusted, in order for the participants to understand. With the pilot study, the interaction between the researcher and the participant was very rigid, which was evident from the responses received. During supervision and reflection, these issues were highlighted and subsequently changed.

3.11. Data Collection

The researcher used face-to-face, in-depth, individual interviews as a means data collection. In qualitative research, the interview is based on a set of topics to be discussed in-depth (Babbie & Mouton, 2001: 306). Babbie & Mouton (2001) propose that, before one conducts the interviews, s/he needs to provide some explanation for the purpose of the study, which the researcher duly did, before conducting the interview with each participant. Punch (2011: 172) proposes that semi-structured individual interviews need to be flexible, as one could get involved in a 'prolonged and intimate conversation'. As indicated earlier, the researcher had to adjust the interview guide, in order to ensure that the conversation flowed better, allowing the participants to be more interactive, and giving the researcher the opportunity to collect richer data. As recommended by Creswell (2013), the researcher was the main instrument for data collection in this study, and, therefore, had to constantly be aware of ethical considerations and being reflexive. The supervision sessions were a useful platform for reflexivity.

During some of the interviews, the participants were quite willing to share and, at times, moved off the topic, with the researcher having to refer them back to the topic at hand. Welman et al. (2005) emphasise the importance for the researcher to manage time and carefully control interviewees, who are overly detailed in their sharing of experiences. Holloway et al. (2010) asserts that in-depth individual interviews generate 'rich information', but it could also have copious information that is useless for the research, particularly when the interviewer is inexperienced.

The interviews, as indicated earlier, were conducted at the CDCs under study, besides the one conducted at the participant's home. Prior to starting the interview, the researcher reminded the participants about the confidentiality of the interview. The researcher also asked permission from the participants to voice record the session, to which all of them agreed. The researcher, firstly, explained the purpose of the study and requested that they sign a consent form. This consent form indicated that the participants were aware of the purpose of the study and that they consented to participate voluntarily, after being guaranteed confidentiality (see Appendices for Consent form). The participants were quite willing to participate and signed without many queries.

During the data collection process, the researcher often experienced challenges, as there were interruptions while interviewing, with people 'barging' into the interview room. Working at the PHC, the researcher noticed that this was a regular occurrence and appeared to be common practice at the facility. One interview had to be conducted outside in the garden, as there were difficulties with the use of space inside the building. Working at a CDC, the researcher often experienced this type of problem, as workers had to manage with limited space available within facilities. All of these challenges, ultimately, impacted on the caring practice.

Prior to the interviews, the researcher always ensured that the voice recorder was fully charged and in working order. The researcher down loaded the voice recordings onto a computer and started transcribing, after two interviews were concluded. The transcription process was quite lengthy, as the researcher had to constantly replay the recordings, in order to record interviews verbatim.

The researcher had to constantly be reflexive because, as an employee at the CDC under study, the researcher had personal experiences, perceptions and values of working there as a care worker. The process of reflexivity requires the researchers to be conscious of their own biases, values and experiences (Creswell, 2013: 216). This is an important feature of qualitative research, as Holloway & Wheeler (2010: 8) aptly suggest, that assists in gaining 'access to the true thoughts and feelings of participants. Researchers also need to adopt a non-judgemental stance towards the thoughts and words of the participants'.

The researcher's role was that of being an active listener and enquirer. As the researcher is a social worker, the interview skills, often adopted in interviewing, were utilised. These were questioning, probing, clarifying, reflecting and checking. The interviews were conducted in English, but the participants were allowed to use a language that they were comfortable with, at which some switched to Afrikaans. These responses were translated into English when the interviews were transcribed.

3.12. Data Analysis

Babbie (2007: 364) suggests that qualitative data analysis is a non-numeric assessment of observations, content analysis, in-depth interviews and other qualitative research techniques with their own set of logic and techniques. Data analysis in qualitative research consists of preparing and organising the data (transcripts, observations) for analysis, then reducing the data into themes through the process of coding and condensing the codes and finally representing data in figures, tables or a discussion (Creswell, 2013: 180).

Content analysis vs Thematic analysis.......

Once the data was collected, the researcher transcribed each interview verbatim, as a process of preparing the data. Holloway et al. (2010) proposes that the fullest and richest data can be gained from transcribing verbatim. The researcher used the following steps as outlined by Creswell, 2013:

- Organising the data – The voice recordings were transcribed by the researcher. The researcher listened to some recordings a few times over, because of the background noise that made it difficult to hear the participants' responses.

- Reading or making memo's – Through this process the researcher tried to make sense of the whole study. Agar (1980, cited in Creswell, 2013) proposes that researchers should read transcripts in their entirety, several times over, in order to make sense of

the data. Once the data was transcribed, the researcher read each transcript a few times, in order to become familiar with the interviews and make sense of the information.

- Describing, classifying and interpreting data into codes and themes – The researcher preceded the analysis by means of coding. Coding can be described as categorising data into smaller categories of the information, seeking evidence and then adding a label to the code (Creswell, 2013). For the purposes of the study, the categories were terms similar to those verbalised by the participants, called 'in-vivo codes'. Once the coding was completed, the researcher identified themes that comprised broad units of information, consisting of several codes forming a common idea (Creswell, 2013). The researcher used various colours to highlight some of the text, which would then indicate a code. During this process the researcher also had sessions with the supervisor, where themes were identified that emerged and linked it to the theoretical framework.

- Interpreting & reporting – The researcher interpreted the data based on informed hunches, her insight as a health professional, personal views, literature identified in the review and her understanding of the theoretical framework. The research also conducted a literature control, where new literature was identified and incorporated as new themes emerged. The themes that emerged were further linked to the theoretical framework.

3.13. Data Verification

Lincoln and Guba (1985, cited in Lietz & Zayas, 2010: 191) suggest that qualitative studies should achieve 'trustworthiness', which implies that a 'study … represent, as close as possible, the perspectives of the participants'. Data verification or trustworthiness entails characteristics, as outlined by Guba and Lincoln, which are credibility, transferability, dependability and confirmability (Shenton, 2004: 63).

a) Ensuring credibility implies how 'congruent are the findings with the reality' (Merriam, 1998, cited in Shenton, 2004: 64). It is suggested that the line of questioning in data collecting and the methods of data analysis should be derived, where possible, from those of researchers who had completed similar studies. The researcher needs to become familiar with the setting in order to ensure trust and

professional judgement, hence, the reflexive practice of the researcher. Participants were informed that they could withdraw from the study, without prejudice, in order to ensure that they responded honestly during the sessions. The researcher used iterative questioning and probes in order to illicit detail. The researcher also had frequent debriefing sessions with the supervisor, in order to ensure reflexivity. Lietz & Zayas (2010) propose that one could do a member checks, but due to the tight time-frames, it was not possible. Thick or detailed descriptions of the study were encouraged and this was reflected verbatim in the findings.

a) Transferability implies 'extent to which the findings of one study can be applied to other situations' (Merriam, 1998, cited in Shenton, 2004: 69). Guba & Lincoln (1985, cited in Lietz & Zayas, 2010: 195) suggest that transferability is the degree to which the findings are applicable or useful to theory practice and future research. The researcher needs to ensure that sufficient contextual information about the fieldwork site is provided, as well as thick descriptions of the situation, to enable the reader to make the transfer. This was further encouraged when the researcher identified key aspects of the contexts from, which the findings emerged, and the extent to which it was applicable to other contexts (Lietz & Zayas, 2010).

b) Dependability implies that the research design and the implementation of the research study should be clearly described, the process should be discussed in detail and, eventually, a reflective appraisal of the project should be presented. This research report is a reflection of this process, as it will identify how the research proceeded, as well as the challenges and reflective processes.

c) Confirmability, according to Lietz and Zayas (2010), is the ability to confirm or corroborate the findings. The recognition of shortcomings in the study methods and their potential effects was highlighted throughout the report, and specifically in this chapter. Lietz & Zayas (2010) identify strategies to increase trustworthiness, namely, reflexivity, observer triangulation, data triangulation, prolonged engagement, member checking, thick descriptions and audit trails.

The researcher ensured that only the original data given by the participants were provided for analysis. The researcher referred to the literature review to ensure that the relevant information was collected. During the data analysis process, the literature and data collected were integrated in the themes and sub-themes that ensued. The interviews were recorded and

transcribed, which could be used for possible future research. During the data analysis process verbatim quotes were included in the report. Some of the findings concur with the main threads in literature.

3.14. Reflexivity

As the researcher was also a staff member at one of the CDCs, she had to be reflexive, in order to prevent over-identifying with the participants. This was also discussed with the research supervisor, during supervision sessions. This process of reflexivity was also important for the researcher to identify her own biases that could, potentially, have impacted on the entire research process.

Often the researcher had to be aware of her biases as she had her own views on care   as a social worker which could impact on the analysis of data.

As the participants were the researchers peers/colleagues a more reciprocal relationship existed, which Holloway et al. (2010: 63) state 'makes it easier for the participants to become equal partners and might have shared perceptions of their work', it is, however, suggested that researchers must be cautioned against becoming rigid in view, and encouraged to challenge evidence.
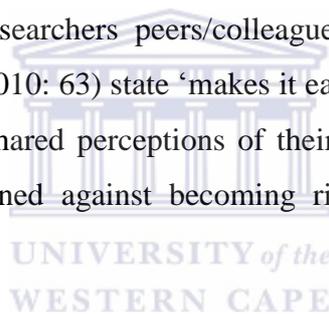
3.15. Ethics Considerations

When discussing ethics considerations, 'the researcher's behaviour and the consequences that the research brings to the people that they study are of importance' (Henn et al., 2009: 79). De Vos et al. (2011) identified informed consent, avoiding harm to the subjects, guarding against deception, violating privacy and debriefing respondents to be vital to the research process. The first ethics consideration is the fact that the researcher is a social worker and is, therefore, bound by the professional Code of Ethics of the South African Council for Social Service Professionals (South African Council for Social Services Professionals, 2015).

Prior to conducting the research approval had to be obtained from the University of Western Cape Higher Degrees Ethics Committee, the Department of Health Strategy and Health Support (Research Coordinator) and an agreement had to be concluded with the facility managers to conduct the research.

- **Informed consent and voluntary participation** – before conducting the interview the participants were informed about the aims of the research and it was indicated to them that participation was voluntary. In accordance with this, deception was avoided and the participants were not misled in any way. De Vos et al. (2011) states that no information should be withheld from participants and nobody should ever be forced to participate in a research project, as participation must always be voluntary. The researcher ensured that all participants were fully aware that the interviews were audio-taped. Once they agreed to be part of the research they were asked to sign the consent form (See Appendix B)

- **Privacy and confidentiality** – Babbie & Mouton (2001) suggests that the interest and well-being of participants require that their identity be protected. The participants were informed that their participation in the research was anonymous and their responses were confidential. The researcher tried to keep the interviews confidential by having it in a quiet, isolated room, however, there were times that other staff members entered the room, which was more of a disturbance, than breaking confidentiality. With regards to anonymity, when analysing the data, the participants' names were not mentioned in the research report.

- **Dealing with risks –** Babbie & Mouton (2001) suggest that social research should never cause injury to the participants. It is further suggested that information that may result in embarrassment, or endanger the lives of the participants, should never be revealed to other sources. This was particularly important for this research, as the participants were encouraged to report openly about their concerns at work, without the threat of being victimised or intimidated by management.

3.16. Conclusions

Chapter Three sets out the methodology that the researcher used in order to conduct the research. The chapter reiterates the aims, objectives and research question, which informed the approach used, namely, qualitative research approach. The approach was clarified, and subsequently, the research design was discussed. For the purposes of this study, the researcher adopted an explorative and descriptive design. The population sampling methods for conducting the research, as well as the data analysis were discussed respectively.

CHAPTER FOUR

DISCUSSION OF FINDINGS

4.1. Introduction

This chapter will present the findings of the current research study. The theoretical perspective chosen for this research is the political ethics of care; therefore, when analysing the data, the themes that emerged were grouped to align with its values and theoretical tenets. These values include attentiveness, responsibility, competence, responsiveness and trust. Care institutions need to have formal practices in place to create space for reviewing and evaluating how well the institution is meeting its caring obligations. These practices need to be highly explicit about its pursuit of purposes, how it copes with particularity, and how power is used within the organization (Tronto, 2010: 160). In addition, the values of the Department of Health's 2030 Health Plan are in synergy with the political ethics of care. These values of the 2030 Health Plan are; caring, competence attentiveness, integrity, responsiveness and respect, which should be exercised at all health facilities, including CDCs, and should be entrenched in their care practices.

The Department of Health launched a competition entitled the C²AIR² Club Challenge (Cape Winelands Health Systems Strengthening Workshop, 2014), which ultimately aims to facilitate a process of improving patients' experiences and contribute towards the realization of the 2030 Health plan (Health Care, 2030). The desired outcome for the club was to enhance employee engagement (and in the process improve management practices), improve patient practices and improve support practices. While analysing the data, it was clear that at the two facilities under study, there were mixed responses to whether the facilities under study were meeting their caring obligations and whether the C²AIR² Club Challenge would make any difference. However, this is only the beginning of the process and numerous structures, monitoring and evaluation tools still have to be implemented.

4.2. Demographics

The research was conducted with 8 female participants, who are in full-time employ at two primary health care facilities on the Cape Flats.

Table 1 Participant Demographics

Marital status		Parental status		Age Category		Years of experience			
Single	**Married**	**Yes**	**No**	**20-40**	**41-60**	**>10**	**11–20**	**21-30**	**≤31**
4	4	7	1	3	5	1	4	2	1

Table 2 Professional Category

4.2.1. Professional Category

Medical officer	Clinical Nurse practitioner (CNP)	Enrolled Nurse	Social Worker	Physiotherapist
1	2	1	2	2

All the participants had a post-matric qualification. All the participants had been employed at that particular facility, or had worked in primary health care, for more than 10 years, except for one, who had been in the health profession for 8 years. This indicates that they were expected to have a sound understanding of the medical facilities they were employed at. The first theme that will be discussed is attentiveness in the work setting.

4.3. Attentiveness in PHC Settings

The participants in the research are care-providers in the facilities under study, as well as mothers, wives and some even offer their services as voluntary workers in their spare time. This indicates that these care-workers perform varied roles as care-givers, and if one considers the inter-connectedness of care, it can pose as a challenge to their self-care practices. Reddy et al. (2014:3) propose that, when one considers the 'care diamond', the amount of time women spend on unpaid work is at least double to that of men. Which means, these women, even though they are able to draw the line between the work and home, are still expected to be mother, wife, and attentive to the needs of the care-receivers in the home, as well. The question, therefore, is, how attentive can a care-giver be in a health facility, if they are expected to be attentive in other care-practices, as well.

The sub-themes that emerged out of the data, while analysing attentiveness in the two CDCs under study, were: the influence of health policies on attentiveness, the differing management

styles and leadership; and concerns about the multi-disciplinary team approach. These sub-themes, therefore, impacted negatively on care-giver's role to be attentive to the needs of people using the health service. If a lack of attentiveness exists, how can good care practices be ensured?

The first phase of care is that of *caring-about*, which requires that the carer be *attentive* to his/her own perceived needs, as well as those of others (Tronto, 2010). In addition, it also implies that the care worker needs to understand what is required to ensure that the basic human needs of clients are being met (Engster, 2005). Razavi (2007, cited in Reddy et al., 2014: 398) suggests that the care system should be viewed as a 'care diamond' with four corners, which indicate the different strategies, institution and practices involved in the 'design, funding and delivery of care'. These include the: households; markets; public sector; and not-for-profit sector.

4.3.1. Influence of health policies on attentiveness

The public health management policy proposes that, in order to respond to effective and efficient quality health care services, it should include 'quasi markets with separated service markets to compete for resources' (Manning, 2001: 297). The 2030 Health Plan also further reinforces targets towards health care, arguing that the biggest impact on the desired outcomes will be prioritised with a strong culture and system of monitoring and evaluation, to ensure that staff deliver on these targets. Participants expressed concerns about this policy, as they felt that this hampered them in providing caring services to service-users. Some of the issues they highlighted were the outsourcing of services and the red tape involved in accessing these services for service-users. In addition, health policy also suggests that services should be quantified in terms of setting targets to provide quality patient centred services.

According to the Department of Health, primary healthcare workers are expected to be caring and compassionate at the coalface, and yet becoming patient-centred and improving the quality of care in this context is a challenge (Mash et al., 2013: 459). When one considers quality of service, the focus is only on the care-receiver's right to receive care – the care-givers' right is totally dismissed, as in the clinics, the researcher has often witnessed how some service-users abuse their power, by being demanding

and treating health professionals with disdain. The following quotes highlight this sub-theme:

Interview 5: (referring to supply chain) "The waiting period for a wheelchair was up to a period of 2 yrs. You know which is very sad because you phone the patient or the family and ask if this person is still alive and it is as if you're bringing up memories..."

Interview 8: "So in terms of procurement, I don't feel that the patient's needs are being met in terms of caring"

Interview3: I think it is sometimes the pressure they put on us with regard to the stats working in the hospital setting the stats and I don't like working with TOP. And the fact that there is a lack of resources which prevents you from doing more"

Interview 4: "it is impossible for every single day for them to have the quota which they want sometimes"

The participants were, generally, of the opinion that staff shortages at the facility impacted on their ability to provide quality service. Some even felt that staff was not adequately utilized, due to administrative overload, which, ultimately, affects care-giving in a caring facility. A number of research studies internationally identified that challenges in the health sector are: shortages of skills; unequal distribution of resources; a desire for more structured and supportive supervision from managers; and an improved transparency in career development opportunities (Coovadia et al., 2009; Hall & Taylor, 2003; Kautzky & Tollman, 2008; Manongi et al., 2006; Magnussen et al., 2004; Rowe & Moodley, 2013). The issue of staff shortages is, ultimately, linked to policies and leadership within the primary health care sector. Some participants felt frustrated as they were of the opinion that they were over-loaded with work, as indicated by the following quotations:

Interview 8: (Referring to staffing) "It makes you frustrated in a certain sense because you know that there is more that you could be doing, much more. If the admin work was less and if it could be identified by the people who are actually

in posts who oversee this rehab......... And so you don't practice your core function the whole day. You're bogged down with a lot of administration"

Interview 4: "......wait for so long and I'm not just talking about patients I'm talking about old people that have to wait. People in wheel chairs and unfortunately that can't be solved overnight because it's the problem of numbers and the amount of staff members that there are. You can only so much and that is the thing that I don't like"

Interview 5: "...because at PHC the influx of patients get more every year. You know if I look at my stats, my stats increased by between 50 -70 patients, which is a lot. You know the patients asked me now the other day why don't I have help. She said she asked the manager and the manager said there are no money for another physio."

Interview 7: Staff ratio vs. the community is not balanced so we often have situations where people need to come back the following day or they are deferred. Uhm...... simply because the demand is too high irrespective of the you know the measures that has been put in place to try and assist and to make help services accessible to everybody and all of those things

Interview 1: "I think if we had more staff there would be more care for patients"

Research worldwide suggests that public hospitals are highly stressed institutions, due to staff shortages, unmanageable workloads, as well as management failures; and that public health outcomes are poor (Holdt & Murphy, 2007: 315). The researcher has personal experience of these problems mentioned by Holdt et al. (2007), while working at a PHC facility. Rumours about staff shortages and management being forced to employ locum nurses, medical officers and pharmacists are rife. These decisions by management could impact on the stress levels of staff in the facility, which was reflected in the analysis.

4.3.2. Differing management style and leadership

At the two centres under study, there were differences in opinion about the management style. At the one facility, the participants reported that the management

style was more *laissez faire*, while at the other; it was more a participatory leadership style. In addition, many of the participants had very limited confidence in management style, as they felt that management was not attentive to the needs of staff, which included, support offered by the manager.

It has been suggested that a leader brings tasks, expertise, abilities and attitudes to the team that influence the group design and norm (Hackmann, 1990; 1992; 2002, cited in West et al., 2003), and through monitoring and coaching develops processes, which enables teams to achieve their tasks (McIntyre & Salas, 1995). However, if this is not in practice, it challenges the processes in the facilities, which was evident at the one of the facilities under study. Research suggests that within the health care sector, poor supervision and support of health care workers is of concern (Chopra et al., 2008: 668).

One of the key aspects highlighted by the 2030 Health Plan is that leadership should demonstrate and represent the organisational values, and that they should have highly developed inter-personal skills, encourage innovation, draw on the capability of all employees and be visibly collaborative with staff and partners (Health Plan 2030). In addition, Moosa and Gibbs (2014) suggest that addressing management capacity at the district health level should be more of a focus, than that being offered in hospitals, currently. This is a shortcoming at the PHC facilities which is indicated in the quotes below:

> *Interview 4: Management don't put a foot in when people come late or people just do as they please, there is no communication... the problem there are no discipline at that facility, everybody just come there, yes they come and do their work, but everyone does it differently..."*

> *Interview 2: I just think sometimes that that direct line at this facility is a "bietjie slapgat" they take too long to get to something. We just came out of a meeting where we had with management and the same question that we asked when the hub was built e.g. when are the toilets going to be fixed?"*

> *Interview 8: "Everybody is frustrated because there are no systems in place......"*

However, two participants felt that management was more attentive to their needs and suggest that not all staff experience the same leadership style. The examples below highlight a more democratic process:

Interview 7: "I can speak to them, but what I say is that they can't always identify with my needs, so would try and assist in their way because they 're not social service professionals they don't understand, they don't always understand the need, but they supportive in what it is that I do."

Interview 3: "I have a good relationship with her (Referring to her direct line manager). She works on an open door policy to you"

There is of concern, however, that the required structure was not in place at one facility under study, and that staff were left to their own devices. Barnes (2012: 70) proposes that 'managerial practices should include practices that concentrate on developing systems and procedures and rules'. All health care services, including social work services, should have procedures and processes in place that could guide them towards ethical care practices; however, management not taking their role seriously, will definitely impact the care process. While working at the PHC, the researcher observed that management do go for training, but questioned why management practices were, therefore, not comparable at all facilities.

4.3.3. Concerns with the multi-disciplinary team approach

At the two facilities there was again a difference of opinion about working in a multi-disciplinary team. Some staff, especially the support staff, namely, the physiotherapists and social workers, felt that, at times, management failed to understand *their* needs, which hampered their care processes. PHC is also primarily nurse driven; therefore, this profession's primary needs are being seen as a priority. Some participants were of the opinion that there was a lack of collegiality between nurses and other care-givers, which also impacts negatively on the team's functioning.

Research suggests that serious power issues are evident in primary health care, where senior managers were of the opinion that nurses were the 'backbone of the primary health Care (PHC) services' (Moosa & Gibbs, 2014: 152), which could hamper the implementation of effective multi-disciplinary teamwork. Nurses are perceived as the

primary driving force behind PHC. The 2030 Health Care Plan, however, stresses the importance of effective teamwork, and emphasises multi-disciplinary co-operation to be a key feature in service delivery (Health Care, 2030). The plan promotes multi-disciplinary intervention, but as a social worker, the researcher often has to be assertive about the value a professional social worker adds in the team. A research study by Atwell & Caldwell (2005: 272) concurs and suggests that, if members in a multi-disciplinary team do not communicate effectively and fail to value the contribution of each member in the team, it will hamper efficacy and efficiency. In the findings, concerns were raised about the multi-disciplinary team, as identified in the following quotes:

Interview 1: (Referring to working in a multi disciplinary team) " It is very poor.... amongst the staff members it generally is very poor... amongst staff we don't work together"

Interview 7: Working with colleagues.......... it is good, I think, being the only social worker at this facility can become draining at times, because you don't have that support from somebody working in the field that you're working in"

Interview 6: Others are judgemental instead of worrying about their own professions more worried about what you do with yours. UHM.... I don't like the slandering and the backbiting."

According to literature, 'although it is widely accepted that no single discipline can provide complete care to patients with a long term condition, in practice inter-professional working is not always achieved' (Xyrichis & Lowton, 2008: 140), which is definitely the case with this current research. The challenge, therefore, is how a team of caring professionals, as a collective, can become attentive to the needs to the people accessing services at PHC clinics.

4.3.4. Care workers' attentiveness to their own needs

Barnes (2012) proposes that it is important to be self-reflexive about our own needs for care and to ensure that the self is not subsumed in the caring. The data findings suggest that for some participants were constantly self-reflexive about the impact their caring

had on the self and put measures in place to address their own need for care. This is highlighted in the following quotations:

Interview 2: "I'll talk about it what upset me or what made me laugh today, but I don't carry issues. I leave it at work it stays here behind the gates."

Interview 3: "No I quite welcome friends and family, in fact most of the times I have friends that pop in at my house, because it is relaxing to sit and to chat. "

Interview 8: "I've just come to the conclusion that I can only do so much and so I switch off."

Interview 6: "I try not to......... No, no, no, my home is my haven. I cannot be stressing at home about work, I'm sorry no."

The next theme that emerged as valid is responsibility within the health care sector.

4.4. Responsibility in PHC Settings

The second phase as proposed by care theorists is *caring-for*, which implies that someone assumes responsibility to meet a need that has been identified (Barnes, 2012; Engster, 2005; Tronto 1995, cited in Sevenhuijsen 1998). The political implication of the inclusion of responsibility within the ethics of care is that states should take responsibility for ensuring the care for its citizens (Barnes, 2012).

The state does take the responsibility to provide a PHC service, but, in the findings, there were concerns that, even though the service is available, the community dynamics, as well as care-receivers' attitudes toward the care-givers, impact negatively on the care process. Another sub-theme that emerged was the fact that care-givers should take responsibility to first care for themselves, in order to provide a caring service to others.

4.4.1. Community power dynamics that influence responsibility of care

The data findings suggest that community dynamics impact on the care process, as the community of Hanover Park and Heideveld are notorious for gang violence and crime. Gang violence related injuries are often treated at the Heideveld and Hanover Park

clinics, and, along with other social problems, have a serious impact on health care-workers' responsibility to care for care-receivers. Working at the two PHC clinics under study, the researcher's consultations with clients are often linked to bereavement over the loss of a family member, due to gang violence, or family members, especially mothers, who are experiencing major problems with a family member abusing substances.

The participants outlined concerns for their safety and the challenges that clients bring from their communities in the following quotes:

Interview 2: Patient that is already poverty stricken comes to the facility, because the facilities are free right. Everything that they get here is free and provided by the government. And when people get things free they want more out of you. They never want you to say no to them.

Interview 3: In Hanover Park there are a lot of deaths and violence in the area and I know people just want to come and talk about what is happening for bereavement counselling and trauma counselling, because they experience trauma everyday in that community and this impacts on the worker."

Interview 4: They verbally and sometimes even want to be physically abusive and that is the challenge that clinicians experience. And I don't even think that people realise what we sacrifice to see patients. And in anytime your life is in danger, ja you might think that is being melodramatic, but (smirk) that is not melodramatic you know with drugs, violence and everything.

Interview 7: You know in the community that I work in you deal with multi-faceted problems so uhm.. Sometimes you just don't know where to start or where to go with certain situations....

Interview 8: The resources are available, however not always accessible. For example there's a computer available, but it's not in my office uhm.............. I can understand why I don't have a computer in my office because it's not safe, it's not ideal

The participants stated that, due to the high rate of theft in the area; the clinics' resources are not safe, which also impacts on care-workers' responsibility to provide a care-service. In addition, because of the gang violence and criminal activity in the area, health professionals are at risk for their safety. It is also not unusual for workers to be exposed to gun shooting, in and around the facility, which is a context that they are forced to contend with, impacting even more on their responsibility of care. The reality, however, is that violence and crime is systemic within the health sector and, therefore, needs macro investigation and intervention.

Exposure to violence in the workplace is common in the health sector, as care-givers have direct contact with people, who are in distress. Nurses, however, are three times more likely, on average, to experience violence in the workplace (Di Martino, 2002). The facilities under study are in sub-economic areas, with various challenges, such as gangsterism, violence, substance abuse and theft, which impacts on care-workers' responsibility to care.

4.4.2. Care receivers' attitudes impacts on responsibility

The issue of power in the caring relationship is also outlined as, what care theorists' term, privileged irresponsibility. This implies that male care-receivers exercise their power and perceive it as a position of privilege and therefore, treat care-givers unfairly or with total disrespect (Zembylas et al., 2010). The theoretical assumption is that care receivers attitudes towards female care givers are gendered. Barnes concurs (2012: 61) by adding that status attached with such female roles, and the extent to which they are acknowledged as professionals, could impact on their responsibility in the health care setting, as well as how they are respected socially. The findings however do not reflect this assumption. One challenge that the research was to specifically highlight gender issues taking into considering that all participants were females and the double role as care-givers in both home and the work.

In the findings of this current study, some female participants expressed that they are not valued for the service that they provide, but it is not necessarily due to the fact that they are women.

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Tronto (2010), however, in contrast, suggests that recipients of state care, who are clients attending the community health centres, are perceived to be dependent on state allocations, and in this way are not perceived as full citizens. This view, however, interrogates the following quotations:

Interview2: Everything that they get here is free and provided by the government. And when people get things free they want more out of you. They never want you to say no to them.

Interview 4: There'll always be those days.............. patients have been rude to you.

Interview7: a lot of people in the community are not interested in improving the service and therefore treat professionals disrespectful.

Interview 6: I don't have a support network (Researcher: Not at all?) So I fly below the radar and keep my mouth shut and I do what I got to do, that is how I get by (physiotherapist).

Barnes (2012: 78), therefore, cautions 'that the manner in which the care-giver becomes responsive to care can be seen as self-sacrifice and altruistic and this can lead to burn-out of and manipulation from care-givers'. The Batho Pele Principles (Khosa et al., 2011) encourage state employees go the extra mile; however, the problem is that, at times, care-receivers abuse this self-sacrificial act and place an extra burden on care-workers. This then raises the issue of whether there is a discrepancy between the different professional statuses in the health care sector, namely, a medical officer, nurse, social worker, occupational- and physiotherapists'. Are the interactions with, and responses to, care in these various professionals different, if one should consider the value that people put on the profession.

4.4.3. Responsibility towards the self

Engster (2007, cited in Barnes, 2012) developed a 'theory of obligation', which is an essential element of the political ethics of care and implies that we should accept our moral responsibility for others, but should start by taking responsibility for one's own care. There was a general consensus that the participants were always aware and ensured that they took care of themselves. They implemented self-care practices, which

they viewed as supportive. The researcher, while being self-reflexive as a female social worker at the facility under study, experienced difficulty, at times, to draw the line between work, home and studies. The researcher tried to be responsible towards self by implementing self-care practices and putting coping measures in place, however, the impact of the work, at times, still became overwhelming. This is often the fate of women, who work, and are also care-givers in the home. The following quotations are responses to whether care-workers are responsible towards their own self-care:

Interview 1: "On a cold day a nice hot bath and a warm day like today a nice cold bath or just a massage"

Interview 5: "I like laughing. I like to watch the Madea Movies they're all Christian movies, but comedy movies."

Interview 8: "Yes that is how I de-tress, just being out in nature. Walking reading, just being out in nature. Watching a good movie sometimes."

Interview 2: "By walking, I take the dog and Mathew for a walk."

Most participants were also involved in other caring, on a voluntary basis, such as being involved in religious activities, working with youth and other charities. They all suggested that it was not a burden, but rather saw it as a means of 'giving back' as indicated by the following quotations:

Interview 1: With religious activities I'm involved in the youth where I give classes to boost their self esteem and morals and to act as motivational speaker and to assist them with education....... I love it

Interview 2: I still do nursing as part of church work, I take communion to the sick people and people that are unable to go to church......... supportive, it is something that gives me strength to carry on.

Interview 4: I sometimes get involved in charity work, because my mother belongs to various organisations. I help her out here, try and see what I can do. That's about ja.... that's about it......... definitely helpful.

Interview 5: yes I'm involved with the youth at our church and the Sunday school.

Consequently, it is important to take into consideration that these female professional health care workers are involved in paid care-work, but also involved in unpaid caring. It is also important to note, when considering the 'care diamond', that the boundaries between its different institutions are neither clear-cut nor static (Reddy et al., 2014). One care worker, however, felt that, even though voluntary work was helpful in her life, she also needed to put boundaries in place and although it could become daunting, she also believed that her faith carried her, as reflected in the following quotation:

Interview 5: "But at the end of the day for me, for me I'm a person with strong beliefs and faith. I believe that is very uplifting for me, because at the end of the day you can ask somebody to pray for you. You can pray with somebody"

Another aspect that was unclear in the participants' responses was whether their role as women impacted on the care that they provided in the community. As proposed by care theorists, 'privileged irresponsibility' allow men to forego the caring in the community (Tronto, 2012).
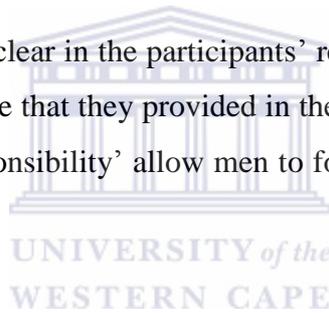
4.5. Competence in PHC Settings

The third phase in the political ethics of care is *care-giving*, which from an ethics of care perspective, requires an element of competence (Engster, 2005; Tronto, 1998). Tronto (1998) proposes that care-giving requires that individuals and organizations perform the necessary caring tasks, as well as have the necessary knowledge about how to care. Competence also assumes that the person has the knowledge and resources to do a good job (Zembylas et al., 2014). The sub-themes that emerged were: a lack of supervision and training; the ethos at the facility; and the lack of resources to be fully competent.

4.5.1. Lack of supervision and training

To ensure competence it is imperative that intervention should be multi-faceted, meaning, training plus supervision, as this will address multiple determinants of performance and might be more likely to improve performance (Coovadia et al., 2009). The question is, however, is supervision provided, as various literature supports the notion that supervision in PHC is a challenge (Coovadia et al., 2009; Hall & Taylor,

2003; Kautzky & Tollman, 2008; Manongi et al., 2006; Magnussen et al., 2004; Rowe & Moodley, 2013).

With regards to supervision and training, the majority of the participants were of the opinion that there was a lack of oversight, in terms of competence on the part of management. The participants felt that they are not adequately supervised or did not receive the necessary training opportunities pertaining to their work. This was also highlighted by the allied health workers, namely, the physiotherapists and social workers. According to the researcher, as social worker at the facility, this is a major lack, as social work practice requires that social workers receive the necessary supervision, especially for debriefing. While being self-reflexive about personal needs, the researcher often felt overwhelmed and over-burdened, as the clients that use social work services have complex problems and, in the absence of supervision for debriefing, this impacts negatively on empathic engagement with service-users. Anecdotal evidence suggests that social workers are not always acknowledged for the work they do, as it is regarded as a profession that, predominantly, involves women and therefore has a lower value. This could be reason that management do not prioritise supervision for social workers in the hospitals.

In addition, the fact that PHC is nurse driven also impacts negatively on supervision and support given to allied professionals. One research study suggests that senior managers were of the opinion that nurses were the 'backbone of the primary health Care (PHC) service' (Moosa & Gibbs, 2014: 152). The following quotations are indicative of the lack of training and supervision:

> *Interview 2: Well initially when I got there, there wasn't much (referring to training)*

> *Interview 6: I don't have a support network (in terms of supervision). "I feel I want to take a transfer to another hospital, because I sometimes feel I'm the only physio here and especially the part where training is part of my development and as I told my manager it's mostly the nurses that go on training"*

Interview 8: "you don't have a supervisor on the premises that can support you (social worker)"

Interview 4: they need to be your support, but sometimes they....they ... it's a lost? everything to make them look good, to make the facility look good and I mean that isn't how you solve problems. That is where staff members loose out where they not get the support from or leaders for wanting to look good at the expense of staff being happy and contented.

There has been a number of media reports of the lack of staff competence at a number of hospitals in South Africa (particularly in the Eastern Cape), which has led to cot deaths and other fatalities. This is likely due to the lack of training and supervision, as well as inadequate resources ((IOL News, 2013; News 24, 2015).

4.5.2. Mixed competence in relation to Ethos of PHC

When considering the ethos at a facility and how competent the staff and management are towards the service-users, there was a difference in opinion at the two facilities under study. The 4 participants from the first facility reported that they provide a good service to clients, but at the other facility it was to the contrary. The participants of the first hospital felt that the ethos was good, but that systems were not working effectively, which hampered the process of implementing a caring facility.

The Department of Health in the amended National Health Act (2013), proposed the National Core Standards and established the Office of Health Standards on compliance, where it provided a legislative framework and mechanisms to ensure that the quality of health service standards are met (Healthcare, 2030). In addition, the Batho Pele Principles and values (Khosa et al., 2011) entrenched in Healthcare 2030; propose that health professionals should provide a quality patient-centred service. When considering these national core standards on care, compared with the quality of care and the ethos at the facilities under study, the findings suggest that the participants had a mixed view, as indicated in the following quotations:

Interview 2: "I can't speak for others, but in.. in my opinion people are just here because they must work, people are nurses because they must work"

Interview 7"I think our operational manager is quite high on you know rendering of ethical services, you know respecting clients, and you know not showing people away from the facility and things like that"

Interview 8: "The ethos, ethos, is good, maybe it just need to be, more systems need to be put in place to make it work better. People are working, but systems hampering people to work optimally.

Interview4: "Sometimes I feel the staff has no respect for authority, they sometimes just speak the way they want to even with the patients"

Interview 3:" I think everybody is you know really trying to do their best you know at all times in terms of that

The lack of respect for health care workers could also influence their commitment to the ethos of the facilities. This is often experienced by women workers in many settings, due to the patriarchal systems that pre-dominate worldwide.

4.5.3. "Resources are available but not always accessible"

There was a general consensus that the resources were available for the participants to provide a competent service, but not always accessible within the buildings. This is in contrast to earlier assertions that there was a lack of supervisors, which is also a resource(supervision as a resource is not readily available). The participants all concurred as they felt that the resources are inaccessible (computers are not available) due to theft, or the physical structure of the buildings (very hot and not well ventilated) does not allow for providing a competent service. Again, this suggests that women workers have less power to request that resources are accessible.

Interview 1: "The structure that I work in is not conducive to work in... it is unbearable to work in... the conditions that we work in is totally unbearable."

Interview 3: "But for groups we don't have the resources at the facility, therefore we have to make use of community structure such as the library."

Interview 7: "resources are available, however not always accessible. For example there's a computer available, but it's not in my office uhm......... so often obviously it hampers service delivery time-management and all of those

things become an issue, because now you need to wait before you can do things and....... I can understand why I don't have a computer in my office because it's not safe, it's not ideal."

Interview 4: "Then in the room you need certain tools to examine patients, for example the Blood pressure cuff. One time it's working, sometimes it not working, you give it in you get a new one, it works sometimes not. The basic tools are there, but I think the big lack of resources is the emergency room, but now that the Heideveld EC is there we don't require that any more."

4.6. Responsiveness in PHC Settings

The fourth phase is *care-receiving*, which involves the response of the client to whom the care is given (Barnes, 2012; Tronto, 1998). In the care-receiving phase, the care-giver engages with clients, in order to determine the nature of their need, and to monitor their responses to the care being offered (Engster, 2005). Responsiveness entails assessing whether care has been effective or not (Zembylas et al., 2014). In order for care-givers to be responsive, they also need to be responsive to their own needs.

Considering that the facilities are focused on the quality of care, one of the primary components of PHC, it is crucial for the management of the facilities under study to know how responsive the care that they provide is. Health care 2030 proposes that quality of care is an important component in the provision of care, which also includes PHC. A sub-theme that emerged during data analysis is, care-receivers response to care as proposed by the participants.

4.6.1. Care-receivers' response to care as proposed by participants

According to the participants, care-receivers respond positively to care as they feel that their needs are being met. One should, however, consider that care-giving and care-receiving is a subjective process and the participants' view might, therefore, be in contrast to that of the care-receiver (Reddy et al., 2014). This research study failed to consider interviewing care-receivers, for their view of the care that they receive at the various facilities. This could be a limitation in the research and, therefore, room for further investigation. The participants' responses are as follows:

Interview 3: They always say that they have benefitted from the sessions and they always come back. Most of my clients come back. In fact they are all the time around.

Interview 4: And you actually feel good about yourself like oh my word that person just came for a minor complaint and here it's something big, something major that needs to be addressed and she would never have known if she never came to the hospital. If she hadn't complained,

Interview 7: I think people are generally grateful for the service that I render.......

Interview 8: me in the passages they will always come running because most of the clients I see also you either give them a mobility assistive device to improve their mobility which means a lot for someone to be more mobile and have their pain reduced maybe you give them a brace to support that knee, but in supporting it you reduce their pain levels. So most of them are satisfied

Interview 5: patients do get impatient, because I'm the only physio, but then at the end of the day they are grateful to have been seen eventually, because the waiting period at physio is 45 min

Interview 3: They always say that they have benefitted from the sessions and they always come back. Most of my clients come back. In fact they are all the time around.

4.6.2. Positive processes of responsiveness at facility level

The Alma-Ata International Conference on Primary Care promoted the principle that people should play a role in developing policies and programmes that affect their health (De Vos, De Ceukelaire, Malaise, Pérez, Lefèvr & Van der Stuyft, 2009). Tronto (2010: 60) concurs that care institutions need to have formal practices in place that will create the space for reviewing and evaluating how well the institution is meeting its caring obligations and how power is used within the organization. Healthcare 2030 further proposes that community governance structures (health committees, hospital boards) should engage with monitoring & evaluation information and support the collaboration between the services and communities for continuous improvement.

At a facility level, both facilities have systems in place for clients to raise their concerns, for concerns to be addressed and ultimately resolved. These systems also double as platforms for monitoring the service and hold the professionals accountable for providing a quality and caring service. At the facilities, there are also health committees that monitor the service and ensure a positive partnership, which is one of the principles of PHC. There was a general consensus among the participants that the clients use the process and, in turn, the facility takes heed of these concerns, which ultimately ensure responsiveness. The following are participants' responses:

> *Interview3"We have a grievance procedure and it actually works, because the clients know that", ".....meetings about certain complaints the patients give and it gets addressed to the staff members"*

> *Interview 6: "There is compliments and complaints box, a help desk and complaint line. Patients can send email, so there is transparency and the no's are all over the hospital where they can contact for what."*

> *Interview 7: "We have a health committee, the members are from the community and they would flag you know problems needs and things that community would want to be either looked at the facility or added."*

> *Interview 3: "they put the client first and we're always looking for ways to improve our services like for the waiting time to be less they always come up with something and if the client has a query or maybe a grievance they know they can feel free to go to the manager's office and put forth the grievance and they know that they'll work on it."*

> *Interview 6: "Ja, there is a process in place, there is a help line a help desk, a complaints line, a compliments and complaint box."*

Again, it would have been interesting to get input from care-receivers on their experience of the monitoring and evaluation process, to ascertain whether their concerns are regularly followed up. However, that was not the focus of this research.

4.7. Trust in PHC Settings

Caring with trust is the fifth phase of care that Tronto has recently added. It refers to the reiteration of the process of care, where habits and patterns of care emerge through time and where the moral qualities of trust and solidarity are developed (Tronto, 2010). Conditions of trust are created where reliance can be developed through the caring practices of others (Zembylas et al., 2014).

None of the participants mentioned trust issues; however, they were implicit in some of the findings. There appears to be a lack of trust in the multi-disciplinary approach in the two settings, as highlighted in an earlier sub-theme. However, other participants stated that the ethos of the facilities was good, which suggests that there are elements of trust in the health-care facilities. Lack of supervision and training may also influence trust between professionals in these settings.

4.8. Conclusion

During the research analysis process, it was noted that the four phases often overlap, and as a result it was complicated to analyse and synthesis the data, therefore, some of the sub-themes that emerged out of the values, also overlap.

The research could identify all four values, however, trust and responsiveness requires a multi-facetted analysis, as one should also take into consideration the care-receivers perception of care practices that they receive. There was a general consensus that, when considering the political ethics of care, issues of management, policy and challenges within the multi-disciplinary team, negatively impacts on attentiveness to care. The research identified, though, that participants were attentive towards their own care needs.

When exploring the value responsibility to care, it should be noted that the state provides a service, but this is influenced by the fact that the facilities are based in sub-economic and disadvantaged areas, characterised by violence, inequality and crime. In addition, care-receivers' attitudes towards the health professionals, who are predominantly women, are often negative, and as a result, impacts on their responsibility to provide care. The participants suggested that supervision and support are challenges, which was particularly highlighted by an allied worker. The participants were of the opinion that they are responsive to the needs of care-receivers, but it should be noted that care-receivers were not interviewed;

therefore, this view is potentially biased. A positive aspect that the research identified, in terms of responsiveness, is the fact that communities are encouraged to become actively involved in monitoring and holding health professionals responsible to provide a quality patient-centred service. The issue of trust was not explored, but inferences were made when exploring the multi-disciplinary team and the ethos, which was positive at both facilities.

CHAPTER FIVE

SUMMARY, CONCLUSIONS & RECOMMENDATIONS

5.1. Introduction

This chapter will present a summary of the findings that developed out of the research, the conclusions and finally the recommendations. The aim of the study was to develop an in-depth understanding on the care practices of health-care workers at two PHC Clinics on the Cape Flats. The aim was met by utilising the qualitative research approach. The research question (What are the experiences of professional health care workers providing care at CDC clinics?) was dealt with in Chapter Four that reported on the research findings. The objectives were to explore and describe care practices of health care workers at two CDC care facilities, and to explore and describe how health care workers' values and ethics influence their care practices at two CDC facilities on the Cape Flats.

The research was guided by the five values of the ethics of care theory, and the sub-themes that emerged out of the analysis, were discussed in Chapter Four. In addition, the values of the Department of Health, as proposed in their 2030 Health Plan, were also considered in the analysis, as it is in synergy to the values of the ethics of care theory. These values should be exercised at all health facilities, CDC's included, and ultimately should be entrenched in the care practices of all workers employed by the DoH. The researcher will unpack the main findings, as well as outline realistic recommendations for the two PHC facilities under study in this research.

5.2. Conclusions

In this section, the researcher will present the conclusions of the research findings. Recommendations will also be made based on the relevant findings. However, it must be noted that these are tentative, as the sample was too small to generalize.

5.2.1. Attentiveness in the PHC setting

The research highlights the care diamond, as proposed by care theorists, and how it relates to the double role that women care-workers, in particular, fulfil. The women care-workers were able to manage the double role, but are of the opinion; however, that the context in which they are expected to work, at times, challenges this balance. The research identified sub-themes, which are seen as the contextual factors that impact on their role to be attentive. These sub-themes are as follows; the impact of health policies, leadership and management styles, challenges with the multi-disciplinary team, and health care workers' attentiveness to their own care.

The research suggested that health care policies and processes guiding care practices in health often hampered health professionals in being attentive to service-users. The participants in this study highlighted concerns about their work context, as well as the required processes to enhance their attentiveness to the care needs of care-receivers. These contextual concerns were staffing shortages, challenges with procurement, and bureaucratic procedures, in general. Various research studies accessed concur that often health professionals are stressed, due to the work context they work in. In addition, policy also dictates that services should be quantified to provide quality person-centred services to patients.

However, the health care workers were of the opinion that the emphasis is placed on targets and quality, at the expense of being attentive to professional health care workers' needs and well-being. Literature reveals that the management styles and practices should fulfil the role of being attentive to care-workers and care-receivers. However, in this current study, the participants identified that the management style at the one facility was undemocratic. This impacted on the kind of attentiveness that staff required, but did not receive, and, consequently, impacted on services provided to service-users. The other facility was identified as more participatory, as the participants expressed that the senior staff were more open and accommodating.

The current study also deduced that there were, at times, challenges to implement a multi-disciplinary team approach at the facilities under study. This was specifically highlighted by the support staff, who were of the opinion that power issues between

them and the nurses impacted on their role in the team. It is insinuated nurses are the 'backbone' of PHC, as it is perceived that nurse 'run' the facility; however Healthcare 2030 clearly states the importance of multi-disciplinary collaboration and intervention. This concern needs to be taken into consideration when making recommendations on teamwork and collaboration. In addition, there may also be power dynamics between the different professions that would impact on their teamwork. Even in hospitals, professions could work with a silo mentality, without considering the broader requirement to provide a quality person-centred service. Although the care-workers highlight these challenges, they are still attentive to their need for self-care, which enhances their attentiveness towards proper care practices, in terms of the ethics of care theory.

5.2.2. Responsibility in the PHC setting

The political ethics of care proposes that the state should take the responsibility of caring for its citizens. In South Africa, this is being done; however, this research study identified challenges that impacted negatively on this responsibility. These challenges were identified as follows: the community power dynamics; care-receivers' attitudes towards care-givers; and the health care workers' responsibilities towards themselves. As the findings identified, one of the factors that impacts on the value of the responsibility to care, was the community power dynamics that influences responsible care practices. The participants identified gang violence and theft among other challenges. The reality is that the CDC clinics are at the coalface of health care service delivery, where these dynamics are predominant in the Heideveld and Hanover Park areas. Due to these factors health workers, as well as the PHC clinics are challenged to provide the type of service that responds to the care needs of the community it serves.

In addition, the participants conclude that the negative attitudes of the care-receivers towards the health care professionals impact on the care process. This is again due to power dynamics between the health care worker and the care-receivers. These power dynamics could be regarded as privileged irresponsibility, as some patients probably expect female care-workers to provide them with the type of services that they expect to receive at home. The Department of Health, therefore, needs to consider how they can address the relationship challenges between female care-providers and male care-receivers in order to ensure responsible caring practices. The research suggested that

health care workers take responsibility to care for themselves, which could potentially ensure responsible care practices.

5.2.3. Competence in the PHC setting

The research concluded that competence in the clinics was a challenge. The data analysis highlighted the concerns that influence competence as follows: a lack of supervision and training; a mixed response to the ethos at the clinics; and the resources to execute their care practices were available, but not always accessible. The lack of supervision and training was particularly highlighted by the allied workers, which include social workers, physiotherapists and occupational therapists. The allied workers suggested that the lack of supervision and training impacted on their ability to provide a competent service. This finding is consistent with the research identified in the review of literature, which also suggest similar challenges. Anecdotal evidence suggests that this lack of supervision and training could be due to the fact that most of these workers are women, and that there professions may be devalued or under-valued. Healthcare 2030, however, clearly articulates the importance of ensuring that processes are in place to compel health workers, irrespective of their role in the department, to provide a competent service.

The research findings suggest that there was a mixed competence, in relation to ethos at the two PHC facilities under study. One thread that emerged was that a positive ethos adds value to providing a quality service. The participants, however, highlighted that even though the ethos could be a positive process, if proper management systems are not in place, it could create a negative work environment, which ultimately impacts on the competence of the whole facility. Challenging work conditions are also likely to impact on the ethos of the facilities. In later findings, the participants commented on the lack of resources and the unattractive building that accommodates the facility. Again, anecdotal evidence suggests that this could also be linked to the fact that care-workers are women.

The political ethics of care theory, however, suggests that resources should be available, in order for health professionals to provide a competent service. This raises a concern about budgets and whether money is spent in an ethical way, so that staff are

content. The concerns are not only about salaries, but whether facilities are upgraded, or new buildings budgeted for. There has been an outcry over the closing of the GF Jooste Hospital in Manenberg that also serviced these communities, and talk of replacing it with a police training centre instead. This, further, highlights the complexities of working in Heideveld and Hanover Park, where crime appears to take precedence over health. These contextual aspects are likely to impact on the competence of staff.

## 5.2.4. Responsiveness to care in the PHC setting

Responsiveness, according to the ethics of care theory, proposes that care-receivers assess whether the services received were responsive towards their care needs. The research suggested that care-workers are responsive to the care needs of the people accessing the PHC clinics, however, this was proposed by the health professionals. According to the health professionals, their assessment was based on responses that they received from clients. Care theorists, however, propose that care is subjective; as the care-receivers might have a different view, which can be seen as a limitation in the research study, as care-receivers were not interviewed. The participants suggested that the PHC clinics introduce systems for clients to communicate their complaints and provide feedback to the clinic staff and management, on the services rendered. This process will ensure that the service becomes continuously responsive to the caring needs of clients. In addition, health committees have been established, which further ensure a process of monitoring and responding to clients needs. The research, however, failed to explore whether these processes are effectively implemented. Care-receivers' feedback needs further investigation and exploration, but would to be a topic of another research project. The ethics of care highlight how people from a working class background may provide feedback, but their thoughts and ideas are less likely to be taken seriously. As most of the clients at these hospitals are from these backgrounds, this may be a concern that needs to be addressed.

5.2.5. Trust in the PHC setting

When considering trust in the PHC clinics, none of the participants mentioned trust in the PHC, but revealed the lack of trust in the multi-disciplinary approach at the two clinics under study. In addition, as reported earlier, the lack of supervision and training offered, especially to allied workers, also posed a threat towards developing trust in the

multi-disciplinary team. Trust and solidarity has deteriorated within the South African context, due to corruption and unethical conduct in Government. This could have an impact on the kind of trust and ethical conduct in institutions, such as hospitals. However, there were participants, who reported that the ethos at the one facility was good, which suggests that there is an element of trust in that particular health facility. The research again failed to consider care-receivers' experiences of care, which could have indicated whether they trusted their care-workers or not.

Having made conclusions about the values, and the impact thereof, on care practices at the two PHC clinics, individually, an understanding of what happens, when you situate all the values of the ethics of care together, is necessary. As the research suggested, there are challenges pertaining to the fact that the facilities are not always attentive to the needs of care-receivers, which could potentially impact responsibility. The reason for this statement is that care is subjective, and care-workers' understanding of care needs, might be in contrast to that of the care-receiver. If the trust in the relationship between the care-giver and care-receiver fails, there could be challenges with being attentive to the needs of care-receivers. As indicated earlier, trust is also related to providing a competent service.
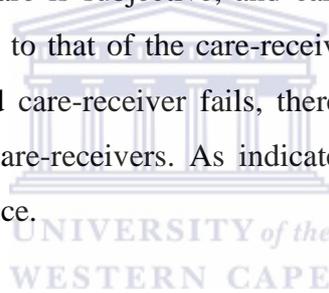
5.3. Recommendations

This section will consider recommendations concerning the qualitative research method used, as well as the research findings and finally, also include future areas for research.

5.3.1. Recommendations pertaining to the research process

- This research was only conducted at two primary health care facilities, it should, however, also be considered at other CDC facilities and possibly at other health facilities, as values and ethics in health care are central to care in any health setting.

- This research just included the clinical staff, however, care in health also involve other stakeholders, such as the general workers, administrative staff, as well as the pharmacy. This will broaden the scope of the findings and will include marginalized staff.

5.3.2. Recommendations pertaining to the research findings

5.3.2.1. In terms of attentiveness towards care practices

- The District management team should ensure training opportunities for facility managers and operational managers across facilities, pertaining to management styles and practices and this should be done consistently with all facilities.

- Support and mentoring should be given to managers, as this will create consistency in their management style at all facilities.

- Constant team building activities should be encouraged, as this will encourage effective and efficient teamwork with the multi-disciplinary team. This should also be extended to support staff in the facilities and will ultimately ensure team collaboration and the provision of a caring service from the time that the care-receivers enter, until they leave the facility.

- As the research concluded that health professionals do practice self-care, it can be recommended that the facilities also provide this, within the care package for staff.

5.3.2.2. "Towards creating responsible care practices"

- The substructure should investigate the physical conditions that staff are working under and are exposed to, and endeavour to create a healthy physical environment that is conducive to health workers physical well-being.

- The violence and crime should be addressed at a macro level, therefore it is recommended that the facilities liaise with community structures in order to address some of the safety concerns of health workers and endeavour to create a positive and collaborative partnership.

5.3.2.3. "Towards the creation of competent staff"

Health care workers, as well as support staff, should be encouraged to be responsible towards the self. Workshops on burn-out and stress could contribute to staff being more responsible. This could be augmented by Wellness Days for staff.

5.3.2.4. The creation of a competent care service

- Supervision and support should be provided, specifically for allied workers (social workers, physiotherapists and occupational therapists). This support and supervision should be specific to the professional needs of the respective allied health professionals.

- The Department should look at creative ways to get all employees based at the PHC facilities on board, to adopt a positive ethos, which is entrenched in the values of Healthcare 2030. The C²AIR² Club is a move in that direction; however, there is a need to get all employees actively on board.

- A systems analysis should be done in order to ensure that all systems within the PHC clinics are working in synergy and collaboratively, as this will ensure a competent care service.

5.3.2.5. "Towards becoming responsive towards the care needs of care receivers"

- Care-receivers should be encouraged to access the 'compliments and complaints' process; at some clinics it is clearly visible, whereas at others not. The management needs to find ways to promote this process among the care-receivers.

- It could be recommended that basic questionnaires be given to care-receivers, in order for them to assess whether the care offered at the facility is responsive to their care needs.

- All CDC facilities should either start heath committees, or revive those that are defunct, in order to create a positive partnership and collaboration, while working towards becoming responsive, as well as working towards achieving one of the Alma Ata declarations towards partnerships in health care.

5.3.2.6. Trusting relationships

- It should be recommended that training and support be offered to all staff irrespective of their role in the multi-disciplinary team, as this will create a sense of trust in the team. There could be team-building days, where all the different team members get together.

- However, there were participants who reported that the ethos at the one facility was good, which suggests that an element of trust exists in that Health facility. A way to harness these positive feelings could be through a 'Whats app' group, which could support staff initiatives.

- It would be recommended that confidential questionnaires to given to care-receivers, in order to establish whether they trust the service, while, simultaneously, evaluating whether the care service is responsive.

5.4. Recommendations for future research

- Explore whether the care service is responsive to care needs of clients. This should, however, be conducted from the care-users perspective.

- Healthcare 2030 and the implementation of the core values that ultimately will assess the effectiveness of the C²AIR² CLUB challenge.

5.5. Conclusion

This chapter provided a synopsis of the research findings, made recommendations with regard to the research process and findings, and, finally, recommendations pertaining to future research in this field of study. Through the study, the researcher was able to attain and gain an understanding of health care workers experiences of caring for people accessing services at two CDC clinics on the Cape Flats.

The aim of the study was obtained by focusing on the objectives of exploring and describing the care practices of health care workers at the two clinics under study, as well as how their values and ethics influenced their care practices. By gaining an understanding, the researcher was able to determine why there is a mixed response when one considers the ethical concerns of care and how they relate to care practices.

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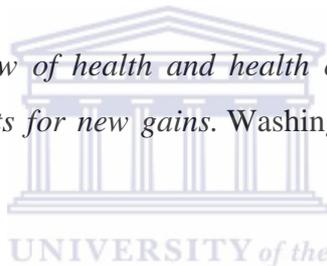
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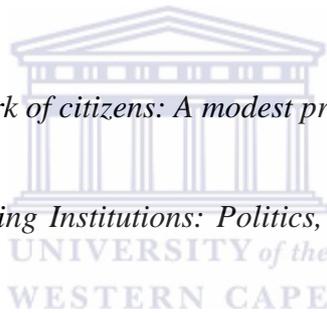
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APPENDICES

Appendix A: Approval letter A

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6052; fax: +27 21 483 7895
9th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2014RP0_155
ENQUIRIES: Ms Charlene Roderick

University of the Western Cape
Faculty of Community Health Sciences
Robert Sobukwe Road
Bellville
7535

For attention: Ms Asma Achmat

Re: PROFESSIONAL HEALTH CARE WORKERS' EXPERIENCES OF CARE AT TWO PRIMARY HEALTH CARE FACILITIES ON THE CAPE FLATS

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Hanover Park CHC	G van der Westerhuizen	Contact No. 021 692 1240
Heideveld CHC	A Eksteen	Contact No. 021 638 3202

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 04/12/14
CC   P OLCKERS   DIRECTOR: MITCHELLS PLAIN / KLIPFONTEIN

Appendix B: Consent Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959-2843, Fax: 27 21-959-2845

E-mail: nhenderson@uwc.ac.za

SOCIAL WORK DEPARTMENT

CONSENT FORM

Title of Research Project:

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name………………………..

Participant's signature……………………………

Witness……………………………….

Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Dr Neil Henderson

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2843

Cell: 072-539-7433

Fax: (021)959-2845

Email:nhenderson@uwc.ac.za

Appendix C: Interview Guide

A.Demographics

1. How old are you?

2.   What is your relationship status?

3. What is your job category at this facility?

4. What are your qualifications? And what are the minimum requirements for your job?

5. Where did you obtain your qualifications and when?

6. In your opinion what do you understand as care in your profession?

B.Work

1. How long are you working as a health professional? How long at this facility?

2. Tell me about a day in your work? What is your routine?

3. In your opinion how would you describe the ethos at this facility?

4. Explain what is it like working with your colleagues?

5. How would you describe your relationship with your direct line manager?

6. How are you coping with your clients? *Do you sometimes feel overwhelmed? (**add if necessary**)*

7. Explain how your clients respond to your care?

8. Does the care process, meet the client's needs?

9. Is there a process at this facility that pays attention to changes in client's needs? Can you explain how it is done?

10. If your needs are in conflict with your client, who resolves these conflicts?

11. At this facility how would you describe is conflict resolved?

12. What resources are required to execute your job?

13. Describe your support network at work?

14. What about your job do you like?

15. What about your job do you dislike?

16. How often do you get supervision?

17. WRT Training, do you ever get to go on training?

18. Are you involved in any other activities at work apart from your job description?

19. Do you take off often from work? If yes, why?

C. Home

1. When you get home after a busy day at work how do you respond to family or friends?

2. How would you describe your relationship with your family and friends?

3. Do you bring work issues home?

4. What do you do in your spare time at home?

5. How do you de-stress?

D. Other Areas

1. Are you involved in other activities outside of home and work?
2. Are you involved in sport, gym or religious activities? Tell me about it?
3. Do you see them as supportive or stressful?
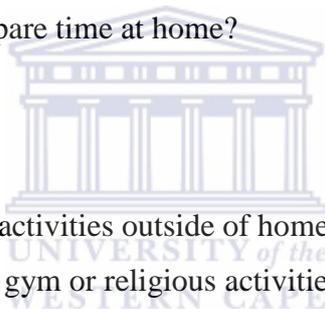
Appendix D: Transcription Interview 4

TRANSCRIPTIONS

Interview 4

A. Demographics
1. *How old are you?* 31 yrs old
2. *What is your relationship status?* I am married with 3 children.
3. *What is your job category at the facility that you are working at?* A medical officer, permanent medical officer.
4. *What are your qualifications?* MBchB. **What are the minimum requirement s for the job that you are doing?** That you must be registered as a medical officer with the HPCSA. You must have completed your internship and community service, because this is a permanent post. You must obviously have the clinical skills. If you have completed your community service you would have acquired the necessary clinical skills. You must be willing to work the hours and the terms that you have agreed to.
5. *Where did you obtain your qualifications and when?* University of Stellenbosch in 2008.
6. *As I have indicated to you that the research is on care, what do understand as care in your profession?* I think if you look at care it is not just the emotive that we commonly use in relationships. It is care that you will stand for certain things that your patients come with, that you are willing to listen to them without judgement, that you are willing to give your best clinical judgement on whatever the situation is. You will manage people correctly and you will keep things confidentially and use the best resources that you have available at your facility to make sure the client or patient gets the necessary management that is required.

B. Work

1. *How long are you working as a health professional?* Since 2008 so this will be my 7th year . *Researcher: And at this facility?* Participant: and at this facility 1yrand, obviously I am on maternity leave, one year and 7 months. Almost two years.

2. *Tell me about a day in your work, what is your routine?* Ok on an average day you come there at 7h30 and 8h00 you do sort of admin work. Maybe check results on patients that you have done yesterday that you're really worried about. Or maybe sort out patients that are at the hosp at that day that doesn't know where they need to be or they want to be seen that day and it is not possible, then you will guide them on where to be or obviously you need to start at 7h30, but if there are acute emergency cases then you are present to help the individual. Then at around 8h00 you will receive your patients that would be your chronic patients, your hypertensive's, diabetics, asthma, epileptic patients. You'll see them till about 13h30, 14h00 and then you will see the triage patients, the patients that come on the day, but they don't have an appointment and you will see them. That is just an average day, but obviously you have an emergency

room that is divided amongst the other colleagues that are there. Two days out of the week you do call shifts, besides the patients that you see and the other responsibilities. Including you will see a patient, you will offer them pap smears, you'll do what is required for your job. *Researcher: And what would that be?* Participant: for example pap smears, you have to ask them about STI, You have to make sure that patients are educated about their illness, make sure that they get the correct medication and also offer them other services for example physio, social worker, OT if it is available and refer appropriately.

3. *In your opinion how would you describe the ethos at this facility?* The ethos I think it is individually based because collectively if you just look as a whole if one wants to get the job done in the time that is required, meaning you see the patients in the time that is required to get the job done meaning to see the patient in the time that is required time and not making any one unhappy. Obviously each one has their own ethos. But I say to see as many patients as we can in the time that is required and do justice to them meaning manage them correctly see them and get their medication and see them happy. *Researcher: Is that what is happening at this facility?* Participant: That is what we want what we would like it to be. *Researcher: but how is it at this facility?* Participant: But in essence there are many factors that, that make that impossible or maybe difficult. So most of the days I would say we please for example 70% of the patients in terms of getting their medication and managing them. How they are managed it depends on the resources that we have. Like obviously when referring a patient, it's obvious when you refer a patient that day, or the folder comes late and you see the patient that late clinics are close and you can't make appointments, then it is difficult the patient must come back again and make another appointment, that means another bus another taxi fee. You know the pharmacy are sometimes full the patients are sometimes turned away. Or if a patient comes at 7 o'clock because of the delays, the barriers *(Researcher: What would the barriers be?* Participant: Staff coming late organisation of the facility, how things are being run, every day people are just doing their own thing instead of there being a firm leader that would said this is how it's being done, everyone is just doing their own thing and i think that is a big problem. People have been here for 30/40 yrs so they feel they are entitled to do things their way. I'm not saying there is no order, but what I'm saying is that sometimes management's orders are not carried though, because of certain personalities of certain individuals. *Researcher: Are you referring to certain personalities at the facility?* Participant: Yes I am referring to certain individuals personalities and maybe the approach on management is where its lacks, because they sometimes just leave it as it is. Like management they do have their protocols and they do want things on paper to get things better, but in reality it doesn't happen. And I guess on their part it is also difficult because of certain individuals in different departments that makes it difficult for them, but I still believe that if you have that leadership skills no matter the personality you're dealing with there are supposed to be avenues no matter who you are even if you are there for 15 years or one day it should be the same. If you do that there will be discipline. That is the problem there are no discipline at that facility, everybody just come there, yes they come and do their work, but everyone does it differently. Some people walk around half of the time that they're supposed to be there and then only they start seeing patients or start doing what they're meant to do. Others

will be very dedicated on their cause and they get frustrated because there is only one person taking the load instead of a whole team. *Researcher: So there is inconsistency?* Participant: Yes there is inconsistency in terms of individual staff. Maybe if you look the staff might also be unhappy so they don't have that energy or that willpower or that wanting to do that extra or go that extra mile for the facility. I mean I go there to do my work to do my job and do it to the best I can and to help where I can, but that basically it and then go home again. There are other people that have different ways of thinking and doing what their job description states.

4. *Explain what it is like working with your colleagues?* Uhm well it is, are you talking medical officer level or general? *Researcher: General?* Participant: Clinicians? *Researcher: Maybe to start off with you medical officer colleagues and then the clinical staff and general staff.* Participant: If I look at that clinicians, we are four clinicians and I think we reasonably work well together, there's never going to be the perfect team. There's always going to be issues and things that will never make it perfect. I don't think you get the perfect teamwork, but generally we work well together. Like I say the things that don't make us work well together is the same things. Management don't put a foot in when people come late or people just do as they please, there is no communication. Like maybe if you can't make it for the day or you can't do something, there is just automatically the other people's responsibility. There is just no communicating and we can make a plan for the few days and say this is what's going to happen. I think as colleagues you can't address it at that level, because management are the ones to tell people, Look here these are the work rules and it applies to everyone and not to one person. Maybe you've been there for 20 years, a senior, it applies for everyone. But other than that I generally feel we work well together. In terms of the other clinicians the CNP's and the nurse we sort of have a reasonable relationship. I think in the beginning it was rocky, because I was new, my other colleague was also sort of new and we had to get used to different personalities and how people work. Everyone work differently, but after we got over that hurdle we are on a level where we have respect for one another and know how we can work with one another. Like I say the same things that becomes negative is management, I can't tell someone's that's been there for 20 years, look here this is how you're supposed to do your job. I can't tell someone that because that is how you're going to create friction amongst clinicians. Whereas if you are in a leadership role or head of department you can do that. You can tell the person look here this is your role nothing else, this is your role, even if you are so tired and you're here for 50 years. Your role is to see patients your role is just that and if that happen everyone gets to do what they need to do. The bottom line is everybody do what they're supposed to do. Besides clinicians people have leadership roles to do and they need to do that and take responsibility for that. That will ensure the smooth running of the facility.

5. *How would you describe your relationship with your direct line manager*? Well there is an open door communication, the manager says you can always come to me if you have a problem and that has been done. You come with a problem and address the issue, but the problem is the resolution to the problem because that is where it gets stuck. What happens there is a problem it either takes a whole year for the resolution to take place or somehow it is forgotten in the air. As a manager it shouldn't be, because as a

manager if someone comes to you it should be written down, it must be jotted down it must be recorded, but that does not happen. It is human nature to forget, but you don't work with 5 or 10 people, there are 50 or 80 staff members and if that 50 or 80 staff members come to you on one day it is just human nature you're not going to remember all the complaints. The management need to have a system in place on how to address these complaints, because if you're not going to address these complaints or whatever it's going to be people are not going to be happy, staff is not going to be happy. They're not going to want to listen to what you have to say and adhere to your rules, because you have listened, but have you truly listened to what they have to say you contemplate and reflect on what is said and come to a resolution. That unfortunately most of the time does not happen. That is the biggest problem between staff and management and that is why there is a continuous rift between staff and management. There is a big problem, because sometimes the resolution part is not much put into that.

6. *How are you coping with your clients?* Uhmm well in general because the thing is you have to see the type of patient that you're dealing with, you don't just deal with the patient and their problem you also deal with the personality and character and sometimes it is very difficult because there are certain clients with unruly behaviour unruly manners and you as an individual will have to deal with that and have to get to the barrier where you can deliver the service but you try and avoid the conflict or the unruly behaviour of your patient, that is a big challenge. *Researcher: Is it overwhelming?* Participant: yes it is overwhelming, its very overwhelming, because sometimes you think to yourself should you retaliate in the same manner, what must you just be quiet and sometimes you try these different steps and sometimes none of that work and in the end you don't manage the patient and I think that is a big obstacle for many clinicians that work there, because sometimes the patients that come there, yes the patient comes first, but what do you do when patients are rude to you or abusive towards you. They verbally and sometimes even want to be physically abusive and that is the challenge that clinicians experience. And I don't even think that people realise what we sacrifice to see patients. And in anytime your life is in danger, ja you might think that is being melodramatic, but *(smirk)* that is not melodramatic you know with drugs and everything. You know how many patients come there that are using drugs and you know they can just snap one moment and then you there and then what do you do? You don't even have security that is equipped to deal with situations like that so that is a big challenge. Another challenge with patients is that you see so many patients for the little time that you have and yet they want you to do the best quality of care for the patient... I mean that is impossible. You have a required pap smear or a certain amount of HIV testing that you have to do a day but then they overwhelm you with so many things, whereas rather the problem that the patient came with solve that and then get the management and in between where you can try and do what you need to do, but it is impossible for every single day for them to have the quota which they want sometimes, sometimes it is possible, because sometimes you don't see so many patients but other times it is not possible and I think it is those times that management have to understand, because they're there(*smirk*) they can see the load, the lack of... shortage of staff because of sick of leave or whatever it is. I mean they have to understand that you can't do what is required of you to do. But also you have to acknowledge that there is a

bulk of patients which really where you feel that you've really done your work for the day and you're happy that they were happy when they left your room. And.. and that's uhm on average if you look at that then the other bad things (*Smirk*) sometimes it just makes it better (*smirk*). *Researcher (laughing) coping?* Participant: It makes it cope I was .... I did want to... oh... I was looking for a word, but ja you cope. Researcher: Is that it? Participant: Ja.

7. Explain how your clients respond to your care? Uhm.… *Researcher: Just in your opinion.* Participant: Uhm in my opinion I think on average they are reasonably satisfied with with... uhm you will get the individuals that are extremely happy about what you've done, maybe its just coincidence that you found something that they're always grateful that you're the one that helped them and you give them that due ..... and you appreciate that they thank you for that. But on average I think that they are satisfied with my care, there will be a portion of people that will not be satisfied with the care, because you can't always keep on to patients what patients want and you have to keep on to what they need and that is the biggest thing that we're trying to drill through patients that you only need that, that you only need what I give you and obviously you will get patients that are unhappy and dissatisfied and unfortunately you have to take that Researcher: *Are you Ok. Participant had to stop to feed her baby.*

8. *Does the care process meet the clients' needs. In your opinion do you think that the care processes at Heideveld meet the clients' needs?* Participant: Huhu (meaning no). *Researcher: Do you think that the care processes at Heideveld meet the clients' needs?* Participant: Um I think to a certain extent we have to say yes, but like I said that if you fully wanna say that you care for a patient more needs to be done in order for one to fully say that we care for a patient and that we're doing that responsibility. But to a certain point I would say yes, we are trying.... I'm not going to say, we are trying, well I'm not going to say our best, but we do try with what we have to deliver the service, but it can get better but it can be improved and that we need to realise the we can be better. Because I mean if you compare our facility the amount of patients to other facilities is not as many and yet we struggle to have a smooth running with you know and that is the problem, but in that process we still sort of deliver a service. Ja we're going to neglect a few patients, a certain percentage of patients that come there, but I think the majority of the patients do sort of deliver that care to that patient.

9. *Is there a process at this facility that pays attention to in change to what client's want?* There is uhm a suggestion box for patients and I think that they know about it that is how we get to know also at meetings about certain complaints the patients give and it gets addressed to the staff members... so ja the suggestion box and then obviously the office if the managers are there then they go there and sometimes I think patients misuse that, when they directly go to the managers. The managers feel entitled to do what the patients said instead of listening to the problem and manage it objectively. They just do what the patient says they must do and I don't think that is right. You don't just do what the patient say, because now you just want to please the client and not look bad. You have to do what is right.

10. & 11 Researcher: *I think this question is linked to what you have started to explain. At this facility if there is conflict how is it being resolved?* Uhm usually when there are conflict situations then we usually first approach the operational manager and uhm

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afterwards we. *Interruption with machine recording...* The operational manager because she is like on the floor so then we can address it with her and if we feel that after a certain time that it hasn't been resolved then we go a step up and we go to the facility manager, and if the facility manager don't resolve it then she'll take the matter up to substructure if it needs to be or she will try and resolve. Sometimes situations are being resolved, but like I say most of the time, that is the crux, that is the problem with staff coming to the manager to solve the problem, most of the time if the operational manager can solve the problem that is ok, but most of the time the problems that she cannot resolve that either it never gets resolved or it takes you six months to a year and that is what staff members don't want. And sometimes you have to go above them, I mean you don't want that because then it becomes a whole saga, a big issue an I mean ja.....

12 *What resources are required to do your job?* Required or do you mean available. *Researcher: What is required and then you can talk about what is available.* What is required for you are to be in a safe environment and so safety, what is available is there, is ok, they do have security that is there, but honestly on situation when we needed security they were just standing there and we literally had to shout at them to help, so safety is no 1. But I think 80% that is OK. Then in the room you need certain tools to examine patients, for example the Blood pressure cuff. One time it's working, sometimes it not working, you give it in you get a new one, it works sometimes not. The basic tools are there, but I think the big lack of resources is the emergency room, but now that the Heideveld EC is there we don't require that any more. But before the problem was there were not enough resources, the ECG is not working properly, the resus, the thing for resus (referring to resuscitation) was never there. The medication that supposed to be in the resus trolley is either expired. I mean those things should be on target if you want to have an effective emergency room, but like I say now that we have an emergency centre that is fully equipped. So at the moment I would say that our resources I would say is ok to manage the patients.

13 *Describe your support network at work?* What they do have is this group I can't recall. They say there is this ICAS that one can access for support whatever. Obviously the managers they offer to be the support for you, and basically your colleagues, but it depends on the relationship that you have with them. *Researcher: And at the facility how would you describe it to be?* Participant: Like I say that is what they have to offer. Do you mean support for staff or for the patients? *Researcher: for the staff.* Participant: for the staff I don't know if it is working,b ecause personally I haven't used it beside my colleagues for support. I mean sometimes you are in situations and you're noy going to phone ICAS there and then. And when you go to the managers, sorry for harping on about the managers, they need to be your support, but sometimes they....they … it's a lost everything to make them look good, to make the facility look good and I mean that isn't how you solve problems. I mean that is not how you solve problems that is not how the facility going to move forward. It must actually be good in order for ... That is where staff members loose out where they not get the support from or leaders for wanting to look good at the expense of staff being happy and contented.

14 *What about your job do you like?* Uhm... grinning... well the fact that you sometimes, maybe not just you per say, but you can use your resources to figure out things, uhm, to

figure out things that they came there for something else, but now actually they now have a problem. And you actually feel good about yourself like oh my word that person just came for a minor complaint and here it's something big, something major that needs to be addressed and she would never have known if she never came to the hospital. If she hadn't complained, maybe if I didn't look at that area understand it is those surprises, it jogs the mind it makes you think out of the box, because it is not the usual everyday diabetic, Asthma thing, and that is the thing, the challenges are what I like. The emergency setting that you're actually really going to help someone now and if you're not going to do something right now it's going to be to the detrimental, detriment of that patient. That is what I like about the job that you can actually be there and actually help someone. Yes a diabetic and helping and asthma patient, that is also helping, but in those acute situations you actually see what you are capable of, because sometimes you feel so despondent you know people don't appreciate you, not that you need their appreciation, but you feel despondent that you're never appreciated and in those situations it just lifts you up to move on and I think those are the moments for many clinicians that makes them feel good and see look here it's worth it to be here.

15   *And what is it about your job that you dislike?* Uh mi think it is the fact that patients had to wait for so long and I'm not just talking about patients I'm talking about old people that have to wait. People in wheel chairs and unfortunately that can't be solved overnight because it's the problem of numbers and the amount of staff members that there are. You can only so much and that is the thing that I don't like. They come here 4 o'clock 5 o'clock, hey only get seen later. I mean if that was me honestly I would have gone long time home. But I mean they sit there they dont have any other choice. They don't have money to go to private, they don't … I mean this is it this is where they need to be and they will wait whether it is 6, 7, 8 hours. And then what I hate more and then they go to the pharmacy and they get told that sorry it is too full you must come back tomorrow that is what the worst possible thing to happen is for most staff members. I mean for patient sitting from 4 o'clock and then at 3 o'clock to be told that you must come the next day. And also the fact that you don't have enough staff,   the shortage of staff. And I mean people think we are overstaffed. I mean if you want to provide a good service you need more staff, you need more clinicians, more CNP's. Pharmacy, you need more pharmacists and I mean you need more in order for patients not to wait so long, for patients not to be turned away. I mean reception you need qualified people to work there, people with the right personality to work there. That is the problem the people that are at the front desk give a bad representation of the day hospital. That is what people take home. They take the front and they take that home and the middle part they seem to overlook and so it's the front and the end Referring to pharmacy) which is the biggest crisis at this facility. I mean seriously being at reception you need to be at your kindest, even is you don't want to be. I mean you're representing the hospital and unfortunately that is nott what's happening and it peeves people off.

16   *How often do you get supervision?* Uhm how often do I supervise or how often do I get supervision. *Researcher: How often do you get supervision?* Participant: Well initially when I got there, there wasn't much. We do have a family physician that supposed to have at least tutorials. Then we realised that we don't have much supervision where do we go to when we have big issues or big problems in the facility in terms of clinical areas

and that is when we requested so now once per month he comes and give tutorials on case studies on how to manage certain things. On acute cases or cases that you need to find out on a higher level you call Grootte Schuur you call your colleague around what to do. But at the facility currently on the floor besides the colleagues that you have there isn't much supervision besides the family physician that comes once per month. That was only after we requested that he comes. Other than that on clinical issues on cases that we can't wait we call upon secondary hospitals and tertiary hospitals.

17 *WRT training. Do you ever get to go on training?* Well it's always said that the list is up everything is up, but when it comes to the book it's already there people are already going on courses. So obviously when you have for example 4 doctors you can't obviously have three doctor is going on a course on one day. So even if you want to go you can't go because there's always somebody in the medical group you can't go during that time. You can't go on courses that is just so by the way but that is suitable for you as a doctor. And you are given options, but there are not that many. *Researcher: How often do you go?* Participant: for the year I've only gone on one formal training session for the year. The others are days training that we initiated at the facility other is training that we have once That is in-house training . *Researcher: What would that training entail?* Participant: that would be on certain topics like diagnosis of diabetes or we'll have a rep coming in showing us the new insulin syringes or we'll have some one talking about asthma and medical management on that. *Researcher: Who arranges that?* Participant: I used to, but now I'm on maternity leave some –one else gets to do it. I initiated this process.

18 *Are you involved in any other activities at work apart from your job description?* Not really, there are so many things to do, your job description in its self will keep you busy till 4 o'clock or even after 4, and you don't get time to do anything else.

19 *Do you take off often from work?* Only when needs to be for example family responsibility or when you're sick. I think that is the biggest problem because they would say when you're sick are you really sick. I mean you work with people that are constantly sick and you are exposed to that. So it is sick days and it would be the odd days. So it is not like it is a regular thing.

C. Home

1. *I'm going to ask you a bit about your home. When you get home after a busy day at work how do you respond to family and friends?* Usually I pick the children up so, so they sort of de-stress you. They come up with stories about school and then you totally forget about work. Unless something really bad happen to someone really upset you. Then you'll be in a motionless mood and then go home. But then you have your responsibilities, you cook food, husband gets home. We usually have an open communication, because when something bothers me I will talk to him and he would generally ease it out. But generally when I get home I try to forget about work.

2. *How would you describe your relationship with family or friends?* Ja I think I have a very good relationship with my family. I don't have that many that one would call friends. The friends that I have

3. *Do you bring work issues home?* Obviously If it is going to affect you personally and if it is issues that if people become personal or want to attack you then personally when you go home it affects you because then you just want comfort or advice from your partner. But

other than that I leave it at work, because when I come here I have children husband and I need to.... because when I bring it home it's just going to make me a miserable person. *Researcher: Does that happen often?* No it doesn't happen that often...Uhm maybe once a week. I don't know if that is often or not often yes maybe once per week. You'll actually come home and feel really down. There'll always be those days when you know you're either short staffed or staff members are rude to you like that or patients have been rude to you. That's why it's probably once per week.

4. *What do you do in your spare time at home?* Well family and family and family. That is basically my spare time my hobbies my everything because they occupy my time most of the time.

5. *How do you destress?* Well distress is probably a morning drive to Muizenberg way, Fish hoek way, take a walk with the children, I mean everything is with the family. But it is usually out of the house, take a drive that is basically what we do.

D. Other Activities

1. *Are you involved in other activities outside of work and home?* Like I say family takes up most of my time, but I sometimes get involved in charity work, because my mother belongs to various organisations. I help her out here, try and see what I can do. That's about ja.... that's about it.

2. *Are you involved in gym, sport or religious activities?* Religious activities and sporting I used to do on a regular basis running, but probably with the pregnancy I needed to retract that but probably now I need to refocus on that. Because ja I need to do something that is suitable around the family. Like going to a gym I need to go a certain time.

3. *Do see these activities as supportive or do you see it as being stressful?* No I think it destresses you, because if you run it you forget about everything you focus on trying to do a certain Km in a certain time. You focussing more on the present on what you are doing at the time. *Researcher: So it's helpful?* No it is definitely helpful.

Appendix E: Editorial Certificate

30 November 2015

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

PROFESSIONAL HEALTH CARE WORKERS'
EXPERIENCES OF CARE AT TWO COMMUNITY DAY CLINICS
ON THE CAPE FLATS

Author
Asma Achmat

The research content or the author's intentions were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax number, e-mail address or website.

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