UNIVERSITY OF CAPE TOWN

FACULTY OF EDUCATION

HOW EFFICIENCY IS CONSTRUCTED AND EFFECTED IN THE PROVISION OF HEALTH EDUCATION

A dissertation presented in partial fulfillment of the requirements for the Degree of

Master of Philosophy
(Adult Education)

by

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MARCH 1994

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ABSTRACT

The focus of this study is on the constraints encountered by health care providers situated at community centers in meeting the local community's health needs. Health education is one way of meeting these needs.

This case study is an investigation into how the registered nurses as health workers of four clinics in the Grassy Park area perceive their roles and identities in relation to providing Health Education as part of Primary Health Care to meet the health needs of the community.

The information obtained attempts to identify the influences and constraints which affect the way in which health workers as professionals interface between their organization which is also their employer, and, the community, and how they conduct their role as intermediaries at ground level.

Data collection methods included non-participant observation, individual and group interviews, and a study of selected documents and placards found in the clinics.

Analysis of the data and discussion reveals the limiting and controlling effects of the dominant discourse embedded in the policy for Primary Health Care and Health Education.

The report concludes that there is scope for developing health education programmes which will be more comprehensive towards reflecting the health needs of the community, and proposes ways in which this might be approached.

DECLARATION

This study represents original work by the author. Where use was made of the work of others, this has been duly acknowledged.

ACKNOWLEDGEMENTS

This dissertation could not have been possible without the generous assistance received from:

- The Cape Provincial Administration for granting me study leave and support;
- The Western Cape Regional Services Council for allowing me access to their services;
- The Health Workers from the four clinics in Grassy Park for allowing me to interview them and for their willingness to talk freely;
- Mrs Judith Slabbert and my colleagues at the Subdirectorate: Nursing for their interest and support;
- My course leaders Professor Clive Millar, Professor Tony Morphet and Mr. Mastin Prinsloo for their provocative comments, support, and critique;
- Mr. Mastin Prinsloo my supervisor, for his guidance support and ability to stimulate my critical insight;
- Professor Tony Morphet for his valued review and comments;
- My fellow-students for the shared experiences and support;
- My family and friends for their love, support and concern; and
- Gabriel for his patience, support and love.

My sincere gratitude to all

ACRONYMS

The acronyms used in this text are listed below for the convenience of the reader. The list is ordered according to initial appearance in the text.

HE	Health Education
PHC	Primary Health Care
RSC	Regional Services Council
TB	Tuberculosis
WCRSC	Western Cape Regional Services Council
WHO	World Health Organization
GOBIFFFF	Growth monitoring; Oral hydration; Breastfeeding; Immunization; Family planning; Female education; Food supplements; and First aid.
SPHC	Selective Primary Health Care
SHE	Selective Health Education
UNICEF	United Nations International Childrens Fund
LDC's	Less Developed Countries
MRC	Medical Research Council
SPN	Senior Professional Nurse
PN	Professional Nurse
CPN	Chief Professional Nurse
SANC	South African Nursing Council

CHAPTER 1

INTRODUCTION

The introductory chapter will serve to introduce the reader to this research study, the research focus and the purpose for undertaking this study.

I suggest that the most important challenge in Health Education (HE) in relation to Primary Health Care (PHC) should be to develop a deeper understanding through research of how to meet the health needs of the local community more efficiently through health workers. For the purpose of this study, the unit of study is narrowed to the field of registered nurses as one group of health workers who interface between their organization and the local community they serve as intermediaries of medical practice.

The existing health service, like other areas of public service in South Africa, finds itself riddled with a complex and confusing maze of ridiculous contortions, as a result of a historically inherited inequitable health system. This situation is reflected upon by De Beer:

> The tragedy for the South African situation, is that it (health) is only one of a range of problems. The fragmentation of the system, and the element of racial discrimination pose equally substantial problems, both for the present delivery of health care, and for the future transformation of the health system.
>
> (De Beer, 1988:77)

The inequities left a schism in society and a profound neglect for the development of the majority of people, while simultaneously securing a disproportionately large amount of resources for the white minority. In the light of providing health care based on sound theoretical constructs, it is also important to take cognizance of the historical context of the situation within which HE is provided currently.

Conversation with a number of members of the multidisciplinary health team such as teachers, social workers, medical practitioners, and health educators revealed that a current concern is the limited effect of HE without adequate and simultaneous programmes of development aid for socio-economic progress of the local community. Myburgh (1989:9) comments that health is a development problem and not a disease problem and should be addressed by all people concerned with health and not just those who are acknowledged as health professionals.

In my work as a manager and consultant concerning maternal and child health services, I have observed that there is an increasing need for health care managers to engage in the wider aspects of public health matters, and to identify the constraints surrounding the efficiency of the provision of health with the understanding of finding better ways in addressing the health needs of the people in South Africa. For this reason the issue of HE was felt to be an appropriate subject for further study and research because HE is an integral part of health care provision in the widest sense.

Institutional background and analysis

The following discussion is informed by the researcher's work in the field as a nurse and health care manager, over a number of years.

The present health system in South Africa is arranged organizationally into three tiers hierarchically i.e. central authorities, provincial authorities and the local authorities.

Registered nurses as one group of health workers in South Africa who participate in PHC within the state health system, are placed within the organization and structure of the local authorities i.e. the Regional Services Council (RSC) who have been mandated by the state with the responsibility for the delivery of PHC.

The RSCs are made up of a small number of representatives from a variety of different local authorities and they are situated geographically throughout South Africa. The RSC is not politically accountable to any single elected body, and the chief bureaucrats were appointed by the State President of the ruling Nationalist government (De Beer, 1988:75).

In the Western Cape region the Health Department of the RSC is responsible for the delivery of Primary Health Care; and as an organization the RSC is structured hierarchically into three broad groups. The first group is led by the management members who are the policy-makers situated at headoffice level, followed by middle managers as supervisors who are responsible for the co-ordination, supervision and

control of clinics in their region and the third group of the structure is the health workers situated at the clinics which are located throughout the Western Cape region.

The RSC has divided the Western Cape Region into smaller areas referred to as regions. Each region has clinics to serve the PHC needs of the local population.

Each clinic has a complement of registered nurses who are usually assisted by other team members such as assistant nurses, health educators, clerical and general assistants. Medical input is directed for the sole purpose of attending to old and new cases of people with Tuberculosis (TB). The clinics' infrastructure is headed by a registered nurse in a "senior" position followed by the other registered nurses and the clinic staff members.

Policy frame

The state's policy on PHC for South Africa reflects the same elements for PHC as stated in the Declaration of Alma Ata of 1978 (WHO, 1978) which was adopted internationally by most governments after being popularized at the international convention.

The PHC policy at international, national and local levels clearly promotes activities for global health, equity, participation and cost efficiency. On HE the policy regards HE

mainly as a means of preventing and controlling health problems and promoting the involvement of people as individuals and as part of a "community".

The policy reflects a medical discourse as a perspective that manifests the professional interests of the medical profession. Community participation is reduced to a simple process through which a group of individuals have common 'health' interests and aspirations that are 'homogeneous'. The context of "community" and "communities" related to in the PHC policy appears to ignore the power relations that are embedded in the different groups of individuals that make up the local community (Myburgh, 1989:5). The PHC policy leaves itself open to this criticism and the policy for HE reflects the same concerns:

> Primary Health Care ... includes at least: education concerning prevailing health problems and the methods of preventing and controlling them ... requires and promotes maximum community and individual self-reliance and participation, ... and to this end develops through appropriate education the ability of communities to participate.
>
> (WHO, 1978:IV)

The criticism of the PHC and the HE policy is of relevance to the policies at international, national and local levels because they entertain the same attitudes. The Health Department of the Western Cape Regional Services Council (WCRSC) adopts and supports the state's PHC policy as cited in its Mission Statement:

> The Health Department of the Western Cape Regional Services Council, in cooperation with other health service providers and in terms of National Health Policy, strives to promote optimal health for the communities it serves, by ensuring a service that meets the Primary Health Care Needs of those communities.
>
> (WCRSC, April 1990)

The WCRSC hereafter referred to as the organization implements the policy for PHC and HE through a programme of interventive strategies. The strategies are selective

strategies that are based mainly on the WHO's interventions towards PHC and HE. The programme includes the following:

'**G**rowth monitoring of all children from birth to 5 years of age; **O**ral hydration fluids for children with diarrhoeal disease; **B**reastfeeding for all newborn infants; **I**mmunization for all children against diphtheria, whooping cough, tetanus, poliomyelitis, tuberculosis and measles; **F**emale education, especially for women who have not had basic education; **F**ood supplements for communities in areas where the diet is deficient in essential nutrients; **F**amily planning; and **F**irst-aid for common injuries, accidents and poisoning' (abbreviated as GOBIFFFF).

The health strategies indicated in the organization's policy stem from the PHC policy of the WHO and the interventive strategies of the 'GOBIFFFF' approach. These health strategies reflect a focus on the "absence of disease" with less attention to the social and environmental aspects of health. This study proposes to look at how such strategies come to be formulated to exclude the broader issues of health.

The interventive strategies used in the health policy place focus on preventing and controlling disease through the specific action programmes as reflected in the 'GOBIFFFF' approach. The programme for HE is located within the PHC policy and it also reflects on disease prevention and control.

The character of the programmes tends to exclude providing for health within the broader context of 'health as development'. Because of the narrow context of health

and the medicalized discourse located in the PHC and HE policy, it is considered more appropriate to view the interventive strategies as a form of selective Primary Health Care (SPHC) and selective Health Education (SHE) which present advantages and shortcomings embedded in the very character of its approach.

SPHC was introduced by 1983 as a result of the introduction of the United Nations International Childrens Fund (UNICEF) 'Child Survival' programmes and the 'GOBIFFFF' programme. Health priorities saw a shift in focus away from programmes of health care provision that had wider scope because of a broader and more comprehensive appeal as compared to the specialized and 'selective' forms of PHC and HE (Myburgh, 1989:6).

The health workers function by translating the PHC policy into service-delivery activities formulated by management in codes of practice referred to as policy or "standing orders". Their roles are defined by their organization in terms of broad guidelines written in their job descriptions. Health workers interviewed in this study are charged by their organization to deliver HE within the context of "change in habits...indoctrination, persuasion or education", (WCRSC, 1993) as indicated in the senior health workers job descriptions.

The dual roles of health workers as employees and as professionals are two potential areas for tension and conflict, because health workers function as intermediaries within the constraints of the health system. The conflicting nature of the health workers

position within the organization gives rise to tensions in deciding how best to serve the needs of the employer and their organization, as well as the local community.

Health workers appear to meet the health needs of the local community by organizing their roles within the framework of the regulating power structures that govern them. The health workers appear to preserve their 'professionalism' by setting themselves up as the 'regulators' of health for the local community as manifest in the way that they use discursive practices to operate in the work setting. For example, the health workers use surveillance techniques as an interventive strategy in the clinics to offer 'help' to individuals with tuberculosis (TB) by coercing them to attend the clinic daily except for public holidays and weekends to receive their medicines. Such an arrangement appears to instil dependence-based relationships within autocratic arrangements, where members of the local community are made to be reliant on the clinic for their health needs.

Clarification of the research concern

The focus of this research is to investigate how health workers deliver PHC and HE. The question arises as to how health workers roles as employees, professionals and as agents of change are influenced and shaped by the systemically located medical discourse in the PHC and HE policy within which they are situated. It appears necessary to understand these influences and how they might affect the way in which the health workers address the health care needs of the individual and the local

community. In order to do that it is necessary to gain an understanding of the health workers in the context of their work setting.

The research question becomes one related to the conceptions developed by the health workers in how they develop and provide PHC and HE.

Research site

The research site is the Grassy Park area situated about 14 kilometers away from central Cape Town. The RSC has defined this area as Region 3 and there are four clinics in this area that serves a population of more than 20 000.

Research questions

The questions that need to be asked, are:

- how do health workers conceptualize their role and identity as health workers?
- how do health workers initiate and develop HE programmes?
- how do health workers measure the efficiency of their HE input?

These questions will reflect on the degree to which:

- the health workers role is shaped by being an agent and employee of the state and\or by being professionals;

- the health workers are agents of change;
- the health workers view the efficacy of their work in relation to the role and identity to which they subscribe.

Chapter review

This introductory chapter has established that the problem which this study is addressing is the way in which the influences of the health system, the PHC and HE policy, and the location of the health workers within an organization shape the role and identities of the registered nurses as health workers at four clinics in the Grassy Park area.

The research investigates how the roles and identities of the health workers affect the initiation and development of HE, and requires an understanding of the way in which the health workers operate in the work setting.

The task of the research is seen as illustrating the factors that impose on the health workers roles and identities and how this relates to their conception of efficiency in the initiation and development of HE.

CHAPTER 2

A PERSPECTIVE OF THE SYSTEMICALLY LOCATED HEALTH SYSTEM OF SOUTH AFRICA

This chapter will deal with the literature reviewed in relation to the issues that health workers encounter as intermediaries who interface between their organization and the local community that they serve in the provision of PHC and HE. The review examines the direct and visible, and indirect and invisible influences that shape their role and identity and the way in which HE is initiated and developed within such a framework.

The researcher's use of sub-headings in this chapter serves to separate aspects of the literature reviewed. The issues discussed under the sub-headings should be viewed as interconnected, and as such an overlap is inevitable. Caution has been exercised in keeping this overlap to an essential minimum for the completeness of presentation.

For the purpose of clarity this study will consider PHC and HE as interconnected elements within the health system. The literature reviewed will advance discussion within this context.

The literature provides a base for developing an account of the dominant discourse embedded in the PHC and HE policy and how this discourse structures the way in which health workers operate as intermediaries. Health workers, like teachers and

social workers, interface between their organization and the local community and experience similar areas of difficulties, complexities and congruence within the organizational structures that they find themselves in.

The literature advances discussion on the policy for PHC and HE which are politicized at the very instant when particular people are appointed and entrusted with developing "apparatus" in meeting the health needs of the community. PHC forms the core of the health workers work and they become part of the "apparatus" that is put in motion to realize the PHC and HE policy. In South Africa, the Declaration of Alma Ata on PHC has been adopted and incorporated in the PHC and HE policy by the state. The discussion surrounding the Declaration of Alma Ata is not intended to denigrate its worth but rather to unwrap the 'layers', so as to understand the discourse within which it is located and the implications for health workers.

Discourse and health

Foucault (Sheridan, 1982:127) asserts that discourse is communicated as a practice that is institutionally based, and that it is arranged in a particular way to have real and piercing effects which are at once controlling. The constraints of the discourse embedded in the PHC and HE policies can be seen in the light of its representation being a closed one, where 'appointed' medical experts speak on behalf of the very people whose needs they propose to serve. In this way the voice of the community is silenced because of the undemocratic selection of the representatives.

The structuring or shaping demeanour of a medical discourse is reflected in Ferguson's (1990:18) discourse of 'development' bureaucrats. Ferguson asserts that they are shaped by their knowledge structures, their thoughts, and utterances in respect of everything that they say and do not say, and everything that they do and do not do. The case of the medical discourse for health holds a similarity to the Ferguson case of the 'development' bureaucrats discourse.

The context of the discourse which structures the Declaration of Alma Ata (WHO, 1978) appears to draw its authority from the medical 'experts' as holders of class, gender and professional positions. There is a reproduction of the particular ideology and practices by the 'experts' through the prescribed programme.

This becomes a point of conflict in the interests of the population's health needs, because the groundwork has a dominant bias towards empirically grounded medical roots excluding a broad social application. Robertson (1991:19) in his chapter "Mapping the Global Condition" refers to the views of Giddens and Turner on the importance of studying society through social theory in the broadest context which cuts across the social and human sciences, and will not reduce research to empirical and comparative-historical routes as is done through the location of the medical discourse.

The state's policy for PHC and HE in South Africa has adopted the PHC and HE policy as cited in the Declaration of Alma Ata (WHO, 1978). The policy in South Africa offers a selective form of PHC and HE through specific service delivery programmes which

embrace the World Health Organization - United Nations International Childrens Fund (WHO-UNICEF) approach.

The approach includes 'Growth monitoring of all children from birth to 5 years of age; Oral hydration fluids for children with diarrhoeal disease; Breastfeeding for all newborn infants; Immunization of all children against diphtheria, whooping cough, tetanus, poliomyelitis, tuberculosis and measles; Female education, especially for women who have not had basic education; Food supplements for communities in areas where the diet is deficient in essential nutrients; Family Planning; and First-aid for common injuries, accidents and poisoning' (GOBIFFFF) (Welman, 1992:11).

In applying the GOBIFFFF approach (and treatment for tuberculosis) as the focus of PHC and HE, the local authorities selectively offer a minimalist PHC and HE programme. The effect of such an approach is goal-driven at best and at worst, it takes on a discriminatory stance against those whose health needs fall outside of its approach (Myburgh, 1989:2-9). This is reflected in the strong bias towards child care provided by the 'GOBI component' and the value judgement and ethical compromise in the selective stance of female education being a premium above that of all people.

Myburgh (1989:4-8) criticizes the Declaration of Alma Ata for proposing changes without taking account of the existing international power relations, where dominant and impoverished populations are class structured, with the impoverished classes reflecting major socio-economic manifestations common to Less Developed Countries (LDC's). 'Development' takes on a redefinition as 'capitalist development' which is

perceived as being inherently good and assumes that it will bring about improvement in health.

The Declaration does not give attention to the current power relations in LDC's countries as is expressed in the 'education of women' through 'organizational and technocratic' change. This attitude reflects the value judgements located in the Declaration. Two points of contention are firstly the exclusion of the majority of people who need to be developed and liberated through education and other socio-economic means and secondly, the slogan 'health for all by the year 2000' (WHO, 1984) which emphasizes accessibility to services as the most important aspiration.

The Declaration's context of health is regarded as limited to 'clinical health' because it regards socio-economic interventions external to the health sector as critical to achieving health. This signifies disregard and poor cognizance of who and what the agents of change are, and where and why conflict and resistance appear both within and external to the health system. This attitude has a defining role for health workers, who are viewed by implication of the medical discourse as 'expert clinicians'.

On the issue of HE the Declaration places the educational objective within PHC programmes:

> Primary Health Care ... includes at least: education concerning prevailing health problems and the methods of preventing and controlling them ... requires and promotes maximum community and individual self-reliance and participation, ... and to this end develops through appropriate education the ability of communities to participate.
>
> (WHO, 1978)

'Community' needs are viewed as being similar and of a collective nature with the serious misconception that 'communities' are homogeneous, given the inequities that exists for individuals within the LDC's communities as is the case for the majority of the South African people.

The utility of HE for individuals poses a problem. The burdens of inequities inherited from health systems and underdevelopment make it difficult for individuals to change their lives without changes to the forces external to them.

> So much health education, so far, has been based on the assumption that the individual has complete responsibility for his behaviour and that unhealthy behaviour is totally the individual's choice. This assumption disregards society which either forces some behavioural patterns on the individual or creates a situation in which the lack of access to facilities makes implementation of desired human behavior impractical.
>
> (Kapiro, 1979:13)

Medicalization of health by the state and its agents such as professional associations and other 'experts' e.g. Medical Research Council (MRC) formulate health policy which is made manifest through the discursive practices implemented by the health workers. Power and knowledge are used by 'experts' to formulate interventive strategies for health needs (Myburgh, 1989:4). For example, epidemiologically based information is used to determine the health needs of the local community. This is considered undemocratic in approach, because specialized knowledge is only available to a select and elite group such as medical experts.

Ozga (1981:1-22) infers that teachers and other groups of 'state professionals' appear to have an outwardly congenial and traditionally conforming relation with the state as their employer. Foucault (Lemert,1982:54) refers to this relation as being put into place

by rules of formation, i.e. a regulatory basis is established by the employer within which the relations are conducted. In this way the power arrangements are structured in visible and direct ways or invisible and indirect ways. Codes for practice such as 'standing orders', membership of state aligned associations and unions, and job descriptions are examples of regulatory mechanisms that serve as forms of surveillance measures that ensures compliance and maintenance of the relations as is understood by the expression 'toeing the line'. In this way the dominant discourse is reproduced through the mechanisms put into place as regulating discursive codes of practice.

Foucault's sense of interventive strategies can be seen in the way that the planned interventions occur as "anonymous constellations of control - authorless strategies that turn out to have a kind of political intelligibility" (Ferguson, 1990:21). This study will be concerned with whether PHC and HE reflects this process.

Health workers as intermediaries

Ferguson (1990:272-273) infers that the power of the state can be viewed as a "bureaucratic state power" because of the way in which it organizes the bundling, multiplying and co-ordinating of power relations through structural arrangements as an "apparatus". Foucault (Ferguson, 1990:273) infers that state workers as bureaucrats assert their power through an increasingly governmentalized form of power relations that are elaborately arranged within state institutions.

This perspective raises the question of whether power and knowledge is embedded in the bureaucratic arrangement concerning the relations between the organization and the health workers. Sheridan (1982:217) comments on Foucault's inference that the impact of knowledge as power, which when mobilized pervasively, is bound to affect the very 'grain' of the intermediary workers lives in the way in which they learn to live and work in a community.

Teachers and health workers as 'state professionals' function in dual roles (Ozga, 1981:20), i.e. as employees of the state, and as professionals. Both these roles have legalized sanctions built into the particular positions if they do not 'toe the line'. Organizations use power through discipline (Rabinow, 1991:198) in a twofold manner, in visible and direct ways, and in invisible and indirect ways to bring about behaviours of conformity and to maintain them through regulatory rules of formation. Foucault (Rabinow, 1991:278) infers that a modernized form of "police" can be seen in the way that the organization arranges itself with hierarchical arrangements and in doing so appears to arrange its workers to dispense services according to its preferred policy.

Teachers, social workers and health workers in their 'professional' roles, use discipline in the form of their specialized knowledge to exert power on the community. This is achieved by the workers compliance with their organization's policy and the way in which they relate their work through rituals in getting the community to 'receive' the service that is 'on offer'. Foucault (Rabinow, 1991:206) views this relation as a disciplinary type of power which infiltrates the social demeanour of life through the intermediaries who in turn use this power as a modality in providing service.

The literature studied reflects on how intermediaries are used to perpetrate power for and on behalf of the state through disciplinary means. Some of the visible and invisible mechanisms (Rabinow, 1991:198) that are used to shape the roles and identities of intermediaries by disciplinary power arrangements occur as discursive practices reflected in the organizational philosophy, mission statements, value determinants, policies, job descriptions and task lists among others.

Foucault (Lemert, 1982:34) asserts that'power and knowledge' are located as disciplining rituals that provide codes for practice. The structure of the health system places health workers as intermediaries in a separate class to that of the community because of the power it places in health workers as a result of their 'expertise'. Foucault (Fairclough, 1992:45) regards roles and identities in terms of social provenance, gender, class, attitudes and beliefs as being shaped by discursive practices situated within discourse.

The PHC and HE policy purports to make individuals and communities "independent" and "self-reliant". However, a study of this policy conveys delivery of its intent through health workers as a 'going back to old habits' where the old 'mould' reappears in the new policy through the rituals as regulatory mechanisms which sets the health workers and the community apart in their separate classes.

The job descriptions of health workers assert a favoured approach to HE through "indoctrination" and "persuasion". This stance reveals the 'going back to old habits' and the imposition of compromised judgements with regard to 'informed choice' and 'free

will' which individuals should be empowered to exercise. The concept of "indoctrination" and "persuasion" is considered by Barrow (1982:78) as "morally reprehensible and fundamentally anti-educational, unless one is prepared to defend the thesis that it is morally acceptable to treat people simply as means." They infer that the message of "indoctrination" is one that clearly states "Think as we think and don't dare question."

Health workers as professionals

The way in which the teachers' roles are shaped does not only apply to their particular situation but can also be generalized to other workers' roles, such as nurses as health workers and social workers who interface (Ozga, 1981:20) in the provision of fundamental services controlled by the state. Ozga regards professionals as agents who determine the structure of society by responding to the needs of their organizing body. In this sense the health workers orientation to, and construction and provision of health education, appears to be steered by the state as protagonists who adopt a technocratic delivery of HE based on the SPHC and the SHE policy adopted. The mechanisms of "indoctrination" and "persuasion" appear to be favoured as documented in the health workers job descriptions.

Ozga quotes Terry Johnson from his book on Professions and Power on the issues of professionalism and the typology of forms of control employed by the state in creating 'state professionals':

> Professionalism, then, becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of particular occupations. A profession, then, is not an occupation, but a means of controlling an occupation.
>
> (Ozga, 1981:17)

On control, Ozga (1981:17-36) reflects on Johnson's typology as being threefold i.e. collegiate, patronage, and mediation. Mediation occurs when the state intervenes between the practitioner and the community to determine needs and ways in which needs can be met. Johnson's explanation can be argued to reflect the states attitude of acting for and on behalf of the community as seen in the medical discourse of PHC and HE.

Johnson considers the state as creating 'state professionals' through mediation by increasingly incorporating occupations within its structure. The professionals are controlled by the state by making them financially dependant, and creating beaurocratic roles to carry out its "policing" work. This modern form of professionalism is shaped on the capitalist state's arrangement of fostering support from the community by promoting marketable principles, such as workers as 'professionals' and 'experts' on whom the community place their trust.

This appears to have relevance to health workers in the way that the community is presented as the 'body' to be subjected to examination through the 'clinical gaze' of experts, and in doing so, secures a work force as a production mode for the state. Ozga infers that this workforce does not materialize as expected by the state because of the constraints of offering a service without the socio-economic opportunities for development. If the rendering of 'health' were to be drawn as an analogy to Ozga's

inference then health workers position through the PHC and HE policy appears to place them as the state's pawn in the business of health.

Professionals within the state system provide a service to the community by becoming part of the state 'apparatus'. The workers are placed by the state within a class structure as 'state professionals' and 'employees' on the one hand, and at the same time the state places them in an elite position in relation to the community they serve. The rationale for this stems from the power and knowledge context of the relations which take place through regulatory rules of formation embedded in discursive practices of the dominant discourse (Lemert, 1982:54). Ozga infers that the state has a 'divide and rule' role in maintaining state workers as 'professionals' and 'employees' who are agents of change for the community but this is done by giving them an elevated status because of their 'expertise' and subsequently placing them 'apart' from the community.

Ozga (1981:39-62,138-148) reviews the changing role of teachers as employees and professionals and likens their position to that of nurses and any other occupation controlled by the state. The state's control led to the de-skilling of the teachers because of their routinized scope of work and the conflict within which they are placed which is created by their intermediary position. Routinized work is considered as requiring increased and specialized supervision which is built into the organizational structure, its management and state professional ideologies. These have an acquiescing effect, making teachers and other state professional workers more concerned with "public service". Ozga quotes Michael Apple on curriculum change:

> When jobs are de-skilled, the knowledge that once accompanied it, knowledge that was controlled and used by workers in carrying out their day to day lives on their jobs, goes somewhere. Management attempts (with varying degrees of success) to accumulate and control this assemblage of skills and knowledge. It attempts, in other words, to separate conception from execution. The control of knowledge enables management to plan; the worker should ideally merely carry these plans out to the specifications, and at the pace, set by people away from the actual point of production.
>
> (Ozga, 1981:142-143)

The attitude of the state's policy can be interpreted as the depersonalization of work which makes the 'job' more important than the 'job holder', and in this way control over work is not personal but through the application of bureaucratic procedures and regulatory mechanisms (Ozga, 1981:101). Such relations based on paternalistic ideologies are not stable because they are fraught with tensions and conflict. This is embodied in the teachers movements of 1913 in England as reflected in Ozga:

> A new era is about to dawn for the class teachers of the Rhondda, they have finally recognized the fact that they are workers - some of them slaves on the brink of poverty, others actually in poverty on the brink of destitution and subject to petty tyranny from those in authority over them.
>
> (Ozga, 1981:86)

The essence of the problems of 1913 as mentioned above are not far off from the situation of teachers and health workers as state workers of today. The relations between the state and its 'state professionals' are no longer as stable as before, because the workers' attitudes to their professional role appears to be moving away from altruism as the primary reason for serving the public because of the 'general good' aspect of their work. Workers are engaged in organizing themselves through various movements such as unions to protect their rights as workers (Ozga, 1981:12). The movements of the professionals have developed at a varied pace for the different professions because of the ethical and legislative constraints.

Teachers and other state workers are placed in constant conflict as they take a re-look at the way in which their roles and identities have been shaped and controlled by the state. Ozga (1981:21) infers that state mediation has negative implications for the practitioner, because the state becomes more reliant on "full-time research institutions" in the development of knowledge and this has consequences for the loss of initiative on the part of the practitioners. The state astutely places the professionals as 'experts' and 'advisers' within its "authoritative...context of government decision-making."

Establishing the 'Gaze'

Foucault uses the 'gaze' as an analytical tool to examine situations and the term 'clinical gaze' is used specifically in Foucault's examination of the 'clinic' as a term related to the health situation in its wider context.

The 'gaze' by the state has a normalizing "bio-power" where it adopts techniques of'watching over' 'governing' and 'administering' the very "life" of society. The roles used for the techniques take the form of a central role, a co-ordinating role, a managing role and a fostering role (Ferguson, 1990:270).

The 'clinical gaze' as a mechanism uncovers the many 'layers' of a situation to reveal its deeper meaning which is not obvious or visible at 'first glance' (Foucault, 1991: 107-122; 149-172). This concept asserts that the situation is not always what it appears to

be. The 'clinical gaze' is embedded in examination through rituals, a play of roles, characters and classificatory technique (Rabinow, 1991:199)

Foucault (Lemert, 1982:71) infers that intermediaries such as health workers use the 'clinical gaze' to assert their relations of power and knowledge as 'experts' and as such have a dominating role. The 'clinical gaze' is constructed in the sense of the community presenting itself as a 'body' to the 'expert' health workers at the clinic. The 'body' places its trust in health workers as 'experts' so that they can be privy to receiving health care.

Expert systems and relations of trust

The organizational arrangements of the PHC and HE policy place health workers as 'experts' because of their specialized knowledge. State organizational structures for 'professionals' are a closed system because of the 'expert' knowledge base. The marketing strategies used for promoting health workers as agents of change are directed at the community through market values of 'professionals' and 'experts'

The literature reveals that health workers operate in relations based on 'trust'. Giddens (1990:83-92) infers that codes of professional ethics ensure that trust is managed internal to the profession by developing legal sanctions for professionals who breach the code of trust.

In such systems, professional colleagues form "facework commitments" by assuming the competence of their colleagues because this is based on trust in each other in the work relations of teams. This situation 'closes down' any doubts that may arise concerning fellow professional competence and is commonly known as the 'closing of ranks'.

"Faceless commitments" occur when the lay public makes use of the health workers service because of the trust placed through faith in the knowledge of 'experts' who are assumed to know best about health matters.

Solutions to health provision

From the literature reviewed there appears to be distinctive patterns of approach to health both internationally and locally. The patterns of approach are homogeneous because the South African policy of PHC and HE is located in the WHO's policy of PHC and HE. The solutions offered as documented are in the context of health located within a particular dominant discourse based on value judgements. This approach appears to have a predictable pathway of predetermined strategies which are easily measured as 'effective' in relation to the 'expert' epidemiological data.

Myburgh quotes Rifkin and Walt from a WHO document concerning the dissatisfaction of populations with their health services and the way in which these are provided:

> ... a feeling on the part of the consumer, who feels (rightly or wrongly) that health services and personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professional but which is not what is most wanted by the consumer.
>
> (Myburgh, 1989:6)

Chapter review

This chapter has shown, through the literature reviewed, that the problems experienced by the state employees such as teachers and health workers are located in the way in which they are organized within hierarchical arrangements. Their problems are not unique because the policy adopted by the state implicates their roles as intermediaries and buffers between the state and the public at large.

The very 'grain' of workers is woven into a texture that remains bound in the prevailing dominant discourse embedded in the state's policy and which appears to have limited effect at ground level.

The needs of the "community" are identified and formulated at a distance from the realities of the social context. The literature reveals the worn out old patterns of repetition that occur, where a privileged and advantaged group 'speak' for and on behalf of the majority of people and their health needs.

Solutions to 'health' provision are approached predictably both internationally and locally by way of a medicalized discourse and regulatory discursive formation that is effected through policy and procedure codes.

CHAPTER 3

RESEARCH DESIGN AND PROCEDURE

This chapter will discuss the rationale for selecting a particular research design and this will be followed by the practicalities of operationalizing the research.

Research design

This study proposed to research the following questions:

- how do health workers conceptualize their role and identity as health workers?
- how do health workers initiate and develop HE programmes?
- how do health workers measure the efficiency of their HE input?

The data required to answer these questions required insight and a better understanding into the work setting of the health workers. For this type of study it was decided to research the problem by using a qualitative approach because a quantitative study with a statistical analysis would not be suitable as the main research approach.

On reflection of the particular problem of this research, it was concluded that the best way to achieve an understanding of the situation was by using the case study as a research method. Bell (1989:6) considers the case study as having merit for situations that call for a better understanding.

> "The great strength of the case-study method is that it allows the researcher to concentrate on a specific instance or situation and to identify, or attempt to identify, the various interactive processes at work. These processes may remain hidden in a large-scale survey but may be crucial to the success or failure of systems or organizations."
>
> (Bell, 1989:6)

Kemmis (1980:124) asserts that qualitative research in case studies provides a real world situation for the researcher. This helps in gaining an understanding of the research situation because the researcher becomes immersed in the study, and constructs the case from the understanding gained through the slow and methodical process which is "deliberate"and "reflective".

The case study method was also considered appropriate because other research methods could be included to gain a better insight into the unit of study. To this end Bell (1989:6) views the case study as an "umbrella term for a family of research methods having in common the decision to focus on inquiry around an instance."

The case study also provides a qualitative method to formulate generalizations about the wider population of the research unit of study.

> The purpose of such observation is to probe deeply and to analyze intensively the multifarious phenomena that constitute the life cycle of the unit with a view to establishing generalizations about the wider population to which that unit belongs.
>
> (Cohen, 1985:120)

The design for this research included the use of methods such as non-participant observation, informal interviews and a review of documents, placards and printed matter found in the work setting of the health workers.

The rationale forwarded by Cobb (1987:138) on qualitative research was helpful to this research because it asserts that attention is given to the social and historical contexts within which events take place, and the social world of the participants is understood from the way that they view it. Research is approached inductively and the primary concerns lie in discovery, description and verification. Hypotheses are developed during the research rather than in advance, and analysis is presented narratively rather than statistically.

Critics of the case study regard this method of research as 'difficult to generalize' and 'subjective' because of the difficulty in the extent of its validity and reliability. Educational research attempts to generalize and to contribute to the development of educational theory but this may not always be the case, because it can illustrate valuable relationships, micropolitical issues and patterns of influences in a particular situation (Bell, 1989:7).

Bassey's (1981:85) view on the merit of a case study is reflected in his statement "The relatability of a case study is more important than its generalizability." On the issue of research data achieved through the case study, Bassey (1981:86) comments " if case studies are carried out systematically and critically, if they are aimed at the improvement of education, if they are relatable, and if by publication of the findings

they extend the boundaries of existing knowledge, then they are valid forms of educational research."

Most studies favour the use of participant observation above that of non-participant observation. The literature reviewed also tends to share this view, however like all studies, the essence of observation as a research method is explained by Bell (1989:89) "whether you are observing as a participant or a non-participant, your role is to observe and record in as objective a way as possible, and then to analyse and to interpret the data you gather." Both methods of observation have documented advantages and disadvantages which may seem appropriate or inappropriate for a particular field of study.

In the case of this research, the researcher conducted informal interviews with the health workers, and at other times the researcher used non-participant observation for data collection. It was decided to be more appropriate for the researcher to be a non-participant observer because of the researcher's present rank and position, and the discovery that the researcher was known as a previous colleague to at least two of the health workers interviewed. This was complicated by the fact that the health workers rotate between the four clinics at limited intervals.

For the reasons cited, the researcher entered the field of study as an educational researcher rather than as a nursing researcher. The latter would have had implications because of professional and ethical constraints, where the researcher would have had to be clad in special clothing and worked as a registered nurse and health worker,

because the practice of nursing is a legally closed one. Because of the health field being familiar to the researcher, it was decided that observation could be carried out unobtrusively, by dressing in civilian clothes and mingling with the personnel and the clients attending the four clinics. Cohen (1985:122-123) infers that "It is frequently the case that the type of observation undertaken by the researcher is associated with the type of setting in which the research takes place."

Unstructured interviewing was chosen as the main method of data collection because it was considered to be a way of getting to know the health workers in the context of their situation and of collecting data on their attitudes, values, beliefs, and their knowledge. Cohen (1985: 292-294) asserts that interviews are like descriptions of what is inside a person's head, "it makes it possible to measure what a person knows (knowledge or information), what a person likes or dislikes (values and preferences), and what a person thinks (attitudes and beliefs)."

The informal interview was identified as one that would allow the researcher as interviewer to conduct the interview in a conversational style, without the use of a questionnaire but using certain key words and issues to obtain data. Cohen asserts that the informal interview as an unstructured interview is not a casual affair, and that it too has to be carefully planned so that the research purpose governs the way in which the interviewer conducts the content, sequence and wording that take place. This method has been documented as an "open situation, having greater flexibility and freedom" (Cohen, 1985:293).

The researcher included a study of the documents, inclusive of placards and printed matter found in the work setting of the health workers. Bell (1989:53-57) infers that "witting" and "unwitting" evidence of underlying assumptions may be revealed unintentionally in the study of documents.

In summary this study was designed to illuminate the world of the health workers in their work setting and how their roles and identities are influenced by their positions as intermediaries in the health system.

Research procedure

The research procedure explains the implementation of the research design of this study.

It was considered that the data required to gain an understanding of the role of health workers as intermediaries in their work setting could be best achieved by focusing on the health workers themselves as the primary source of information. This was thought to be the best way to illuminate the real world situation of the health workers, and to understand the context of how they conceptualize their role and identity as health workers, how they develop and initiate HE programmes and how they measure the efficiency of their work.

It was initially considered useful to conduct interviews with some of the managerial members of the organization. However, on deliberation this idea was abandoned as not being crucial to the focus of this study, because the health workers have an interfacing role as intermediaries, and as such information from them as primary sources would probably reveal the workings of the organization's 'apparatus' and their relations with the community.

Approval and contractual arrangements

Approval to carry out this research was obtained by the Faculty of Education's Higher Degrees Committee of the University of Cape Town. Further approval to execute this research in the field was obtained by the Health Department of the Western Cape Regional Services Council. The health workers at the clinics were also asked for their permission prior to participating in the interviews. Each interviewee was briefed about the study by the researcher, and the need for the researcher to use a recorder if necessary for interviewees who were seriously constrained by time limits. The subjects were given the option to participate or withdraw from the research. The researcher agreed to the conditions of keeping the identity of the participants anonymous by maintaining the anonymity of the individuals, the identity of each clinic, the careful storage of field notes and transcriptions.

Sampling

A total of 13 registered nurses as health workers were included in this study for individual and group interviews. The sample selection included a senior and a deputy health worker from the four clinics which totalled 8. The other 5 health workers were from the same four clinics and were also included in the study for a reasonably sized sample, and to reflect data that is representative of the subjects. The subjects were representative of registered nurses as a category of health worker, and as the unit of study. Representation was ensured by including subjects from each clinic, and from the two ranks held by the subjects in their work setting i.e. Senior Professional Nurse and Professional Nurse. The subjects were also representative of the three positions of hierarchy occupied by them i.e. that of the health worker in charge of the clinic, the deputy, and the health worker who functions outside of these two positions. At the time that this study was undertaken there were two other registered nurses who decided to refrain from participating in this study for personal reasons unrelated to the nature or scope of the research.

Arrangements for the interviews

The group and individual interviews were conducted at the four clinics where the health workers were located. The group interviews were conducted during the tea and lunch breaks of the subjects. The times for the individual interviews were prearranged with

the subjects concerned. Opportunity to conduct interviews was also taken when the clinics experienced a lull in activities.

Interviews

The researcher's familiarity with the health situation was beneficial, in view of the particular terminology used, and the researchers understanding of the hierarchical arrangements of the organization. Valuable time was saved and as a result channeled to other areas of the study.

The researcher's understanding of, and familiarity with, the health situation was also helpful in directing the informal group and individual interviews in such a way that key words or issues were introduced conversationally to meet the purpose of the study. This could be done with ease because of the familiar terrain and by ensuring that areas of relevance were not omitted during discussion.

In order to avoid the danger of bias in the interviews, the researcher was sensitive to creating a relationship of congeniality and respect with the health workers, so as to foster the development of a relationship of trust with the participants and to avoid any form of possible antagonism in their responses.

In view of the reliability of the data obtained from the interviewees, with a few exceptions, the responses to the key issues were expressed in a similar vein. The

validity of this study will be indicated by the extent to which the proposed research questions will be answered.

The aim of the interviews was to obtain information on the role and identity of health workers, how they initiate and develop HE programmes and how they measure the efficiency of their work. The key issues introduced into conversation during the group and individual interviews inquired about the following aspects:

- the reasons for working as health workers?
- views on who forms the health team and why?
- what the health workers liked most and least about their work, their organization and their professional development, and why?
- how they worked on a day to day basis?
- views on the 'community' they serve
- comment on their clinic as a health center
- how they relate to the policy for PHC and HE?
- comment on their views to expand their service if necessary in meeting the health needs of the community
- comment on the resources available and resources needed to perform as health workers

Data analysis

Interviews that were recorded were transcribed verbatim to avoid changing the context and focus of the information. All the interviews were studied individually. Information concerning similarities and differences were categorized into groups. Common patterns of information were recorded. Further interviews were conducted to clarify information that was ambiguous or to gain further insight regarding particular issues. The grouping of information into larger categories made it possible to consolidate the information into meaningful sources of data. The perspectives that were revealed by this process of categorizing and consolidating the information reflected on the research questions posed.

Non-participant observation

The researcher carried out non-participant observation at each clinic to develop a better understanding of the way in which the service at the clinics were rendered in terms of the organizational arrangements. The researcher sat in the waiting rooms for a limited time and thereafter spent time with the health workers observing individual consultations between the health workers and members of the local community. The researcher was free to move from one site to another and this was done as unobtrusively as possible. Information in the form of statements were recorded as soon as possible after the observation session ended.

Review of documents

Selected documents, placards, and printed matter were studied to gain an understanding of how information is transmitted between the organization, the health workers, and the community as the recipients of educational content. Documents such as policy and procedural information revealed insight into the organization's 'apparatus' at work, while the information directed at the community was studied for the context of the message and the level of literacy. The intention of studying the selected documents was to capture and reveal some of the dynamics of the relations in motion.

Chapter review

This chapter dealt with the research design and the practical aspects of implementing the research. Reasons for the preference of using particular methods were discussed. The need for caution in selecting and employing certain research methods was addressed in addition to ensuring that the reliability and validity of this study was also taken cognizance of.

CHAPTER 4

ANALYSIS AND DISCUSSION

This chapter will deal firstly with presentation, analysis and discussion of information obtained through the fieldwork research within the milieu of the health workers work setting. The identity of the health workers are kept confidential as agreed with them. Sub-headings are introduced mainly through questions. This is done to separate issues that need to be illuminated with the aim of delivering a coherent analysis and interpretation of the information and the theoretical significance.

The research questions formulated in Chapter 1 are repeated here to ensure that they are addressed as proposed:

- how do health workers conceptualize their role and identity as health workers?
- how do health workers initiate and develop HE programmes?
- how do health workers measure the efficiency of their HE input?

This chapter concludes with a review of Chapter 4 followed by a discussion on the limitations of the study.

Health workers' perceptions

Why nursing?

Most of the health workers chose to enter this field of occupation for similar reasons, i.e. as a result of historical reasons; this was one of the few formal occupations that people other than 'whites' and males could enter previously to supplement family income, and to provide a 'caring' service to others.

> *"My father was retrenched and I just passed matric so I had to go and earn money"*

> *"We lived in a rural area and there was nothing for young people to do there, I didn't really want to do nursing, I wanted to become a social worker but there was no place for us. The only things we could do was to become teachers or nurses."*

Expectations and the reality of the nursing situation for all the health workers interviewed were similar initially, but the present situation appears to be more challenging with new tensions such as demands through direct and indirect pressure for professional development by undertaking formal courses.

> *"You just feel so pressurized to study, even if you don't really want to, because that is the only way to get promotion."*

> *"No one tells you that you must study further, but if you want to improve things for yourself you must do a degree or some other course."*

> *"Some of the others are studying and you that's older must try to keep up otherwise you are left behind."*

Why work at the clinics?

The attraction for most of the health workers to work in the clinic was because the salary was better than that which other state authorities pay, as well as the regulated hours of work during the week - which meant no overtime work, no night duty shifts or other unsociable hours of work; weekends were free to spend with family and friends.

> *"My husband was getting really fed-up with all my late shifts at the hospital, I was always late with the childrens supper. Working at the clinic just made my life easier and I'm also more happy now because my marriage was starting to suffer."*

> *"RSC pays better than the Cape Provincial Administration so I left the hospital to work here. It's not that I don't like my work but in the end how you pay is very important."*

The pace although busy, is slower than at most hospitals and responsibility is scaled down in relation to dealing with people that are not seriously ill. The health workers experience less stress in the clinic than in the hospital situation. Stress experienced in the clinic appears to be of a short term duration, and is usually due to limited resources experienced when making arrangements for "home" visits - when they move into the 'heart' of the community, and the poor socio-ecomomic status of the community.

> *"Sometimes I feel like a big fool because I go and ask the people why they didn't turn up and they say "what for, that still leaves us hungry" and I just try to do my duty, but in my heart I know that I'm wasting my time because why bother with pills when you don't have food in your stomach and you don't know when is the next time there will be at least one meal guaranteed every day without worrying about it."*

How does the clinic service the community?

'Health' service is provided at the clinic and the community has to come to the clinic to obtain this service. In some instances the health workers venture into the community, but this is done on a small scale and conditionally, depending on whether there is enough staff to 'spare' whether transport is available and whether the environment is stable in terms of the present volatile conditions present in the township area. Health workers are sometimes under threat to their security during their "home" visits and appear to experience some anxiety during these visits.

> *"I noticed you (researcher) were nervous when we went to X Street. Jong, those ouens are unpredictable I had a close encounter there once but I just kept my cool. You have to be so careful the gangsters don't always like us coming into their territory to tell them about what's good for them."*

The health workers hold mixed views in response to the character of the service they provide. For some it is a comprehensive service, for others it is a partial PHC service and for others it is a service that is meant to be a PHC service but it has turned out to be a curative service mainly. The reason for the service being a curative one is based on the clinic's scope of service being expanded, and this is also because of minor ailments being referred away from the larger hospitals and directed to the clinics'.

> *"I'm not so sure that we are really doing a good job, because you can talk until you are blue in the face, but some of the TB clients will just not turn up for their medicines."*

> *"We are 'clinic bound', people come to us for a health service...we should spend less time in the clinic and more time in the 'community'."*

"We offer the people a good service and a lot of it has to do with the way we respect them ... they don't need to pay any money except for the medicines, and that too is only if they can afford to pay."

"We offer a comprehensive service but this is actually more curative."

The range and extent of services offered and the times that these services are available are predetermined by policy decision made by the managers. The clinics are open five days a week from Monday to Friday from about 07:30 to 16:30. The specialized clinic sessions cater for the community by offering services that reflect the GOBIFFFF approach. The clinic sessions offered take the form of 'newborn clinic', 'immunization', 'minor ailments for children under 6 years', 'family planning', 'nutrition clinic', and 'TB' clinic.

"All the RSC clinics offer the same services because we do Primary Health Care."

Community members whose health needs fall external to the GOBIFFFF approach make use of the other health organization in the area i.e. the Day Hospital which is managed and organized by another health authority.

"We don't cater for all the adults needs generally except for the services we offer ... for things like the minor ailments, they must go to the Grassy Park Day Hospital. So, its not easy for the people because they must still go to more than one place in the same area for help."

Some of the health workers are engaged in setting up special interest groups in a bid to serve the excluded members of the community through sessions for adolescents and the elderly in the form of support groups.

"We are trying to meet the needs of the teenagers and the elderly people in this area. The teenagers here have problems that are common to adolescents and there's nothing here that offers them help. It will take a lot of work but we are slowly moving in that direction."

How are the clinics organized structurally?

The top structures of the organization are responsible for the decision-making processes that decides how the clinics are organized in terms of its processes in rendering the local community with a 'health' service.

"Everything that we do here is decided at our head office, in fact, just about everything is written in the 'standing orders'."

The Grassy Park area has 4 clinics that serve more than 20 000 people, as a very conservative estimate, taken from an un-dated 'community profile' found in one clinic. The clinics are situated within one to two kilometers apart from each other, but they all serve different catchment areas with some geographical overlap. Community members are encouraged to use the services of the clinic nearest to them, although there are no strict rules about this.

Each clinic has a staff establishment that includes a general assistant, a housekeeper, a health educator, enrolled nurses as 'sub-professional' nurses and registered nurses. The services of a social worker and clerical staff are shared between the clinics. A part time medical practitioner attends only to TB patients on a weekly basis at each clinic.

The health workers from all the clinics work towards achieving the aim expressed in the organization's Mission Statement. This is done by working through criteria in the form of organizational objectives and goals. The Mission Statement expresses its intention:

> The Health Department of the Western Cape Regional Services Council, in cooperation with other health service providers and in terms of National Health Policy, strives to promote optimal health for the communities it serves, by ensuring a service that meets the Primary Health Care needs of those communities.
>
> (WCRSC, April 1990)

The registered nurses in the rank of Senior Professional Nurse (SPN) are placed in charge at each clinic. The other registered nurses in the rank of Professional Nurse (PN) and all the other full time clinic staff work subordinately to the SPN. In the absence of the SPN a PN is appointed to act as deputy. Each staff member has her own job descriptions. The PN's do not have clarity regarding which job description to subscribe to when they deputize for the SPN. This has resulted in some tension between the two ranks and conflict with the organization as a result of taking responsibility for the clinic without receiving appropriate compensation. The reason for this conflict can be put down to the difference in salary between the two ranks.

> *"Some of us complained about the responsibility we take when the SPN is on leave or away for a few days, then they expect you to stand in, and it's okay but then it's not okay to pay us for taking charge. We are still waiting to hear from them."*

Since 1994 the organization restructured the operating function of the 4 clinics. Previously the clinics were organized by a supervisor who holds the rank of Chief Professional Nurse (CPN). With the restructuring, part of the CPNs previous role has been delegated to the 4 SPN's so that each SPN assumes full responsibility for her

own clinic. The SPN's have mixed reactions to this move. On the positive side they enjoy arranging their own clinics and the reduced bureaucratic red tape in relation to limited aspects of their work, on the negative side they resent the increased administrative responsibilities and complain of too much time being spent on 'paper work' and the absence of additional remuneration for taking over the CPN's responsibilities.

> *"Sometimes I wonder about all this, you study so much to become a nurse, and in the end if you are good with the patients you get promoted, but it seems to me you end up looking after the papers."*
>
> *"I really like my work but the paper work takes the joy away."*
>
> *"We are doing work that the supervisor used to do, so our work has increased, the money we earn and the staff at the clinic are still the same."*

Most of the health workers are suspicious of any change introduced by the organization concerning the organizational structure. Health workers appear to have an increasing lack of trust in the integrity of the organization which appears to occur as a result of the hierarchical arrangements for communication channels. This situation results in messages and information being misunderstood or lost at times. As a result of this the health workers succeeded in organizing a forum with their managerial representative on a quarterly basis.

> *"We were very unhappy with the way we just get told what to do in the 'standing orders'."*
>
> *"... We meet on a quarterly basis with the person from headoffice who is in charge of our region because we 'kicked up a fuss'... we only had one meeting so far, ... we could already see that our messages to them and their messages to us were not always getting through...."*
>
> *"We in the clinics haven't got any input, we discussed this with the Director already. Because we don't always agree with the 'standing orders', what they (management) think*

we must do and how we see things is not always the same. We who work on the ground knows what works and what doesn't ... they said they're going to work on that, and they formed committees but I wasn't interested in their committees. Up till now I don't know who was on the committees. There was no one from the clinic just the supervisor and the others from head office ... we still get 'standing orders' without our input."

The health workers regard the clinics as functioning independently of each other because each clinic organizes its own internal affairs which is 'overseen' by the supervisor. An informal system of rotation exists where health workers offer help to the other clinics on request in the event of crisis situations.

"Up until late 1993, we worked in such chaos, all of us worked in the different clinics. I don't know how we kept up, If I look back I don't think I could work like that again. If it was TB at our clinic, the other clinics had nothing going on because they came to work here. You can see for yourself how small this place is. We were like a 'travelling circus' but now each clinic is open everyday from Monday to Friday and if anyone else's clinic gets too busy they phone us and we go and help out."

What aspects must health workers subscribe to daily?

The health workers operate as a team and each person knows exactly what to do on a day to day basis. Work is organized so that the organization's 'mission', 'objectives' and 'goals' are achieved. This is reflected in the way that the health workers formulate their task allocation lists. The task list in turn is the operationalizing of the PHC and HE policy.

"Whoever is in charge of the clinic draws up the allocation list and we work according to this. It goes according to 'all the clinics' offered here."

Cognizance is taken of the "standing orders" which are policy documents that health workers receive from their organization throughout the year. The "standing orders" provide communication in the form of instructions and information that must be observed and complied with in the work setting.

> *"When the "standing orders" come out we don't always agree with what it says, we work on the 'ground' and we know what things doesn't work but until recently it was like talking to a blank wall."*

Each health worker is 'given' a written job description that reflects their duties as employees and professionals. The activities written in the job description reflects guidelines about what should be done, within what constraints, how the activities should be done, and conformity with the network and hierarchical connections that must be observed.

> *"... Everything that one should do is in it."*

The job descriptions are formulated by the supervisors, and on completion these are presented to the health workers for perusal and consensus. Health workers resent the way in which job descriptions and standing orders are communicated in a 'top-down' manner without any input from the health workers in formulating them. This creates a source of tension because the health workers are in conflict with the actual content and context of the messages communicated. Health workers experience this as a lack of respect for their expertise and experiences which could contribute to improving the service provided.

"The supervisor writes our job descriptions and then it gets given to us. We must sign and if there is any comments we must write it down ... what's the use, because its already written out, there's no consultation."

"Before things were worse, more autocratic, things were just handed down to us, but now things are slightly different, things are still handed down to us but we can at least make comments if we want to ... I'm not sure if anything will happen."

In relation to the job descriptions, health workers disagree with the way in which their 'jobs' have been described. They consider their job descriptions as not reflecting everything that they actually find themselves doing, e.g. filling in for other members of the clinic that are not available such as clerks and domestic help. The job descriptions ascribe percentages to the different aspects of their 'jobs'. This serves to inform them about how much of their attention in terms of time and activities to give to administrative tasks, educational tasks and actual interaction tasks with the local community.

"Can you imagine calculating your work time in percentages. I really don't know how they come to get those figures. What they say I must do and what I actually do are two different things, but they mos always know what's best for us, they are so used to telling others what to do."

"I can't count how many times I had to wash the cups, mop the floors and just keep the place clean, because if the domestic worker is not here you must do everything. When I told the supervisor that the job description must include this .... I was told no one asked me to do the work. So where does that leave me? Must I look the other way and work in a dirty place, what about our clients, how will they feel if they come to a place that tells them how to live their lives ... but we should not talk. I think that maybe they (head office) are afraid to put 'it' in the job description because they are afraid that I might ask for more money and why not?"

In practice the actual role of the health worker is realized differently to the percentages reflected in the job descriptions. Health workers in charge of the clinics have a mainly supervisory role i.e. more than 80% of their role is supposed to be a supervisory one. The supervision task includes supervision of the other health workers, all the clinic staff

and the general 'housekeeping' aspects of the clinic. The health workers view this as ridiculous to realize presently because often there are only two health workers (registered nurses) present to provide a service, and if the supervision aspect is to be taken seriously, then one of the two health workers should be supervising the situation.

> *"I will look like a fool, we have a 'full clinic' and I must now supervise the other sister (health worker) and the other assistants in the clinic, and this is the case most of the time so where they get this ridiculous percentage of supervision from beats me ... I agree I must take responsibility for the clinic but I think they are a 'bietjie' out of touch."*

The health workers do not appear to 'own' their job descriptions and this is expressed by their detached attitude towards it.

> *"To tell you the truth I don't know when last I looked at that 'thing'. Maybe it was three years ago. I know what we need to do in the clinic everyday so I just get on with it. I must really try to make some effort to look at that 'thing' again."*
>
> *"I do what needs to be done for the day, I can't still worry about the job description. In any case it is someone else's story."*

Who should be providing 'health'?

This question is concerned with illuminating the health workers' professional identity by encouraging them to contemplate an ideal institution

The health workers consider a multidisciplinary team as being ideal in providing 'health'. This is considered to include members across the 'helping professions', administrative support such as clerks, and representation from the local community.

The health workers appear to be central to any operation in the clinic because of the 'expert' knowledge base and the 'professionalized' skills common to them, for example, administering medicines. The central position of the health workers is reflected in the fact that individuals with TB come to the clinic daily except on weekends and public holidays to receive their medicines. This arrangement can last for six months or longer.

> *"The TB patients must come every day to clinic for their medicines so that they can get their treatment from us."*
>
> *"We tell them to come to the clinic, its for their own good."*

The organization's appointment of another category of worker known as the health educator, is welcomed by the health workers because community members are referred to the health educator for health education regarding health problems mainly related to the GOBIFFFF concept. Health workers focus on aspects of traditionally formal treatment, and education is mostly focused around this formal view.

Some of the health workers expressed the need for the services of a general medical practitioner who should be available if the clinic wants to address the needs of the local community for minor health problems. The rationale for this is that it will stop the local community seeking help from another health organization in the same area that has medical practitioners. The implication of this situation is that the service does not provide a 'one stop' place. The clinic service is free except for a standard minimal charge for medicines if the person can afford it, but if use is made of the other health organization in the area, a 'fee for service' is charged.

"I know that the clinics are supposed to be run by the nurses, but it would help the clients if there was a doctor available at least once in a while to handle minor ailments, there is a need for this...they come here for one thing and then they go to the Day Hospital for another."

"The people must pay for the same medicines at the Day Hospital and if they come around the corner to us they can get it for free...but the funny part is that the authorities of the Day Hospital provide us with the medicines ... things are in shambles."

The health workers and the organization use western medicine as the only frame of reference and the health workers confine solutions to 'health problems' within the confines of the western medicalized model.

"Sometimes they take all sorts of funny things if the child gets sick. We tell them to stop taking the 'Dutch' medicines and all the other concoctions and they must rather come to the clinic for help."

How is 'health' provided for the people?

Members of the local community who approach the clinic for their 'health' needs are referred to as clients by the health workers. The reason and origin for this term appears unclear to some of the health workers. Some health workers were instructed to refer to these community members as clients during their orientation to the clinics at the education unit, while some of the other health workers regard these community members as clients because they are not ill except for some of the TB patients. The remaining health workers view all contact with the clinic attendants in the more formal and traditional role of 'patients'.

"I'm not sure where this 'client' name came from but I suppose it makes sense because they are only coming for a specific treatment. It's not as if they stay overnight or anything like that."

"When I was on the orientation programme, I was told to call them (clinic attendants) clients and not patients, I think that we have clients and patients. Some people come to buy milk for the baby while others come for TB medication."

The clinic has advertized its hours and days of operation so that the local community is aware of them. The range of services are also made known to the community. The presentation of these arrangements is the result of formalized decisions that have taken place at the organizations management center.

"The notice board outside the clinic lets the community know what times and days we are open."

Community members attending the clinic are orientated to the rituals of the clinic which are made known to them by the health workers or the health educators. They are 'educated' about when to attend through an appointment system. They are also encouraged to become "responsible" and "independent" by knowing where to report on arrival to the clinic, where to leave their clinic cards or documents, where to collect a "number" which determines the order in which they are attended to, and they are also informed about where to sit while waiting for their "number" to 'surface'.

"People take responsibility for themselves. They know where they must come to for their health needs."

"They are well informed about how things work at the clinic, so when they come here they don't have to wait on anyone...they know what procedures to follow. We don't have to tell them."

During this waiting period, they 'receive' health education on various topics which are predetermined by the health educator. Health education is also promoted through placards on the walls and printed matter. The printed matter is freely available for perusal and to stimulate interest and impart knowledge. The placards are usually received from the 'education unit' or they are made by the health educators. It was observed that most of the clinic attendants barely pay attention to the placards and even less so to the printed matter. Cooking recipes in the printed matter appear to generate some interest.

The operating process of 'sorting' through the clinic attendants begins by them being called one at a time to a desk in the waiting area where they are 'sorted out' according to what the health worker determines are their needs. They are either channeled to one of three routes i.e. to the health worker for consultation, to the health educator for health education of a specific nature, or to the clerk for a referral to another agent, or a further appointment.

> *"At the front desk we decide where to send them in the clinic because we ask them questions and we know what their needs are."*

The 'health' service that is provided only caters for newborn infants, immunization for prevention of diseases in children, children under 6 years with minor ailments, family planning, and food supplements in the form of infant formula and mealie meal for infants and adult attenders that are diagnosed as being underweight.

What about HE?

Health workers are not satisfied with the way in which they deliver HE presently. They regard the health educators role as important and express relief that there is someone to give the community members HE because they are 'caught up' in running a service and experience time constraints. The health workers assert that this problem can be solved if they are given additional staff. All the health workers put down their frustrations to a shortage of staff such as clerks, social workers and registered nurses which will bring about valuable relief for the extent of the service that they provide individually.

> *"I don't have time to really give each person that comes to the clinic enough time to deal with everything, so I just concentrate on the problem that they come to the clinic for. Like if its scabies, we tell them how to use the treatment."*
>
> *"I'm not really happy with the way that we provide health education, I feel we can do more, but then we will need more help like a full-time clerk and more nurses."*

The health workers provide HE with a sharp focus in support of the GOBIFFFF approach, and added to this, attention is directed to the serious problem of TB. During clinical consultation sessions it is common practise for health workers to refer the community members to the health educator. The reason for this is usually a lack of time because of a 'full clinic'.

The placards and printed matter available in the clinics are received from the "education unit". This unit together with the "production unit" that produces the placards are the "experts" who attend to the clinic's specialized needs regarding HE.

The placards are designed with pictures that depict the ethnicity of the community for whom it is intended. 'Messages' and information take the form of pictures with captions. The printed matter is developed and provided by the states central health promotion structures. These take the form of leaflets, and glossy printed magazines for the literate.

'Community participation' and 'responsibility' in view of the lack of it is reflected in this anecdotal introduction of new clinic attendants by a health educator:

> *"... Please sterilize the (baby milk) bottles, there should be no milk markings around the rim of the bottle, teats should be clean and not discolored ... cut out all Holland medicines, if you have problems, speak to the Sister at the clinic, don't do your own thing at home when we at the clinic say something else ..."*

The parameters used to measure the effects of HE are established by using epidemiological statistics which reflect increases or reductions of the various profiles kept such as the number of people attending clinic, receiving services, non-compliance to treatment, defaulting clinic appointments and weights of infants.

> *"When I look at our stats over the past few months I can tell if we are getting through because the number of people using the service gives us an idea ..."*

Continuous training and education for health workers is left mainly to their individual input. The organization has an "education unit" which tends to focus on orientation programmes and in-service education for health educators and the 'sub-professional' nurses. The health workers expressed a need for more educational training and development with regard to their role in initiating and providing HE.

"There are so many changes in the way we must provide 'community care' I feel we should have more training to help us with this. We all don't have the same understanding of what certain things mean like 'health promotion'."

"We don't get any inservice training, only the health educators and the assistant nurses."

"We get a list with the seminars that are taking place, but it's not always what interests us ... because the list comes from head office. They said if we want to attend something else, it must be work-related and we must let them know in advance. This is not always practical because sometimes you only hear about something two to three days before."

From the data it is evident that health workers confine HE to the traditional western medical model of 'health'. No communication refers to the practicalities of living without running water, sanitation or family disruptions because of social conditions. This is considered to be the domain of other people such as social workers, health inspectors and the 'government' of the day.

"If the people get jobs, then at least they can be sure that they will eat everyday, but the way things are now, it's so sad. You can only do so much, otherwise your hands are tied."

"We need more social workers to help people with getting grants and other help."

Has the clinic changed peoples lives?

The health workers see change in terms of disease control, prevention, and the alleviation of minor physical ailments. They view their work as important in contributing to the 'health' of people. However, this has limited effect because the basic living conditions of most of the people remains unchanged with no running water supply, no sanitation and rudimentary housing in the form of shacks which has an unspecified number of occupants that can range from 15 to 50.

"... They have a room and everything happens there, they cook eat and sleep there. The children sleep with the parents so they must see when their parents are physically intimate. And on top of this they take in others that haven't got anywhere to go to ... I once did a head-count of all the people that live in the 'hokkie' (shack) it was about fifty. They take turns to sleep ... and then you have a lovely house right next door. If you go down the street you won't see all these 'hokkies' from the front because there's a brick house in the front ... The owners sub-let the 'hokkies' and get income of about R50 from each 'hokkie' this can give them about R300 to R500 a month. It looks like there are always ways to exploit the poor but at the same time the owners are giving the people a piece of ground to put up their 'hokkie' ... how much difference can we make at the clinic? We can continue to immunize and prevent disease but if there's no food or toilets or water then I'm not so sure."

Some of the health workers have difficulty in coming to terms with the impoverished situation of the local community around them and they experience conflict and stress at the limited scope of their service. Almost every health worker related examples of the diversity of the images of the person attending the clinic and the same individual at home.

The 'face' that attends the clinic is neatly dressed and groomed and polite, but the same 'face' visited at home is unfamiliar, because of being unkempt and slovenly and sometimes inebriated. There is embarrassment and awkwardness on both sides when this happens and this makes the health workers unsure about the 'real' effects of their work.

"Sometimes a person feels so guilty because when you go out and do 'home visits' then you see the truth of how people really live. They use a dish which they leave outside their 'house' and this dish is always covered. Do you know why? ... It's their toilet. Can you imagine how much disease can be caused through things like that? But the people learn how to cope. You don't get any 'smells' that are funny. Think of that ... no running water, no sanitation, no ventilation, no security about the next meal. So how can TB be controlled...the TB rates in the Western Cape is the highest in the country and the country's rate is the highest in the world."

"I was shocked when I went to see a client ... the place was so untidy, and I saw this bottle (babys milk bottle) in the corner and it was really dirty and she comes every time to the clinic with a clean bottle, and you think to yourself what's happening here? ... We both felt

uncomfortable ... she (client) says "Nee suster, dit (dirty bottle) is my bottel vir die huis ... die ander een (clean bottle) is vir die kliniek." And when you see this person at the clinic she is dressed so well she will even have on earrings and she is always so polite...so you get used to working with clean bottles, because that is what they present you with."

The same situations do have a positive side too. Health workers assert that positive change in the local community is reflected in the community's 'discipline' towards using the service 'correctly' i.e. by observing times for the particular clinic sessions, and the improvement of their grooming and appearance when attending the clinic. The health workers encourage the community members to be 'proud' of their clinic and to show 'respect' for their clinic. The health workers promote a particular culture in terms of the behavioural norms of the local community members.

"I had this one client who was really so dirty ... I spoke to her for long and told her this is her clinic and she must be neat and tidy and have respect for the clinic. Now its like she is another person."

"Some of them do their washings (laundry) first and after this they come to clinic, by then they are late, I sent them away and said they must decide what is important for each day ... the clinic can't run to suit everyone ... there must be some order."

How do health workers divert their concerns socially?

Some of the health workers get 'bogged down' by the routine of their work and life is viewed fatalistically, others get involved in external activities like special interest groups such as the church and women's organizations while others channel their energy through political organizations to encourage change in the community. Some health workers use altruism in the form of promoting a Christian ethic and fostering a belief that things must change, because how much worse can they get?

"We get so busy at the clinic, if we don't have busy clinics, there's always the paper work to keep you occupied ... there's no time for other things really."

"What I can't do for the community in the clinic I can offer outside in my own time by the work I do for the women's group at my church, I tell a lot of the clients to join the group."

"Our people must be made aware of how to organize themselves so that they become aware of what their rights are as workers and how to address these issues ... but I do this work in my own time."

Mainstream changes

The health workers are eloquent about their rights as workers and their positions as health workers. They experience tension between their role as a worker and those of individuals with private lives and as community members.

"The state can no longer treat us like objects to dictate to. We may be nurses but we are no different to other workers. Times are hard and we don't just work for the money, but it is very important because it affects us ..."

Their relations with their organization are tense and fraught with mistrust and suspicion. The current political situation in the country affects them closely because of the silent pressure of 'getting involved' 'without choice' as they decide on whether to vote or not in the coming elections in South Africa. They feel that this situation forces them to address the issues that concern their daily lives, such as health and education, more now than at any other time previously.

"I don't like politics but now I must decide whether I must vote and who I must vote for. My children expect me to play my part.'

"The way things are going at the moment, 'baaskap' is alive and well. You can see how things are run, the same people are in top positions and they still give the orders, ... there have been changes but its just like the 'tricameral parliament' where one 'Coloured' and one'Black' is appointed in the more junior ranks of management."

They are in a process of empowering themselves as workers in the same way that teachers and all workers are engaged in on a larger scale. The tensions experienced stemmed from the compulsory membership (as a condition of employment) of racially organized unions aligned to their organization. As a result of dissension among the workers, the union agreed to change membership to being voluntary. This decision was welcomed by the health workers but the tension is unresolved, as the organization continues to deduct membership fees from the health workers.

"We want our own union that will really represent our interests, not like the one we were compelled to join if we wanted to work for RSC."

"I and others received telephone calls from our personnel 'admin' office asking us if we were sure that we wanted to terminate membership now that it's no longer necessary. They find it hard to let go of us so that we can make our own choices."

Pressure from the administrative staff was exerted on the health workers through telephone calls enquiring about whether they were sure about wanting to terminate their membership. The process was delayed further by the organization requiring letters from all members with the expressed intent to terminate membership. In addition to this, until recently, the health workers had to subscribe to compulsory membership, through state legislation of the professional association for nurses i.e. South African Nursing Association, which was also racially organized, until recently.

"Then they said we must each one write letters to say that we don't want to be members ... this after it was decided at the meetings set up to handle these problems that

compulsory membership was no longer necessary ... but they still continue to deduct membership fees after this decision was taken, they say the process takes time."

"Everyone wants to make money from the workers because it all adds up ... the profits are in someone's pockets. I am glad that compulsory membership days are over. Now I can decide what is offered and what suits my needs after all it is my money."

The tensions expressed have served to widen the gap between the health workers and their organization.

DISCUSSION

This discussion is developed from the analysis of the data. The interpretation of the data is discussed within the context of the health workers located within a systemically organized health system. The discussion will relate to the theoretical schema illuminated in the literature reviewed in Chapter 2. The discussion will address the research questions formulated and proposed in Chapter 1 and which reappear at the beginning of this Chapter.

The problem of controlling the role of health workers by the organization in direct and indirect ways relates to the health workers being shaped in a particular context. This possibly leads to the particular way in which health workers provide HE. This study will attempt to reveal whether this is a real possibility.

Primary discourse of health workers

The attraction to nursing and the reason for continuing to work as health workers contain altruistic elements explained as wanting to work in a way that would 'do good' by 'helping' others to help themselves and by instilling a 'caring' attitude towards the members of the community. This rationale provides meaning to the work of health workers and it also justifies their position in the health structure arrangements.

The RSC provides a better remuneration package for health workers than the other state authorities and this incentive indicates that the work of health workers is not only altruistic but is also a way of improving their living standards, and a means of survival. This discourse becomes backgrounded by the dominant medicalized discourse of health which is initiated and postured into placed by the medical experts through policy.

Foregrounding of the dominant discourse

The health workers do not appear to object coherently about the way in which their role is organized by the formulators and decision-makers of health policy for PHC and HE. Health workers appear to be 'swallowed up' in the business of rendering a service. They busy themselves with the rituals and routines of the service as arranged by their hierarchical structure. The discursive practices inherent in the medical discourse ensures that the activities of health workers are organized in a manner that is continuous and the routinizing processes clears the path for the discourse to be reproduced and sustained.

The influence of the medical discourse appears to have 'silenced' the health workers into submissive lackey-like behaviours in relation to their controlled positions within the health system. This is revealed by the acquiescing roles of the health workers in the way that they accede to their routine of ritualistic working mechanisms as reflected in their daily activities.

The impact of the medical discourse has effect on the relations of health workers that are like two sides of the same coin, they are both positive and negative. The positive effects can be construed as the health workers being placed centrally for continuity of health because of their location within the community that they serve, but the negative effect appears varied and multitudinous, with its roots located in the way that the health policy positions them as 'lackeys' and 'experts' of prescribed programmes. The policy can be translated as one that exerts its will through a 'top-down' effect without empowering the health workers to have the autonomy to exert their will in working towards meeting the real and not the assumed needs of the community.

The medical discourse enhances the 'worker' role as in 'getting the job done' because the regulatory rules of formation are evident at all levels of the hierarchy which shapes the role and identities of the health workers in the way that the organization instructs and controls them through the surveillance measures of policies and procedures. In this way work that is routinized is repetitive resulting in the de-skilling of the practitioners. The health workers become a 'means to an end' and the organization concentrates on the 'job' and not the 'worker'.

This situation appears to have an annihilating effect on the health workers who do not realize the extent of the organization's macro and micro level of power on them becoming de-skilled. Their 'expert' role is manipulated conveniently to act as the agents of 'change'. This is compounded further by the discourse inherent in the socialization of nurses, and the historical disciplined and ordered character of the nursing profession's militaristic and religious influences both internationally and locally.

The voices of the health workers and the public are silenced because the decision-making process of 'health' excludes them from being equal participants. This situation immediately holds problems in relation to the community being co-owners of the programmes and projects that are 'bestowed' 'benevolently' by the state on them. Ownership is by choice and by consensus and this is not reflected in the way that policy is made, legislated and enacted. The state appears to come off as the 'house with power' in a negative context because the arrangements appear to have a manipulative and exploitative effect on both the health workers and the community who end up being pawns in the business of 'medicine'.

The discursive practices as formalizing rules in the medical discourse uses the bias of an epidemiological base to lay down roots through the GOBIFFFF approach to 'health'. Health workers and other participants of health provision use empirical data to reproduce and sustain the medical discourse. The analogy between the demeanour of the medical discourse and Ferguson's (1990:18) discourse of 'development' bureaucrats holds true in respect of how the knowledge of the 'experts' shapes all structures, through the 'experts' knowledge, their thoughts and their utterances in all that they say and do not say, and all that they do and do not do.

The health workers who work in the local community are organized to sustain the privileged class by implementing the health policy and making it produce the expected results through the epidemiological statistics that reflect the extent to which the GOBIFFFF elements have been achieved. Profits from this discourse are for the privileged class of 'experts' in maintaining their 'expert' status and the exclusive powers

of decision-making which always appears to take place at a 'distance' from the very people it serves.

Unmasking the health policy

The selective character of the health policy reflects it as particular, and how medical ethics and value judgements are put into place on a 'divide and rule' basis.

The GOBIFFFF approach encourages the education of females preferentially and has a bias towards child care. The focus on the preferential education for women can be understood in relation to discourse which shows evidence of the visible and direct and the invisible and indirect forms of power exercised through this approach. The visible and direct are expressed as the intention to 'do good' by trading on altruism in the empathy shown to the 'cause' of women and children by the sympathetic mainly male dominated representatives of this discourse. The invisible and indirect expressions of power are revealed in the discriminating sexist bias shown towards males which is reflected in the exclusionary element of the medical discourse's 'silence' towards males.

LDC's that strive to engender a culture of equity for all its people will fall short in empowering people if policies at national and central level take control through enforced discriminatory programmes which addresses the needs of people in a sexist and biased manner. Value judgements have a moral tone which is out of place here

because of its 'divide and rule' demeanour. Do the policy-makers as decision-takers, and the health workers as 'pawns' of the 'medi-business' have a democratic mandate to provide services that are partial to a particular stance?

The strong bias towards child care as reflected in the 'GOBI' component of the PHC policy is evidence of the strong representation of UNICEF involved with the Alma Ata Declaration. The lesson to learn here is not the issue of whether child care is more or less important than adult care, but, that strong representation gets results in terms of a committed political will, a workable policy, a structure and a budget to deliver the goods.

The 'selective' character of the policy for PHC and HE shapes the role and identity of the health workers. The medical discourse inherent in the policy considers the health workers as 'experts' and professionals who interface between the organization and the end-user by providing for the health needs of the "community". The selective character of the PHC and HE policy gives western medicine an elite status because it excludes alternative forms of medicine through its professionalized approach reflected in the GOBIFFFF approach. The dependency on the health workers as 'experts' who are central in realizing the policy is crucial to the success of the policy, its privileged class, the regeneration and maintenance of the dominant discourse and the promotion of western medicine.

This state of affairs is not a denigration of the worth of the GOBIFFFF approach to health, but rather of the mental orientation at play in initiating and formulating health

policy globally and locally. If the selective approach to 'health' excludes 'health' in the wider context of 'health as development', then the road ahead is one of gloom and doom. The present delivery of PHC and HE does not reflect real community participation, no claims can be laid in terms of ownership of the health programmes by the local community. Equity does not even appear to be within sight, because health policy for PHC and HE begins with where the 'health system and its agents are at' and not where the 'individuals of the local community are'.

The health workers render a service to the "community" based on the way in which they are structured by their organization and the ruling PHC and HE policy. The service plays down the needs of the individual and addresses the issue of 'health' in relation to the needs of the local community. The local community is not homogeneous as some groups within the local community have access to basic necessities in the form of running water, sanitation, housing, employment and the assurance of regular daily food supplies, while others do not have any of these except for a rudimentary forms of 'housing'.

The way in which the regulating discursive practices of health workers are arranged in rendering a service for the local community espouses the view of 'health' as one that is 'where the organization is at' as opposed to 'where the local community is'. This explanation goes far beyond the reference to the geographical location of the two groups. The rationale for 'health' delivery in the present context divorces itself from the 'development' potential of health. It will take more than disease prevention and control through traditional western medicine to provide a healthy nation globally and locally.

The differences in basic living conditions that are experienced by individuals from the same local community suggests that communities are not homogeneous and even less so in LDC's. The health workers programme is arranged to have a limited effect on the individual and the community, for example a person with TB is living in a 'shack' with many others, the state subsidy that is sometimes received by the unemployed adult TB sufferers is used to provide basic food which is shared with all the other members that live in the same 'shack'.

The social problems that result from this situation are beyond the scope of the health workers and the organization, because of the inappropriate and inadequate way in which the health 'providers' address 'health'. The health policy is put into place to address the health needs of the people who need it most, but evidence suggests that the policy falls short of this, then who does the policy really serve?

The focus of aid in any form that will contribute to changing the 'real' situation of impoverished people appears to lie in improving the quality of life of the people by starting with addressing the individual's health needs within a wider context, as opposed to the "community's" needs, because "communities" are not homogeneous. The social inequities will remain if the discourse of 'health' remains aloof by operating at a safe distance from where people are.

The narrow medicalized demeanour of addressing health problems is pointed in the direction of the epidemiological and other 'experts' at the cost of playing down the environmental and social elements that are part of any developing strategies. The

dominant discourse does not make room for simultaneous social developments because of the closed nature of its representation. The health workers are put into a position of having limited desired effect on the local community because they address the 'assumed' health needs which are located in the PHC and HE policy. Critique of the existing forms of social order should be encouraged as an essential part of the process for justifying whether interventions should continue in terms of its integrity.

The health policy promotes the accessibility to health services as a priority indicator. Perhaps this is the reason for organizing the location of 4 clinics within close range of each other. The advantage of this arrangement is that the community members do not have to travel long distances in the absence of the taxis' irregular transport schedules.

The role of health workers as 'clinical experts' is located within the health system through the health policy. Health workers observe certain codes of discursive practices in the implementation of the health policy's GOBIFFFF programme through strategies of intervention. Foucault (Ferguson, 1990:21) infers that organizations' use interventive strategies to enforce discipline through power at macro and micro levels which occur as 'anonymous constellations of control'.

The positioning of health workers

The hierarchical arrangements of the organization together with its prescriptive policy has a disempowering effect on health workers in addition to contributing to them being de-skilled.

Health workers as intermediaries are manipulated to deliver the 'goods' because they are the 'experts' and they are dependent on the remuneration received from their employer\organization while on the other hand the community is 'charmed' into accepting the service of 'health' provided by the health workers. This is achieved by promoting marketable altruistic values such as passing the health workers off as 'experts' and 'professionals'. This cultivates a belief in the community that 'health' placed in the hands of these 'experts' is both 'good' and 'safe' and the 'right path' to follow. The use of health workers as 'experts' and 'professionals' has a controlling effect on other parties by excluding them because of the 'closure' through the use of 'experts' and 'professionals' built into the arrangements.

The bureaucratic way in which the organization operates locates health workers as intermediaries who are part of the state's working "apparatus" that is placed in the local community they serve. 'Technocratic' procedures instituted by the organization shape the health workers in a particular way, to help them to get on with the 'job' of delivering 'health' according to the plan reflected in the policy.

The health workers play a central role in the delivery of 'health'. On the one hand they provide a stable 'face' for the local community by being locally situated geographically, but on the other hand they are 'separate' from the local community since the system passes them off as 'experts' and 'professionals' because of their specialized knowledge. This situation creates class divisions between the health workers as 'agents of change' and the local people whom they serve. The specialized knowledge of the health workers is pervasive and as such affects the very 'grain' of the health

workers in the way in which they speak and do not speak, and the way in which they act or do not act. It is evident that the dominant discourse 'takes ownership' of the health workers, and the way in which they operate.

The manner in which the organization excludes the health workers and community members from its policy-making processes and the way in which policy is prescribed to the health workers for implementation, has a paternalistic 'top-down' approach. In this context the health workers come to occupy the opposing positions of 'experts' and 'lackeys'.

The clinics are organized to function within a hierarchy at local level with the modern day "police" built into the system in the form of supervision. Surveillance measures are placed at all levels in the fold of 'authorless constellations of control'. The measures enacted upon health workers take the form of rules that are prescribed and arranged within policy and procedure documents. In this way the organization is sure that the health worker is 'toeing the line' and in doing so the dominant medical discourse is kept active and is sustained by being reproduced on a day to day basis.

The 'top-down' way in which the organization communicates with the health workers ensures that health workers conform to the regulatory rules of formation. These rules are embedded in visible and invisible surveillance mechanisms that are put into place to "police" the behaviours of the health workers. Surveillance occurs at macro and micro level and takes the form of providing the organization with monthly

epidemiological statistics, and on a micro level the supervision that is built into the job descriptions serves the "policing" needs of the organization as just two examples.

The success of the organization to "police" the health workers creates the opportunity for it to succeed in penetrating the local community and getting the community to conform through "police" measures implemented by the health workers such as regulating the clinic times, the hours of operation and the way in which the various clinic sessions are organized and the very 'offer' of 'expert' knowledge to the local community. The intermediary role of the health workers becomes one in which power through knowledge becomes a mode of operation.

This 'top-down' effect at the micro-setting of health delivery is a system which can leave itself open to abuse by the health workers, who are in 'elite' positions to exert their will on the community, unknowingly or intentionally. By the same token the organizations 'top-down' arrangements has resulted in misinterpretations, misrepresentations, and a lack of trust by the health workers. The structures relating to communication between the organization and the health workers are arranged hierarchically, and this creates suspicion and mistrust, rightly or wrongly, about the organization's strategies.

The hierarchical structure of the organization lends itself to being abused and misused at each level, because of its 'tight' arrangements. Even if the organization's intention and will is meant to be 'good', the very character of the structure closes the organization and makes it difficult to penetrate. This leads to the organization being set

up as a dense operation and one that cannot be considered as being transparent. Transparency lends itself to reducing suspicion and mistrust because it is open to scrutiny that would reflect the processes involved at every level of the organization's development. The health workers experiences of suspicion and mistrust appear to stem from a 'closed' health management system.

The health workers do not have a coherent view of the PHC and HE other than that reflected in the policy adopted by their organization. However, they infer that all is not well as expressed in the views that health delivery should be more "comprehensive", "less curative", and the desired availability of a general practitioner to provide a 'one stop' shopping for 'health'.

The PHC policy emphasizes another value judgement in providing a 'basic health service' by removing the medical practitioners and replacing them with the health workers as consultants who 'fill' the medical practitioners role. The health workers have modelled themselves on their medical predecessors because they have 'taken to' the consulting rooms to 'offer' health through the power of their 'expert' knowledge and their 'professionalism'. This situation is not having the desired effect, because by merely reshuffling the "apparatus" , the health needs of the people remain the same.

People still experience minor illnesses for which hospitalization is not necessary, but because of the short-fall of the PHC clinics they still have to 'shop around' for their needs to be met within the narrow and traditional definition of 'health'. The other miscalculation is the 'piecemeal' approach in the formulation of the PHC policy. Health

workers, as registered nurses, are controlled by legislation which elucidates their scope of practice in relation to the administering of medicines.

Unless prior 'permission' is obtained to extend their scope of practice in the prescribing of specified medicines, they are guilty of transgressing the law. This situation places the health workers in the precarious position where they transgress the law as a result of forces external to them. Only a very small number of the health workers could consider themselves as being exempt from this transgression. This situation serves as a reminder of the dangers of developing strategies without due consultation and due representation, especially of the people for whom the strategies are being developed.

Health workers are well aware of the Alma Ata concept of PHC but convincing evidence of the policy being internalized and activated to address local needs seems to fall short, this is visible in the serious increase of TB, which is a preventable disease. The health workers acquiescing manner makes outward appearances of the situation appear as one that is stable and working well. They are trapped in their regulatory daily rituals and appear not to be aware of the power of organizing themselves as the health advocates of the local community, by mobilizing themselves to generate change through exerting their will in the direction of the organization.

This is not a means to incite violent change, but to look critically at the system which is 'mandated' to provide 'health' for the community but is not in a position to do so because it operates in 'closure' by not having clear mechanisms put into place to

'listen' to the voice of the community through their 'health advocates'. The communication is very strong in the top-down direction but 'sickly' in the 'bottom-up' direction.

Health workers view themselves as professionals who have many roles, some of which are as helper, counsellor, educator, and expert. The significant position of health workers will be put to better use if the health workers roles were those of "enabling, mediating, and advocating, not directing" (Macdonald:1992:72). Health workers as agents of change have not been used to their full potential as one of many participants in collaborating towards 'health as development'.

Health workers work hard and well at their tasks but as 'gate keepers' of health they appear to have failed in relation to collaborating with the local community members to participate and to hold ownership of 'health projects' that affect their lives. The superficial view of ownership is reflected in the way in which the health workers aim to engender emotional ties through the local community's relation with the clinic measured in terms of improved grooming, respect, and polite relations with the clinic staff. This situation is inevitable because the health workers themselves are placed in positions of powerlessness, although they exert power on the community through their 'expert' knowledge.

The demeanour of health workers

Health workers draw on their 'expertise' in the context of their professional role in the work setting. In this way they develop an indicator to measure their efficiency in the delivery of PHC and HE. This efficiency is a very narrow vision which stems from the health policy according to which they work. Efficiency is measured in the traditional western medical context of their intervention strategies which are provided mainly through selective health programmes such as 'nutrition clinics', 'immunization clinics' and 'family planning clinics' as part of the organizations PHC and HE policy.

The way in which the health workers arrange their work reflects the 'old mould' in the way that they implement the new policy. They view their role as 'traditional' and by doing so channel their efforts within the 'professional' identity that they hold. This is observed in the referral of their clients to the health educators. This 'going back to old habits' does not consider the extension of additional 'formal' groups within the health system as one that continues to put 'others' in charge of the health needs of the local community instead of mobilizing the community members to become collaborators for their own health.

The organization's expectations of health workers to deliver HE through "indoctrination" and "persuasion" is a moral indignation of human dignity and the coercive elements of this attitude is reflective of how strongly cast the 'old mould' is in the way that the health providers at all levels reflect their roles as 'going back to old habits'. This attitude illuminates the paternalistic and autocratic intransigence of the power of the

privileged class. The arrangements for implementing the policy is cast in the job descriptions of the health workers.

The health workers arrange their work within their organization's policy. In this way the health workers are used by the organization as the "apparatus" through which the SPHC and SHE programmes are delivered. This leaves the health workers with no opportunity to change the policy that is prescribed to them and to which they must ascribe. The task lists, job descriptions and "standing orders" are all regulatory discursive codes of practice which provide the health workers with rituals within which they become 'immersed'.

The health workers concentrate with getting the 'job' done on a daily basis and the achievement of this gives them a gratifying feeling of worth and 'efficiency'. They hardly notice that their initiative has been backgrounded by the 'mediatory' arrangements of their organization. In this way the organization exploits the dual relation that health workers have i.e. as employee and as 'professional'.

The "policing" of the health workers makes them 'state professionals', the role of employee is lifted out by the organization because of the financial dependence of the health workers on the organization, while the role of 'professional' is backgrounded because the health workers are de-skilled and because their 'expertise' is used as a means to an end.

This is revealed in the way that the health workers are put into place as the agents of the organization to do a 'job', to 'indoctrinate' and 'persuade' the community members to accept the 'benevolent' offer to 'improve their health'. The organization calls on the 'expert' individuals and institutions such as the MRC to provide epidemiological solutions to formulating strategies for 'health', at this level the health workers are not consulted or considered as important collaborators. This conflicting attitude reveals the double standards of the 'house with the power'.

The health workers use screening as a form of assessment to diagnose the health problems that are directed to them by the members of the community. The health workers use their 'expertise' in visible and invisible ways through the 'clinical gaze' to make assessments of the local community's health needs.

This is done by employing various rituals through power relations in positive and negative ways. Knowledge is transferred to the local community positively to those who seek it by availing themselves to the service offered at the clinic. The health workers use knowledge to create classificatory codes to arrange the way in which they organize themselves and the "community" as the 'body' attending the clinic.

Classificatory codes are specialized terms that the 'experts' use to create their own language, for example, 'defaulters', 'new cases', 'first visit for newborn babies' and 'developmental assessment'. The negative aspect of the SPHC and SHE programmes are that they reflect an authoritarian and paternalistic attitude in the way that they are structured and delivered, and the programmes appear to encourage servility, greater

dependency and an unquestioning acceptance of regulatory mechanisms as is illuminated in the custodial way in which treatment for TB is provided.

Health workers operate in the work setting by developing relations of trust between fellow health workers. This is illustrated in the way in which health workers mutually uphold their integrity, and in this way accept each other as competent to deliver 'health'. In this sense 'trust' is used by the health workers as a measure of their efficiency. The health workers use relations of trust as 'facework commitments' to create a team approach that has a stabilizing effect in the work setting. The health workers hold the view that if a health worker has complied with the requirements of the SANC, and is registered with this body then the level of competence is acceptable to them.

The competence of health workers is promoted by the dominant discourse in the health system as an inherent trait because of the health workers being 'experts' and 'professionals' with specialized knowledge. Their expertise is further endorsed by their employer and their state professional body which limits entry into the system of 'experts' by applying criteria based on specialized formal education and training courses and formal methods of evaluation such as assessments, examination and certification.

The relations of trust are also extended between the "community" as the 'body' and the health workers in the form of 'faceless commitments'. The local community places their trust in the health workers because the health workers are considered as 'experts' and

'professionals'. This view held by the local community reveals the ability of the organization to penetrate the "community" by manipulating the "community" to accept the 'health' that is 'benevolently bestowed' on them.

The marketable altruistic values of the health workers as 'experts' and 'professionals' are 'traded off' by the organization in a bid to ensure the success of its SPHC and SHE policy, and in this way to reproduce the dominant medical discourse. This is reflected in the way in which the community as a 'body' both anatomically and structurally submits itself to be 'gazed' at by the 'experts' who subject them to various surveillance measures and rituals, such as monitoring 'blood pressure' and 'developing the art and technique of breastfeeding babies' as just two examples of how health workers engage in rituals as 'state professionals' of the organization.

The tensions and conflict experienced by health workers in relation to their role as employee and professional have resulted in them making efforts to develop ways of 'defending' themselves from manipulation and exploitation by the organization as the 'state'. Is this the beginning to the insurrection of 'rupturing' the bastion of the medical discourse?

Chapter review

In this chapter the data was analyzed and discussed within the theoretical context illuminated in Chapter 2. The purpose of Chapter 4 was aimed at addressing the

research questions posed at the beginning of Chapter 4. Many similarities in the responses and experiences of the health workers in the work setting were revealed from the interpretation of the data.

The dominant medical discourse reflected in the health workers role is evident in the way that they conduct their professional role and identity. The incentives for health workers to work in the clinics are mainly the socially acceptable working hours and the financial incentives. The irregular hours and unpopular shifts of the hospitals appears to secure the availability of health workers for the clinics.

The service that health workers provide for the local community is predetermined by the PHC and the HE policy of the organization. The health service is provided for the "community" by offering them a selective service according to the GOBIFFFF approach. In this way the service is offered by reflecting 'where the organization is at' as opposed to providing a service to meet the needs of where inidividuals 'are at'. The selective trait of the policy reveals a discriminatory demeanour that is based on value judgements and the mould of traditional western medicalized health.

Health workers are located within the hierarchically organized health system. They are used as employees and as professionals to provide 'health' as agents of the state. The way in which health workers are controlled through surveillance measures by the organization is reflected in the visible and invisible forms of power that control the way in which they function. Power is exerted by the organization through regulatory discursive codes in the form of Mission Statements, job descriptions, policy, and task

lists. These forms of power exerted at macro and micro levels ensure that health workers succeed in implementing the PHC and the HE policy. The success results in the dominant medical discourse being reproduced and sustained.

The class interests of the privileged group that shapes the dominant discourse is protected because of the development of intervention strategies and structures that reflect the location of a state "apparatus" to 'bestow' the 'benevolent' health policy. The discursive practices keep the health workers busy by 'immersing' themselves in the rituals of routinizing their daily activities in the work place. In this way the organization focuses on the health workers getting the 'job' done and the emphasis is on the 'job' as opposed to being placed on the health workers. The routinizing of health workers roles results in them becoming de-skilled. The 'old mould' that reappears in the new policy requires health workers to provide HE through coercive measures of "indoctrination" and "persuasion". This reflects the 'going back to old habits' of taking away the right to choose by disempowering people through advocating the force of will upon them.

Health workers as 'experts' and 'professionals' exert power on the local community that they serve through their specialized knowledge. This places the health workers in a separate class to the community and has a 'divide and rule' effect. Relations of trust in the work place operate as 'facework commitments' which are used to regulate and normalize relations between the health workers by accepting competence as being an inherent trait found in the health workers. Relations of trust between the health workers and the local community operate as 'faceless commitments' where the local community

places its trust in the health workers because the health workers are considered as 'experts' and 'professionals' who will 'do good' for their health.

The health workers 'gaze' upon the local community as the 'body' to assess their health needs and to provide selective strategies to address these needs. Health workers cannot lay claim to collaborating with the local community so that the individuals from the local community are enabled to take ownership of health programmes. The narrow and traditionally western medical definition of 'health' excludes the concept of 'health as development'. The inability of the present policy to address the inequities of individuals falls far short of empowering the community because of the way in which the elite representatives of the medical discourse stand aloof and 'at a distance' from the very people they intend to serve in the way that health policy is initiated and formulated.

Health workers appear to experience tensions and conflict between their roles as employees and professionals. The anger of the health workers does not appear as though it can be easily placated.

Limitations of the study

The small scope of this study can pose speculation about the reliability and validity of the results. If the study were to be repeated it can be anticipated that the data will reveal a similarity in the experiences and responses of the health workers interviewed.

It is not certain whether this study can be generalized to health workers who work for other state organizations but the results of this study can be related to the health workers in other RSC clinics because the organizational arrangements would most likely be the same. The literature reviewed reveals sufficient correlation to suggest that similarities could be anticipated in organizations that are similarly arranged.

Confining the study to how health workers initiate and provide health education excludes other unrevealed contributory factors that need to be considered. This limitation creates a sombre impression of the day to day lives of the health workers in the work setting. This is not the way that the health workers experience their work, on the contrary the extent of their interactions with their clients provides many genuinely fulfilling moments for them. The health workers are not about to 'down tools' because the rewards of their interactions with the community hold encouraging promise for them to remain.

CHAPTER 5

CONCLUSION

This chapter discusses the possible solutions towards addressing the real 'health' needs of people. Key elements such as empowerment and a radical change in the mental orientation towards health policy development and delivery are proposed as being crucial towards change.

In conclusion the discussion in Chapter 4 illuminated the following areas of concern:

- the context of "health" is interpreted in a traditionally medicalized narrow sense as expressed in the approach to PHC and HE;
- the misconception that "communities" are considered as being homogeneous;
- emphasis is placed on service-rendering through selective programmes rather than on a more comprehensive needs-based approach;
- the particular approach to HE appears to be based on institutional goals rather than through a social theory for which there is an absent intellectual and ideological basis for giving HE a legitimate value for funds and support through the political process to sustain a more comprehensive approach;
- the appointment of a different category of health workers as "health educators" gives more credence to the selective orientation to PHC;

- "health educators" are considered as easing the "burden" of the registered nurses as health workers, by largely loosening their responsibility with regard to HE, and through this enabling them to continue with "professional duties" and the delivery of the selective PHC and HE programme;
- the role of health workers are 'officialized' and 'professionalized' and they act as the health regulators and as bearers through whom 'health' can be obtained;
- the efficiency of PHC and HE programmes are calculated in epidemiological terms at the compromise of environmental and social shortcomings;
- the rising cost of health care to the taxpayer is blamed solely on the historical past without realization that the discourse of health and the health politics of those in powerful positions of influence is one of many factors that contributes to the difficulty of employing successful approaches that will work for the South African situation;
- 'health' and 'development' are considered as separate entities and the provision of 'health' is arranged to exclude 'development'.

What solutions if any?

It is evident that state bureaucracy serves the hegemonic interests in society as revealed in the medical discourse of the health policy. The state emerges as the author of benevolent 'health' interventions which it 'bestows' on the public through marketable values such as the altruistic elements of the policy to 'do good'.

The partial way in which the policy is developed excludes attention to the basic needs of the majority of impoverished, displaced and unemployed people partly because of its narrow and conservative definition of 'health', as exemplified in the attitude concerning policy delivery and the distinct detachment of 'health' from 'development'. In South Africa this arrangement is politically located to provide health policy in mainly epidemiologically measurable terms without a broader anthropological base.

There does not appear to be any 'quick fix' or simple solutions because of the complexities of the South African Third World situation, and the inequities of the social order that is the shameful reminder of human indignity inherited historically. The possibility of looking at a wider and a more relevant definition of 'health' with the simultaneous reshaping of the entire health 'apparatus' is proposed as a departure point from which to work.

All concerns point in the direction of developing a sincere change of heart which will be reflected in a new and radical mental orientation to 'health'. This means breaking the 'old order' by opening up the membership of decision-makers and the processes to a wider public representation. By doing so the 'old mould' can be ruptured and the 'old order' can be 'laid to rest'. It is proposed that this new and radical mental orientation will contain elements that work towards removing all forms of humiliation and degradation that lock people into powerlessness.

The state should not be the sole party mandated to provide 'health', nor should international institutions be charged as the 'experts' that provide solutions because this

can lead to "false universalizing and heroic views" (Ferguson, 1990:284). Ferguson asserts that both the international agencies and the state pose the same dangers, because although one has an international agenda and the other a local agenda, both act as "guardians" of global and local hegemony. The only difference between them are their varied degrees of interests and effects, but both are equally conservative in their approach. This was clearly observed in the adoption of the international 'health' policy as a 'package' for local effect.

A serious advance towards the empowerment of people is advocated if there is to be any relief from "poverty, sickness and hunger" in the Third World (Ferguson, 1990:279). 'Health' should move away from being side-tracked into focusing on the illusory arguments concerning efficiency in terms of individual versus community or freedom versus responsibility by favouring an enabling empowerment strategy for all people that will improve the quality of life.

Strategies for empowerment can be secured within structures by identifying processes for this and taking affirmative steps. Non-state forces on a wide scale should be encouraged to engage in 'health' matters and to challenge the existing dominant order. Such groups will become counter-hegemonic orders that will challenge decisions and policy that are not representative of the real basic needs of people.

In order for PHC and HE to be constructed and provided efficiently there will have to be a mental reorientation towards redressing the political and structural determinants in developing the socio-economic status of people. Presently there appears to be little

hope of public belief in the merit of 'health' provided by health workers and the health system, because despite the 'health interventions, the quality of life is only superficially touched. The powerlessness of impoverished conditions remains much the same.

In conclusion it is evident from this study and the literature that a strongly biased medical model does not provide all the solutions for health care needs presently, nor has it done so in the past. This axiomatic demeanour continues presently as illustrated by the present (March 1994) Minister of Health's answer in reply to a question posed to her on national television concerning a unitary health policy for South Africa, she stated, "What we need to do, is to educate the public about what their needs are" (Davies, 3 March 1994). This response reflects the reappearance of the 'old mould' in the 'new' policy by illustrating a 'going back to old habits'.

The development and use of medical strategies exclusively in providing 'health' will not alleviate nor contain problems that are embedded in the inequitable allocation of resources without concrete strategies to improve the quality of life through creating a shift from powerlessness towards enabling forms of empowerment. The present lack of political will for addressing 'health and development' collectively appears to be a hazardous path to follow.

Chapter review

This chapter discussed the concerns of the study and the state's role in preserving hegemonic interests in the way that the 'health' policy is developed and delivered.

Marketable values of altruism are used to 'sell' the programme which colours the state as a benevolent agent.

Immediate solutions are not easily found, given the complexities of the South African situation in terms of the divisions created through social inequities. Solutions proposed in the longer term favour a real 'change of heart' in developing a radical change in the mental reorientation towards 'health' in terms of a broader context that reflects 'health and development' collectively, and which will transform the lives of people from powerlessness to empowerment, with particular attention to the majority of people impoverished as a result of forces external to their control.

Reluctance to address 'health' and 'development' strategies collectively appears to be a precarious option to pursue.

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APPENDIX

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9 September 1993

Ms M Khan
9 Baris Road
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Dear Ms Khan

MPHIL IN ADULT EDUCATION

I am pleased to inform you that, on the recommendation of the Higher Degrees Committee, the Board of the Faculty of Education has approved the provisional title of your minor dissertation as follows:

Title: How 'efficiency' is constructed and effected in the provision of health education
Supervisor: Mr M Prinsloo

As you know, the due date for submission is on or before 15 March 1994. If your dissertation has not been submitted by that date, you will be required to re-register for the 1994 academic year to complete the work.

If you wish to make any alterations or amendments to your dissertation title you should, after consultation with your supervisor, inform me in writing so that these may be approved by the Higher Degrees Committee and Faculty Board. As this process takes some time, any notification of changes should be made before 31 January 1994. Please contact me if you have any queries in this regard.

With best wishes for your continued good progress,

Yours sincerely

Mrs T Nicolay
FACULTY OFFICER
for Registrar

ct: Mr M Prinsloo

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