Epidemics and the Health of African Nations

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Nurses and community health workers (CHWs) far outnumber doctors in Africa’s health workforce. They are on the frontlines when epidemics strike. Investing in these frontline health workers has been identified as a key strategy for strengthening health systems and preventing future outbreaks (for example, of Ebola) (Perry et al., 2016; Sagar, 2015). During the 2014–2015 outbreaks of Ebola in Liberia and Sierra Leone, frontline health workers played important roles in screening and educating communities about the disease, at the same time as tracing active cases and contacts (Perry et al., 2016; Sagar, 2015), often at immense risk to their own lives. A substantial body of evidence further demonstrates the effectiveness of nurses and CHWs in managing...
malaria cases at community level (Corley et al., 2016; Paintain et al., 2014). Finally, despite early scepticism that an understaffed health system could effectively administer antiretroviral treatment (ART) in response to the HIV/AIDS epidemic, treatment programmes led by nurses and CHWs have halved AIDS death rates in South Africa since 2005 (Setswe, 2016). While initiating patients on ART, these frontline health workers have also led support groups to bolster treatment adherence and ensure long-term health (Mottiar & Lodge, 2018).

In multiple African contexts then, nurses and CHWs have played essential roles in bolstering epidemic responses at a community level. Nurses, in particular, also play an invaluable role attending to critical cases in hospitals, since doctors are often in short supply. Africa’s epidemic preparedness rests heavily on its ability to retain frontline health workers, and create enabling environments so that they are able to perform at their best. Drawing on South African case studies of nurses in tertiary hospitals and CHWs in primary health care clinics, this chapter describes key systemic factors that constrain frontline health workers’ ability to provide high-quality patient care.

Whether as nurses in hospitals or CHWs in clinics, the health workers we discuss in this chapter are patients’ first and primary point of contact, and it is on this basis that we refer to them as ‘frontline’. Yet, relative to other health workers in their facilities, they are also on the lowest rung of the professional hierarchy. Indeed, the under-recognition, and subordination, CHWs experience in relation to nurses in primary health care clinics mirrors what nurses in tertiary hospitals report experiencing from doctors. Both nurses and CHWs are overburdened and poorly paid, and their unique knowledge and experience of patients are often undervalued. Despite these similarities, there are also key differences between these two sets of frontline health workers: nurses have professional status (and their own professional hierarchies), accredited training, an established labour union, and full employment. In contrast, CHWs, who are recruited from the communities they serve, operate as lay workers, with highly tenuous job security and varying levels of training. Growing state reliance on CHWs to shoulder the burden of primary health care has been attended by a growing call for proper remuneration, accreditation, and
employment benefits (Trafford et al., 2017). In Gauteng, and elsewhere, CHWs have publicly protested for labour rights (Molelekwa, 2016; Swartz & Colvin, 2014). As the scope of work for CHWs at a primary care level continues to expand, research needs to consider how CHWs accrue and deploy workplace knowledge, and under what constraints.

While much of the literature, and indeed the public media focus, has been on the need to improve skills among frontline health workers (Dawson & Joof, 2005; O'Donovan et al., 2018; Wu et al., 2017), this chapter argues that these workers are often constrained in their ability to deploy their knowledge. Beyond their training (which is comprehensive for nurses, and variable for CHWs), frontline health workers have unique expertise in enhancing the patient–provider relationship. Nevertheless, they are often diverted from this core area of their expertise. This is not only due to unmanageable workloads and struggles for workplace recognition, but is exacerbated by the interests of the ‘new public management’ that has attended the emergence of neoliberalism in public health systems; elevating cost cutting and administrative tasks at the expense of the caregiver–patient relationship has had a deleterious effect on health care.

The chapter draws on studies conducted by two researchers: Di Paola conducted ethnographic research with public hospital nurses in Johannesburg, from April to September 2017 and then in September and October 2018. She spent five months observing in two different wards – pulmonology and postnatal – in an academic hospital and, in addition, conducted 16 in-depth interviews with nurses' and key informants, including academics, nurse educators, one policy maker, and representatives from the health labour movement. Di Paola investigates what Sawchuk (2017, drawing on the work of Smith, 1987) calls the everyday knowing, working and judgement-making of nurses. Methodologically, she combines observation with the analysis of nursing labour process and with the political economy of health care provision (as in Valiani, 2012; White, 1993; and Norrish & Rundall, 2001). Vale draws on a long-term (the past seven years) research engagement with CHWs: beginning with fieldwork conducted between 2011 and

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i Health workers’ and key informants’ identities have been protected through the use of pseudonyms; only in the case of Dr Armstrong was a real name used.
2012 with CHWs in two Western Cape public health clinics (see Vale, 2012a; 2012b; 2012c), and later in 2013 with rural village health workers in the Eastern Cape (see Vale et al., 2017). This was complemented by a scoping review of the community health worker landscape, produced in 2018, for the DG Murray Trust’s Zero-Stunting Initiative. While Vale’s fieldwork is some years old now, South Africa is still in the process of formulating a national CHW programme. Vale’s 2018 review reveals that challenges facing CHWs when the research was conducted have not changed very much. This has significant implications for the ‘Re-engineering of Primary Health Care’ and the formulation of the country’s National Health Insurance (NHI).

The chapter begins with a description of the structure of the South African health system, which is characterised by stark inequalities, a heavy burden of disease, as well as class, race, and gender dynamics that mirror wider South African society. We then locate the challenges of frontline health workers who are positioned as ‘mediators’ between ‘the community’ and the ‘health system’, struggle to assert workplace authority, and must regularly negotiate professional, gendered, and race-based power relations.

Following this, we define the ‘new public management’ and describe how it has affected the everyday practice of frontline health workers. In public hospitals, cost-cutting imperatives associated with new public management worsen staff shortages and can result in patients’ early discharge. Meanwhile, in primary health care clinics, the scope of work expected of underpaid CHWs is ever expanding. Frontline health workers find themselves overwhelmed by duties, struggling to juggle time spent on patients and paperwork.

As evidenced in both popular and academic literature, South Africa’s frontline health workers are often described as incompetent, uncaring, or abusive (Honikman et al., 2015; Kruger & Schoombee, 2010; Khumalo, 2011; Seid, 2017; Zwane, 2017; Makhubu, 2016; Berquist et al., 2018). Without excusing patient mistreatment, this chapter illustrates how systemic pressures on health workers constrain and erode care. Frontline health workers in both Di Paola and Vale’s studies felt that the core of their work, the caregiver–patient relationship, was displaced by heavy workloads, pressure to meet cost-cutting goals and
therefore rush care, managerialism, and under-recognition of their specialised contribution.

SOUTH AFRICAN HEALTH CARE SYSTEM

Despite significant progress made in granting access to health care to the majority of the population, 25 years after the fall of apartheid South Africa is still battling with health outcomes that are similar to those found in lower-income countries.

Progress can be seen in that child mortality in South Africa reduced significantly from 74 deaths by the age of 5 per 1,000 live births in 2000, to 44 in 2013 (UNICEF, 2014). This may have been the result of the introduction of large-scale antiretroviral treatment post-2005 (Stats SA, 2018), but it has to be noted, nevertheless, that these results are similar to the low-income Democratic Republic of Congo (49 in 2013) and much higher than those reported by other upper-middle-income countries, e.g. Brazil (14 in 2013) or Algeria (25 in 2013).

South Africa is a country where access to health care is significantly unequal and overall inadequate when compared to the country’s economic development (DoH, 2014). High levels of inequality, unemployment, persistent poverty, and a migrant labour system still in place characterise the socio-economic context.

The public hospital setting, which serves the majority of the population, is historically underfunded and beset by health worker shortages and patient overcrowding (Coovadia et al., 2009). Racial policies adopted during colonialism and apartheid led to a race-based division of health services into segregated establishments, subsequently exacerbated by the institution of separated Bantustans, each with its own health department and professional bodies. These had a great impact on the historical maldistribution of health professionals and on the unequal access to health services (Van Rensburg, 2014).

In 1994, the democratic government inherited a country marked by racial segregation, acute socio-economic inequalities, and highly unequal access to health. Major achievements have been made in the past two decades in the provision of health care: first, in transforming a segregated system into an integrated, comprehensive national
health service (McIntyre & Thiede, 2007); second, in terms of a more equitable provincial funding distribution; third, in financing and provision of primary care (through the use of funds previously used in tertiary care rather than availing additional funds); and finally, yet highly significantly, affirmative action policies which made the public sector workforce more race representative (Baker, 2010). Policies aiming to redistribute health professionals towards primary health care have been implemented, for instance through compulsory service of post-secondary graduates. The result has been an overall increased use of health facilities by the most disadvantaged groups in society, most of whom rely on primary health care. In the past few years, the Department of Health (DoH) has been formulating plans to ‘Re-engineer Primary Health Care’ in South Africa (Barron et al., 2010; Morrell et al., 2011). These plans situate CHWs as drivers of primary health care services, offering peer education, treatment support, screening, and home visits, as well as referrals to social services. Often, the work of CHWs is supervised by a nurse.

These improvements have nevertheless been overshadowed by other shortcomings. Primarily this can be seen as the failure to address the fallacies of the private/public mix and the restriction in public spending (McIntyre & Thiede, 2007; Baker, 2010). Of the 8.7 per cent of South Africa’s GDP that goes towards health, 4.5 per cent is spent subsidising the narrow segment on medical aid (16 per cent of the population) (Motsoaledi, 2018). This means that although South Africa spends as much as many European countries on health care, its health outcomes are not comparable, since much of its resources are diverted to a privileged minority of the population. As argued by McIntyre and Ataguba (2018), a macroeconomic policy that puts redistribution rather than discipline at the centre, and allows for the development and implementation of comprehensive social policies that modify living and working environments, is pivotal to address the failures of the health system and the maldistribution of health workers between private and public institutions, and between rural and urban settings.

Compounding, and in many ways emanating from these challenges is South Africa’s quadruple burden of disease: HIV/AIDS and tuberculosis (TB); high maternal and child mortality; non-communicable diseases
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(NCDs); and injuries linked to significant levels of violence and crime (DoH, 2014). These factors, exemplified in the poor health of the majority of the population, have a direct impact on the heavy workloads experienced by health workers and consequently on access to health care for the black majority (Breier et al., 2008; DoH, 2014).

During Di Paola’s observation, several nurses pointed to the hardship of the public hospital setting as related to the quadruple burden of disease (Breier et al., 2008). Hence, Sister Smith, a professional nurse in pulmonology, explains that many patients are recurring patients dealing with multiple morbidities:

Many patients here have multiple diagnoses, for instance: one or several COPDs [chronic obstructive pulmonary diseases] together with embolism, and HIV. This happens because of permanently damaged lungs resulting from recurrent or poorly treated tuberculosis. The lungs are like cardboard! They can’t clear the airflows from mucus because they lost elasticity; the phlegm sits there [in the lungs] and gets infected causing all sorts of diseases. Then there’s nothing you can do to fully cure the lungs (Sister Smith, interview, 2017).

Due to the severity of this quadruple burden of disease, nurses witness high levels of fatalities and morbidities. At the same time, because of cost-cutting policies, the institution is constantly overcrowded and health professionals, including nurses, are forced to make decisions with significant ethical aspect, regularly having to weigh up the quality and quantity of care provided.

At both primary and tertiary levels of health facilities, there is awareness that patients’ poor socio-economic conditions dramatically impact on the functioning of wards and clinics. In an attempt to respond to the severity of patients’ socio-economic circumstances, regular meetings are held in hospitals and clinics to assess their needs and, where appropriate, to arrange for social worker intervention. Austerity measures and a culture of cutting costs run counter to health personnel being able properly to address the socio-economic needs affecting their patients’ health. In particular, patients are discharged
early (nurses refer constantly to the mantra of ‘emptying beds’) which negatively affects their care. This practice is not aligned with patients’ socio-economic needs, as this example confirms:

*During the morning round, Sister Nancy tells me about the patients in most critical conditions ... During the round the consultant keeps discharging patients without consulting with Sister Nancy. She is staring at him without saying a word. He only says, without looking at her: ‘We need the beds.’ Sister Nancy tells me she doesn’t think the patients discharged before doing the necessary exams will come back [for the exams booked after two or more days] because most of them don’t have transport and discharging them on the same day means the nurses won’t have the opportunity to arrange transport with the family or the hospital (field notes, 19 July 2017).*

Frontline health workers often feel overwhelmed by the needs of their patients, and often ill-equipped to address their scope. They constantly have to find ways to come to terms with unsuccessful care – whether in the form of non-adherent patients, helpless cases, or the deceased. Of course, the experience of being overwhelmed and overburdened is not particular to CHWs and nurses – doctors experience this too – but it affects health workers in different ways. Partly this is influenced by class dynamics and workplace power.

**FRONTLINE HEALTH WORKERS AND THE SOUTH AFRICAN HEALTH SYSTEM**

South Africa’s public health care system is severely impaired by a crisis of production, recruitment, and retention of health workers, particularly nurses (Rispel & Bruce, 2015). Addressing the health workforce ‘crisis’ is central to responding to the gross inadequacy of access to health care in the country.

The nursing profession has high levels of attrition both during and after training, and particularly in the public health care system. Some nurses leave the profession to seek employment in other sectors of
the economy or emigrate abroad (Rispel, 2015). Moreover, since the end of apartheid there has been a significant decline in the social and professional status of nursing (Blaauw et al., 2014: 18).

While shifting tasks to lay (community) health workers has served as one strategy to address staff shortages in nursing, turnover rates among CHWs often exceed 40 per cent (Nkonki et al., 2011). Much of this is due to the precariousness of their employment. During Vale’s fieldwork, for example, a passionate CHW and HIV activist left her post to work at McDonald’s, where she would have a lesser workload and greater job security (Vale, 2012b).

As the current standard in health care delivery in under-resourced African settings, community health worker programmes have been widely celebrated for their ability to improve the health of large numbers of people at low cost (Igumbor et al., 2011; Kabore et al., 2010; Nglazi et al., 2011; Williams et al., 2006). But this success depends on the ability of CHWs effectively to negotiate a highly onerous scope of work, and be retained in care work.

The understaffing of health workers, rather than being the result of a ‘skills shortage’, is a consequence of historical under-resourcing of public health facilities. This is exacerbated by organisational and power dynamics which ultimately disempower frontline health workers, and render them unable to use their specialised knowledge of patients.

Patient care represents the core of frontline health workers’ specialised knowledge. Rather than being concerned about a ‘skills shortage’, attention should be paid to these health workers, who express confidence about their specialised knowledge and commitment to deliver patient care, to the point of servicing patients even beyond their scope (Le Marcis & Grard, 2015). Frontline health workers’ roles also routinely include cultural mediation between patients and the health care setting. In both Di Paola and Vale’s research, these workers expressed concern that this unique knowledge of the caregiver–patient relationship was not valued and that their work was evaluated based on administrative outcomes (this is referred to as managerialism) rather than patient care.

While most studies of professions focus on the specialised body of knowledge that underpins each profession (Freidson, 1989), they often overlook power relations in the workplace, including class and
gender dynamics. These dynamics influence the capacity of workers in professions to assert their claim over specialised knowledge (Livingstone, 2014; Sawchuk 2017). Structural dynamics informing work in public health care, including the everyday practices of frontline health workers in deploying their specialised knowledge, deserve further attention in both academic debates and policy interventions.

**PROFESSIONAL HIERARCHIES**

Feminist scholars have highlighted the consistent devaluing of care across countries, including in relation to salaries and social status (Valiani, 2011). It has been argued that studies of the professions, in particular those concerning health workers, have sometimes reproduced the devaluation of women’s work (Davies, 1996; Halford et al., 1997).

Historically, in South Africa as well as in the United Kingdom, nurses’ legitimacy to make claims over knowledge and work has been linked to doctors’ control and ‘permission’ for them to exercise these claims (Marks, 1994). Power relations in 1880s South African hospital settings were informed by strong gender/class dynamics and were also enmeshed in racial structures. If women were to perform biological and reproductive roles in the family structure, similar tasks were given to them in hospitals. The profession was highly gendered, as exemplified by Florence Nightingale’s famous quote that ‘To be a good nurse one must be a good woman’ (Nightingale, 1881). Moreover, it has been noted that the hospital setting mirrored the archetypical Victorian family, composed of the knowledgeable father-doctor, the caring mother-nurse, and the needy child-patient (Schneider et al., 2010; Marks, 1994).

The vast majority of nurses and CHWs in South Africa are black women. More likely to be unemployed (Stats SA, 2018) and often subject to gender-based violence (Dunkle et al., 2004; Kim & Motsei, 2002), the social, cultural, and economic power of black women in South Africa is regularly and powerfully undermined. Even when

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ii The first nurses working in South Africa in the mid-19th century were British citizens linked to Christian orders. The first training institutions established in the country were also started by British sisters coming to South Africa to serve the motherland. In this sense nursing in South Africa shared a similar trajectory to that of nursing in the UK.
they are educated and employed (as nurses are), black women struggle to assert social and professional clout. In the case of CHWs, a lack of professional status and precarious employment are exacerbated increasingly by generational hierarchies, as rising numbers of young women enter community health work.

Vale observed that care delivered to older male patients by younger female CHWs, which often involved instruction, reprimanding, and probing into intimate bodily and behavioural functions, was not readily accepted. While CHWs experienced fewer difficulties asserting their authority over men in the clinic, the home space presented a significant challenge. Some CHWs reported being fearful of sexual violence when visiting a male patient. While none of the CHWs in Vale’s study could recall there having been an instance of sexual assault in a patient’s home, some had been sexually harassed. Male patients have overtly flirted with CHWs, phoning them at inappropriate times and professing their love to them. In one instance, a patient pulled down his pants in front of a CHW, and in another, a CHW was invited into a patient’s home despite him being naked (Vale, 2012a).

Workplace power is defined by Livingstone (2014) as the capacity to direct oneself and command others to achieve the goals of an organisation. This influences the ability of professionals to enclose and make legitimate claims over a specialised body of knowledge. The class position of the professional, e.g. professional owner, professional self-employed, professional manager, and professional employee, and non-professional (in the case of CHWs), impacts greatly on the level of workplace power. As professional employees (in the case of most nurses) and lay workers (in the case of CHWs), frontline health workers tend to have very little or no control over the goals or the final service of their organisations.

In the context of her fieldwork, Di Paola noticed that despite being responsible for the functioning of the ward, nurses were not consulted when strategic decisions were being made about their patients. Their autonomy was limited to the pacing of their work, but even that was further limited by heavy workloads. Sister Hlubi points to this:

_The thing is, I know, by the end of the day, I should have done_
everything; done the reports, done the books, delegations, patients’ rounds, medication rounds, vital signs, done the matron’s report because I also have to do a matron’s report. Yah. All the admissions, all the discharges, all the beds. By the end of the day, I should have accomplished everything so that when the night staff comes I am able to hand over to them (Sister Hlubi, 2017).

In both the pulmonary and postnatal wards in which Di Paola observed, the subordination to doctors is evident and not always justifiable by knowledge differentials. For instance, medical interns may have the same years of training as registered nurses, but their knowledge of patients – their experiential knowledge – is not as thorough as that of nurses. Nevertheless, medical interns make decisions over treatments, medications, and procedures, often without consulting nurses.

Di Paola witnessed several occasions when nurses reported that what was written in patients’ folders was not correct and had to be changed. For instance, during a medication round in the pulmonology ward, Sister Moyo put a large ‘X’ on what was written in the folder of a patient and wrote something else. During an interview, Di Paola asked Sister Moyo whether there was a mistake on the prescription that she was supposed to administer and, if so, who had made the mistake. She responded:

*It was the doctor. The doctor prescribes but we are also trained about the medication. We know the rules and the regulations: you can give this to this patient, you can’t give this other medication. If ever the patient, let’s say is hypertensive, Brufen is a no-no because it’s gonna make the patient worse ... Even the fluids, if ever the patient is hypertensive you can’t give Ringer’s lactate because it’s gonna make him sky high. So you have to give normal saline which will stabilise the blood pressure of the patient ... Sometimes they [doctors] just do things without any insight. They just ask the patient: how you feel? They don’t read, they don’t check the folder and then they don’t consult us (Sister Moyo, 2017).*

Also expressing frustration at nurses’ subordination to doctors, one midwife in the postnatal ward said:
I do have a problem because the doctors don’t want the advice from the nursing staff. They think they’re better, they know everything. They forget that they come here for a short period. We are the ones who stayed with this patient for 12 hours … Even if you are having an emergency, you’re the one, we’re the ones who start by attending the patient … before the doctor comes. They don’t trust anything that we tell them. They’ll be busy telling you, ‘You didn’t do medicine, I didn’t see you in Medunsa or Wits.’ They really think they [are] better than us but they aren’t (Sister Sindi, 2017).

In both wards, Di Paola encountered nurses who described their nursing cohort as being scared of doctors. An advanced midwife she shadowed in the postnatal ward talked extensively about fear among her colleagues; she said that ‘the hospital should offer training on building nurses’ confidence’ (fieldwork notes, 6 June 2017).

Similarly, as lay workers at the bottom of the professional hierarchy, CHWs in clinics struggle with confidence and with asserting their workplace knowledge. More so, the everyday proximity of carers and cared-for makes it difficult for CHWs to assert their authority or protect workplace boundaries. One of the Western Cape CHWs, Bulelwa, said:

Sometimes when you pass there [by the patients], or you do education, or you [are] just standing there outside, we’ll hear what they are saying about us: ‘These people they think they are clever. Why should they come to our houses?’ Stuff like that. (3 June 2011).

In saying that respondents ‘think they are clever’, patients may be pointing to CHWs’ performed and ascribed superiority, which is used as a means of manufacturing social distance despite living in the same community. Without accreditation or professional status, the expertise that might underwrite CHWs’ authority is called into question, both by patients and nurses. CHWs also lack those symbolic markers of authority bestowed on their professional counterparts through uniforms and technical instruments.

In the primary health care clinics where Vale observed, health
professionals continued to refer to CHWs as ‘volunteers’, calling their training and job security into question. Many CHWs believed a lack of professional qualifications discredited their knowledge, and some cited instances in which their expertise was undercut by clinical professionals. Some resented having to translate for other clinic staff, arguing that this was not part of their job description (Vale, 2012a: 5). Others said nurses behaved like ‘bosses’, rarely giving CHWs credit for their contribution to patients’ well-being (Vale, 2012a: 5).

**THE KNOWLEDGE OF FRONTLINE HEALTH WORKERS**

In recent years, South African public opinion has pointed to nurses’ poor performance and to a diminishing ethic among nurses (Hall, 1994; Armstrong & Rispel, 2015). Dissatisfaction with nurses has become a mantra in the media and in the literature (Breier et al., 2008; Armstrong & Rispel, 2015), which points to a lack of commitment and preparedness. During Di Paola’s observation, she found, in contrast to popular perspective, that nurses were highly confident about the professional knowledge acquired during their studies. Moreover, and as confirmed in several interviews, nurses consider their theoretical knowledge as empowering them in relation to other health workers, particularly doctors. For instance, in relation to pharmacology and nursing knowledge, Sister Hlubi explained that knowing your subjects and the medications well may save lives and it empowers you in the workplace:

*If you get a patient coughing up blood and severe headache, I’m not going to wait for the doctor to come and prescribe morphine. Morphine is a schedule seven, a doctor needs to prescribe that but I’m going to give morphine, and call the doctor. When he comes I’d say, ‘I’ve started morphine, just write it down’* (Sister Hlubi, 2017).

Nurses take pride in their qualifications, particularly in terms of theoretical and practical subjects. In the following quote, Sister Raja points to two important aspects of nurses’ knowledge and qualifications: first, the complexity and intensity of the degree and,
second, the importance of knowledge in claiming autonomy.

The first two years are like the stepping stones in nursing. When you get to third and fourth year it’s when you are seniors, by then you have done a lot of theory: anatomy, physiology, psychology, sociology, community nursing, and fundamentals of nursing. From third year the course is way more pressurised and compact, then you must be independent, you have to do everything yourself, you have to make decisions. If I’m being immature, unknowing [it means I] can’t be independent, responsible. If you don’t know things you can’t be independent. Knowing your subjects gets you into looking after a patient holistically. So, theory helps with that (Sister Raja, 2017).

The nurses Di Paola interacted with valued their knowledge as a weapon to claim autonomy and assert power within a specialised body of knowledge – that is, the knowledge required to nurse patients. These data on nurses’ perceptions of their education and knowledge, supported by the researcher’s observation of their challenges at work, suggest findings contrary to the skills shortage discourse: professional nurses do not see their knowledge as weak and do not point to a need to strengthen their theoretical knowledge.

In the context of the ‘nursing crisis’ and the government’s focus on the supply of nursing skills, findings pointing to the fact that nurses are confident of their knowledge of theoretical disciplines compels us to explore power dynamics in the workplace and in society with the aim of recognising nurses’ knowledge-based contribution to the hospital setting. Livingstone (2014) points to the continuum of disempowerment certain professions may experience in society and in the workplace: if specialised knowledge in nursing is not socially recognised, it cannot be translated into workplace power.

Staff shortages and heavy workloads, as well as the wider imperatives of new public management (described in the next section), have direct consequences for nurses’ ability to deploy their specialised knowledge through activities like patient education.

As part of their scope of practice, nurses educate patients on health,
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hygiene, nutrients and, in the case of postnatal care, how to breastfeed, monitor a caesarean section wound, and other important aspects of the mother’s and child’s health (see Esterhuizen, 2016). During Di Paola’s observation, she appreciated how educating patients was something nurses always tried to make time for, as reflected in her fieldnotes:

While administering the immunisation, Sister Busisiwe explains every step to the patients. She takes the immunisation round as an opportunity to educate patients about the importance of early pregnancy detection and testing; she explains that they advise mothers to register at hospitals or clinics after the first period missed and to get tested straight away; in this case whether they are RVD or RPR positive, which may suggest HIV and syphilis respectively, they can start treatment and the child will be healthy. If they don’t get tested they won’t know if they are positive; in the case of syphilis, if they don’t take medications the child may be born blind or have severe skin disorders (field notes, 16 August 2017).

Today, due to shortages of doctors in South Africa’s public health institutions, nurses’ scope of work has extended to meet the needs of the population. In general terms, although South African nurses undergo longer training, due also to structural shortages of other health professionals, a tension remains as to what they are formally requested to perform in terms of nursing practice, and what they find themselves doing, the latter being more complex than what is institutionally acknowledged.

Educating patients takes a specific form in South African public health facilities. Nurses play the role of educators as well as translators. Their role blurs into one of cultural mediators reflecting the socio-economic inequalities, as well as the differences in terms of languages, and cultural beliefs between nurses and doctors in hospitals.

Nurses describe their role as facilitators in the communication between doctors and patients, first in terms of language, but also in terms of values and beliefs. This role is rooted in the history of nursing in South Africa, in which nurses were identified as conduits between Western and traditional medicine (Horwitz, 2013). In the ward, they play a highly specialised, albeit unrecognised, role as cultural mediators,
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as their predecessors did during colonial and apartheid times.

In order to understand this aspect of the work and knowledge of nurses, it is important to appreciate certain specific characteristics of the South African public hospital setting. It reflects society’s divisions and inequities which are enmeshed with racial and class relations. The majority of patients in the hospital Di Paola conducted research in are black African and coloured people from disadvantaged socio-economic backgrounds, whereas doctors are mostly white, Indian or black foreign nationals. Communication between doctors and patients is impaired not only by language, but also by socio-economic and cultural divides. The nurses’ mediator role between doctors and patients entails the mastering of scientific knowledge, English and African languages, as well as cultural differences. This is reflected in the following example:

*During the patients’ round in pulmonology the doctor was explaining to a 54-year-old woman, suffering cardiovascular diseases and lungs malfunctions, that she had to stick to a low-fat and low-carb diet. The patient would understand and speak English but she was visibly perplexed by the core message the doctor was trying to convey. Sister Hlubi, who was accompanying the doctors on their round, decided to explain to her what the doctor meant and gave her several examples of ‘good food’ and ‘bad food’. By the time she was finished the doctors had already visited two more patients without Sister Hlubi (field notes, 26 June 2017).*

Combined with their language versatility, the knowledge nurses acquire during their studies gives them a unique ability to convey the required information in ways that patients can grasp more easily. At the same time, nurses share, or at least are profoundly aware of, patients’ values and beliefs. They are positioned in a liminal space between scientific and cultural knowledge and because they master both they can mediate between the hospital setting’s protocols and patients’ needs.

Similarly, CHWs in Vale’s study (see Vale, 2012c) felt confident in their ability to know and understand the needs of patients better than their nurse counterparts in the clinic. This is partly because they
are recruited from the same communities as patients, and because they spend significant time in patients’ homes. One CHW, Caroline, remarks: ‘It is good [to work in the community where you come from] because you know your community. You know […] their belief[s], their religions. […] You must understand most of your people’ (8 June 2011). CHWs believed their knowledge of their target population aided in the delivery of quality care.

As will be explored in the sections that follow, such unique caregiving skills are not part of the evaluation and auditing system. Instead, they are largely taken for granted or brushed off by other health professionals. Nurses find themselves in a position where they are asked to perform tasks that are not technically part of their scope of practice, even though they have become essential to delivering on this scope, e.g. translating and mediating. Yet these tasks are sidelined by the system, significantly undervalued, and go largely unrecognised. This lack of recognition of their expanded role aggravates nurses’ low morale and stress levels.

NEW PUBLIC MANAGEMENT

Management reforms in health care, which have been taking place internationally since the 1980s, and in South Africa since the 1990s, have allocated greater power to managers. This has elicited concerns among health professionals, as efficiency and financial soundness goals have seemingly surpassed the need for patient care. Under the new public management, public services have been increasingly encouraged to behave like businesses, aimed at efficiency and performance management measured in terms of administrative rather than clinical goals.

New public management and managerialism have been a global feature of the restructuring of the state under neoliberalism (Saad-Filho & Johnston, 2005; Eagleton-Pierce, 2016), including the restructuring of health care provision (Norrish & Rundall, 2001; Valiani, 2012; Sawchuk, 2017). Public sector reforms started in South Africa with the first democratic Public Service Act, promulgated in 1994, and are still ongoing (Pearson et al., 2016; Naidoo, 2016).

Over the course of the 1990s and 2000s, several legislative and
policy measures have been adopted to achieve new public management principles of efficiency, effectiveness, and accountability. Performance-based and results-orientated principles have been adopted, while market-based mechanisms to implement accountability have replaced democratic devices based on professionals’ authority (Chipkin & Lipietz, 2012). These reforms have implied that managerial structures as well as the following of rigid procedures have gained importance in the running of the hospital, while professional employees are subjected to stricter accountability measures to achieve cost-containment and efficiency goals. As a result the role of managers, at different levels, acquired unprecedented importance (Klikauer, 2013) at the expense of the role of professional employees. In terms of labour relations and organisational structures, hospital employees, including health professionals, have been organised into a silo system of accountability and subjected to a management and evaluation system based on outcomes (Von Holdt, 2010; Carvalho, 2014; Chipkin & Lipietz, 2012). As a result, power relations in the workplace are altered by the adoption of new public management devices: while managers and managerial procedures acquire greater importance, clinical care drifts away.

As Di Paola’s research indicates, the reforms that the public hospital sector has undergone internationally and in South Africa have had a profound influence on the labour process in terms of the nursing model adopted (Sawchuk, 2017). Nursing models included the total patient care model used in many institutions until the mid-1990s when it was largely replaced by task-based nursing when shortages of registered nurses began to be felt (Dr Armstrong, interview, March 2018).

Historically, there has been an assumption that professional health workers only look after patients, somewhat overlooking the cost impacts of clinical activities, while administrators focus on the financial and organisational soundness of hospitals and overlook clinical results. Recently, clinicians have critiqued the growing power of managers and ‘managerialism’ for focusing on financial orthodoxy thereby compromising the quality of their clinical practice (Doherty et al., 2014). The displacement of the nurse–patient relationship that nurses point to may result from an over-emphasis on efficiency at the expense of quality care.
The nurse–patient relationship has always been a fundamental aspect of nursing (Henderson & Jones, 2017). Nurses establish and maintain this relationship, drawing on their professional knowledge and skills and, at the same time, applying the fundamental ethical principles of nursing care. The main ethical principles, as defined by the nurses’ scope of practice, relate to the protection of the patients’ rights (as human rights) and the empowerment of patients, even beyond their stay in the hospital setting, specifically through patient education (DoH, 2013). Always having been centred on the nurse–patient relationship, the nursing profession in South Africa underwent a significant broadening of its scope in the last three decades of the 20th century, as reflected in the regulations to the Nursing Act of 1978, issued in 1984 and amended in 1987, 1990 and 1991 (SANC, 1978) in relation to the nursing curriculum and the nursing practice.

Structural dynamics, such as organisational and managerial reforms ascribing to new public management, have greatly impacted on the running of the public hospital setting and on nurses’ work (Von Holdt, 2010; Carvalho, 2014). These dynamics may not be mirrored in the formal scope of practice, yet they have prompted significant change in nurses’ actual work and knowledge. The material and organisational conditions under which nurses work are reshaping their practice away from the nurse–patient relationship and towards a greater emphasis on administrative and managerial tasks, based on efficiency and cost containment.

Vale’s (2012c) research suggests that the mandate of efficiency, cost containment, and administration has placed similar pressures on CHWs in primary health care clinics. This is exacerbated by the fact that many CHW programmes, including the one studied by Vale, are co-funded by major international donors who set their own targets and reporting standards.

In the sections that follow, we outline how cost cutting, along with the prioritisation of particular performance measures, have delimited frontline health workers’ ability to provide quality care and fully utilise their expertise.

Cost cutting
Although much of the debate on the nursing crisis is tilted towards
skills shortages, austerity measures and cost-containment goals at the provincial level, and consequently at the hospital level, are major contributors to the crisis. In fact, despite the greater role acquired by hospital managers and managerial structures, hospital CEOs have little autonomy when it comes to budgets. In his research on the role of hospital CEOs under new public management, Naidoo (2016: 115) argues that:

As far as staffing is concerned, CEOs in the majority of provinces can replace staff that leave during a financial year, but any new staff appointments have to be motivated for at head office\textsuperscript{iii} ... All new posts and unfunded vacant posts need to be approved by head office before filling them.

Budget cuts for tertiary hospitals, like the one in which Di Paola conducted fieldwork, are aggravated by the shifting of resources from tertiary to primary health care, in order to redress the legacy of apartheid without increasing expenditures. As a result, Von Holdt and Maserumule (2005) argue that in tertiary care institutions shortages of nurses are rampant, and today public health workers are subjected to workloads that are, overall, far greater than those experienced by those who work under market pressures in manufacturing and other private industries.

Nurse shortages in an institutional environment marked by new public management translate into heavy workloads and stressful conditions, which add to nurses’ emotional labour (Schneider et al., 2010). Shortages in the health profession, particularly the shortage of nurses, have significant consequences on workloads, nurses’ work satisfaction, and, ultimately, service delivery (Khunou & Davhana-Maselele, 2016). In Di Paola’s interaction with nurses, she observed that they perceive the workloads they are subjected to as unbearable:

This week I did night shifts. I worked 84 hours ... in a week ... and it’s too much for a normal human being, it’s too much. And they expect you to excel in everything (Sister Busisiwe, 2017).

\textsuperscript{iii} Head office refers to the provincial Department of Health, which liaises directly with the National Treasury.
Health worker shortages at the hospital level are exacerbated by poor information systems on recruitment and retention of health professionals, particularly nurses (Rispel & Bruce, 2015). This was confirmed by one of my key informants, a health researcher, who said:

_Major shortages of health workers that affect public health are only partly documented because of a lack of updated standards and norms on the minimum number of health workers required for each clinical setting (Dr Armstrong, interview, April 2017)._ 

This key informant had been involved in a study on nursing norms commissioned by the Department of Health; the study was indeed aiming at identifying the right number of nurses needed in a hospital setting, considering the population to cater for. The informant explained that:

_When the study released the first figures to head office, those figures were dramatically higher than the number of nurses actually employed. As a result of the discrepancy between the number of nurses needed and the capacity of the national or provincial departments to release additional funds to create more posts, the recommendations were not implemented. The study was interrupted (Dr Armstrong, March 2018)._ 

Cost-cutting measures remain pervasive not only at the provincial DoH head office but also at the level of the hospital. A culture of austerity may trigger the early discharge of patients. During Di Paola’s observation, early discharge was suggested several times in order to make space for new patients and to meet cost-saving goals. Often patients were discharged even when not fully recovered and asked to come back to do the exams necessary to establish a medical therapy. This is reflected in the fieldwork notes:

_During the morning round, a patient suspected to have a lung tumour is waiting for a CT scan. The consultant asks the registrar (and not Sister Nancy) if they have enough beds to keep the patient_
until he gets the scan. The registrar responds: ‘We’re just surviving.’

Hence, the consultant tells the patient she can go home and come back in two days for the CT scan (field notes, 19 July 2017).

This excerpt reveals a practice in which nurses are asked to arrange early discharges in order to meet cost-cutting goals. Such a practice creates ethical dilemmas for nurses as they are, according to the Nursing Scope of Practice (South African Nursing Council, 2005), fully responsible and accountable for ‘the provision of comprehensive nursing treatment and care’, ‘protection of the human rights of individuals and groups within the health care environment’, as well as for ‘the creation and maintenance of an enabling environment for ethical practice’.

Cost-cutting and staff shortages have also been central to the debates surrounding a national level community health worker Policy Framework (DoH, 2017), which will be a crucial component of delivering on primary health care. On the one hand, government, which has often outsourced the employment of CHWs to NGOs, has been encouraged to employ CHWs more directly to standardise the programme across the country and grant decent wages. This would also be a cost-efficient way to deliver on many of the ambitious primary health care goals. But cost-cutting incentives will also limit the number of CHWs that can be employed. Already, draft policy prescriptions about household coverage and CHW workload are of major concern. Most recent suggestions are that each CHW will be responsible for 250 households, with little indication as to how often these homes should be visited. To add to this, CHWs’ scope of work is intended to include HIV/TB care, maternal and child health, chronic illness support, lay counselling, household screening, health promotion, palliative care, social service referrals, and administrative tasks. Many worry that the management of these tasks will result in reduced contact with patients overall (Vale et al., 2017).

The hardships incurred from cost cutting are exacerbated by the socio-economic conditions of South Africa’s public health patients. The vast majority of public health care users are socio-economically vulnerable (Nambiar & Mander, 2017). From this point of view, heavy workloads in the context of cost-cutting measures, such as early discharge, expose nurses and community health workers in public
health settings to renewed strains linked to emotional labour (Valiani, 2012; Smith, 1992) and related stress.

As Di Paola notes, nurses are aware of their contribution to the functioning of the ward and the fact that taking leave, including sick leave, may have a negative impact on the work of the other nurses. Moreover, shortages impact on the way in which shifts are organised and have important consequences for nurses’ lives beyond the workplace, as well as affecting their morale. Sister Sindi in Di Paola’s study points to: ‘The worst part of our job is little family time. The shifts can be awkward and difficult to organise your time when you’re not at work’ (Sister Sindi, 2017).

Community health workers in Vale’s study also felt a heavy emotional burden about being unable to relieve their patients from the stresses of poverty. One CHW, Miriam, said:

*Yoh! You feel bad, man. You feel bad. It seems you can take the client with you to stay with you. But even you […] like I’m earning this stipend. How can you take another person to stay with you? You get so little money (Miriam, 24 May 2011).*

Jacob, another community worker, described his emotional distress in this way:

*You refer the patient […] The social worker played his/her own role into this situation. [But] still the problem is still there […] and there’s nothing I can do about it. That is what is killing me the most (Jacob, 29 April 2011).*

In a 2017 scoping review, Vale found that this experience continues to be reported by numerous CHWs across the country, and that many spend up to 5 per cent of their small stipend assisting patients with basic household needs.

**Paperwork**

In the context of new public management, performance measures in the form of extensive reporting and auditing are believed to ensure the
viability of health care practice. Meanwhile, the caring work of frontline health workers including their role as translators, cultural mediators, and educators often remains invisible to the health care system, hospitals, and clinics in which they work (Toffoli et al., 2011), precisely because it goes unmeasured. The reality of staff shortages and heavy workloads, described earlier, is also characterised by an emphasis on administrative tasks.

Di Paola observed the increased pressure this put on nurses, who would occasionally respond to these pressures by rushing nursing tasks in order to resume and complete administrative tasks by the end of their shifts. As a result, a causal relationship can be drawn between heavy workloads, the emphasis given to administrative tasks, and the compromise to nurses’ core activities. This is exemplified in the following excerpt of Di Paola’s fieldwork notes:

At the end of the meeting that we attend together, Sister Hlubi gets back to her morning reports: she is late in submitting them. Soon a patient arrives in a mobile bed; he’s been sent from ICU without notice. Sister Hlubi has to organise for him to be admitted and to record admission before getting back to her reports. The patient suffers from asthma. He must have had a severe asthma attack. He needs to be on oxygen and has a catheter. The patient arrived naked from ICU, he needs to be dressed. Sister Hlubi helps the auxiliary nurse to find him a bed (they get one from a female cubicle). Then she approaches the patient, addresses him in isiZulu, she prompts him to stand up and seems impatient because he struggles to follow her instructions. She swiftly takes the oxygen out, helps the patient getting dressed and puts the oxygen back on. Her manners are harsh (fieldnotes, 6 July 2017).

As Sister Hlubi would later explain, she had been under pressure to submit her reports. Yet, as the shift leader, she was also the one best positioned to admit the patient and stabilise him. Drawing on her nursing ethics and knowledge, she put aside her administrative responsibilities and attended to the patient’s needs first. She wanted to make sure the patient was stable and secured on his bed. In a context of heavy workloads, the nurse decided to prioritise her core nursing
tasks over her administrative tasks, and as a consequence was brisk and disrespectful to the patient.

Despite the assumption that nurses need to be upskilled to keep up with the changing needs of the hospital settings, in the course of Di Paola's fieldwork, she noticed that new public management has entailed routinisation and new forms of control over nurses’ work due to the emphasis given to strict procedures, data capturing, and reporting. According to Gorman and Sandefur (2011: 282), ‘rationalisation and codification also have implications for expert occupations’ ability to maintain control over ‘their bodies of knowledge’. In the case of nurses, strict procedure and the focus on ‘paperwork’ come at the expense of the nurse–patient relationship which lies at the core of nurses’ specialised body of knowledge, thus challenging the scope of nurses’ professionalism. An excerpt from a discussion with Sister Smith is illuminating:

Sister Smith tells me how much she hates her job and she states that she does it only to service the patients although nobody seems to care. ‘The pay is terrible and your work is never acknowledged. The biggest problem is management, even your own area manager attacks us all the time. It doesn’t matter how many people in terrible conditions we treat … they come with health, family, and all sort of problems that make our work even more difficult but that doesn’t matter, it’s only about papers. “The papers aren’t right, you can’t write a proper report,” that’s what they [management] say. ‘And we never stop writing, we compile reports all the time and then we have to submit a paper on each report we have written’ (field notes, 21 June 2017).

Nurses talk about ever more pressing obligations to follow strict procedures and document every single decision they make and task they perform. During their day shift, nurses take vital signs every four hours, and again three times a day when they give medications to the patients. Each and every task performed and all information collected is captured in the patients’ files. In addition to writing their activities in the patients’ files, nurses write three reports per day where they fill in all the tasks performed. For each report compiled they have to write a letter stating
that the report was submitted. The same protocol applies to the night shift.

As a result of changes in the health system and in the institutional environment, including a new emphasis on administrative and managerial tasks, nursing professional skills as well as the founding ethical principle of the profession, of treating the sick, may be eroded. Professional nurses are constantly under pressure to make decisions as to whether they should prioritise their core nursing activities or their administrative tasks (Sawchuk, 2017).

The monitoring and evaluation system in place perpetuates fragmentation, and emphasises administrative tasks over nursing work. As results-orientated practices are adopted, results-measuring processes, such as performance management, acquire importance in the running of the hospital and in the organisation of nurses’ work. At the same time, clinical activity receives progressively less attention than the following of rigid protocols. Moreover, nurses are subjected to two types of evaluation: the auditing of nursing units based on the National Core Standards for Health Facilities in South Africa (2011) and the evaluation of the individual nurse through the Nursing Records and Performance Management and Development System. According to one of Di Paola’s key informants, an academic researcher in nursing, both require following long processes of recording and reporting, but fail to mirror the amount and the quality of nursing activities performed in the workplace: ‘professional nurses end up nursing papers not patients’ (Dr Armstrong, interview, 2018).

The ward-auditing system reinforces the emphasis on administrative tasks at the expense of nurses’ relationship with patients. Wards are audited often and without warning. Audits, or inspections, may be performed by an external or internal inspection team or as part of an internal self-assessment process. The so-called five keystones of the auditing process are: the client, teamwork, focus on data, focus on system, and processes. The auditing consists of an examination of the compliance to data capturing protocols and reporting systems.

Overall, the auditing and evaluation systems contribute to the displacement of the nurse’s relationship with patients. As we have shown in the previous sections of this chapter, structural changes in public health provision have had a pervasive impact on the organisational environment of the hospital as well as on the culture of clinical care provision. These
changes pose new challenges to the professional power of nurses in the workplace, and in society, as they negotiate social recognition of their specialised body of knowledge. The new hospital organisational structure and its culture, and what these entail in terms of work intensification, fragmentation, and the principles underpinning work evaluation, do not stem from professional principles and values but from a managerialist approach to service provision, as it is seen in studies on professionalism in the neoliberal era (Carvalho & Santiago, 2015; Baines et al., 2010). As happened in other contexts, for instance among Ontario nurses working in public health in Canada as studied by Sawchuk (2017), new public management reforms deeply affect professional power by affecting workplace practice, even if they do not entail substantial formal adjustments to the professional scope of practice. Rather, adjustments occur in the form of ‘a dynamic that changes ongoing professional judgement-making, changes the professional practice of attention and dis-attention to specific tasks, skills and knowledge in such a way that professional knowledge (and identities) as a whole become significantly reformulated’ (Sawchuk, 2017: 13).

A very similar set of managerial practices have entered South Africa’s primary health care clinics. As a result of funders’ reporting requirements, the success of CHW care programmes, like the one Vale observed, is often measured in terms of outcomes, particularly the number of patients enrolled, visited, and retained in the system. Quantifiable proof is required in order to demonstrate work completed. ‘We are told that it is important to fill in the forms because […] it’s proof […] there are funders to the organisation, so you need the forms […] as back up that you are doing the job,’ said Jacob, a 23-year-old community health worker (28 June 2011).

While the utility and efficacy of the care provided is assessed on the basis of quantitatively reported outcomes, the content of care appears to be given less attention. Illustrating the potential consequences of this, Andile (another male CHW) spoke about the number of home visits he completes per day:

*The most I’ve done on one day was 11. Because why? Sometimes you don’t find the people, so there’s no wastage of time. Then you*
go to the following [visit]. Sometimes you do find six out of those 11 [patients at home]. So four they are also visits even though [no one was home] (interview, 7 June 2011).

Here Andile suggests that when he does find his patients at home, it is possible that time might be ‘wasted’ talking. But if no one is home, ‘there’s no wastage of time’ and the visit is still recorded in daily statistics. Hence cost efficiency is measured in terms of the number of visits a CHW is able to complete (or, more accurately, report) in one afternoon. Ironically, this goal is impeded when CHWs spend quality time with patients.

Hence, in an effort to provide good care (defined by meeting measurable targets), CHWs run the risk of providing an uncaring service. While Andile’s excerpts seem to imply a commitment to outcomes-based, quantity-driven care, it may be that Andile is simply expressing the pressures of working within a target-driven paradigm. His supervisors expect reports that reflect a high number of visits completed.

Similarly, while nurse supervisors and managers of the CHW programme promote a target-driven, measurable, and numbers-orientated approach to care in order to meet the reporting needs of funders, they also make claims that CHWs should be compassionate and take their time. This further highlights the tensions and complexities of the prescribed practice of care. Joan, a supervisor of the CHW programme, said this:

*If you’ve been to a clinic, everything happens fast and there’s very little time that this Sister and this counsellor can spend with a patient. So if we can get that relationship building […] with the CHWs – because you do find patients saying, ‘You know what, I didn’t have a chance to ask the Sister this’* (17 March 2011).

The trouble is that this relationship building, which clinic-based nurses no longer have time to do (and was in this instance deferred to CHWs), is eroded regularly by the demands of managerialism. As with the hospital nurses in Di Paola’s study, Vale observed that CHWs were similarly burdened by administrative work. The quantity of
paperwork that CHWs were expected to process meant that 50–60 per cent of carers’ daily activities were consumed by administration. The paperwork load had become overwhelming for many CHWs, who complained of having no time for their families or part-time study. ‘We are not laptops,’ Miriam, a CHW, remarked.

**RESISTANCE**

Despite relatively little power in the professional hierarchy, frontline health workers in both Vale and Di Paola’s research felt a great responsibility towards patients and tried to put their patients’ interests first. As Sister Nancy explained:

*The patient doesn’t know things, he cannot talk. I need to talk on behalf of the patient. When we were in college they used to tell us, ‘You are the advocate of that patient’* (Sister Nancy, 2017).

In so doing, nurses draw on their professional knowledge and scope of practice to assert their specific role and related power (Carvalho, 2014). During Di Paola’s fieldwork, she noted that older and highly experienced professional nurses or specialised nurses, such as advanced midwives and neonatal nurses, took very seriously the need to resist subordination to doctors. It may take a deferential form, consistent with the historical role played by nurses in hospitals, or it could also take a more confrontational form, as Di Paola observed in the postnatal ward. Here, interactions between nurses and doctors are less structured and they appear more confrontational. There are advanced midwives who feel entitled to carry out certain procedures, e.g. inserting a drip, and who express disapproval about what they perceive as under-recognition of their work and practical knowledge.

In the context of managerialist-driven adjustment to the nursing practice in the workplace, drawing on scientific knowledge to challenge subordination, and putting patients first, as in the traditional professional scope of nursing, could be seen as avenues of resistance. When nurses put the interests of patients first and use this to challenge authority they are also stating the centrality of nursing care to protect
their professional boundaries and to reassert power in the workplace as based on their professionalism.

In certain instances, as seen among some nurses in Portugal in response to new public management reforms, nurses use professionalism as a tool of resistance:

*The way care, and the scientific knowledge associated with it, is identified as the specific domain of nursing, is a strategy to retain control and autonomy over their work in the face of the presence of potential threats from management* (Carvalho, 2014: 532).

Although they are under pressure to submit reports several times a day, Di Paola observed instances in which nurses resisted the pressure and prioritised patient care. The alternative to this scenario is to accept the fragmentation and delegate a large part of their core nursing activities to nurses’ auxiliaries, who have a lower level of training. Nurses were often torn between different activities and tasks and had to make constant decisions on what to prioritise. This entailed new forms of judgement-making in which they had to negotiate an ethical dilemma: continue nursing patients as they have learned to do, or give up that role and focus on the administrative tasks by which they will be evaluated. Despite the pressure to write and submit reports, nurses may try to organise their work in a way that their nursing tasks are dealt with first. This is one of the ways in which nurses assert their professional power and specialised knowledge, amid managerial pressures. The conflict between managerialism and professionalism may well affect the pace and quality of a nurse’s performance.

Similarly, Vale (2012c) observed that CHWs in primary health care clinics sought strategies to resist administrative demands. Like many CHWs, Caroline felt immense anxiety at the prospect of returning to the clinic with nothing to report. Despite her supervisors having condoned it, she did not subscribe to the practice of recording as visits cases in which patients were not found. This was her subtle tactic for protecting the definition of care having been provided. Articulating his frustrations with the target-driven reporting demands, Andile, another CHW, said:
The most important part [of my job], they [our supervisors] say it’s the visitation. But the most important part to me is not about the visits. It’s about are they doing well? Are they taking their medication correctly? (7 June 2011).

Amid a highly bureaucratised system of care, CHWs found ways to strategise and improvise, appeasing authorities while attending to other pressures (see also Livingstone, 2012). Sinazo, a Western Cape CHW, admitted that she sometimes cheated the system, choosing not to fulfil all the paperwork requirements: ‘I’m not doing all the paperwork […] I don’t follow all those procedures’ (17 May 2011).

CONCLUSION

Drawing on case studies of community health workers and hospital nursing professionals in South Africa, this chapter has argued that, despite the vital contribution, and unique knowledge, held by these frontline health workers, structural dynamics related to professional hierarchies, historical underfunding of public health services, and new public management have served to undermine the care that health workers provide. As a result, retention of these essential care providers is threatened along with patient care. This has indelible consequences for epidemic preparedness, both in South Africa and further afield. More so, given that nurses and community health workers are the core of health staff across Africa, the implications of these South African case studies are far-reaching.

Experience from epidemic outbreaks in resource-limited settings illustrates how essential it is that frontline health workers are able to prioritise the patient–provider relationship. When a cholera epidemic strikes in Haiti, for example, nurses are reported to be in far greater demand than any other health professional (Fisher et al., 2014). The key functions for nurses during a cholera outbreak include direct patient care, offering counselling and emotional support to patients, as well as family education. As this chapter has illustrated, these functions are also at the core of South African nursing practice, but are thwarted by underfunding, managerialism, and under-recognition (Fisher et al., 2014).
Similarly, the success of CHWs in combating the Ebola epidemic, particularly in Liberia, has been attributed precisely to the fact that they were embedded in communities. Following the height of the Ebola outbreak, public health experts recommended greater investment in CHWs (Perry et al., 2016). In order to be effective, however, these investments would need to ensure that the relationships between CHWs and communities are maintained. The same will be true to ensure the ongoing efficacy of community health worker programmes in South Africa.

Di Paola’s fieldwork has provided significant insights into contemporary constraints on South African nursing practice, and specifically into factors which could affect the readiness of these frontline health workers to assume roles of countering epidemics if or when they occur. Most scholarly work on professions focuses on the specialised body of knowledge that underpins a profession, but overlooks the power relations in the workplace that influence the capacity of professionals to assert their claim over specialised knowledge (Livingstone, 2014). In the case of power dynamics between nurses and doctors, Di Paola observed a tension between the institutionalised subordination of nurses to doctors, and the practised power of nurses who often have to make decisions in the interest of patients in the absence of doctors. Nurses use their knowledge to make these types of judgements, but they may be doing so in contravention of formal regulations, stretching their scope of practice. Considering the level of biomedical scientific preparation nurses undergo in their four-year studies and the knowledge they further acquire in the workplace, extending the scope of practice for experienced nurses could be envisaged; this could aim at including powers and decision-making processes that already take place in practice.

Despite some differences between the pulmonary and postnatal wards, the labour process and the related power dynamics in both shared several similarities. Di Paola observed that nurses’ daily working, making judgements, and knowledge (Smith, 1987; Sawchuk, 2017) were largely influenced by structural economic conditions due to cost-containment goals, such as early discharge of patients and ‘managerialism’. The material conditions and institutional setting under
which nurse employees work affected their ability to make legitimate use of their multidimensional knowledge, to establish a sense of reward and belonging to their professional work, and ultimately to do their work well. The nurse–patient relationship was affected and as a result patient treatment was impaired. The chapter has argued that, due to pressures emanating from managerialism, including diminished power in the workplace, under-recognition, and cost-cutting goals, the core of nursing knowledge is displaced and the nurse–patient relationship is affected.

Vale’s (2011/2012) fieldwork, as well as her recent review (Vale, 2018), suggests that many of the dynamics that Di Paola observed among nurses in tertiary hospitals are mirrored for CHWs in primary health care clinics. These dynamics are critical considerations in ensuring high levels of preparedness of health care systems in the event of epidemics outbreaks. At the centre of CHWs’ role in clinics is their unique relationship with patients. Relative to other staff in the clinic, they spend the most time with patients, and have unique knowledge of their needs, context, language, and culture. CHWs are the only members of the clinic staff who visit patients’ homes. CHWs must find tactical and sensitive ways to assert their workplace knowledge and authority in contexts where they are not only intruding on patients’ private lives but are also often recognised members of the patient’s community. Despite what CHWs gain from the time spent in patients’ homes, they often feel their expertise, and experience, are dismissed by the clinic when important decisions are being made about patients. Without accreditation, uniforms, or even secure employment, CHWs struggle to make a case that their knowledge is valuable. To add to this, the work of patient care, where their experiential knowledge lies, is often eroded by unrealistic targets for the number of patient visits to be completed per day, and the paperwork burden they have to carry.

This chapter has shown that the essential, and unique, contribution of frontline health workers to the functioning of South Africa’s public health system is being undermined by a number of significant structural burdens: first, that their work is undervalued and often unrecognised. This is frequently tied up in professional hierarchies, as well as their class, race and/or gender position relative to other
health staff. Second, cost-cutting imperatives, heavy workloads, and numerous administrative tasks burden frontline health workers with significant dilemmas: having to choose between direct patient care and meeting the requirements of their supervisors. These pressures have significant implications not only for the retention of frontline health workers, but ultimately for patient health outcomes in situations of outbreaks of epidemics.

Any successful strategy for the future of South African health care, and indeed epidemic preparedness across the continent, will need to nurture and strengthen frontline health worker programmes. It must prioritise patients over paperwork, pursuing clinical and care goals, rather than efficiency and cost-saving targets. In addition, it must work to address class and gender injustice, both beyond and within health facilities. Empowerment of frontline health workers should be institutionalised and governing bodies, from the national treasury to national and provincial departments of health, should come to terms with the fact that in many cases poor health outcomes and health provision failures are systemic, as outlined in this analysis. Finally, frontline health workers should be recognised, valued, and supported, since prevention, control, and treatment of epidemics rests very much on their shoulders.

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The last section of the book explores several interrelated issues that concern the future of health systems in Africa. A core emphasis is the potential of groundbreaking technological innovation in building strong health systems and addressing the efficient treatment of epidemics. It further addresses the issues around financing of health care, all with a view to building stable systems that will also embrace the poor and destitute. The common thread in this section is access to quality health care, first through faster and cheaper medical technologies and, second, through a form of national health insurance. To explore the potential of technological innovation in health systems, the first chapter maps briefly the state of health research in Africa and reveals the insufficient number of researchers on the continent. This is despite Africa bearing a large burden of disease.

Zamanzima Mazibuko and Steven Mufamadi explore the two