CARING FOR CAREGIVERS:

DEVELOPING A PSYCHODYNAMIC UNDERSTANDING OF A PROCESS OF STAFF SUPPORT FOR PRIMARY HEALTH CARE WORKERS

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Dissertation presented for the degree of Doctor of Psychology at the University of Stellenbosch

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STATEMENT

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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SUMMARY

The South African primary health care (PHC) system is in a period of transition. This, and the growing HIV epidemic, place tremendous strain on PHC workers in public health services. Staff morale is low and this results in turnover and poor quality of care. Therefore, staff need to be supported, so that they are better equipped to provide quality care for patients.

This dissertation describes a process of action research that aimed to explore possibilities for staff-support interventions to health teams in the public PHC sector. Data were collected through in-depth interviews, group interviews, focus group discussions and consultation sessions, with health staff and middle managers. Data were analysed using a grounded theory approach, with the assistance of the Atlas.ti 4.1 software package. The interpretation of data was informed by psychoanalytic and open systems theories.

Four cycles of action research were conducted. The first action stage involved a qualitative assessment of the nature of stressors in the PHC system. The second action stage describes the experiences of two staff teams from a health prevention clinic and a day hospital (curative service) as they prepared to merge and integrate aspects of service delivery. In the third action stage the research team explored the feasibility of a short programme aimed at building capacity amongst middle and facility level managers to act as containers for staff stresses. However, due to external factors the programme was not completed. The final action stage describes interviews with selected participants to reflect on the effects of the current action research process on them and their work.

The current research suggests that a psychodynamic approach may be a useful component of action research in health settings. This approach makes room for interpretation of unconscious processes in the stress experiences of health workers, and has the potential to move health staff and management to alternative modes of functioning and coping.

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OPSOMMING

Primêre gesondheidsdienste in Suid Afrika is tans in 'n proses van transisie. Die toenemende druk wat die VIGS-epidemie op gesondheidsdienste plaas, maak dit eweneens moeilik vir gesondheidswerkers om aan te pas by 'n gedurig-veranderende stelsel. Dit bring mee dat moraal laag is, baie werkers die publieke sektor verlaat en gehalte van dienslewering verswak. Hierdie situasie noodsaak dat programme ontwikkel moet word om gesondheidswerkers te ondersteun in hul werk, sodat hulle beter toegerus is om kwaliteit sorg aan pasiënte te verleen.

Hierdie proefskrif beskryf aksienavorsing wat gedoen is met die doel om ondersteuningsprogramme vir gesondheidswerkers en hulpwerkers in openbare primêre gesondheidsdienste te ontwikkel. Individuele en in-groepsverband in-diepte onderhoude, asook fokusgroepbesprekings en konsultasies met gesondheidswerkers en middelvlak-bestuurders is gevoer om data in te samel. Data-ontleding was gedoen volgens die gegronde teorie aanslag en die Atlas.ti 4.1 sagteware pakket is vir hierdie doel gebruik. Teorieë van psigoanalise en oop stelsels is deurgans geraadpleeg met die interpretasie van bevindinge.

Die navorsingsproses bestaan uit vier siklusse van aksienavorsing. In die eerste navorsingsiklus is die aard van stress in the publieke primêre gesondheidstelsel ondersoek. Die tweede siklus behels 'n beskrywing van die ervaringe van twee personeelgroepe soos hulle gereed gemaak het om aspekte van hul onderskeie dienslewering te integreer met die oprigting van 'n gemeenskaplike gesondheidsentrum. Die derde siklus beskryf die implementering van 'n kort program wat gerig is daarop om middel-vlak en diens-bestuurders vaardighede aan te leer om personeel beter te ondersteun. Eksterne invloede het meegebring dat hierdie opleidingsprogram nie ten volle uitgevoer kon word nie. In die finale siklus is onderhoude met geselekteerde deelnemers gevoer om te bepaal hoe deelname aan die aksienavorsingsproses hulle in hul persoonlike hoedanigheid asook in die uitvoering van hul pligte beïnvloed het.

Die huidige navorsing stel voor dat die psigodinamiese benadering 'n gepaste komponent van aksienavorsing in publieke gesondheidsomgewings kan wees, omdat hierdie benadering insig kan verleen tot die onbewuste prosesse wat

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gesondheidswerkers se belewenis van stres beïnvloed, en verder ook die potensiaal het om gesondheidswerkers en bestuurders tot alternatiewe funksionering en hantering van stres te motiveer.

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LIST OF ABBREVIATIONS

ART	Antiretroviral therapy
CBO	Community-based organisations
CHC	Community health centre
DHA	District Health Authority
DHS	District Health System
PHC	Primary health care
PLWHA	People living with HIV/AIDS
STI	Sexually transmitted infections
TB	Tuberculosis
WHO	World Health Organisation

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CHAPTER ONE

CARING IN PRIMARY HEALTH CARE

> *"the health and well-being of people all around the world depend critically on the performance of the health systems that serve them"*
> Former WHO Director-General Dr Brundtland
> (World Health Organisation [WHO], 2000)

Health care is central to health and well-being (WHO, 2000). Though health is essentially the individual's responsibility, national government is mandated to provide infrastructure for public health service delivery as a service to the people and in the interest of public health. Health services should be based on the best available scientific evidence to ensure that the outcome of health care is beneficial and not harmful to recipients (Clarke & Oxman, 2000). Good planning and management of implementation is needed to make sure that scarce health resources in a country are used in a cost-effective and cost-efficient manner (Blecher & Thomas, 2004; Padarath, Ntuli & Berthiaume, 2004). Increasingly it is being realised that public health services should work closely with their grassroots constituencies to ensure that health services are relevant and acceptable to the communities that they seek to serve (McCoy, Buch & Palmer, 2000). It is therefore essential that the major focus of health care delivery in the public health care sector be on primary health care (PHC) facilities as the first line of contact between communities and the health system. This is especially applicable in developing countries where the biggest proportion of the population falls within the low-income category, which is more dependent on public services (McIntyre & Gilson, 2002).

Equitable access, responsiveness and quality are critical dimensions of health care delivery (Mills, Palmer, Gilson, McIntyre, Schneider, Sinanovic, et al., 2004; WHO, 2000). PHC facilities should be as close as possible (accessible) to communities to promote positive health-seeking behaviours. PHC services should be comprehensive in order to be able to respond to the needs of the community. Service coverage should therefore include provision for acute and chronic health needs, effective health promotion and disease prevention, and appropriate responses to new health threats as they emerge. In seeking to improve on access and responsiveness, health

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systems in many countries are currently in the process of restructuring their PHC sector (McIntyre & Gilson, 2002). However, while reforms are underway, health workers need to continue to provide quality services that produce good health outcomes (Benatar, 2004). Yet when it comes to implementing interventions to improve health system performance, emphasis is often placed on the technical aspects of health service delivery with little consideration of the human effort involved in health care (Atkinson, Medeiros, Henrique, Oliveira & de Almeida, 2000; Petersen, 2000; Petersen & Swartz, 2002). This tendency goes back to the training of health care professionals where emphasis is traditionally placed on technical and biomedical aspects of care (Van der Walt, 1998). This type of training, called task-orientated training, is done to ensure that health workers are competent in technical procedures related to health care. However, little regard is given to training health workers to cope with human elements involved in health care, such as caring for patients and dealing with communities (Industrial Health Research Group [IHRG] & South African Municipal Workers Union [Samwu], 2005). Stoter (1997) argues that since health care is by nature labour-intensive, aspects related to the professional caregivers themselves need to be considered when developing interventions to improve quality of service delivery and over-all health system performance.

Health system performance and worker motivation

In studying the impact of health reforms in two developing countries Franco, Bennet, Kanfer and Stubbledine (2000) found that health worker motivation was one of three critical factors that affected health system performance. (The other two were worker competency and availability of resources.) Overwhelming evidence from studies in other countries show that health care staff generally are over-stressed, and that this affected worker motivation and work performance. *Worker motivation* refers to a health worker's willingness to exert and maintain efforts towards achieving the goals of health service delivery as defined in the setting and by the organisational context within which he/she works (Franco et al., 2000). Having (high) worker motivation translates into health workers coming to work regularly, working diligently and being flexible in carrying out their tasks. Lack of worker motivation, on the other hand, results in low staff morale and this could undermine the delivery of quality health care services.

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In the World Health Report 2000 the South African health system was ranked 175th out of 191 countries on dimensions of stewardship, financing, provision of services and generation of resources (WHO, 2000). This was despite the fact that the country was ranked 75th out of 191 on per capita income. The indication was thus clear that South Africa did not utilise its resources efficiently for effective health service delivery. This finding may give support to and find explanation in qualitative reports of patient abuse and general poor service that members of the public received when attending public PHC facilities (Jewkes, Abrahams & Mvo, 1998; Strachan, 1999b; Van der Walt, 1998). One of the reasons given by staff to explain their uncaring attitude towards patients is that they were demotivated themselves and suffered from low morale. Although issues of lack of resources and lack of worker competency are pertinent to delivery of quality health services, these on their own do not account for the poor quality of services that are rendered in PHC facilities in South Africa (Strasser, 1998). Strasser argues that health workers need to be supported by the health organisation to enable them to provide good quality care to patients. Support interventions for health workers should be directed at the organisational level to facilitate change in the caring ethos of the whole health system (Van der Walt & Swartz, 1999; 2002). The goals of such a support intervention should be to create capacity within health workers to deal with work stress in a positive way and to facilitate changes in the individual and team's professional behaviour that would lead to positive health outcomes.

Dealing with stress among health workers

When developing (support) interventions to improve worker motivation, it is necessary to understand the determinants of health worker motivation (Franco et al., 2000). The determinants of health worker motivation are those factors and events in the work situation that causes distress among health workers. Not only do we need to know what is causing job stress among health workers, we also need to explore how these factors interact with psychological factors within the individual and in team context to cause stress experiences. The causes of job stress among health workers are numerous and well-documented in occupational health literature reports (O'Henley, Curzio & Hunt, 1997). Three categories of stressors can be distinguished, namely *extrapersonal* (external) factors that relate to the broader organisation and environment, *interpersonal* factors that relate to relationships at home and at work

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that influence the health worker and his/her work, and *intrapersonal* (individual/personal) factors related to the individual's personal history and work orientation that he/she brings into the work situation. In addressing job stress and worker motivation among health workers the context and environment in which health care is delivered need to be taken in consideration. In Chapter Two I describe PHC service delivery in South Africa as the background setting to the current research.

The need for staff support

Davidhizar and Bowen (1992) argue that one of management's central tasks is to provide support to staff so that staff morale would improve and burnout be prevented. Although this is the ideal, it was reported that health managers on middle management level rather stayed away from PHC sites in attempts to avoid having to deal with staff problems (Bachman & Makan, 1997). This behaviour was attributed to middle managers feeling too stressed themselves to be able to provide support to staff (Muller, Leon & Van Wyk, 2000; Poggenpoel & Gmeiner, 1996; Van Wyk, Benjamin & Sandenbergh, 2002). Although health organisations have employee assistance programmes (EAPs) in place, these were reported to be grossly understaffed and therefore unable to handle the overwhelming demands for their services, which extended beyond stress management (Muller et al., 2000). A review of municipal health services showed that EAPs' activities were mostly reactive, and at best, involved referring health workers for treatment by other professionals (IHRG & Samwu, 2005). These reactive measures would include sourcing outside agents to provide occupational stress management or other training programmes for staff in accordance with perceived needs. Stress management programmes, however, have been found to provide only short-term positive effects on relieving staff stresses, if at all (Murphy, 1996; Van der Hek & Plomp, 1997). Walker and Gilson (2004) recommended that mechanisms be put in place to support and motivate health workers so that they would be committed to 'quality' implementation of health policies.

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OUTLINE OF DISSERTATION

This dissertation describes action research conducted by a team of health systems researchers and clinical psychologists, aimed at exploring ways to support PHC teams in their work. As will be seen, the process took a number of unexpected turns, which will be documented.

Chapter Two sketches the background and context in which the study took place. I introduce some of the challenges that South Africa's national health system faces in restructuring the PHC sector and dealing with the emerging HIV/AIDS epidemic. Although HIV/AIDS is not the focus of the current research, the extent of the HIV/AIDS epidemic and its impact on the PHC system and its staff, in terms of morale, motivation and stress, cannot be ignored (Petersen, 2000). In this chapter I describe the PHC system, its roots and development, reforms that were underway at the time of the research and conclude with the challenges that the abovementioned together with the HIV/AIDS epidemic pose for health workers.

In **Chapter Three** I review occupational stress interventions. In particular, I compare conventional approaches to *stress management interventions*, with preventive staff-support programmes and discuss why the intervention team believed that the latter approach had greater potential to be beneficial within the context of public PHC settings.

In **Chapter Four** I propose psychoanalysis as a useful framework for consultancy when exploring ways of developing staff-support interventions in organisations. I describe the Tavistock model for psychodynamic consultancy, which has proven to be useful elsewhere, and informed the action research process that was followed in the current research. I conclude the chapter by providing an outline of the process of consultation and the role that the consultant would play.

In **Chapter Five** I explain the rationale for using a developmental action research approach. I place this discussion within the framework of the work conducted in the research unit within which the researchers were based. Due to the nature of action research, research methods were not chosen *a priori*. However, I note the methodological preferences and strengths, which might have biased the researchers'

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decisions to use a particular approach in qualitative methods for data collection and analysis. I describe the basic epistemological viewpoints that under-girded this approach, and describe in detail in later chapters how these techniques were implemented in the respective action research stages.

Chapters Six to Nine contain descriptions of the various action stages of the current study. In **Chapter Six** I described the first action stage, which involved a qualitative assessment of the nature of stressors in the PHC system as well as the support systems available within the system. **Chapter Seven** (second actions stage) describes the experiences of two staff teams from a health prevention clinic and a day hospital (curative service) as they prepared to merge and integrate aspects of service delivery. In **Chapter Eight** the third action stage where the research team explored the feasibility of a short programme aimed at building capacity amongst middle and facility level managers to act as containers for staff stresses, is described. However, due to external factors the programme was not completed. In **Chapter Nine**, I report on the final action stage, where I reflected with some participants on the process of research. These action stages differ markedly from each other and reflect the shifting nature and changing focus of research actions in action research.

In **Chapter Ten** I conclude the thesis by discussing some implications of the current research findings for future staff-support interventions in PHC settings and give recommendations for further research.

NOTE ON THE USE OF RACIAL TERMINOLOGY

Race or colour distinctions in South Africa are often associated with language (Bheekie, 2001; Van der Walt, 1998). In this thesis I use the term "African" to refer to indigenous South African people who speak indigenous languages. I use the term "coloured" to refer to South Africans "loosely bound together for historical reasons rather than by common ethnic identity" (Erasmus, cited in Bheekie, 2001). These would include people whose heritage or descent comes from indigenous San, slaves brought to the Cape Colony from Indonesia and Malaysia and the offspring of intermarriage. I use the term "white" to refer to South Africans who are of European descent who speak Afrikaans and English. I as researcher do not agree with the division of society on the basis of race or colour. However, I do acknowledge that discrepancies exist between people of different races in terms of social, economic

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and health service factors due to the history of segregation and other apartheid policies in South Africa. Where race or colour is mentioned in this thesis, it serves to highlight particular differences in displayed attitudes and behaviour that were relevant (or had potential relevance) to the research process. I do not seek to stereotype individual or group behaviour on the basis of colour and qualify perceived and/or observed effects of racial differences within the contexts that these occur.

A NOTE ON THE USE OF THE PERSONAL PRONOUN

Action research acknowledges the role that the researcher and research team play in the process of inquiry. In keeping with the tradition of qualitative research writing, I use the personal pronoun rather than "the researcher" or "the author" to situate myself in the research. I also use the convention of referring to the research team as "we" to indicate my participation in the processes.

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CHAPTER TWO

PRIMARY HEALTH CARE AND RESTRUCTURING IN SOUTH AFRICA

THE PRIMARY HEALTH CARE APPROACH

The World Health Organisation (WHO) identifies primary health care (PHC) as the most appropriate vehicle to ensure that health services are both accessible and responsive to the needs of communities (Petersen & Swartz, 2002). Although primary health care existed in various forms before as a concept, it was officially defined at the Primary Health Care conference in Alma Ata (WHO & UNICEF, 1978). At this conference an international delegation formulated a new philosophical approach to first line care, which they called *the primary health care approach (PHCA)*. According to the PHCA primary health care is defined as:

> *essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.* (WHO & UNICEF, 1978)

The new definition of primary health care (PHC) rested on three principles: equality, accessibility and community involvement (Walt & Vaughan, 1981). Greater focus was placed on health prevention and promotion. It was also propagated that technology used in PHC should be based on the best available evidence. Appropriate consideration should be given to ensure that methods and services are both acceptable and appropriate to community needs. Education about diseases, health problems and their control, maternal- and childcare, immunisation against major infectious diseases, appropriate treatment of common diseases and injuries and the provision of essential drugs should therefore be basic components of PHC delivery. PHCA, furthermore, propagated a multi-sectoral approach to health care, which includes attention being given to nutrition, education, water supply and shelter.

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Although most countries lauded the ideals of PHCA, there was little uniformity in the way it was implemented (Petersen & Swartz, 2002). Chopra, Sanders, McCoy and Cloete (1998) pointed out that the Alma Ata declaration was too vague and lacked specificity in stipulating how PHCA was to be implemented on a services level. They (Chopra et al.) argued that implementing a comprehensive PHC service coupled with the suggested multi-sectoral support required strong political will. The suggestive tone in which the Alma Ata document on PHC was phrased did little to persuade governments to commit to the objectives of the PHCA. In the end many countries adopted the PHCA in principle, but implemented it in ways that the WHO (2000) two decades later described as "primitive" rather than primary.

PRIMARY HEALTH CARE IN SOUTH AFRICA

South Africa by and large follows global trends in health reforms (Petersen & Swartz, 2002). South Africa adopted the PHCA eagerly in the eighties, but implemented it *"in a selective and piecemeal manner"* (Van der Walt, 1998, p.6). Whereas PHCA promoted a developmental agenda with emphasis on community participation and empowerment, PHC service delivery in South Africa violated these principles. Some argued that the PHC system in South Africa was used as a vehicle to provide a cheaper form of health care to the poor and rural black people (Marks, 1994). Due to institutionalised apartheid there was not equal or equitable distribution of health services (McIntyre & Gilson, 2002). Health service coverage favoured the minority white population. Health services were inefficiently and inequitably biased towards curative and higher level (hospital) services. In addition most of the services were located in urban areas (Petersen, 2000). Inequalities in service delivery were further entrenched through the fragmentation of the health system into 14 different departments of health, which managed services for respective racial groups and within specific geographic regions (Dick, 1994). Within provinces, some PHC services were allocated to local government structures, while the majority of curative care services in PHC continued to be administered by provincial health departments in separate facilities.

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Fragmentation of primary health care programmes

The fragmentation of PHC services within provinces is rooted in the history of unification in South Africa (Bachman & Makan, 1997; Shisana, Zondi, Hadland, Mosala & Mfecane, 2003). At the time of unification there were fierce political battles between the Boer republics and the British provinces over control in their respective provinces. To ease tension between the four provinces it was decided that control of service delivery and corresponding budgets would remain in the hands of provincial authorities, with central government acting in a overall legislative capacity. Within provinces prevention and environmental health services (which were then regarded as minor functions on the basis of budget allocation) were delegated to various local government structures such as municipalities and district councils (Dick, 1994). Control over all hospital services, including those of day hospitals, remained with departments within provincial government as these received a bigger portion of the provincial health budget (Shisana, et al., 2003). The day hospitals provided a wide range of *primary level* curative services. As time went on more functions were devolved from tertiary and secondary levels to PHC level, because the latter was considered to be a cheaper form of care. At the time that the current research was conducted, services provided by local government clinics[1] included primary level pediatric care, STI and family planning, pre-, post and antenatal services, TB management and dispensing of chronic medication (Van der Walt, 1998). Day hospital services included first-level diagnostic and curative services for illness and injury, mental health services, geriatric care, oral health and transport of referrals to hospitals.

The fragmentation of the PHC system into separate curative and preventive programmes hindered effective service delivery in several ways (Clarke, 1999; Shisana, et al., 2003). In the first place, running two administrative and managerial systems parallel to each other was costly in terms of human and financial resources. Bachman and Makan (1997) found that over all nursing designations employees from local government organisations received higher remuneration than their counterparts in the provincial health services. Differences in salaries, job descriptions and conditions of service resulted in staff being resistant to working together

[1] In the South African context the word "clinics" is used to refer to primary health care facilities run by local health authorities that provide health prevention and promotion services.

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(integrating) at facility level (Van der Walt, 1998). Due to lack of communication between the two health programmes duplication of certain services and functions occurred (Marks, 1994). Furthermore, the separation of the two PHC programmes was not user-friendly. Not only were patients often confused about which services ran on specific days, but they had to spend extraordinary long amounts of time at the health centre when they wished to make use of both services on a given day (Van der Walt, 1998). This did little to encourage positive health-seeking behaviour. It was proposed that integrating the two PHC programmes would bring about a more cost-effective and user-friendly PHC service (Clarke, 1999). With the emergence of the first democratically elected government in 1994, major restructuring started to create a single comprehensive, equitable and integrated national health system (Ntuli & Day, 2004). Since PHC is widely acknowledged to be the most equitable level of care, the health reforms that followed targeted this sector.

Restructuring the primary health care sector

The vision for the new health system was to emphasise health and not only medical care in health service delivery. In 1995 the National Department of Health reconfirmed its commitment to the ideals of the PHCA (Benatar, 2004). The goal was to provide every person with equal access to quality health care. The challenge was to equalise the coverage of services, as major discrepancies existed across provinces (McIntyre & Gilson, 2002). However, due to lack of funds to upgrade all PHC services to provide a comprehensive service, it was decided to introduce a core package of services that would give immediate attention to priority diseases related to poverty (Petersen & Swartz, 2002). This selective approach to PHC (SPHCA) focused on increasing coverage of immunisation, growth monitoring, breast-feeding and oral hydration services, with emphasis on technical expertise and cost-efficiency to increase child survival rates (Chopra et al., 1998). The SPHCA, however, failed to improve the over-all health status of children despite achieving great successes in coverage. Werner, Saunders, Weston, Babb and Rodriquez (1997), for example, showed that children who survived childhood diarrhoea due to great coverage of oral hydration, died later of malnutrition, because no attention was paid to promoting a multi-sectoral approach to health care. In addition, these programmes were introduced as vertical programmes to the PHC system, and thus placed further strain on the services. In 1997 the National Department of Health aborted the SPHCA and

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committed to implementing a comprehensive PHC service (Pillay, 1999). A policy decision was taken that all PHC services would be integrated under the district health system (DHS).

District Health System

Central to the establishing of the DHS model was the decentralising the management of health services to the local government level (Barron & Assia, 2001). The DHS would facilitate local accountability and community participation in health service planning, and this would in turn make health care delivery more responsive to local community needs. The DHS management would have greater autonomy to make health care decisions in their districts, which would cut out long bureaucratic processes typical of health organisations. It was further envisaged that the DHS would facilitate the integration of curative and prevention PHC programmes within their districts to achieve the goal of a single comprehensive PHC service. In this way resources previously consumed by duplicate services and functions would be freed, and utilised in more efficient ways. However, transitioning to the DHS has been a long and challenging process (Barron, Monticelli & Leon, 2003).

Setting the DHS up involved two first steps: (1) setting boundaries for health districts and (2) establishing appropriate governing structures within these boundaries (McCoy & Engelbrecht, 1999). The first step was accomplished by taking existing municipal areas and regrouping these to form geographically adjacent areas or health districts. At the time of the current research the geographical mapping had already taken place and 53 districts had been demarcated across the country (Barron & Assia, 2001). Establishing appropriate governing structures on national, provincial and district levels that would preside over health service delivery proved to be much more complicated. By 2001 progress had been made in establishing a National Health Authority and Provincial Health Authorities in several provinces in accordance with the legislative framework passed in the National Health Bill, 2001 (Department of Health, 2001). In this Bill it was stipulated that Provincial Health Authorities must provide legislative frameworks for the establishment and management of district health authorities (DHA) in their health districts. According to this Bill the DHA would be tasked with the management and delivery of *all* health services (primary, secondary and tertiary) within a designated health district. The Bill allowed space for

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the DHA to be a municipality, a provincial department or a body constituted by provincial legislation. This vagueness in specifying the constitution of the health district governing body gave rise to political in-fighting between local and provincial health authorities management over control of PHC service delivery in metropolitan and large local municipal areas. Although the Health Minister/Members of Executive Committees stated their vision of PHC being delivered through a DHS that was the extension of local government, differences in various provinces made formulating clear national legislation difficult (Haynes & Hall, 2002). In some provinces the local government structures were weak and not able to manage the DHS. In these cases the provincial health departments formed the basis of the DHS management. At the time of the current research only partial success was achieved in setting up DHS's nation-wide (Barron & Assia, 2001). Another component to the DHS that proved more difficult to implement than envisaged at first, was that of setting up structures for comprehensive PHC delivery.

Integration of primary health care services

One of the ideals of the DHS was to provide a "one-stop shop" where clients could receive everything they need with respect to PHC under one roof (Clarke, 1999). While problems to set up DHAs persisted, some provinces went ahead and implemented what was called a *functional integration* of frontline services. Functional integration was defined by the National Department of Health as:

> *A structured cooperation and collaboration between provincial and local government health rendering authorities for the purpose of decreasing fragmentation and duplication, enhancing integrated service provision, and increasing efficiency and quality of primary Health Care, in the absence of legal, financial and administratively integrated governance and management structures* (Barron, et al., 2003, p.5).

In practice functional integration involved the integration of health services provided by provincial day hospitals (curative care) and local government health promotion and prevention clinics by moving these two staff teams into the same building and requiring them to work together, while still reporting to the different management

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structures in their organisations (Barron, et al., 2003). This formed one of the central points in the current action research process. At the time of the research several day hospitals and prevention clinics merged or were in the process of merging to form community health centres (CHC). In the province where the current research took place, some attempts were made to form integrated management teams to oversee service delivery in these CHCs (Barron & Assia, 2001; Haynes & Hall, 2002; McCoy & Engelbrecht, 1999). The lack of fit between the pace at which functional integration[2] took place at frontline (services) level and the pace at which amalgamation[3] of the respective health organisations and management structures took place, was reported to be a major source of frustration for health teams from all organisations (Muller, Leon & Van Wyk, 2000). While it is said that decentralisation of management in the health sector remains a long term goal, health service personnel are challenged to contain the biggest health threat in the modern era, HIV/AIDS, amidst unsettling, destabilising and drawn-out reforms (UNAIDS, 2004).

The impact of HIV/AIDS on primary health care

By the end of 2003 it was estimated that South Africa had the largest number of people in the age group 15 – 49 years living with HIV/AIDS globally, with an estimate of 5.3 million people (UNAIDS, 2004). In 2003 the national government approved an action plan for the roll-out of a comprehensive treatment and care plan for people living with HIV/AIDS (PLWHA), which included antiretroviral therapy (ART) for pregnant mothers infected with HIV (Department of Health, 2003). Based on WHO recommendations (WHO, 2003), it was decided that PHC services should include, as part of the basic package of care, HIV prevention and testing (Voluntary and Confidential Counselling and Testing), roll-out of ART and establishing facility-based home and community care and support programmes. Although large increases in funding of the abovementioned services have been set aside, it has been argued that additional staff would also be needed to provide these services (Ntuli & Day, 2004). This and many other challenges faced PHC workers as they sought to implement the expanded range of services.

[2] Throughout the thesis I use the terms 'integration' or 'functional integration' to refer to the integration of preventive and curative health care services at facility level. Where this concept is used in another context I refer to this further.

[3] I use the term 'amalgamation' to refer to the process of merging local health authority structures and provincial health organisations within a health district.

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The supply of health workers will continue to decrease as a result of AIDS-related deaths (Shisana, Hall, Maluleke, Stoker, Schwabe, Colvin, et al., 2002). In this study, which was conducted in four provinces in South Africa, it was found that 15.7% of health workers in public and private health facilities were infected with HIV. As HIV-infected colleagues become symptomatic, an increased burden will be placed on remaining staff to handle the workload as absenteeism increases. It is estimated that in 2002, of the 5.3 million PLWHA, about 7% (390 000) were likely to be symptomatic, which would place pressure on already strained health care systems (Dorrington, Bradshaw & Budlender, 2002). The increases in number of PLWHA seeking care at public PHC services are not evenly distributed, but, in all probability, predominate from poorer communities where people do not readily have medical aid or financial resources to access private health care services. In preparation for the roll-out of comprehensive HIV/AIDS care and treatment, additional training of health workers needs to occur (Padarath, et al., 2004). This means that staff are taken away from their daily tasks, adding further burden on remaining staff. Notwithstanding the stresses that coping with a threatening epidemic place on health workers, the core challenges of providing health care in a primary health care setting remain pertinent (IHRG & Samwu, 2005). In the next section I discuss these core challenges.

CHALLENGES FOR HEALTH WORKERS

A PHC worker has to demonstrate technical and emotional competency in delivering care to the public (James, 1992). Though it is said that health care is about promoting health and well-being, in reality it tends to be limited to a focus on fighting disease and sickness (Sullivan, 2003; Van der Walt, 1998). The health indicators used normally measure the incidence or prevalence of disease. Though many have argued persuasively that public health needs to move away from its purely biomedical orientation (Petersen, 2000), this has not filtered through to those slogging away on the frontline fighting the evils (diseases) that threaten our society (public health). Van der Walt and Swartz (1999) traced this back to the training of

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South African nurses[4], which is based on a task-orientation approach. Thus, it comes as no surprise that nurses' foremost concern when it comes to providing care is paying attention to performing the task (e.g. giving an injection) with technical competency, while taking care of the patient's well-being is often neglected (Van der Walt & Swartz, 2002).

Technical competency

Van der Walt (1998) points out that many PHC nurses were ill-prepared for the challenges of PHC in community settings, because their basic training was predominantly hospital-based. As already mentioned, in their training nurses are taught how to perform the whole range of tasks. Little attention is given to the patient and how he/she might respond to or feel about the task that is performed on him/her. In curative care, as technically understood, this may be seen not to pose too much of a problem, because giving stitches, for example, may not require too much interaction between caregiver and patient. Yet when it comes to health procedures such as giving family planning advice or TB medication, interaction is inevitable and necessary. In PHC the health worker is dependent on the voluntary cooperation of the patient to achieve good health results (Petersen, 2000). After all, the patient is going to leave within five minutes and there is no way that the health worker can ensure that health advice is followed. In a hospital the situation is somewhat different. The daily routine in the hospital provide boundaries wherein the health worker has reasonable power to ensure that treatment regimens are followed. The lack of clear boundaries between PHC facilities and the community implies that health workers are required to engage the patient in a patient-centred way to increase compliance and adherence (Atkinson, et al., 2000; Schilder, Kennedy, Goldstone, Ogden, Hogg & O'Shaughnessy, 2001). This involves treating the patient as a client – with respect, listening to their experiences and providing helpful solutions to ensure that health advice is followed or treatment regime adhered to (Lewin, Skea, Entwistle, Zwarenstein & Dick, 2004). Therefore the first challenge for the PHC worker is to move away from their task-orientation (something which they

[4] In this section I focus on the work of nurses, because PHC in South Africa is predominantly nurse-driven. The experiences described here may also apply to other members of the public PHC team.

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are trained in) towards a patient-centred approach in which they receive no training at all.

In addition to learning and adopting a new approach to giving care, PHC workers still face challenges with acquiring new skills to do their job. Since the adoption of the comprehensive PHC approach, more functions have been devolved from tertiary and secondary levels to PHC level (Laurent, Sergison, & Sibbald, 2004). This requires that nurses go on short courses to learn procedures that were previously performed by doctors. Upon their return to the health facility, they are required to perform their newly acquired skill(s) with precision and efficiency (in quick time). PHC workers are drilled during training that health care is about not doing harm. Mistakes are not tolerated as people's lives might be at stake. However, the conditions in public health services are such that nurses have to work at a quick pace to see to all the patients (IHRG & Samwu, 2005). Performing technically challenging tasks at pace could lead to health workers making mistakes. Sometimes these mistakes can cost the lives of patients, as in reported cases when patients were sent home with some medication instead of being referred to the hospital and died. These events are often widely reported in the media and place further pressure on health workers to make sure that they make the right health decisions all the time.

The context in which PHC service delivery takes place in South Africa makes providing quality health care difficult, if not impossible (IHRG & Samwu, 2005). There is a shortage of nurses working in PHC (Gwele, 1998). This means that already qualified nurses do not have the luxury to go for additional or longer training to make sure that they are confident about performing a new procedure before being called upon to perform this task at her/his facility. New nurses are not trained properly before being released to work in PHC facilities. These nurses encounter tremendous patient loads upon starting to work in busy PHC settings after training, which leaves little time for them to be oriented into the work or learn from their senior nurses, as the last-mentioned have to battle through the large number of patients as well (Gwele, 1998; Van Rensburg, Viljoen, Heunis, Janse van Rensburg & Fourie, 2000). Many patients' vulnerability to sickness is related to lack of services such as clean water, sanitation and nutrition. In providing health promotion services the health worker has to help clients overcome these obstacles to good health (Van

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der Walt, 1998). This requires a different type of competency – emotional competency.

Emotional competency

Health care delivery is not only about performing technical procedures such as diagnosing, treating and prescribing medication – it also involves giving emotional care to patients and clients (Petersen, 2000). The advantages of providing patient-centred care in establishing positive health provider-patient relationships are well documented (Lewin et al., 2004). Yet even for health workers who insist on focusing on the patients' diseases only, the need to demonstrate emotional resilience is inevitable. Health workers are subject to on-going reforms and changes that are constantly introduced to their work. The reforms bring uncertainties about their job security and career path (Fulop, Protopsaltis, King, Allen, Hutchings & Normand, 2005). Changes to job descriptions can also leave them unsure about their own abilities. Yet, the health worker is required to provide a service to the public amidst both personal and professional stresses and anxieties. As the AIDS epidemic progresses, PHC workers have to deal with HIV positive patients (Benetar, 2004; IHRG & Samwu, 2005). The fear of infection from these patients as well as others remain, and health workers need to dig deep into their emotional resolve to overcome anxieties with respect to this when required to provide care to these patients. Those health workers who seek to see their patients as whole persons, find that they are exposed to the patients' social context, which often include illiteracy or low levels of education, poverty and malnutrition (Gwatkin, Guillot & Heuveline, 1999). Being confronted with the social and health conditions of people from similar backgrounds to oneself, can evoke much anxiety in health workers (Van der Walt, 1998). As professional caregivers nurses might feel burdened or compelled to help beyond giving health care, or approached (by the patient) to help in other areas of need (such as food). Reactions such as anger and resentment may also occur. Whichever reaction the PHC workers choose, they are challenged to demonstrate emotional competency and strength in dealing with demanding and difficult patients and communities. Not only do they have to cope with these situations for themselves, they also need to engage the community in active partnership to achieve their goals for public health (Atkinson, et al., 2000).

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CONCLUSION

The challenges for health workers in the public PHC sector are tremendous. Specific interventions are required to help health workers deal with work-related problems, or failing which the national health system runs the risk of losing its staff to the private sector or abroad (Padarath, et al., 2004). Technical training would go a long way to reduce pressure on PHC workers (Gwele, 1998; Strasser, 1998). Improving in-training programmes would equip existing staff to feel more confident in performing their tasks. Aggressive recruiting and comprehensive training curricula for community nurses would produce new nurses who would ease the pressure of workload on existing staff complements.

Petersen (2000) argues further that South African nurses need to be provided with the necessary skills to work autonomously as primary decision-makers in PHC services, to understand illness in its bio-psychosocial context, and to negotiate with community members as equal partners with respect to health promoting behaviours and decisions. With a more holistic understanding of illness, PHC nurses, and the services as a whole, might be more amenable to treating the patient as a whole person and not just as someone with a disease/condition that needs to be treated using biomedical procedures. However, training interventions on their own would not be sufficient to relieve the stresses that nurses are experiencing in their work (IHRG & Samwu, 2005). To quote Strasser (1998):

> *Even in a system where all the nurses are adequately trained, we may still not reach our goal of equitable primary health care services if the system is not in place to care for its largest group of workers* (p.85).

As already discussed the challenges faced by health workers are not only technical in nature, but also influence their emotional experience of work and the organisation (Gibson, 2002). Van der Walt (1998) suggests that the challenges of PHC service delivery are too great to be placed on health workers alone and that interventions to improve health systems performance should address the organisation of work as well. She reasons that management systems should be involved in finding new ways to humanise their system of care to support staff and create capacity in staff to form caring relationships with patients. On a systems level this translates into improved

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responsiveness of the health system as defined in the World Health Report 2000 (Petersen & Swartz, 2002). The need for interventions to support PHC staff and improve levels of job satisfaction and morale amidst poor working conditions, unsatisfactory management, low salaries and the crippling HIV epidemic is urgent (Ntuli & Day, 2004). In the next chapter I review several approaches to providing support to staff in the health sector.

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CHAPTER THREE

STAFF-SUPPORT INTERVENTIONS IN HEALTH CARE

INTRODUCTION

In this chapter I discuss various approaches to dealing with stress and supporting health workers in their work. In the first and second sections I explore the causes of stress amongst health workers and how stress is conceptualised, and compare conventional approaches in occupational health to managing stress. In the third section I discuss opportunities for staff-support interventions in health care settings and argue why this approach may provide a better alternative to dealing with stress amongst health workers.

STRESS IN HEALTH CARE

The challenging context in which health care takes place, places great stress on health workers (Calnan, Wainwright, Forsythe, Wall & Almond, 2001; Cunningham, Woodward, Shannon, MacIntosh, Lendrum, Rosenbloom, et al., 2002; Hemingway & Smith, 1999; Strasser, 1998). It has been reported that staff working in human services organisations (caring professions) are particularly susceptible to stressors in their work environment (Gibson, Swartz & Sandenbergh, 2002; Greenwood, 1997; Irish Nursing Organisation, 1998). The most commonly noted stressors among health workers are heavy workloads, dealing with death and dying, team conflicts, lack of resources and management style (Lees & Ellis, 1990; O'Henley, et al., 1997). Hemingway and Smith explained that people in caring professions, such as nursing, often experience role conflict and ambiguity between organisational goals (being healers) and treatment or therapeutic goals (being carers). Ongoing reforms in the health sector add to health workers' confusion and uncertainty about their roles and future (Bachman & Makan, 1997; Franco, et al., 2000; Lökk & Arnetz, 2000).

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Stressors amongst health workers

Extrapersonal factors are those elements in the organisation over which the individual has little or no control, including function, culture and structure (O'Henley, et al., 1997). Stressors in this category include management style, communication patterns and decision-making policies. In general health service organisations are very bureaucratic with a strong top-down decision-making structure. Decisions are typically made by senior management, and front-line staff have to implement these without asking any questions. This could be stressful for staff, because they might feel isolated and distant from the policies that are introduced in the services. In many cases these top-down decisions would involve increases in workload that have not been negotiated with staff. When high psychological task demands are combined with health workers having little control over their work, it might be very stressful for staff. The impact that management decisions have on hindering fulfilment of individuals' needs and desires for job satisfaction, security and career development could also affect staff stress directly. The work environment is also influenced by socio-political and economic factors that operate in local, national and international spheres. Social and political factors influence the work environment directly and indirectly, but are not easy to quantify.

Interpersonal factors are defined as those aspects that relate to relationships at work (O'Henley, et al., 1997). Team conflict is another stressor that is prominent in PHC settings. Health workers in PHC facilities are vulnerable to interpersonal differences and conflicting personalities, because it is required that they work as a team (Van der Walt, 1998). Strained interpersonal relations have been associated with lower job satisfaction amongst nurses (Calnan, et al. 2001). Research showed that female nurses, for instance, may experience stress as a result of conflicting demands of work and home and the lack of social support at home. Health workers are affected by incidents of rudeness by patients and conflicts with patients (Calnan, et al., 2001).

Intrapersonal factors are relating to intrinsic stressors related to the individual (O'Henley, et al., 1997). These include personality characteristics such as type A behaviour, sense of control, and gender (Ross & Altmaier, 1994). Persons with type A behaviour pattern are typically driven to achieve more in less time, are highly competitive in everything they do and are hostile towards other people in their work

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environment. These characteristics make them more vulnerable to job stress, and less likely to have good social support systems. Discrete events such as the death of a patient or a patient defaulting from treatment may cause stress for health workers, because they may experience a personal sense of failure (Van der Walt, 1998). The personal lives and history of health workers also play a role in their experience of job stress, but ecological models tend to pay little, if any, attention to these dynamics.

Conceptualisation of stress

Although a fair amount of stress is needed to stimulate individuals to overcome challenges, extreme or persistent stress can be detrimental to the person's physical and mental health (Giga, Cooper & Faragher, 2003; Hobfoll, 1988). Distress (negative experiences of stress) occurs when the person cannot, or perceives that he/she cannot, meet the demands placed on him/her, or when meeting the demands do not bring personal satisfaction (Brief, Schuler & Van Sell, 1981; Quick & Quick, 1984). Job related stress occurs when increased job expectations do not match the capabilities, resources or needs of the worker, and this causes stress (National Institute on Occupational Safety and Health [NIOSH], 1998). Work-related stress affects individual physiologically, psychologically and behaviourally and blocks the achievement of organisational goals in several ways (Dollard, Winefield, Winefield & De Jonge, 2000).

The effects of stress on physical health are well documented (Moch, 1999). Selye (1974) showed through his experiments that humans respond in predictable ways to threatening stimuli (stressors) in the environment. He formulated the general adaptation syndrome (GAS), which described three stages (alarm, resistance and collapse) that the human body undergoes in response to prolonged exposure to stressful situations. The body goes from physiological *preparation* (increasing blood pressure, metabolism (heartbeat and breathing), the production of blood sugar, cholesterol, fatty acids and stomach acids, faster blood clotting, localised inflammation and decreasing protein synthesis, digestion and immune and allergic response systems) to *adaptation* (trying to maintain equilibrium) to *exhaustion* (where it can no longer resist stress anymore). Collapse, the final stage, occurs when alarm reactions are too intense or occur too frequently over an extended period. Selye's model is useful in explaining the link between stress and sickness

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(Cooper, Dewe & O' Driscoll, 2001). NIOSH (1998) linked stress with physiological conditions such as cardiovascular diseases, stroke, increased susceptibility to infections, gastrointestinal tract problems, diabetes, sleeping disorders, concentration problems as well as general increases in blood pressure and cholesterol levels.

Others have added to Selye's stress model by arguing that stress responses are not only the result of external forces, but also dependent on the individual's cognitive appraisal of these forces (Hobfoll, 1988). Perceived level of coping is thus central to the stress experience (Lowe & Bennet, 2003). When the individual encounters a situation that threatens his/her goals or aspirations (primary appraisal), he/she assesses whether adequate measures or resources are available to resolve the situation (problem-focused coping) or adapt emotionally (emotionally-focused coping). When adequate coping mechanisms are not available within the work situation, emotions such as anger, fear, resentment, bitterness, anxiety or frustration may occur (Hinshelwood & Skogstad, 2000; Schäpper, 1997). These emotions are normally directed at the organisation and its management (Bachman & Makan, 1997; Strachan, 1999a), but could also be directed at colleagues and clients, who may be considered to be the beneficiaries or the cause of current distress (Gibson, Swartz & Sandenbergh, 2002; Muller, Leon & Van Wyk, 2000). Work-related stress may lead to lowered worker motivation and self-esteem (Franco, et al., 2000; Jordan, Gurr, Tinline, Giga, Faragher & Cooper, 2003), which, in turn, may lead to increased absenteeism and turnover and decreased productivity and performance (Fang, 2001; Hemingway & Smith, 1999; O'Henley, et al., 1997). Cunningham et al. (2002) found that health workers, who did not rate their coping ability highly, were more resistant to getting actively involved in, or to support, organisational change processes. Burnout is considered to be one of the biggest problems amongst health care workers in public health services (Rowe, 2000). Maslach (1982) defined burnout as the end-state where caregivers are so emotionally exhausted and depleted that they lose ability to "connect" with patients, and instead distance themselves from patients by, for instance, focusing on the task and disregarding the person as a whole (Van der Walt, 1998). Caregivers suffering from burnout experience loss of efficacy and competency in their work, and show intentions to leave the profession (Rowe, 2000).

The effects of organisational stress can be summarised in the resultant deviant physiological, psychological or behavioural states that individuals and groups adopt

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to cope under the strain of their work (Bolle, 1988). Two approaches dominate organisational responses to prevention and management of workplace stress – stress management and staff-support (Jordan, et al., 2003). Stress management interventions (SMI) focus on dealing with stress through primary, secondary or tertiary level interventions. Staff-support programmes on the other hand, focus on the employee and attempt to increase coping capability by moderating the effects of stress. Although the overlap between these two approaches is evident, their distinction lies in the perspective that the organisational practitioner or manager takes on organisational stress. These two approaches also reflect two types of practitioners consulting to organisations – the organisational or occupational psychologist and those operating from one of the other counselling psychology disciplines (Carroll & Walton, 1997; IHRG & Samwu, 2005).

STRESS MANAGEMENT INTERVENTIONS

Occupational stress management interventions (SMIs) are implemented widely and often unsystematically in various organisational settings to provide worksite health services to employees (Murphy, 1996). The level of intervention is based on (i) the nature of the organisation, (ii) management's understanding of its priority stressors as well as (iii) their (management's) commitment and willingness to change (Reynolds, 1997). *Primary prevention* interventions seek to reduce occupational stress by eliminating sources of stress (stressors) within organisations (Cooper et al., 2001). This approach has been lauded by several reviewers for its bold intentions to change factors relating to the physical and socio-political environment of the organisation (DeFrank & Cooper, 1987; Jordan, et al., 2003; Van der Hek & Plomp, 1997). Examples of primary stress interventions in health settings include initiatives to reduce individual workloads, improve management and communication processes, increase health workers' control over task demands, and increase job satisfaction through establishing career paths and other changes to the work environment, organisation of work and conditions of service (Barriere, Anson, Ording & Rogers, 2002; Hemingway & Smith, 1999; O'Henley, et al., 1997). Burke (1993) found that organisational level interventions generally had positive effects and urged for a greater focus on primary stress prevention interventions.

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Secondary stress prevention programmes aim to reduce the impact of work-related stress by helping employees deal with stress in more constructive ways (DeFrank & Cooper, 1987; Murphy, 1996; Reynolds, 1997; Van der Hek & Plomp, 1997). Interventions on this level invariably include training elements. Training may be directly related to stress management, such as teaching individuals to identify stressors and stress responses and applying meditation, relaxation, biofeedback and other stress management techniques (Lökk & Arnetz, 1997; Reynolds, Taylor & Shapiro, 1993; Rowe, 1999; Tsai & Crockett, 1993; Von Baeyer & Krause, 1983-1984; West, Horan & Games, 1984) or may teach specific skills that would increase capacity to deal with work-related challenges, such as decision-making, assertiveness, problem-solving, communication and management (Lee & Crockett, 1994; Weir, 1997). A common feature of secondary stress intervention programmes is that they do not seek to alter or eliminate stressors in the organisation (Cooper, et al., 2001). This approach (secondary prevention) has been criticised for its implicit assumption that the problem with stress lies with the individual and his/her behaviour or lifestyle and for its demonstrated lack of management commitment to tackling the stress problem within the organisation (Jordan, et al., 2003).

Tertiary prevention programmes focus almost exclusively on helping individuals that are suffering from stress-related conditions that affects their work performance (Murphy, 1996). Programmes in this category aim to "*to limit the extent to which a chronic disorder is disabling or restricting for the individual*" (Reynolds, 1997, p.94). Activities include counselling, psychotherapy and debriefing of individuals who experience persistent problems in their work lives (Jordan, et al., 2003). The purpose of tertiary stress prevention programmes is to help individuals adapt their behaviour and lifestyles to meet the requirements of the work. Tertiary stress intervention programmes are useful and necessary to avoid loss of trained staff (Reynolds, 1997). However, it has been convincingly argued that more emphasis needs to be put on strategies that work preventively to reduce the occurrence of stress and related conditions in employees because the effects of work-related stress are costly for organisations (Caulfield, Chang, Dollard, Elshaug, 2004; Sparks, Faragher & Cooper, 2001).

In practice most organisational interventions in stress management focus on secondary and tertiary prevention (Caulfield, et al., 2004; Giga, et al., 2003). In the

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absence of management commitment to change, organisational psychologists opt to implement stress management training interventions (secondary interventions), as these are easier to implement for several reasons. In the first place the training content is narrowly defined and it is thus easier for the consultant to gain measurable goals with the training programme. Secondly, these training interventions do not normally require major re-organisation of work, apart from giving employees time off work to attend training sessions. Outcomes for evaluation are pre-specified and by and large show significant improvements in stress responses under simulated conditions or through self-reported measures. Researchers like Rowe (1999), however, have shown that gains from stress management training are only temporary, and often not implemented when employees return to workplaces, which have remained unchanged. She argues that initial training has to be followed up with "refresher" sessions to maintain benefits of training intervention (Rowe, 2000). The absence of management taking responsibility for environmental characteristics that cause work-related stress, is another reason why secondary prevention strategies in stress management do not improve worker health in the long-term. Primary stress prevention programmes, as mentioned before, target stressors directly and cannot be implemented without active management intervention. This direct involvement of management in programme implementation increases programme legitimacy, sustainability and the likelihood of success (Van der Walt & Swartz, 2002). Although some challenges need to be overcome as managers may use their power to block thorough analysis of organisational stress or veto recommendations based on budgetary considerations, and in ways that neglect the views of the employees, these far outweigh the devastating effects of lack of management commitment to organisation-wide stress programmes. Giga et al. (2003) recommended that participative approaches be followed in developing organisational-level interventions for primary stress prevention, but that these programmes should not exclude interventions on secondary and tertiary level to constitute what they termed as "work-directed and worker-directed prevention" (p.293).

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STAFF-SUPPORT INTERVENTIONS IN HEALTH CARE

Staff-support programmes in health organisations focus on creating a supportive environment, wherein health workers would be motivated to provide quality care to patients (Jooste, 2003). Van der Walt and Swartz (2002) argued that health workers who feel cared for themselves may be more capable of being "caring" towards patients and clients. Motivated staff, in turn, would also be more likely to implement and support the goals of health care reforms (Franco, et al., 2000). Staff-support programmes look at what is happening interpersonally with employees (that leads to experiences of stress) and place these dynamics within an organisational context (Carroll, 1997). Stoter (1997) described staff-support in health care as a function that seeks to promote well-being among health workers so that they (staff) would be able and motivated to contribute towards achieving of the organisational goal of providing quality health care. Staff-support programmes include a wide range of services for individuals, from prevention to rehabilitation.

Setting up staff-support services

The process of setting up a staff-support programme starts with the identification of stressors or points of conflict or pressure (anxieties) within the system (Stoter, 1997). Within the staff-support model stress is viewed as related to certain factors inherent to the health care setting and organisation (stressors). It is acknowledged that organisational distress may be a function of the nature and quality of interactions amongst staff, and between staff and management. Dealing with stress, therefore, requires a systemic approach. The different levels within an organisation, as well as influences from outside the organisation need to be taken into consideration, as these contribute to the organisational climate wherein stress is generated (IHRG & Samwu, 2005). In addition, it is also realised that what individuals bring into the work situation in terms of their life history and experiences, may contribute to specific stress responses (Stoter, 1997). Comprehensive staff-support programmes operate systemically, starting with individual staff members and aiming to get them to take responsibility for their personal welfare as well as their environment (Stoter, 1997). Meulenberg-Buskens and Daniels (1997) found that in order for health workers to be more caring to patients, they have to start with caring for themselves (self-care). The second area of focus for comprehensive staff-support

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programmes is interpersonal relations and teamwork. Van der Walt (1998) noted that teamwork is absolutely invaluable to nurses working in public health care facilities, because they have to support and compliment each other as they deliver complex services to often demanding clients. Another study found that the relationship between the nurse and his/her manager was the most significant indicator for intentions to leave (Houkes, Janssen, de Jonge & Bakker, 2003). The roles of immediate (middle) managers in providing support to staff are thus critical (Davidhizar & Bowen, 1992).

Types of staff-support programmes

Staff-support programmes seek to create buffers between stressors in the work environment and staff's exposure to these stressors in order to moderate the influences of stressors on staff (Cooper et al., 2001). Buffers could be introduced into personality characteristics by making sure that there is a fit between the worker and the work environment. These measures could be implemented during the recruitment stage or to inform placement of health workers within an organisation. Staff-support programmes may also seek to build employee-profiles to ensure that individual personalities match work demands and the context within which this must take place. Research showed for example that Type A behaviour patterns, negative affectivity (predisposition to low self-esteem and negative emotional states), hardiness (vulnerability/resilience), self-esteem and self-efficacy may affect the onset of psychological strain.

Staff-support programmes may also target factors within the work environment that lead to much stress (Cooper et al., 2001). It has been shown that when high job demands are combined with low job control, stress factors are very high. In these cases the programme would seek to identify and relieve points of conflict or tension, which normally arise between management and staff, by giving the staff increasing levels of freedom and decision-making ability. It is often found that giving employees sufficient information helps relieve fears of the unknown. As the need arises and is identified, specific training may be implemented for staff to help them resolve certain stressful matters within the organisation at the request of staff. Though the content may be the same as with secondary stress prevention, the approach is a bottom-up one. Organisations may seek to support staff by setting up structures to help

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individuals perform their tasks – *instrumental support*. Examples of this type of support include employee assistance programmes (EAP). The most common form of staff-support is through support groups. These groups may be formal or informal, practical or spiritual in nature, formed among peers or open to anyone who is interested (Carroll & Walton, 1997; Lederberg, 1998; Reynolds, 1997). Many companies have EAPs and workplace counselling programmes, which could facilitate these processes. Bolle (1988) found that giving staff *appraisal support* through supervision, mentoring and feedback from line supervisors and managers, caused decreases in burnout, despite health workers maybe still being under-paid and overworked. The value of *instrumental* support, where the worker is given practical help to slot in with the team goals, cannot be underestimated. Bolle (1988) suggested that seeking to create a caring and supporting environment should be a crucial part of providing support to stressed health workers working with chronic or terminal patients, such as people living with HIV/AIDS. It has been argued that staff-support programmes may present an opportunity to change organisational culture in health services organisations and change from a bureaucratic organisation to one that is more caring for patients and its staff (Van der Walt & Swartz, 2002).

CONCLUSION

Cooper et al. (2001) pointed out that although the concept stress has been through several improvements, current definitions and theories are still lacking the ability to provide a comprehensive framework to enable practitioners to understand organisational stress responses. What is known is that stress is the result of the interaction between certain work factors (stressors) and individual personalities, and between conflicting personalities on a work team. All practitioners agree that stressors on their own do not cause stress. Stress results from the outcomes of evaluative processes that individuals attach to events in their environment. Although the main stressors among health workers are clearly noted and agreed upon by the majority of researchers (O'Henley, et al., 1997), different viewpoints exist on whether stress is the direct result of these stressors (NIOSH, 1998) or the result of individual characteristics of health workers (Calnan, et al., 2001). The ecological model on which studies of stressors are based, falls short in three glaring ways:

(1) It fails to explain how factors in the environment (stressors) interact with individual workers to invoke stress responses.

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(2) It does not recognise the effects that personal characteristics and life histories of individual workers have on their experience of job stress.

(3) It lacks specificity to guide intervention building to manage stress in organisations.

While acknowledging the valuable contribution that the ecological models of stress made in identifying stressors amongst health workers, a conceptual gap remains between stressors and individuals. The exact processes by which factors in the environment (stressors) interact with individuals to cause stress responses, are still not clear. Staff-support interventions may benefit from a conceptual framework (theory) that would explain the onset and experience of stress within individuals in the face of stressors. In the next chapter I propose and introduce psychoanalytic theory as a framework for developing staff-support interventions.

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CHAPTER FOUR
PSYCHOANALYTIC FRAMEWORK FOR ORGANISATIONAL CONSULTANCY

INTRODUCTION

Although psychoanalytic theory has been criticised for being too narrow and individualistic in its approach to be of use in social psychology, Swartz, Gibson and Gelman (2002) report that increasingly more South African psychologists have found the psychodynamic approach useful when consulting in community settings and organisations. They observed that some of the criticisms against psychoanalytic theory came from writers who appear to have very little understanding of psychoanalytic theories and practices. Gibson (2003) noted that "*there seemed to be a fledgling awareness of its [psychodynamic approach] potential to offer a valuable and different understanding of social processes and to connect with the very issues that community psychologists were struggling with: oppression, racism and colonialism*" (p.36). Several new developments within the psychoanalytic field provide contemporary researchers with tools and concepts to understand relational dynamics in teams and organisations (Hinshelwood & Chiesa, 2002). In this chapter I describe some of these new developments in psychoanalytic theory, its origin and constituent theories and concepts, and how this approach has and can be implemented in consulting with individuals and groups in health settings and organisations.

Developments in psychoanalysis

Arguably the single most important change from classic psychoanalytic theory is the contemporary emphasis on the social origin of human experience. This change allows space for psychoanalysts to apply insights, normally attributed in individual analysis, to understand group behaviour. Whereas Freud (Richards, 1976) emphasised the influence of earlier psychosexual stages on adult functioning, later analysts stress that social context and relationships also play a significant role in adult behaviour. The last-mentioned introduced a more developmental view of the self, presenting a

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moving away from Freud's deterministic view of the self, which was understood to be driven by attempts to relieve conflicts created by life (survival) and sexual instincts. In the new analysis it is recognised that self is influenced by a complex combination of present social context and past relationships. Hinshelwood and Skogstad (2000), for example, found this understanding useful in consulting in health services organisations, because what health workers brought to the work situation in terms of personal history and life experience could be accounted for in analysis of individual and group behaviour. Psychoanalytic understanding makes it possible for the consultant to create awareness among staff of how the group is acting out anxieties and other emotions that may be felt unconsciously (Halton, 1994; Palmer, 2002). Within the psychoanalytic approach a hermeneutic view is adopted. Focus is placed on creating meaning of manifested behaviours and communication patterns, rather than explaining these behaviours. No claims about the empirical truth of forthcoming interpretations are made. To quote Gibson (2003): *"This emphasis appears to fit well with concerns in community psychology and more progressive ways of thinking to provide a space within which professional and culturally biased interpretations do not obscure alternative ways of interpreting experience"* (p.39). In psychodynamically oriented action research the focus is on communication within relationships rather than exploring underlying causes of behaviour. Within this process of making meaning, the emphasis of analysis is on discovering new patterns within a relationship or set of relationships. This approach to analysis makes psychoanalytic theory quite compatible for use in developmental methodologies such as grounded theory (Petersen, 2000). Schäpper (1997) added that the new emphasis in psychoanalysis that the patient and therapist engage both consciously and unconsciously in the relationship with one another provides space, by analogy, in action research to explore the dynamics between researchers and participants, and the possible roles that power and professional alignment play.

Another question that needs exploration is that of how the unconscious would be accessed when seeking to apply psychoanalytic interpretation to understand group behaviour. Through the development of the notion of "phantasy," psychoanalysts have found a way to access the unconscious in ways other than that of Freud's classical psychoanalysis (Young, 1992). According to Freud, the unconscious is largely hidden and revealed only intermittently through dreams, parapraxes and symptoms (Richards, 1976). Phantasy, on the other hand, is understood as the

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outward manifestation of the narrative that occurs between the conscious and unconscious (Gibson, 2003). Isaac (cited in Young, 1992) linked the notion of phantasy with Freud's "instincts" by stating that phantasy is the mental expression of instinct. According to Isaac reality thinking cannot operate without concurrent and supporting phantasies. Thus, by observing behaviour and communication in relationships contemporary analysts understand that they are able to interpret what may be felt on the unconscious level. This type of analysis (interpreting phantasies) presents a more comprehensive way to access the unconscious than that introduced by Freud, who sought underlying meaning through analysis wherein he sought to draw association between the symbol and its meaning by tracing back to the patient's past (path of distortion). Our understanding of adult phantasies provides a means of interpreting primitive phantasies by observing of group behaviour and communication as exemplified by Bion (1961) in his monograph, *Experiences in Groups,* which I explain in a later section.

The above-mentioned developments contribute towards making psychoanalysis a viable alternative to addressing the gap in theory between understanding broader organisational and social processes, and making sense of their influences on individual behaviour and experiences (Gibson, 2003). Psychoanalytic understanding has also been used to complement established organisational theories in formulating social interventions for groups (Obholzer & Roberts, 1994). This method of work was developed by a group of researchers (which included Bion) at the Tavistock Institute of Human Relations (Correale & Di Leone, 2002). They combined studying institutions as social systems using established social science methodologies *with* using psychoanalytically informed analyses to interpret unconscious aspects of group behaviours. The groundbreaking work that the abovementioned institute did in applying psychodynamic principles in organisations informed the work conducted in the current study. In the next section I describe how this tradition was formed and the theories and concepts that underpinned the work conducted at this institute.

THE TAVISTOCK TRADITION

The Tavistock Clinic was founded in 1920 by a number of professionals who pursued psychodynamic treatments of individual patients, clients and analysands on a part-time basis (Halton, 1994). After World War II some military psychiatrists and

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psychologists who had been exposed to the work of Kurt Lewin about field theory and group dynamics, started to explore how these concepts could be integrated with psychoanalytic ideas (Hinshelwood & Chiesa, 2002). Through the contributions of various members of the institute, a model for consulting to organisations was developed. It started with the training of six industrial fellows in unconscious group processes in the workplace, Eric Trist's study of the work organisation in the coal-mining industry and Elliot Jaques' intensive study of the internal relations of a manufacturing company (Fraher, 2004). Trist's study contributed to the understanding of the organisation as a socio-technical system. The organisation was seen as the product of the interaction between the work task, its techniques and technology and the social organisation of the workers pursuing it. Jaques (1951) contributed the recognition that social systems in the workplace functioned to defend workers against unconscious anxieties inherent in the work. Later consultants from the Tavistock Clinic developed the work of Kurt Lewin further through the adoption of the organisation as an open system that interacts with its environment (Roberts, 1994a). Gibson (2003) notes that rather than a hard line on how behaviour is to be interpreted psychodynamically, the Tavistock tradition or paradigm proposed a *way of thinking* about organisational processes, which consisted of a loose collection of ideas and practices brought together by various contributors. Palmer (2002) noted the following commonalities in the way consultancy was conducted by various members of the Tavistock Clinic over the years:

- A predominantly Kleinian account of the individual and defence mechanisms.
- Implementing Bion's understanding of basic assumptions that operate in groups.
- A systemic perspective of organisations and groups.

Object relations theory

Klein developed the notion of humans being object-seeking rather than pleasure-seeking, thereby placing emphasis on the role relationships play in development (Young, 2000). In observing children at play with toys, Klein made interpretations of how children split off elements of feelings that cause anxiety within themselves and project these onto external objects. She developed the concept *projective identification* to describe the process whereby the child relates to the caregiver in part as if the latter embodied the split-off element that the child projected onto the caregiver (Glover, 1998). Simply put, projective identification may be seen as a

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means of identifying as part of another, parts of the self which are difficult to manage and own. Through the processes of splitting and projection the child developed an unconscious inner world peopled by different characters that personify differentiated parts of self or aspects of the external world. According to Klein all human development begins from a *paranoid-schizoid position,* where bad parts within self are split off and projected onto external objects (Halton, 1994). In adulthood the person may re-live past relationships with significant others that might have been stressful, and project these feelings onto new relationships. Klein understood this as regression to infantile stages through adult phantasy. The goal of therapy is to help the client to integration of conflicting and difficult emotions into the self. Klein termed the end-state of integration as *the depressive position.* Although Klein never went on to apply concepts from object relations theory to groups or social processes (Gibson, 2003), others applied these concepts to help them understand group dynamics and relations in organisations.

Splitting and projection in organisations

Hinshelwood (1987) argued that the child's externalisation of phantasies into play with toys as observed by Klein, could also apply to groups. Thus, dramatised[5] relationships in groups could be outward manifestations of internal object relations. He went on to claim that the same processes whereby children arranged toys in play occurred with adults in psychotherapy as they fit the analyst in different roles and positions. He went on to state: *"the way in which people in communities and community meetings place each other in roles and relationships corresponds exactly to the unconscious positioning of 'objects' in adult or child psychoanalysis"* (Hinshelwood, 1987, p.51). Group behaviours that have valid meaning at a conscious level could simultaneously carry unconscious hidden meanings (Halton, 1994). Through application of what is known about splitting and projection, consultants are able to reach deeper levels of understanding and meaning of organisational processes (Obholzer, 1994). The concepts, *projective identification* and *countertransference,* provide the consultant with powerful tools to make links between observed individual behaviours and institutional dynamics (Halton, 1994). Gibson (2003) argues that through projective identification feeling states and emotional experiences become shared within groups as the boundary between the

[5] Dramatised = enacted display (behaviour) influenced by unconscious processes.

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social network and the person gets lost. Through countertransference, which Young (2000) argued to be a form of projective identification, the consultant may experience a reaction to emotions that he/she unconsciously received from the group and experienced as his/her own (Hinshelwood & Chiesa, 2002). In similar ways, projections could also be carried by groups within an organisation. This means that a particular group or team could be experiencing fears that are actually felt/shared by all the employees of an organisation. The members of that group would for the most part be unaware of the true source of their feelings, but through the consultation process they could be made aware of these projections. To quote Halton (1994): "*such an understanding can create space in the organisation in which staff members can stand back and think about the emotional processes in which they are involved in ways that reduce stress and conflict, and can inform change and development*" (p.17).

Concepts from object relations theory could also be applied to understand leadership styles and authority in organisations (Obholzer, 1994). According to Obholzer authoritative leadership is a depressive position state of mind, whereby the leader is in touch with his/her roots and sanctioning of authority and limitations. Authoritarian leadership on the other hand, refers to a paranoid-schizoid state of mind, where the individual is out of touch with him/herself and his/her surroundings. Such a leader deals with his/her unrecognised shortcomings by increased use of power to achieve his/her objectives or goals. Bion took the concept of humans as being object-seeking further in applying it to group behaviour.

Basic assumptions behaviour in groups

Bion (1961) observed many groups and found that certain dynamics seem to be recurrent within groups. Observing similarities (patterns) in the way groups work or resist working, he developed the notions of the *work group* and the *basic assumption group*. Bion described the **work group** or sophisticated group as one that is effective in performing its primary task. The primary task is the task by which the organisation finds meaning for its existence or the reason why the group or team was formed in the first place. The work group is able to reach high levels of functioning because the group meets the individual members' need to belong by providing opportunities and space for individuals to utilise their competencies and

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participate creatively to meet various task demands (Stokes, 1994). **Basic assumption groups** on the other hand, are distracted from performing their primary task and engage in various defence mechanisms to relieve anxieties associated with the task. The group's behaviour is directed at attempting to meet unconscious needs of its members (Stokes, 1994). The group adopts deviant or basic assumption behaviours where they look regressively for "magical solutions" that will free them from having to do the tasks that are set before them (Sempsey, 1994). Bion (1961) distinguished three types of basic assumption behaviours: dependency, fight-flight and pairing.

Basic assumption dependency groups cluster around the leader, who is called upon to provide in all the members' emotional needs (Bion, 1961). The group members remain passive and without responsibility while projecting their feelings of authority and capability to the leader (Young, 2000). Sempsey (1994) reasoned that this type of behaviour is essentially a form of regression to the parental/child relational pattern of omnipotence/dependence as described by Freud. The leader (or parent) is expected to protect the members from the anxieties that might be associated with the demands of the group's real purpose (Stokes, 1994). Leadership style in basic assumption dependency groups is characterised by a sense of heaviness and a resistance to change. A salient feature of basic assumption dependency groups is their preoccupation with status and hierarchy as the basis for decision-making. In health settings a sophisticated use of the dependency mentality is mobilised, to encourage patients to give themselves over to health professionals in a trusting, dependent way (Stokes, 1994). This mentality is often characteristic of well-run hospitals and clinics (Hinshelwood & Skogstad, 2000). In an aberrant form this mentality could produce a *culture of subordination*, where authority is entirely derived from position in the hierarchy, requiring unquestioning obedience as observed in the nursing profession (Menzies, 1960).

Basic assumption fight-flight groups believe that the group is assembled for the purpose of fighting against some enemy or fleeing from some danger (Bion, 1961). The basic drive behind fight-flight assumption behaviour is to preserve the group's sense of identity or survival from some external threat that could be real or imagined. The group projects negative feelings (anxiety) towards external objects and keep positive feelings (belonging and loyalty) inside the group (Young, 2000).

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Cohesion and solidarity within the group are facilitated by developing an unconscious agreement on what is considered to be good and what is bad. Fight-flight assumption groups usually find a great sense of togetherness in discussing and worrying about potential threats, which also serves the purpose of distracting them from having to face the anxieties of the work itself. The group is preoccupied by rigid application of rules and regulations, which they use to control bad objects (the enemy – external and within), but tend to be very vague about their goals. Leadership in basic assumption fight-flight groups is characterised by aggression or suspicion (Stokes, 1994). In an aberrant form this mentality produces a *culture of paranoia* and *aggressive competitiveness*.

Basic assumption pairing groups hold the unconscious belief that the coupling or pairing of two members of the group or the leader with some external person or object, would magically produce the solution to the group's problems (Stokes, 1994). Bion (1961) observed how groups that held this assumption concentrated all their activities around the pair, forcing the pair to take over. By focusing their attention on the current idealised state of the pair, the group is 'saved' (successfully distracted) from the anxieties connected to the real task of the group. Bion postulated that the group's fear of dissolution is subverted to the hope that the overt libidinal ties of the pair will reinforce the libidinal ties of the membership, and therefore reinforce group cohesion. He noted how the individuals in the group would seek to connect to the pair in some way so that they would not feel excluded from the group. Young (2000) noted that the hope that the pair would produce solutions for the group is always kept in the future tense, (in other words, must not be fulfilled) so that the group would not have to tackle reality. The group is preoccupied with alternative futures and would typically request that the leader meet with external authorities to find solutions that would carry unsubstantiated hope for better outcomes. In an aberrant form this mentality produces a *culture of collusion*, where the group's mission is clear, but no way of achieving it is defined or discussed.

According to Bion (1961) basic assumption groups might become work groups, when they are made conscious of their basic assumption behaviour. The consultant's role is thus to interpret at selected moments the latent meaning of the group's behaviour.

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Perspectives from open systems theory

The Tavistock tradition supported the idea that organisations are *open systems* (Palmer, 2002). The idea of an open system is borrowed from biology, where it is understood that living organisms can survive only by exchanging materials with their environment (Roberts, 1994a). These exchange processes need to be regulated to maintain the delicate balance within the organism in the face of changes in the environment. In a similar way, organisations receive inputs on the one end and produce outputs at the other end (Figure 1). In-between there is a system of activities (processes) that are designed to convert the inputs to outputs. In a health service this could mean that patients coming in from one side and leaving the other side having received health care (education, treatment, medication or referral to higher level of care) (Zwarenstein & Bachman, 1997). However, there are also other inputs to the system such as health workers with their skills and attitudes, resources and other materials that are needed to perform the *conversion process*. The quality and quantity of these inputs would influence the measure of success achieved with respect to producing the intended outputs. In healthcare services the intended output relates to quality healthcare.

Around these processes is a *boundary*, which serves the purpose of regulating interaction with the environment or outside world (Roberts, 1994a). In organisations this boundary is supposed to be maintained by management functions. *Management of the boundary* requires that management be aware of what is going on in the world outside the organisation and regulates the measure of influence that outside events has on the processes within the organisation. It is crucial that a measure of diffusion exists between the organisation and the outside world, because this would enable the organisation to adapt to a changing environment. If the boundary is too open, the organisation may be distracted from its primary task by a host of other demands. If the boundaries are too tight, then the organisation is at risk of becoming irrelevant to the world around.

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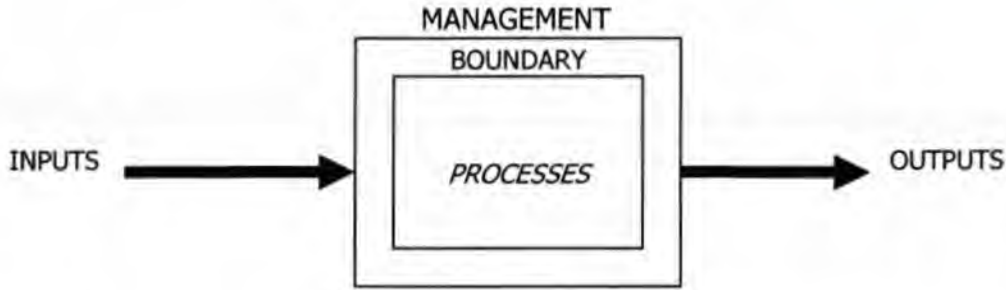

Figure 1. The organisation as an open system (adapted from Roberts, 1994a)

Viewing the organisation as an open system has several advantages for psychodynamic consulting. Firstly, it facilitates the identification of sources of conflict within the system. Secondly, it informs the consultation process, by showing how subsystems interact within an organisation. Thirdly, it provides concepts that are easily understood by employees and thus useful to help the organisation learn from its own experiences and adapt accordingly.

Social defences

The notion of social defences is fundamental to the consultancy work of Tavistock consultants when working with organisations (Palmer, 2002). In psychoanalysis it is understood that an individual has conscious and unconscious anxieties and conflicts, which are dealt with by developing psychological defence mechanisms (Hinshelwood & Skogstad, 2000). Jaques (1951) broadened this concept to understand that a social system could serve the purpose of supporting an individual's own psychological defences. Although it is the individuals who experience anxieties, the social system operates in a way that allows individuals to avoid certain anxieties and conflicts, especially those anxieties related to the primary task (Menzies, 1960). Menzies understood anxieties to be caused by unconscious phantasies concerned with human aggression and damage caused by them. The person may feel responsible to repair damage caused by these phantasies, because the individual would not differentiate on an emotional level what is real and what only exists in his/her phantasies. Tremendous guilt is often experienced when the outcome of providing healthcare does not restore the person to full health or when the patient dies (Roberts, 1994b). Health workers would use various defence mechanisms within the organisation to help defend against their own anxieties evoked by the work. Social defences are

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reflected in rituals, the way tasks are performed, and management practices that are justified at a conscious level, but actually serve to protect against unconscious guilt and anxieties evoked by the work (Hinshelwood & Skogstad, 2000; Menzies-Lyth, 1990). As members of the organisation unconsciously interact with each other, the social defence develops and becomes part of the organisational culture. Certain individuals may be drawn to particular professions or organisations, because their own defences match aspects of the social defence system of the organisation (Dartington, 1994; Roberts, 1994b).

Institution as a container

Social institutions may also play a containing role for individuals (Hinshelwood, 1987). Gibson, Swartz and Sandenbergh (2002) explained containment, by analogy, as the process whereby the mother processes the feelings of the infant that are both strange and fearful, which are projected onto her. Through the mother's acceptance and integration of the infant's feelings, the infant is reassured that the world is a safe place. The mother thus becomes the container for the emotional contents of the infant that are too stressful for the infant to handle. In similar ways, the institution can become a container for individuals where they can find mental space to arrange elements of thought (Correale & Di Leone, 2002). The organisation's boundaries (rules, roles and regulations) provide a framework (contained space) where the individual can integrate aspects of him/herself. Correale and Di Leone concluded that:

> *If the institution is conceived as a container, all the events that take place within the institution itself gain importance as they all pertain to aspects of the mental life of the individual, placed within aspect of institutional life* (p.87).

Organisational culture

Trist first introduced the link between sociological and psychological processes through the notion of psycho-social systems (Hinshelwood & Chiesa, 2002). According to him the enactment of organisational culture could be linked to the manner in which the external requirements of the organisation were internalised in the minds of the employees and clients and management (Gibson, 2003). This

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means that an employee might fulfil a certain role because this has been assigned to him/her (on a conscious level); but may also have his/her own motives for taking part in it (on a unconscious level). In consulting to organisations, the link between the practical and material conditions of organisational life and that of the social system of organisation need to be studied.

Organisation in the mind

Armstrong (1995) commented that the individual's construction of the organisation is not merely his/her own mental construction, but also reflects the emotional reality of the organisation that is registered in him/her. Thus, the individual may carry within him/herself aspects of the unconscious life of the organisation, being the object of counter-transference. As Palmer (2002) pointed out this is true for the individual working in the organisation and for the consultant. Gibson (2003) was of the opinion that aspects of the shared culture within the organisation could be accessed through the individual's conscious beliefs and unconscious phantasies about what the work and organisation requires of him/her.

EXAMPLES OF PSYCHODYNAMIC CONSULTANCY IN HEALTH SETTINGS AND OTHER ORGANISATIONS

Several researchers from South Africa and abroad have applied psychoanalytic understanding in supporting staff in care organisations. Staff working in human services organisations often experience working with people with great emotional and physical needs as very stressful (Obholzer & Roberts, 1994). This stress is mostly attributed (by staff) to conscious anxieties that arose from heavy workloads, lack of resources, staff shortages and other factors relating to service delivery. Unconscious anxieties stirred up, on the other hand, are kept out of awareness by personal and institutional defences. Menzies (1960) was the first person to apply psychodynamic theory to understand nursing practice (Van der Walt & Swartz, 2002). Her interpretation of social defences amongst British hospital nurses is widely regarded as a classic in the field of psychodynamic theory and continues to inform organisational consultancy in social welfare, education and business management (Van der Walt & Swartz, 1999). Van der Walt (1998) drew on the insights from Menzies' work in her ethnographic study of nursing in the tuberculosis control

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programme in South Africa. She described how task orientation was implemented by nurses to protect them from having to deal with patients' emotional experience of their illness and the fear of being contaminated by dangerous and infectious diseases. In the following sections I review the work of Menzies-Lyth and of Van der Walt. I also review the work of several researchers in various community settings in South Africa, which demonstrates that psychoanalytically informed consultancy work could make a valuable contribution to support interventions to care workers in this country.

Rituals as institutional defence

Menzies (1960) described how nurses developed and participated in rituals that were designed to protect them against the anxieties evoked by their work of caring for the sick and dying. These defences included splitting up of nurse-patient relationship, depersonalisation, categorisation and denial of the significance of the individual, detachment and denial of feelings as well as other measures to avoid taking responsibility. She showed how these rituals, though protecting against the anxieties induced by the work, eventually caused more anxiety as the nurses were cut off from their primary motivation and aim of their work. This resulted in student nurses not completing their training, high turnover of senior staff and absenteeism due to minor illnesses.

Several important lessons could be learnt from Menzies' work. Firstly, that the reason why the consultant is approached by the organisation initially might not be the primary problem. In Menzies' (1960) case she was first asked to address the problem of student-nurse allocation, which was the *"presenting symptom"* (p.3). It is therefore imperative that the consultant explores the nature of staff's anxiety as Menzies did by conducting interviews with staff individually and in small groups, and doing observations in the hospital.

Secondly, consultation should always be done with the *primary task* of the organisation in mind or else the consultant may become irrelevant to the functioning of the organisation. In Menzies' case the primary task was to *"provide continuous care for patients, day and night, all year round"* (Menzies, 1960, p.5). By exploring the primary task and all the possible distortions and deviances from this, the

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consultant is able to uncover what primary anxieties are evoked by the work, and how staff dealt with these anxieties. Menzies found that in caring for patients with incurable diseases, nurses in her study were directly confronted with suffering and death, as recovery was never certain nor complete. The work situation aroused strong, mixed feelings within nurses of pity, compassion and love; guilt and anxiety; hatred and resentment of patients; and envy of the care that the patients received.

Thirdly, through the application of psychodynamic thinking, one could reach deeper levels of understanding of the unconscious processes that motivate human experience and behaviour (Van der Walt & Swartz, 1999). She found that conflicting feelings experienced amongst staff were strongly related to the unconscious phantasy situations in the minds of humans (Menzies, 1960). By applying psychodynamic interpretation to this situation, she traced elements of these phantasies back to infancy where, according to Klein (Young, 1992) the infant would experience two opposing sets of feelings: libidinal (life-giving) and aggressive (death-dealing).

A fourth contribution that Menzies' work made to psychodynamic understanding in health settings, was in describing how nurses were the recipients of *projections* from patients and their families. Patients projected complex feelings of appreciation, gratitude, affection and respect as well as resentment and envy (Menzies, 1960). This resulted in behaviours where patients were often demanding, possessive and jealous for having to be subject to the discipline of the hospital routine and treatment. They would often lead to non-compliance with the treatment regime and abdicating full responsibility for their illness to the nursing staff.

Lastly, Menzies' (1960) case study showed that awareness in itself was not a guarantee for change. The individuals involved must be *willing* and *emotionally ready* to change. When she fed back her findings to the senior management of the hospital, only changes that involved minimal disturbance of the existing social defence system were implemented. Thus, psychodynamic consultancy should not be regarded as a magic wand that would "heal" the organisation's problems. It only provides tools for understanding unconscious processes, which, if taken up by committed individuals, would provide the impetus for change in the organisation.

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The work of Menzies, and in particular her development of the notion of social defences, influenced the later work of other researchers who worked dynamically in health settings (Hinshelwood & Skogstad, 2000; Van der Walt, 1998). Of particular interest to the current research is the work of Van der Walt in the National TB control programme in South Africa, who described task orientation amongst nurses working in public PHC services.

Task orientation in SA nursing

In exploring poor adherence to TB treatment by patients in public primary health care in one of the provinces in South Africa, Van der Walt (1998) found similar patterns of task orientation being practised by staff to that described in Menzies' (1960) study. This should not be of too much a surprise since it was previously noted that the nursing profession in South Africa was shaped by British colonial traditions (Marks, 1994). In her deliberation of what she termed "too close for comfort" Van der Walt explained how nurses' *identification* with patients' racial background, presented difficulties for providing patient-centred care. She observed that nurses experienced great anxiety and demonstrated less tolerance when caring for patients from similar backgrounds to themselves, when compared to their colleagues who came from different ethnic backgrounds. Through application of Bion's (1961) understanding of group processes, she was able to explore the responses of a staff team to a training intervention aimed at improving healthcare to TB patients, which related to the staff team's perception of authority and leadership within a bureaucratic health structure. She suggested that staff might benefit from group consultation with outside consultants, wherein they are made aware of their anti-task activities – that is, activities that are not aligned with the primary task, but kept the staff occupied. In her opinion, work-related staff support may go a long way in containing staff anxieties and helping PHC staff teams in South Africa adapt to changes in the health sector as well as implement changes in their nursing practice. Although this type of support work has not been implemented in PHC in South Africa, other researchers implemented this approach in consulting in other types of human services organisations (Swartz, Gibson & Gelman, 2002). Lesson learnt in these contexts may be useful when considering consultancy work in PHC settings.

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Lessons from community work in SA

Gibson (2002) noted that the legacy of apartheid in South Africa left a society internally divided and intrinsically suspicious of institutions and organisations. This posed specific difficulties for psychologists who want to work in community settings or with community-based organisations (CBOs). The relationship between the psychologist and the client or client group typically mirrored divisions and conflicts such as present in broader society. Thus, in consulting, the consultant has to come to terms with his/her own biases as well as those of his/her client or client group. Sometimes just engaging in this process by itself brings healing to the relationship. She developed the notion of "traumatic living" (p.10), which depicted a state of continuous stress that many South Africans live under as a result of a politically volatile past. Unlike "trauma", which can be clearly diagnosed and treated as if it was a disease, traumatic living may operate on a broadly unconscious level. From these levels it may influence the way relationships develop posing particular problems for building trust in participatory research models.

Other issues to consider in consulting to and in community settings are those of *fear and safety*, and *power and powerlessness*. Unless the consultant takes particular note of these factors, and makes specific provision for resolving these issues in the consultation process, he/she may run the risk of experiencing that the process being derailed by 'hidden' processes. Resolving these issues remains one of the toughest challenges for consulting in communities or organisations with strong community affiliations. Sterling's (2002) case study noted the dangers of consultants going to the extreme in emphasising the strengths that lay in the community (as client group), which could lead to *"idealisation of the community"* (Hinshelwood, 1987, p.138). Sterling explained that in trying to reduce the gap between those who have power (the psychologists with the skills and knowledge) and the historically powerless (the community), psychologists may have underplayed the role they played as professionally trained consultants and placed unrealistic expectations on community members to be empowered to act after only a brief training intervention. In this regard, a clear balance needs to be maintained wherein consultants do not jump in to produce solutions, but provide contained space for client groups to gain greater awareness and explore alternatives that might lead to more positive resolve (Van den Berg, 2002). This requires much patience from the consultant, something

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which Maw (2002) argued must be accompanied by much reflection about the process and other outside processes that might impact upon it.

Tomlinson and Swartz (2002) summed this debate up by stating that knowledge gathered through training and experience as well as that gathered from literature should be combined to develop community interventions, while being open to learn and draw on the knowledge that already exist within the community – essentially a participative approach to developing interventions. Swartz, Gibson and Gelman (2002) argued that psychoanalytic models could provide social researchers with an excellent opportunity to contribute to social transformation in South Africa through their unique quality of leaning toward a more reflective assessment of relational dynamics within organisations, and between organisations and communities. Social change requires changing relationships, which is impossible to achieve on national level. By consulting with human service organisations the social researcher has the opportunity to reflect upon the broader social and political context, and how these factors influence individual behaviour within the organisation, and between consumers and providers of service. By intervening on the level of human relations, the organisation could be moved towards alternative thinking (which is a prerequisite for change to take place). Changes that take place in human service organisations would then have good prospects of facilitating change in the communities that they serve.

Psychodynamic upheaval in organisations that merge

One of the key changes occurring in South Africa at the time of the current research was the decentralisation of health authority structures to local government level. As described in Chapter Two, this required the amalgamation of various local government health structures with provincial health authorities to form autonomous, self-governing health districts. Gilkey (1991) used the metaphor of a "blended family" (p. 349) to interpret the anxieties that staff often experience when their organisation merges with another. When organisations merge, staff teams are brought together with different 'family' histories – experiences, organisation of work and constitution. On a unit or division level it might mean that managers are faced with the task of assisting staff, who in some ways see themselves as stepchildren, to adapt to new rules and regulations and work towards organisational goals. It is thus

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common for staff to experience the traumas of coming to terms with new structures and systems, power from outsiders, territorial battles, boundary delineation and start-up problems after the merge or acquisition has taken place. This trauma might cause staff to regress to early childhood experiences where psychosocial crises related to development were primary. Gilkey proposed that staff experiences after an organisational merge follow similar predictable stages as the stage of psychosocial development stages described by Erikson (1960). I will briefly describe how Gilkey applied these stages to staff experiences during mergers.

When organisations make their intentions known that they are going to merge, employees go through a period where their current predictable, known environment is threatened with change (Schäpper, 1997). The anxiety caused by the anticipated change re-evokes employees' infantile anxieties (Gilkey, 1991). In Erikson's theory (1960) about individual development during the infant stages, containment of these anxieties through sensitive parenting leads to basic trust – a sense that the world is a safe place; whereas lack of containment would lead to a basic mistrust. In an analogous way, employees would seek the assurance that the new environment would be as stable, predictable and benevolent as the previous work environment to develop basic trust in the organisation (its management and members and processes). Until this fundamental sense of security is established the employees would find it difficult to contribute or commit to new organisational goals and values. The inevitable loss of love (relationships), support (networks and loyalties), sensory input (information received) and capacity to act (power) that accompany most mergers might lead to protracted periods of dysfunctional depression amongst some employees. Gilkey suggested that organisations would do well to provide clear communication and detailed information about the transition process and the task forces that are involved, to help employees develop basic trust in the new organisation and its constituencies. Management needs to allay fears of job security as soon as possible. In the likely event of certain staff members losing their jobs, those that remain need to be given time to mourn these losses.

It is also essential that staff who remain behind be made aware of their new roles as well as their involvement in the merging process (Gilkey, 1991). Clear communication about these allows employees to successfully resolve the crisis of *autonomy versus doubt and shame* and gain confidence about their contribution to the new

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organisation. The outcome of amalgamation tends to resemble the notion of being "winners" or "losers" in the process (Schäpper, 1997). This outcome is not always sure, because "winners" may also feel like powerless victims played with by large forces. This is especially the case when there is no clear communication of management's plan to execute the merger. Staff members who "survive" the merge might feel guilty for being promoted at the expense of others to whom they feel emotionally attached (Gilkey, 1991). Guilt may be exacerbated when new managers view themselves as accomplices in ruthless exercises of power in rationalising and downsizing programmes. In both cases it is important that management be proactive and explain how these decisions were made and where the new appointees fit in with the new strategic objectives of the organisation. When *unconscious guilt* is dealt with, the employee can move on to safely take *initiative* in line with the direction that the new organisation is going. In Schäpper's case study (1997) some employees were able to adjust comfortably to change as a result of their managers' commitment to "work through change" with them.

Through a mixture of strong business and political acumen and people skills in organisational leadership, paranoid fantasies about the organisation's future can be contained and employees safely navigated through the first three stages of conflict in the organisational merger (Schäpper, 1997). The organisation can then set itself the task to restore psychological strengths (industry and identity) and move to higher levels of organisational functioning (intimacy, generativity and integrity) (Gilkey, 1991). The conflict between *industry versus inferiority* can be resolved by restating the organisation's vision and the rationale for the merge (i.e. why the merge was a good or necessary decision). A conscientious effort should be made to clarify goals in the new organisation in this intermediate phase where the old is "no longer" and the new has not yet come. Gilkey suggested that the conflict between *identity versus identity confusion* could be resolved by setting performance appraisal and promotion systems in place. Consistent implementation of these systems could contribute to individual employees' feeling that they belong – a successful resolution of the conflict between *intimacy versus isolation.* From here on the organisation could seek to further develop a sense of their mission amongst their employees and managers and set out strategies for realising its mission (*generativity versus stagnation)*. In both instances the roles that the employees could play towards fulfilling these are clearly communicated. In the final stage the organisation could seek to instil a value for past

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and present contributions and linking these to the future vision of the company (*integrity versus despair).*

Gilkey's interpretation of the experiences of employees when their organisations go through mergers, not only illustrates the usefulness of applying psychoanalytic insights to social phenomena such as mergers, but also provides a useful framework for developing staff-support interventions.

THE ROLE OF THE CONSULTANT

General approach to organisational processes

Members of the Tavistock Clinic advocate that consultants stay as close as possible to the environmental and emotional realities as presented in the organisation (Mosse & Roberts, 1994). This requires that the consultant recognise that organisational constraints, such as staff shortages, work overload (as well as work underload), and lack of resources, impact on the organisation and its members. Gibson (2003) reasons that a dual perspective on organisational (hard) and emotional (soft) issues is not necessarily contradictory, and in fact, could be complementary. She argues that external conditions may be creating possibilities for internal experience through the medium of phantasy. Moylan (1994) describes how stresses caused by work factors manifest in unpredictable ways in the psyche. The role of the consultant is to consider both internal and external realities and provide meaningful interpretations that would link individual experiences with organisational issues and that would provide direction for change in the organisation.

When organisations seek (or agree to) the help of external consultants, they often do not know what the real nature of the problem is, except that there might be problems with high absenteeism, turn-over or low morale (Moylan, 1994). The first objective of the consultant is thus to clarify the *nature of the problem* (Menzies, 1960). The nature of the problem usually has two aspects that are interlinked. First, there are the conscious factors, which are related to stressors (overt causes of stress) in the organisation. Menzies termed these the 'presenting issues'. Secondly, there are unconscious ways that staff and management are seeking to deal with stress and the work, which might exacerbate the problem. In this section I will

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explain how the consultant may practically go about exploring the nature of the problem and then offer interpretations. Even though I describe these two processes separately, these do not necessarily following in linear order. In fact, these processes tend to overlap and run parallel to each other. Aspects like length of time and priority would also differ across groups and settings. I describe the process of exploring "hard issues" (organisational factors) in describing the role of the consultant. I deal with the "soft issues" (emotional factors) in describing the role that interpretations play in consultation in the Tavistock way.

Nature of anxiety and the primary task

According to Menzies (1960) anxieties experienced by nurses may be related to the primary task and the phantasies that these evoke in staff, projections from patients and their relatives, and the failure of the social defence system. Although primary tasks vary across health settings, their task-demands invariably contribute in large part to staff anxieties (Menzies, 1960; Skogstad, 1997; Van der Walt, 1998). Anxieties may present in the form of conflicting feelings like pity and sadness, resentment and guilt, fear of illness, contagion and death, doubts about one's ability to care for patients, and helplessness. In the current global context of health reforms, with its emphasis on rationalising of health services, resources are decreasing, sometimes rendering fulfilment of the primary task impossible (Van Wyk, Benjamin & Sandenbergh, 2002). The degree to which resources, organisational structures and worker skills and competencies are available and present within the organisation, may lessen the measure of anxieties experienced by staff (Gwele, 1998; Van Wyk, Van der Walt, Swartz & Firfirey, 2001). However, especially since healthcare involves emotional labour, it is understood that what the health workers bring to the work situation regarding the unconscious may also impact on conscious anxieties experienced in their work (James, 1992). Menzies' (1960) example showed how nurses experienced considerable anxiety when caring for patients in physical and psychological distress, because these situations evoked unconscious memories of past relationships. Health workers might also take up what Roberts (1994b) termed the 'self-assigned impossible task' in their ardent pursuit of the primary task, which actually serves to fulfil their unconscious need for reparation.

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Whereas nurses in Menzies' (1960) study were simply tasked *"to provide continuous care for patients, day and night, all year round"* (p.5), as I have discussed earlier, the primary task in primary healthcare is more complex, i.e. *"to protect society against illness and disease"* (Van der Walt & Swartz, 2002, p.1008). Primary care nurses are tasked with contradictory roles as caregivers to individual patients and as combatants against epidemics that are threatening the health of the public such as TB and HIV/AIDS, which give rise to strongly felt anxieties. Unlike the nurses in Menzies' study, primary care nurses are also not able to exercise direct control over patients and their contact with the outside world, and are totally dependent on patient compliance to achieve good health outcomes. Poor adherence to treatment or health protocols is another cause of anxiety for primary nurses in performing their health tasks, partly because the ramifications of poor adherence will be borne by the community at large through, for example, the spread of multiple drug resistant TB.

Projections

Health workers are often the objects of projections of the patients' anxieties (Moylan, 1994). Through the process of projective identification health workers experience these anxieties as their own. Patients might also express their anxiety by being demanding of health services and not adhering to treatment (Menzies, 1960). These undesirable health behaviours add to the complexity of the nurses' tasks and their anxieties. Thus, Menzies' assertion that unconscious projections of patient anxieties add to staff anxieties, can be extended to include conscious projections of anxieties in the form of health behaviours. Identification with patient's anxieties can become even more pronounced when there is imminent danger of health worker being infected by the patient and crossing the 'divide' to become a patient as is the case with TB, which is airborne through sputum (Van der Walt, 1998). In primary nursing the open boundaries between the PHC setting and the community might also create anxieties about psychological contamination, which is exacerbated when nurses come from the same communities in which they work (Van der Walt & Swartz, 2002).

In projecting their fears and anxieties about their illness onto health workers, patients also tend to displace responsibility for their health and well-being onto health workers, which frees them, in turn, to engage in careless, if not risky, health

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behaviours (Menzies, 1960). Outcomes such as poor adherence and defaulting of treatment have further implications for health workers' anxieties, as mentioned above (Van der Walt & Swartz, 1999).

In summary, it could be said that the nature and feasibility of the primary task, the complexity thereof as well as the individual's internal response to it, affect the measure of anxiety experienced by staff. Secondly, Menzies' notion that patients and relatives project their anxieties onto staff members, could be extended to include overt health responses, because these also affect staff anxieties. Lastly, the impact of social defences on staff anxieties, clearly indicate that staff's responses to work stresses or stressors, might be as important as the stresses itself. I will now explain how a consultant might go about exploring these anxieties and then how he/she would work with staff in dealing with their anxieties.

The role of interpretation

Taking a systemic view

The first task of the consultant when embarking on work in any organisation would be to conduct a systems analysis (Roberts, 1994a). It is imperative that the consultant seeks to define and clarify roles, tasks, lines of accountability and communication, etc. within the system. This is important for both the consultant and the client group. The benefit for the consultant is that he/she is informed about the stresses that staff are experiencing, albeit on a conscious level. The process of gathering this information might involve interviewing key informants in the organisation as well as observations and informal interviews with staff members. This contact with members of the client group could go a long way toward overcoming suspicion amongst the staff group as well as managers that the consultant is listening to them (Cohn, 1994). One of the critical challenges for external consultants is to show that they have an understanding of the organisational issues, because these have implications for the consultants' perceived credibility with staff (Greenwood, 1997).

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Building trust

The importance of building trust with the client group (staff or managers) cannot be underestimated. Upon entry into the organisation the consultant's credentials might induce some credibility with staff. However, several other factors need to be taken into consideration as well such as race (especially in the South African context), professional background and perceived alignment with managers (if dealing with staff) (Gibson, 2003). It is important that the consultant be aware of his/her perceived frame of reference as well as his/her own cultural or professional biases. The presence of the consultant may feel like criticism to clients, because it carries implications that they are not able to cope, and therefore need outside help (Cohn, 1994). This is particularly problematic for health workers, who tend to feel that they should be well able to cope with their emotions. Once initial staff resistance has been bridged, it is important for the consultant to be aware that trust is an on-going process, and that in every session, he/she needs to make sure that trust has been re-established before moving on. It may be that trust has to be re-negotiated at a later stage due to the occurrence of a parallel event(s) that occur within the organisation and that may influence how the consultant is perceived.

Contained space

One of the primary functions of psychodynamic consulting is to support. It is essential that the needs of staff be explored in offering a support service. To explore staff stresses an atmosphere needs to be created in staff groups where staff feel safe and assured that their feelings are respected and not judged (Mawson, 1994). It is important to establish clear boundaries so that staff feel encouraged to share openly in the first place. Issues like venue and time of meeting, length of meetings, punctuality and the content that is to be discussed in these support meetings need to be clarified upfront and adhered to, because these structures provide containment for staff to communicate their emotions. It can be very disturbing for staff if the impression is created that their feelings dictate the shape and structure of the meetings. Whereas staff are consulted initially about the content to be discussed in the group, it is then the consultant's responsibility to make sure that this is adhered to during the duration of the process. If there is a need to re-visit earlier decisions, the consultant will bring this to the whole group and make sure that the process

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happens in an orderly fashion that does not create confusion or give in to chaos (which might exist within the emotional states of some of the group members). It is usually good practice for the consultant to set up an emotional contract with participants where issues such as confidentiality and reporting are clarified upfront.

Learning in groups

Another key objective for the consultation process is to facilitate learning in the group. This is done by helping staff to greater awareness of unconscious processes through interpretations of group behaviour by the consultant (Gibson, 2003). Learning can only take place once staff members feel safe enough to share their emotions and are ready for self-examination. The consultant plays the role of facilitator and provides interpretations of group dynamics. It is imperative that the consultant seeks psychodynamic understanding without being judgmental of their clients or themselves (Halton, 1994). A useful way of going about the process is to start with the presenting symptom (the reason why the consultant has been approached for help) and talk to staff individually and in the group about this. The consultant may utilise support or sensitivity groups to aid exploration of work anxieties (Mosse & Roberts, 1994). To discover what is wrong, the consultant needs to listen to their stories, noting content, mood and the way the information is presented during consultation. In learning to listen it is crucial that the consultant be aware of his/her own experiences, because what often happens is that the consultant may experience what the staff is experiencing via *countertransference*. Another tool that is useful in consultancy is that of *projective identification* in communication. It is the consultant's task to help staff learn to understand and interpret their communication. The consultant takes particular note of the emotional atmosphere in the organisation, because these would give indications as to the defence mechanisms used (Skogstad, 1997; Speck, 1994). Staff members invariably have the need to develop adequate defences to protect themselves from institutional stress and the barrages of clients' projections, or else they might succumb to despair, illness or withdrawal and eventual burnout. The consultant also needs to be attentive to ways that staff become entangled with projections from clients and use the same defences (Moylan, 1994). The goal is to give interpretation of unconscious anxieties and show how they are linked to certain behaviours (Bion, 1961).

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Palmer (2002) states that the consultant must be willing to act as a container for group anxieties. It is crucial that the consultant hold on to these anxieties until the group is ready to receive the interpretation. Gibson (2003) argues that it might be useful for the consultant to develop, with the group, during consultation a capacity for thinking about experience. Within this, it is recommended that the consultant play a passive role rather than give advice on how to address specific needs within the organisational context. It is important that the consultant resist the temptation and pressure from the group to put things right immediately. It is important that the consultant work with and in the transference, which might manifest in an inner urgency (in the staff as well as consultant) to repair damage or heal the situation. Palmer reasons that it is imperative the autonomy and capabilities of the consultant as well as the participants be maintained in the consultation relationship. It might be useful for the consultant to interpret and use his/her own feelings, fantasies, impulses and behaviour, and communicate these to the group when this is appropriate (Schäpper, 1997).

Limitations

The limitations of psychoanalysis in providing a thorough analysis of work in a health service organisation are noted. Though psychodynamically oriented consultation recognises the role that 'hard' issues play in staff stresses, it does not seek to intervene directly on this level. As mentioned previously, the psychodynamic social scientist uses psychoanalytic theory to explore the unconscious motives of workers within the organisation and how organisational issues such as authority, work roles, autonomy and dependency affect relations between workers, between workers and clients, and workers and management (Czander, 1993). Thus, the focus of the work is on relational dynamics that affect health workers' ability to provide thoughtful, patient-centred care. As Halton (1994) stated, the psychoanalytic approach to understanding organisational dynamics does not claim to provide a comprehensive or complete explanation or description. Following this approach does provide a potentially creative tool, which may help in understanding and dealing with certain issues in organisations. Thus, with the interpretations provided in the current research I do not claim exclusive truth, but do seek to contribute towards understanding relationship dynamics in public primary healthcare settings in South Africa.

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CONCLUSION

As previously mentioned, the causes of stress in health services organisations are well-documented, yet the process whereby individual workers are influenced by these stressors are not well understood (Cooper, et al., 2001). Gibson (2003) showed that new approaches within psychoanalysis provide means to interpret unconscious processes that occur in groups and in organisations, in ways that do not obscure dynamic interactions and relations between individuals and on individual-organisational interface. Furthermore, being aware of unconscious aspects of self and groups can create the space for staff members to reflect on the emotional processes in ways that could reduce stress and conflict and inform organisational change processes (Van der Walt & Swartz, 2002). A committed consultant displaying emotional energy and much patience would be able to work through staff's initial resistance to change and help them to move to alternate ways of dealing with anxiety and stress evoked by their work (Menzies, 1960; Palmer, 2002). Although knowledge in itself may not be sufficient to change behaviour, creating space for thinking about work is a necessary precursor to action and behaviour change. In this sense, psychodynamic consultancy might go well beyond its obvious usefulness in providing emotional containment, to empowering staff to change not only their behaviour, but also the prevailing cultures within health organisations (Cilliers & Kossuth, 2002). It has been argued that individual change without concomitant changes in the prevailing culture in health organisations would not result in meaningful changes in the organisation of work in ways that would relieve experiences of workplace stress and prevent burnout (Cilliers, 2003).

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CHAPTER FIVE

METHODOLOGY

INTRODUCTION

The current study was framed within the tradition of health systems research (HSR) as conducted by a research unit within a parastatal research organisation in South Africa. Traditionally, HSR aims to improve the health of the population through generating knowledge that would lead to improvements in healthcare delivery (Crombie & Davies, 1996). Health systems researchers employ rigorous scientific methods to investigate identified problems in planning, organisation and management, and evaluation of health services (Zwarenstein & Bachman, 1997). The outcomes of HSR are geared towards promoting equity, efficiency and effectiveness of healthcare delivery. HSR is conducted in partnership with stakeholders in the health services at either frontline or management level to facilitate common or shared understanding of complex problems in service delivery, their causes and proposed solutions (Dick, 1994). The focus of HSR is on various components that constitute the healthcare system – inputs (staff, equipment and money), processes (health care delivery) and outcomes (user satisfaction, improved health and cost-effectiveness) – and specific associations between these.

The above-mentioned research unit places great emphasis on developing and evaluating innovative interventions to improve aspects of care delivery in the health system (Dick & Henchie, 1998; Dick, Van der Walt, Hoogendoorn & Tobias, 1996; Zwarenstein, Schoeman, Vundule, Lombard & Tatley, 2000). The range of issues that is investigated includes clinical and psychosocial aspects of health care as well as professional behaviour (Bheekie, 2001; Dick, 1994; Lewin, et al., 2004; Van der Walt & Swartz, 2002; Zwarenstein & Bryant, 2004). In exploring problems related to effectiveness in health service delivery, it has become clear to these researchers that many of these problems were universal and that intuitive managerial interventions as implemented by health service organisations did not lead to successful resolution of these problems (Muller, Leon & Van Wyk, 2000). The researchers focus their efforts on developing innovative interventions using scientifically rigorous research methods.

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Two main methodological approaches characterise the work of this unit: (1) rigorous qualitative research methods to explore and aid the understanding of underlying dynamics which contribute to ineffectiveness in service delivery (Bheekie, 2001; Van der Walt, 1998) and (2) large, well designed randomised controlled trails (RCTs) to assess the effectiveness of proposed interventions in selected sites, which could be generalised to others in the province or country (Zwarenstein, Schoeman, Vundule, Lombard & Tatley, 2000). Van der Walt's study, which was discussed in Chapter Four, illustrated how applied ethnography in health services could assist in understanding health care dynamics between providers and patients. Bheekie demonstrated the usefulness of qualitative research in identifying barriers to change in professional practice and informing the development of a tailored intervention to improve primary care of asthma in children. The effectiveness of the last-mentioned intervention was tested through a RCT (Zwarenstein, et al., 2000).

Although RCTs are widely regarded as the gold standard for measuring effect (WHO, 2001), they have been shown to be less practical or not feasible in evaluating the effectiveness of behavioural interventions (Hyde, 2001). Increasingly, health systems researchers recognise that many psychosocial interventions evaluated through RCTs tended to show little or no effect, even though these interventions showed great potential for effectiveness (Lewin, et al., 2004). One of the explanations given is that large scale RCTs evaluating the effectiveness of behavioural interventions cannot adequately account for the psychological and relational complexities that exist in health settings and that these are not controlled for (equally distributed between intervention and control groups) by randomisation. Some researchers suggested more in-depth exploration of behavioural dynamics within health systems using qualitative methods. The current research recognised the shortcomings of RCTs, and therefore did not set out prematurely to evaluate any support model based on evidence from literature, even if these were derived from rigorous critical appraisal of evidence. Instead, an action research process was followed where development and refinement of the intervention took place in consultation with partners in the health services.

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FORMULATION OF THE RESEARCH QUESTION

As discussed in earlier chapters, stress and anxiety are key issues among nurses and support staff in public primary health care (PHC) settings in South Africa, and these affect health provider-patient relations and quality of care (Petersen, 2000; Poggenpoel & Gneimer, 1996; Strasser, 1998; Van der Walt, 1998). Van der Walt and Swartz (2002) suggest that one of the ways to improve quality of patient care and health outcomes in PHC is by setting interventions in place that are aimed at supporting staff in their work. It has been suggested that an association exists between health workers feeling cared for and supported, and their being willing and capable of caring for patients (Bolle, 1988; Franco et al., 2000; Lederberg, 1998). Some researchers argue that successful intervention at facility level should involve working with PHC workers as a team rather than working with individuals (Poggenpoel & Gneimer, 1996). Van der Walt and Swartz (1999) add that support interventions should include managers to make them part of the change process, as they are often contributors to the problems experienced by staff. Davidhizar and Bowen (1992) argue that supporting staff is essentially a management function.

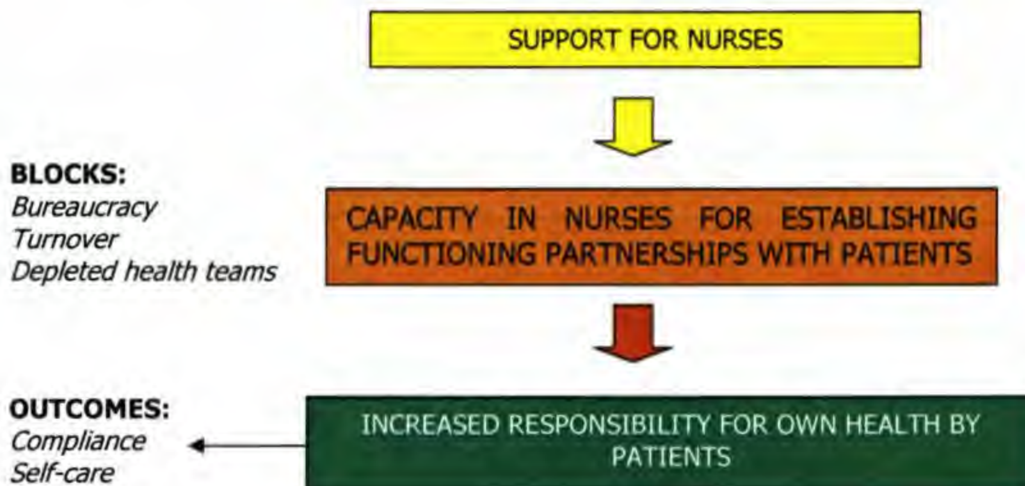

Figure 2. Rationale for the study

The rationale behind the current study is illustrated in Figure 2. Based on previous research suggesting a link between staff being supported and the quality of care that they provide, and the further link between quality of care and health outcomes, we envisaged that supporting staff would lead to changes in the way they care for

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patients and consequent health outcomes. Thus, if we could design effective staff-support interventions, this might create capacity in PHC teams to form functioning partnerships with the community and patients. Through collaboration with the community, patients might be successfully motivated to take more responsibility for their own health, and in so doing, the health service would achieve their goal of promoting public health.

The rationale behind the study can be translated into the following research question:

> *Could nurses as the primary caregivers in public PHC be supported in ways that would enable them to care for patients more effectively?*

Within this question several further questions arise:

1. Firstly, could health teams be supported in ways that would motivate them to change their behaviour towards patients?
2. Would being motivated to change translate into functioning patient-provider relationships?
3. Would these partnerships be sufficient to produce good health outcomes, i.e. adherence to treatment in the face of external challenges in the environment?

The aim of the study

The aim of the current study was to explore ways of developing support interventions for PHC teams in public services. This aim focuses on the first step in answering question 1 mentioned above, which is to provide support to staff. Staff-support was defined as interventions aimed at facilitating positive coping behaviours in the face of workplace stress and improving staff morale and motivation (Franco et al., 2000). In pursuing this aim we envisaged an action research process whereby we would learn about the dynamic nature of stress experienced by health teams in PHC, while exploring possibilities of and providing support services to them. The following research question drove the action research process:

> *Could health workers in public PHC settings be supported in ways that would help them to cope better with job stress?*

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Specific research objectives were not set beforehand. Rather, the outputs from action research processes were specified: learning and developing while providing a support service. Setting the research question beforehand was done to ensure focus and direction throughout the research processes. This type of approach is quite compatible with the type of action research that we conducted – which we called developmental action research (DAR).

Because, as will be seen, the research process differed considerably from what was planned (the changes are described, and reasons given for them, in Chapters Six to Nine), this thesis will develop a psychodynamic understanding of this changing process – even though this was not the goal at the outset of the process. In research of this nature, the process is not controlled by the researcher, and these changes are an important part of the process of learning through the fieldwork of developmental action research.

DEVELOPMENTAL ACTION RESEARCH

Action research is well suited to identifying problems in health care delivery and aiding the process of developing solutions to improve health care (Meyer, 2000). Dick (1994) illustrated the usefulness of participatory research methods in bringing together people with a common interest in resolving a problem in the health services, to explore the dimensions of the problem and the potential for transformation. The proposed research in the current project entailed finding ways to navigate around possible blocks to developmental and implementation processes as presented by bureaucratic management structures, and high turnover and burn-out among staff complements (Van der Walt & Swartz, 2002). By taking an action approach we could work *with* relational dynamics in the health system rather than around them. The active participation of health managers and staff would bring further insight into the complex nature of relationships between health staff and patients, amongst health workers, and between health workers and management. Through participation in the research processes health workers and managers might be empowered to develop and implement interventions to support staff (Mikkelsen & Saksvik, 1999).

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Although participation is fundamental to all action research, its relative importance as an objective of the research process varies (Dick, 2000). For instance, in some traditions of action research empowering participants by involving them in various aspects of the process is considered to be the key outcome. In such cases research outcomes such as producing solutions to specific problems take lower priority. To achieve this outcome, time and energy need to be expended to educate participants about research before involving them in the decision-making processes. Participants would then also be called upon to be part of the process of formulating the research question around which the action research would revolve, give input on the selection of methods used to collect and analyse data, be part of interpreting results from data analysis as well as disseminating the results back to grassroots constituencies. The inevitable drawback of this approach is that it can be very time-consuming as stakeholders with different voices have to agree before the process can progress to the next stage.

Our model of DAR differs from the traditional models in participatory action research as described above, in that our focus was on *learning* about the organisation in seeking to change it. Though participation was central to our approach, it was not considered to be the primary outcome of the action research conducted. Our main objective was exploring ways to support staff. In this, we sought to learn about stress dynamics in the health setting and develop interventions to support staff in their work (cf. Menzies, 1960). Meyer (2000) argues that action research could make an important contribution to social science (learning) and social change (action). Learning and change enhance each other, and action research facilitates both these processes. Lewin (1948) stated that in trying to change an organisation or organisational behaviour, one learns about the true nature of the organisation and relationships amongst its members. Our DAR process involved three components:

(1) developing and refining a model for staff-support (DEVELOPMENT);
(2) providing a support service to staff and managers (ACTION); and
(3) learning through data collection and analysis about stress dynamics in the setting (RESEARCH).

The "development" component related to the main objective of the study, which was to develop ways (an intervention model) of supporting staff. The "action" component involved providing a support service to health staff in exchange for their continued participation in the process. The "action" was essentially the application of the staff-

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support model in the form that it was at that stage. The action fed into the "research" component, which involved observing and interviewing participants, and analysing and testing the effects and results of the action.

Process of implementation

The nature of action research approaches means that research actions are not spelt out *a priori* (Meulenberg-Buskens & Daniels, 1997). Instead, interlocking cycles of planning, implementation and evaluation of actions (interventions) are implemented (Greenwood & Levin, 1998). Each cycle of research leads to the refinement of the research question and planning for further action stages based on the evaluation of the outcomes from the previous cycle. The initial cycles in action research are usually explorative, because a thorough understanding of the setting and relationships between various stakeholders and role-players is imperative for planning further action. A major consideration in the initial action stage is identifying and establishing partnerships with relevant stakeholders in the research setting. Initial research activities are undertaken with potential partners' needs and wishes in mind. This is done in an attempt to win their trust and get them to commit to participation in further processes. Gaining accurate information is considered of secondary importance at this stage. The validity and reliability of findings from initial research activities would be tested in analysis of further research actions through the method of constant comparison (Strauss & Corbin, 1998).

In the current DAR process we chose to set the research question upfront, even though we realised that in following a participatory process the research question might be reformulated, adapted or altogether cast aside (cf. Muelenberg-Buskens & Daniels, 1997). Setting the research question *a priori*, however, holds several advantages when starting action research processes. At the beginning stages a pre-specified research question serves the purpose of drawing interested parties (health managers and researchers) into the process, while minimising the number of people coming into the process with alternative, distracting or competing agendas. Holding the pre-specified question up as the primary research question may also help maintain focus and direction later on in the process amidst conflicting ideas and changes in priorities within the research setting. Yet, within setting and maintaining a primary focus for action research, there is a measure of flexibility with respect to

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choosing research activities, to allow space for learning and implementing new learning, and out of respect for the spirit of collaboration, which may be achieved in the process.

DAR follows two guidelines: (i) a cyclic procedure and (ii) working with multiple information sources (Dick, 2000). The cyclic procedure means that research activities can be organised in cycles of planning, implementation and data collection, and analysis and evaluation – which I call action stages. Each subsequent action stage is driven by a specific research question. The research question is formulated based on the outcomes of previous action stages. Although the completion of an action stage is not pre-defined at the start, the goal and direction of activities in the action stage is set out in the research plan. This serves as an indicator to when the action stage has reached completion. Due to the dynamic nature of action research, it may also happen that the initial research plan is aborted or amended in a significant way. When this happens, it is also an indication that an action stage has reached completion. This would not constitute failure in implementing the research plan in action research, because the ultimate goal is to develop and refine interventions. Thus, the formulation of a new research question could be considered as a marker indicating the start of a new action stage. The research plan stipulates the methods that would be used in sampling and collecting, analysing and interpreting data in the next action stage. As "actions" in action research invariably involve implementing interventions, data analysis includes some form of informal evaluation of the outcomes or process of implementation.

It is the researchers' responsibility to ensure that the research component in action research is rigorous, given probable constraints with respect to time and access. By working with *multiple information sources* data can be verified by using more than one source/mode of collecting data. This process may involve increasing the sample to include participants representing different levels in the organisation or using different data collection methods to clarify a question (e.g. individual interviews, focus group discussions and participant-observations). In analysis, this data is handled in a manner similar to the method of triangulation used in grounded theory and ethnography. Agreements and disagreements in earlier action stages are carried further to later cycles for further testing (agreements) or explaining (disagreements). Idiosyncratic information (information that only appears once) is discarded at the

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end. In the current DAR process the method of data collection was mostly qualitative.

QUALITATIVE METHODS

Qualitative methods are useful when the goal of research activities is to increase understanding of a particular phenomenon (Morse, 1992). In the current research we mostly used individual and group interviews as means to collect primary data. Secondary data was collected from team debriefings and feedback sessions to these groups. At two occasions we (the principal investigator and I) conducted participant-observations in the research sites to verify information collected during group interviews.

Sampling

The sampling pattern follows close on the trends set by emerging research questions (Dick, 2000). As research cycles in the current action research process followed an iterative fashion, where one cycle feeds into another, decisions about sampling were taken at the start of each action stage (Van der Walt, 1998). Purposive and/or inclusive sampling methods were followed throughout all the action stages. Participants for individual interviews were purposively selected based on their availability and willingness as well as their ability to provide the information we needed. A snowball method was followed in identifying suitable participants for interviews. In the initial two action stages we sought to involve all available staff members in the health facilities in the group interviews. The third action stage shifted focus onto the management group, and here we purposively selected various participants to be part of the group. Two types of data collection techniques were implemented during group meetings, namely focus groups and group interviews.

Focus group discussions

During the first action stage focus group discussions were conducted, because we wanted to test staff opinion about a few pre-specified aspects. Utilising focus group discussions allowed for rapid assessment of pertinent issues, which was needed in the first stage of information gathering. The pace of focus group discussions is much

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faster than for group interviews, allowing the researchers to gain staff's perspectives on a limited number of issues in a relatively short space of time. Focus group discussions took no longer than 60 minutes, which suited the fast-paced environment in public health services.

Group interviews

Group interviews were chosen as a method of data collection during consultation sessions rather than focus group discussions for two reasons. In the first place, we wanted to encourage a wide range of responses from participants. We did not want our biases to interfere with the natural development of the relationship between researchers and participants, and hinder us from really "listening" to staff. In particular, we wanted to shed any images that they might have of us as being representatives of management, and trying to persuade them to agree to whatever directives came from management. By giving staff freedom to express themselves, we hoped to win their trust and, in so doing, encourage them to participate in the process. We hoped that in the process they might feel safe enough to express their feelings and experiences. In the second place, we did not want to follow a focus group discussion format where staff responses are solicited solely to test their opinions about a number of issues that have been decided on beforehand. We wanted to remain open to new ideas and experiences that staff may bring to the consultation situation. Particularly, we did not want to portray the image that we were the experts and that we merely called upon them there to agree to what we have already decided would be the solution to the situation. Our purpose for the process was for it to be truly participative, and therefore, in facilitation we sought to elicit each staff member's opinion as far as possible.

Group interviews were conducted with all available staff members at their respective health facilities. These sessions took place in the afternoons when major patient-loads had already been attended to. The prevention service closed clinic services for the afternoon. The day hospital operated with one or two staff members as skeleton staff to deal with emergency patients, with the rest of the staff being on stand-by. Sessions lasted between 60 and 90 minutes. The principal investigator (PI) or the co-principal investigator (co-PI) facilitated the group sessions. The rest of the research team members who were present would give insights or ask questions to clarify

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issues being brought up by staff or introduced/discussed in the research team's pre-session planning meeting. The facilitator made sure that the sessions were conducted in a non-threatening relaxed atmosphere, where the focus was on mutual learning through the process. The facilitator remained mindful of group dynamics, drawing out the more quiet participants and balancing out the inputs from more vocal participants, where this was appropriate. Sessions were recorded on audio tape, when permission to do this was obtained from participants. In addition, field notes were made by at least one researcher. The broad topic for discussion was decided upon beforehand. When the facilitator felt that no new information was forthcoming (a saturation point was reached), she/he either introduced or invited new questions or inputs from the floor and dealt with these, or closed the session if the allotted time had elapsed. At the end of each session, a plan of further action was discussed and agreed upon. This was then placed on the agenda for the next session, if applicable. In cases where we only had one session with staff, we promised to visit them again to give feedback from the analysis of the information that they and other groups had provided.

Individual interviews

Individual interviews were conducted with middle and facility managers only. These interviews were conducted in a free attitude manner as described by Meulenberg-Buskens (2000). Although we had a fixed agenda in setting up interviews with health managers, we always asked them to give their views on staff issues particular to that stage of the process. These interviews took place at various venues, and lasted between 20 to 90 minutes. Where possible the interviews were recorded on audio tape and transcribed verbatim. Where this was not possible, one of the interviewers would take field notes. Most of the interviews were conducted by the PI or co-PI and myself. Individual interviews were conducted in the initial and last action stages. In the initial action stage we conducted the interviews to obtain the managers' views on problems in the health service and to get their buy-in to the proposed action research process. During the last action stage we conducted the interviews to get the managers' views on what the effects and shortcomings were of the process in which they were involved. In both the introductory and closing interviews we encouraged the manager-participants to give their recommendations and suggestions as well. These interviews were always conducted in such a manner that

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the manager would be respected by virtue of his/her experience and position in the health service.

Debriefing/planning sessions

From the start of the project we placed great emphasis on reflection on the process and documentation, so that valuable information would not go lost. After each interview (group and individual) or round of interviews, the research team held debriefing sessions. If some time elapsed between a group session and the consequent debriefing meetings the notes from the session would be distributed amongst all the research team members. These notes would include a preliminary analysis from the session, as well as aspects from the session that the person wanted to flag for attention. Prior to my entry to the project, data from the debriefing sessions was mainly written up in the form of personal notes or memos by the PI. With my entry into the study, data was meticulously recorded by audio tape or short-hand and distributed amongst the team members for verification. Minutes from the debriefing sessions were taken and used in further triangulation processes and for planning. Debriefing sessions served the purpose of consolidating the observations from those who were present at the group session or conducted the interviews, and obtaining outsider comments from members of the research team who were not involved in data collection. After a discussion of emerging issues and adding a theoretical lens on what was happening in the group or setting, we would plan further actions planned. The debriefing sessions also served the purpose of evaluating where we were at with respect to our research objective and conceptualising our model for staff-support.

Feedback sessions

Three feedback sessions were held. The feedback sessions gave participants the opportunity to verify and comment on the findings derived from analysis of the data. Another important advantage of feedback sessions was that they facilitated greater participation between the researchers and the participants and gave the last-mentioned the opportunity to influence the next step in the action research process in more direct ways. Although many more feedback sessions were planned, these did not materialise, as many changes occurred within the health setting where we

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conducted the research. New managers that were appointed did not upheld commitments made by their predecessors, and also did not share priorities that their predecessors' had of the process. Notes were taken during feedback sessions and incorporated in the analysis.

DATA ANALYSIS

Recorded interviews were transcribed verbatim from English and Afrikaans to prevent loss of information through premature closure in the early stages of analysis (Kvale, 1996). Research actions taken prior to my entry into the project were drawn from the field notes of the project leader. Though this is less desirable than verbatim transcriptions, these data sources were included in the analysis, because they were the only available accounts of these interviews. These accounts were regarded as the researcher's interpretation of the interviews and not as representations of the interviews themselves. All data analysis was conducted using computer-assisted qualitative data analysis software called Atlas.ti 4.2, except data collected in the first action stage.

Grounded theory

Analysis was done using grounded theory procedure as described by Strauss and Corbin (1990, 1998). This procedure is an improvement of grounded theory in its original conceptualisation because of its systematic lay-out and ease of application (Van Wyk, 2001):

> *Strauss laid out a procedure to process raw data in response to the criticism that grounded theory was very subjective and not standardised as an analytic procedure* (p.67).

Grounded theory is a sound procedure to follow when one wants to develop hypotheses that are thoroughly grounded in the data (Strauss & Corbin, 1998). Through the process of triangulation various sources of information can be compared against each other and checked for validity (Miles & Huberman, 1994). The hypotheses developed in the earlier stages of research can be tested in later action cycles. Thus the end-result will be hypotheses or theories that will be robust enough because they are thoroughly grounded in the data. The procedure of grounded

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theory involves three phases of code generation: open coding, axial coding and selective coding.

Open coding

Phase 1 of grounded theory involves ascribing open codes to data. In this phase I read through the transcripts or field notes a couple of times to familiarise myself with the data and its content, in order to get a holistic view of the transcript (Gibson, 2003). When I felt that I have sufficiently gained an idea of the general trend of the interview, I went through the data line by line and looked for empirical indicators of behavioural actions and events and assigned 'open codes' to these (Tesch, 1990). Open codes are cryptic (usually) one-word descriptors of actions or events described in the data. In the open coding stage I sought to be as inclusive as possible, so that potentially important information would not go lost. After assigning open codes to all the text of the transcript, I look at all the open codes again and check them to see if they could stand on their own, in other words, whether they were sufficiently distinct. Where codes appeared very frequently, I would look to see if the code should be broken down into a lower level description. In such cases I would assign new code names to these codes. Where codes appeared only once, I looked at all the codes to see whether these codes could be joined to another code. If this was possible, I would assign a new descriptor as a code to the two (or more) codes that were collapsed into one or assign one of the existing code names, but broaden the definition of the code. During the process of and after assigning open codes, I would write clear definitions of each code, which described what the codes mean.

Axial coding

After I had ensured that each open code was sufficiently distinct, I printed out a code list and checked to see which codes could be grouped together (Strauss & Corbin, 1998). At this stage I looked at the open codes again to see whether the descriptors that I had assigned as codes were clear enough in describing the text linked to it. I would then assign names to the groups or coded categories. I would also at times make further changes to open codes by renaming them or collapsing codes. The coded category or group name would be appended at the beginning of the code followed by a separator, "-", in-between. Thus, noted as <**coded**

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category>-<**code**>. I followed these two processes with all transcript data collected in an action stage. With subsequent transcripts I followed the following procedure when encountering text that describes an event or action that was already coded in the manner described above, yet adding more information about the event or action. I used the same coded category and code and append a "/" followed by a further descriptor of the characteristic assigned to the main action or event. This combined code served as a potential subcategory to the open code. I went through all the data collected in the action stage in this manner.

Selective coding

In the final phase I selected coded categories that appeared consistently or most prominently across all the interviews conducted in the action stage (Strauss & Corbin, 1998). Through the process of constant comparison I compared data from the various informants to check their adequacy and accuracy (Dick, 2000). Coded categories that contradicted each other were either discarded on the basis of negative evidence, or where there was justification or explanation for the contrasting views, a theme was formulated depicting this contradiction. The existing themes were ordered to form an analytical story line. A thick description of each theme was constructed, which served as hypotheses that I tested in later action stages.

Vaughan (quoted in Strauss & Corbin, 1994) describes theory elaboration as the process whereby theories, concepts or models are refined to specify more carefully the circumstances in which these offer or refute potential explanations for the phenomena. In the selective coding stages, theories and concepts that emerged during team debriefings and concurrent review of relevant literature during the process are brought into analysis through theoretical elaboration (Petersen, 2000). Theoretical elaboration is especially useful in analysing action events in action research in organisations, because it allows integration of structure (specific elements in the health setting) with process (the action and interaction between the role-players), and allows space to maximally utilise the skills and insights that the consultants brought into the current process. The comparison between existing theories as suggested by consultants and literature and the emergent theories from the data, makes grounded theory an ideal tool to use in developmental approaches to research as applied in the current DAR.

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ETHICAL CONSIDERATIONS

This research project was subject to and adhered to the ethical guidelines laid out by the South African Medical Research Council (2002). Permission was obtained from management to interview staff at respective facilities. Verbal consent was obtained from participants prior to data gathering. Findings from the interviews were fed back to the staff and managers for verification and correction. Where interviews were recorded on audio tape, permission was obtained from the participants before switching on the tape recorder. The participants were informed that they were free to request that the tape recorder be switched off at any time, if they wished to say anything off the record. All participants were guaranteed anonymity with respect to their names, their positions as well as the name of the health facilities involved. Ensuring anonymity was difficult when it came to middle managers as there were few of them, and therefore easily identifiable. I have therefore used fictitious names for the health district and health organisation involved to guarantee anonymity for the manager participants. The managers involved consented to the information gathered in this project being used for dissemination and research purposes, with the understanding that their identities will be hidden. Access to research material was limited to those involved directly in the research processes of data collection and analysis.

MY ROLE AS RESEARCHER

The research was conducted under the guidance of the PI and my supervisor at the research organisation where we both worked. Her expertise as a qualitative researcher in nursing studies was complemented with co-principal investigator, who was a senior academic in the Psychology Department of a local university. The rest of the research team consisted of three clinical psychologists and a social psychologist (myself). Two of the clinical psychologists were used as consultants to run groups with staff and managers from the health services. The research was conducted in partnership with the middle management from a local authority health organisation and their counterparts in a provincial health organisation, and involved staff under their management from two PHC facilities in a pilot. At the time of the research I was employed as a research trainee in a research unit that focused on

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conducting health systems research. My initial role in the research team was that of the qualitative researcher, being responsible for collection and preliminary analysis of data. Later, I assumed the role of coordinator of the project, when the PI retired from work. From my entry into the project, I was co-interviewer in all the individual interviews. The results and interpretation of data analysis reported in the current dissertation are my own work. During the study the PI and I was responsible for doing the preliminary analysis of interview data in preparation for team debriefing meetings. I took part in all debriefing meetings, and had the additional duty of recording the proceedings. With the retirement of the PI from the research process I took over as coordinator of the project under the supervision of the new PI.

The chapters that follow describe the four action stages conducted in the current project, which we called Caring for Caregivers. The first action stage, *"Baseline assessment of stressors"* involved a qualitative assessment of the nature of stressors in the PHC system. The second action stage, *"Journey towards integration"*, describes the experiences of two staff teams from a health prevention clinic and a day hospital (curative service) as they prepared to merge and integrate aspects of service delivery. In the third action stage, *"Containing the containers"*, the research team explored the feasibility of a short programme aimed at building capacity amongst middle and facility level managers to act as containers for staff stresses. The final action stage, *"Reflections on the process"*, describes interviews with selected participants to reflect on the effects of the current action research process on them and their work.

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CHAPTER SIX

BASELINE ASSESSMENT OF STRESSORS

ACTION STAGE ONE

The first action stage in the current action research process involved conducting an assessment of the stressors and extent of stresses experienced by health workers as well as what measures of support were available to staff within the system.

ENTRY INTO THE SETTING

The principal investigator (PI) approached one of the nursing staff managers (Cindy Jacobs*) from a local health authority, City Health, whom she knew from previous collaborative research work. A fax was sent to Ms Jacobs inviting her to discuss ideas around a project aimed at developing support interventions for health workers. The fax read as follows:

> *As you know I have completed my thesis on nurses and their work at clinics. It has given me a better understanding of the relationships between nurses and patients. One of the key issues is the stress and anxiety that stems from this kind of work. I would like to discuss a few ideas with you for a new project, which would be aimed at "caring for the caregivers". In thinking about this, I have worked closely with the people at the [psychology institute], who are experienced in doing supportive work with organisations. I have also discussed the possibility of this kind of project with [a senior health manager], but it is still very much in the planning stages. I would like to discuss it with you and get your views.*

Ms Jacobs met with two research team members at her office. The purpose for this meeting was two-fold. Firstly, we wanted to solicit her views on the extent of stress-related problems amongst staff in her district. Secondly, we wanted her to buy in to

* All names of people and organisations have been replaced with pseudonymns to protect the identities of the participants, and for ease of reading.

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the proposed action research project. This meeting was very successful as we were able to meet both these objectives. Ms Jacobs confirmed that nurses in her district suffered from low morale as a result of many stresses in the health setting. She voiced her support for our proposed research stating that there was a definite need for intervention in this regard. At that stage Ms Jacobs impressed as someone who had the qualities to become an informant and partner with us in the action research process.

The informant

Ms Jacobs was manager in charge of the nursing staff and general assistants in eight clinics in the health district. She had years of experience as a professional nurse in the public health service, and this was evident in the firm grasp that she displayed of the stresses that staff experienced in the health service. From encounters in previous research projects, we (at the research unit) got to know her as a dynamic manager who was not hesitant to acknowledge problems in service delivery and implement changes to rectify these. She was open and supportive to research that would provide much needed answers to problems in the health system. Her motto, *"My job as a manager is to keep staff happy so that they can keep the patients happy,"* articulated her agreement with our rationale for developing support interventions for staff. Ms Jacobs suggested that we interview other managers as well as staff from her district to build a more comprehensive view of the state of stress and staff-support in the services. We agreed to her suggestion and set out a research plan to map a clearer understanding of the stresses and staff-support structures that were in place in the health system.

THE RESEARCH PLAN

Based on our informant's suggestions we approached a health manager who worked in the environmental health office, and staff from two community health centres[6] in her district for interviews. In addition, we approached two health managers from a

[6] Health centres were combined facilities where curative and preventative PHC services were provided by staff from local and provincial health authorities, respectively. In this thesis I used the convention of referring to facilities that provide curative health services as "day hospitals" and those facilities that provide preventive health services as "clinics". This was also a convention used by both health staff and management at the time of the research.

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provincial health organisation, Province Health, who managed the day hospital services in the geographic area that corresponded with the abovementioned health district. We obtained permission from Ms Jacobs to interview the staff teams at the health centres. (At that stage we were not aware that staff at these centres constituted two teams who reported to different management structures that were part of different health organisations.)

Research questions

The following two questions were asked during interviews in the current action stage:

1. *How do staff experience and perceive stress in their work?*
2. *What forms of formal and informal support already exist within the services and are these adequate?*

Data collection and sampling

Data was collected through individual interviews with managers and focus group discussions with staff and verified through feedback sessions. A depth interview was conducted with a senior environmental health officer (SEHO) as suggested by our informant. After meeting with the SEHO, we were slightly confused about the management structure in this health organisation. We set an appointment with the area manager, Dr Louw, to clarify the organisation's organogram and to establish rapport. At that time, however, she was outside the country and not available for an interview. In her absence we went ahead and conducted the focus groups with staff at two health centres. On Dr Louw's return we learnt about the diverse nature of the staff constitution in health centres. She gave her permission and support to our involving staff members and managers from her organisation in the research, and suggested that we also obtain permission from the relevant managers from Province Health to involve their staff. Dr Louw promised in return to inform her counterparts in Province Health of the proposed project, and to open the door for us to meet with Province Health.

We sought to set appointments with Ms Randall and Dr Sweat, who were middle and senior managers in charge of primary health care services at Province Health. We

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were not successful in setting a meeting with the senior manager and proceeded to meet with the middle manager only. As Ms Randall was the vertical manager for nursing services only, we decided to meet with another manager (Dr Ali), who managed the medical staff in this health district. The purpose of these meetings with middle managers was to obtain their views on the above-mentioned research questions and to persuade them to participate in the process.

Focus group discussions were conducted with health staff from two health centres. Health centre A was situated in a low-income urban area and served a dense population. Health centre B was situated in an affluent, semi-rural area and served the surrounding farms through mobile clinics. The staff participants were predominantly nurses, but also included pharmacists, medical doctors, environmental health officers and administrative staff. In health centre A the sister-in-charge invited all staff members to participate in the focus groups, because she did not want to exclude anyone. In this health centre the local authority staff complement was in the majority. The sister-in-charge from the local health authority acted as facility manager of the health centre. The sister-in-charge of the day hospital staff (provincial health department staff) acted as her deputy.

In health centre B sixteen staff members were present at the focus group sessions. These, we were told, were the ones that have been "chosen" by the sister-in-charge from the local health authority to participate in the discussion. It was not clear what the criteria for their selection were. The sister-in-charge in question was not present at the time of the group session and gave an apology through her counterpart, the sister-in-charge from the provincial health department. At this facility the two staff health services operated parallel to each other with no sharing of function on service or facility management levels.

Three feedback sessions were conducted at the completion of data collection and analysis. The first feedback session was conducted with invited middle managers from the two health organisations in question. However, representation favoured the local health authority who had five managers in attendance, compared to one manager from the provincial health department. The purpose of this meeting was to verify findings derived from the analysis and to discuss the next step in the action research process. Two subsequent feedback sessions were held with two health

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centres where focus group sessions were conducted. The findings of the research were presented to them, whereupon they were asked to comment, clarify or question. Based on the comments from middle managers, we conducted two more focus groups at health facilities where integration did not happen – in other words, in facilities that operated either as a day hospital only or as a clinic only. The findings from these group sessions are discussed in the DISCUSSION section of this chapter.

DATA ANALYSIS

After consultation with other researchers, I decided to apply the SWOT-analysis (analysis of strengths, weaknesses, opportunities and threats) as a schema for categorising codes. The notion of strengths and weaknesses in the system related well to our research questions, which were aimed at finding out what support structures were available and the nature of the *stresses* experienced by staff, respectively. Attitudes and statements that supported the idea of developing staff-support interventions were categorised under "opportunities". Statements and actions that could be interpreted as resistance to co-operate in the proposed study, or statements about actual or perceived hindrances/obstacles to the effectiveness of staff-support interventions or attempts to develop such interventions, were categorised under "threats." A comprehensive list of the codes from the current action stage is included in Appendix A.

RESULTS AND DISCUSSION

SWOT analysis revealed that *weaknesses* in the system were related to three main sources of stress, namely heavy workloads, demanding patients and integration of services. Low morale amongst staff and lack of adequate support structures were themes that depicted *threats* and *opportunities,* respectively, to our proposed developmental action research process. The participants, with the exception of the last staff group interviewed, did not mention any *strengths* within the system.

Heavy workloads

The managers reported that the workload in PHC services had increased since the restructuring started in 1994. Services that were previously delivered at secondary or

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tertiary level were delegated to primary care facilities, without increasing the staff complement to provide these additional services.

> *Since the start of the new dispensation several additional work has been devolved from hospitals to the primary care level; yet there has been no new posts allocated during the last four to five years.*
>
> \- Nursing staff manager

The problem with increased workloads was exacerbated by the high turnover of senior nurses and general shortage of medical officers.

> *This [problem with increased workload] has been made worse by many experienced staff members who have opted to take retrenchment packages.*
>
> \- Nursing staff manager

The shortage in medical officers combined with the increased number of patients meant that they were pressured to make quick decisions about the seriousness of presenting cases, without the benefit of thorough diagnoses. This meant that many patients were sent home, because their conditions were judged to be not serious enough to receive further attention.

> *Unlike here that there is the stresses of numbers, where they have to turn away at least 50 patients per day. The doctors have to see over 100 patients. Then we have to make the decision: can we see him or can't we see him? Shall we refer him?*
>
> \- Medical staff manager

The increase in patient numbers was associated with the introduction of free healthcare for mothers and children under 13 years. Staff complained that because treatment was free, members of the community came to the health facility with their minor ailments rather than treating them on their own at home.

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But they [policy makers] possibly did not foresee the snowball effect that these numbers would basically come here... So they would do very little for themselves at home prior to coming here.

- Medical staff manager

Where all participants agreed that general workloads were unmanageable, some managers felt that the situation was unresolveable as a result of ever-increasing patient numbers and functions that were added to PHC services.

Demanding patients

In addition to the increases in patient numbers, patients were also very demanding on health workers to deliver in spite of limited resources. With the development of democracy in South Africa, communities have become increasingly aware of their rights and especially of exercising their right to voice their demands. One facility manager was quoted saying:

The community sets their own demands. Or they tell you what they need. And they make certain demands... People are fast learning that "we need to shed our demands. And that is the only time that people will produce something."

The backlash from years of political discrimination contributed to communities being intolerant of public services not meeting all their basic health and other needs immediately. The close proximity between PHC facilities and the communities that they serve meant that health staff, and especially facility managers, had to face the brunt of public demands and expressions of dissatisfaction. One nurse manager related the story of how one community staged a lockout of staff until their demands for a 24-hour service were heeded. Within a relatively short space of time public demands were adhered to. Some managers felt that some health decisions were totally politically motivated, without adequate consideration for the practical limitations present within the health system.

And if you consider from the demand aspect again, the patient community has totally unrealistic expectations. That again is fuelled

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by promises by the politicians. On the one hand politicians know that they can't meet the demand; yet on the other hand they keep on fuelling their [the community's] expectations.

- Medical staff manager

As part of the drive to make public health services more accountable to the communities that they serve, health committees were established in several communities. The health committees served as a vehicle for the community to have a say in the running of their local health services. Facility managers experienced attending these committee meetings as extremely stressful, because they were called to account (on their own) for the state of service delivery in their respective facilities.

Another issue that health staff experienced as extremely stressful was the implementation of a Charter for Patient Rights. *Batho Pele,* as this charter is called, is the Sotho translation for "people first." Health staff felt aggrieved that patient rights were promoted at the expense of disempowering staff.

Die client is altyd reg. Hoekom is dit so? Die Regte beinvloed mense. [The client is always right. Why is this? The Rights influence the people.]

- Professional nurse

The staff felt that policies like *Batho Pele* and the implementation of free health care contributed towards patients becoming more demanding of service delivery and abusive towards health workers, while taking less responsibility for their own health. Some patients would refuse to comply with the rules of operation in the health service, and instead verbally abuse staff when their [the patients'] demands are not adhered to.

They cannot be educated about self-care, about the rules of the hospital, especially the hours and the quota that can be seen by doctors. They are impatient and do not want to wait their turn.

- Professional nurse

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Hulle storm die plek binne en vloek jou uit. [The patients come storming in to the health centre and swear at staff members.]

- Professional nurse

In summary, it could be said that staff felt that while dealing with demanding patients remained stressful, new health policies continued to exacerbate the situation by empowering patients and stripping health workers of their status as health professionals. Thus, the power balance lay with patients, making it difficult for health workers to form functioning partnerships with patients in the interest of individual and public health.

Integration of services

As discussed in the background to the current study (Chapter Two) the PHC system in South Africa was in a period of restructuring (at the time of the research), where previously separated prevention and curative health services were in the process of being integrated. In the health centres where the focus group discussions were conducted, partial integration of frontline services occurred. Staff members experienced this transition stage where they had to work together with staff from the other health organisation, while still reporting to their management structures, as anxiety-provoking and stressful. Although staff accepted that amalgamation would take place, they were anxious about what the outcome of the integration process would be. To quote the medical staff manager from Province Health:

It is more anxieties and uncertainties of the future. What the future holds for them... And they always complain that we are not giving them sufficient information from the top. The information is there in various reports, but it is too impossible to give feedback on these thick documents and reports to each and every person down to the grassroots level. We try in informal talks to talk to them, to inform them of various forms and to inform them of how far the process has gone. But it has created its stresses of its own.

Province Health staff were not content to perform the same work, while being paid less than their counterparts in the other health organisation for doing it. One of the

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facility managers argued that tensions between health workers within health centres would not ease until conditions of service at least were equal.

> *It [integration] remains difficult. It will not be resolved unless the different conditions of service and different pay scales are addressed.*
> - Facility manager

Even in the health centres where staff members were forced to share functions across the prevention-curative services divide, there was agreement [amongst staff] that they *"work side by side, but not together"*. The staff teams continued to operate separately as they were subject to different organisations, management structures and conditions of service. Most of the stresses stemmed from the fact that, at facility level, staff was still split into two teams. Each team felt that they were expected to help those in the other team, but they were too understaffed to cope properly with their own tasks. In discussions about working together within the health centre, one nurse remarked:

> *"hier is baie verskillende mense met wie ons saamwerk"*
> *[here is a wide variety of people that we work with]*

The differences in organisational cultures between the two health organisations added to the difficulties that staff experienced in working together. Where City Health management was described as *"progressive and democratic"*, Province Health staff reported their management hierarchy to be very bureaucratic, and decision-making processes more cumbersome.

> *One has to go through all the right channels before decisions are taken. And the chances are that action on these decisions could happen five years later.*
> - Facility manager

The differences in management style reflected in the respective staff teams' attitudes towards plans for integration. City Health staff were reportedly prepared for integration and encouraged to participate in in-service training courses in various aspects of adult curative care. The sisters-in-charge of City Health services took a

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more proactive role in facility management, where they were given the mandate to take authority in the work situation. The sisters-in-charge of Province Health services on the other hand, regarded themselves as nurses (clinicians) rather than managers. Their status as facility manager was viewed as a means to bring their salaries on par with the higher pay of their counterparts in City Health. The responses from Province Health staff created the impression that they felt "cheated" by the whole integration project, because they were not consulted or informed about the process as it progressed.

Low morale amongst staff

There were several indications from the managers interviewed that staff suffered from low morale and burnout as a result of the stressful conditions under which they were working.

> *And they conducted a few workshops with us. And they picked these things up immediately. In the report that they submitted to the managers, they said that they could pick up that there is this stress and burnout that exist at grassroots level. So it is a well-known fact that it does exist. In fact at one of our ... talks we had three psychologists talking to us, and they circulated a questionnaire about these staff to us. And we sort of had to just jot down. And in that they showed that 90% of the staff definitely suffered from burnout.*
>
> - Medical staff manager

In an interview with a nursing staff manager, she stated that morale amongst facility managers in her district was low. She was quoted as saying:

> *At a previous meeting they said there were no highlights in the last year for them; only low lights!*

The state of low morale presented a possible threat to the proposed study, because the success of the action research process would be dependent on staff's willingness to work towards finding solutions for the stresses that they experienced in their work

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setting, and once solutions were found, to experiment with these to see what the effects would be.

Lack of support structures

Although both organisations had employee assistance programmes (EAP) in place to provide various support functions for staff, these services were described as not adequate. At best, the EAPs provided limited, short-term relief for staff who were overstressed and not able to fulfil their job requirements. The EAPs did not have the staff capacity to deal with the enormous need amongst staff for their services.

> *The only system in place is the EAP. Three staff members who deal with 7000 staff. They handle matters like injury on duty and provide primary services for low paid workers. All they can do is work reactively.*
>
> - Medical staff manager

The nursing staff manager from Province Health service admitted that, "*the EAP does not operate as we would like it to.*" In the absence of a well-functioning EAP, staff lost confidence in their organisation and its managers to provide for their support needs.

> *They [staff] often do not know who turn to. They do not feel comfortable to turn to their managers because the perception is that the managers are not doing anything... Again the perception is that management don't care, to put it bluntly. That is the common perception that there is... You can sit in the tearoom and that is the talk that goes on that management doesn't care. That might not be entirely true but that is the perception that is out on grassroots level.*
>
> - Medical staff manager

The managers on the other hand, felt that giving emotional support to staff was not what staff wanted or needed. They felt that acquiring more resources in terms of staff, equipment and drugs, would be the solution to staff's stresses. However, these

were subject to financial constraints on a higher level, and thus they were unable to provide relief for staff.

> *And the managers feel that there is only so much that they can do to assist. We can offer them some moral support to things like that ... We have been taking to management again this whole issue that they require further resources. But management says that they are committed to that, but they are unable to commit additional resources to the area of need.*
>
> - Medical staff manager

In the absence of formal support structures, staff relied heavily on informal support networks that existed at the health facilities. Due to excessive staff movements to compensate for staff going on leave, senior staff leaving the services and new staff groups joining the facilities, these support networks have been eroded. One nurse commented on how lost she felt after returning from maternity leave, to find a group of strangers in the facility. Staff reported a sense of nostalgia for past times when they worked together *"like a big family".*

With no formal or informal support structures being available to them, staff were generally supportive of the idea of setting up psychosocial support interventions in the system.

VERIFICATION OF FINDINGS

After analysis of data gathered during interviews with staff and middle managers, we presented the findings to the three groups mentioned above for verification and to discuss consequent actions that could be taken.

Comments from managers

The managers confirmed that the baseline assessment of stressors provided a fairly accurate reflection of the stressors in the PHC services. With respect to staff's complaints about work overload, the managers reported examples where patient numbers have doubled within the last year. They also attributed stresses to new

legislation that required nurses to acquire additional skills to perform functions previously performed by doctors. The managers added that the emotional load associated with HIV/AIDS counselling and attending to rape survivors made nursing even more stressful.

The managers agreed unanimously that integration was *"one of our biggest goals, but also one of our biggest stressors".* However, they attributed difficulties with integration at facility level to differences in personalities and leadership styles amongst facility and middle managers who have to work together. Some managers were of the opinion that staff were creating their own stressors by refusing to accept one another and work together as a team. They suggested that staff could be using integration as a scapegoat to mask their resistance to change.

The managers admitted that they could be contributing to the problems experienced with demanding patients, through their promoting of the health centre as a *"one stop shop ... where you should go for everything you need from condoms to medication".* This promotion campaign may have created the impression amongst patients that receiving health care meant receiving medication, and thereby creating a resistance to health education. They suggested that current over-prescription in the PHC services could also be related to health workers feeling that they had to give the patients something because they were waiting so long. The managers, however, felt that strong health committees were needed to help with health education, lobbying for posts and as a vehicle to make the communities aware of staff experiences and stressors.

Comments from staff

Staff agreed with our findings, but clarified that they were not opposed to integration, only to the way that the process was managed. They used the analogy of marriage to explain that management should invest effort into preparing staff for integration:

> *Like marriage partners ... you prepare yourself for your partner before you marry that person. So that you would be ready to marry that person when he arrives ...*

As part of preparation, space should be created where staff could air their grievances freely. They suggested that facilitated small group discussions should be conducted at facility level to deal with issues such as staff conflict. Such groups should be facilitated by a neutral outsider. Province Health staff reiterated that the playing fields (perceived power to negotiate respective roles, responsibilities and rewards) needed to be levelled between the two health organisations before they could work together at facility level. At the feedback sessions, health staff confirmed their support for the idea of setting up support programmes for staff. Participation in such a support programme, however, should be voluntary and options should be available to participate in groups and as individuals.

REFLECTIONS ON THE PROCESS

We had the impression that in some instances frontline staff seemed to cope well despite the many stressors in their work environment. The baseline assessment confirmed our suspicion that staff were in need of support and that current structures were not adequate to meet this need. The high turnover of senior nursing staff pointed to a health system that was over-stressed. We compared this tendency with international findings that showed that turnover is negatively associated with age and experience (Fang, 2001). Thus, indications were that nursing in South Africa was heading towards a crisis. We took this as a strong confirmation of the relevance of the Caring for Caregivers project. Suggestions were made by some managers to focus our intervention on facility managers, because of the high attrition of staff on this level. We felt that such a decision at that stage in the process, was slightly premature though. Instead, we decided that we needed to do some more exploration of the nature of the stresses at facility level, specifically around integration. We decided to conduct further focus groups at two facilities where integration has not yet occurred.

Triangulation of data

We conducted focus group discussions at a day hospital and a clinic. The day hospital staff confirmed that heavy workloads and demanding patients were the most prominent stressors in their work. They did not mention problems with respect to

integration at first. However, when we introduced the issue of integration, we were given a clear sense that staff at both facilities dreaded the day that they would have to integrate with another facility. They already anticipated that such an occurrence would be stressful. To quote the facility manager:

> *We all work for the same people, have the same conditions of service and the same management structure. But let the other lot come in – I can bet you there is going to be trouble!*

Representation of managers

In the first action stage we sought to engage middle managers from both health organisations to get their support for the proposed action research and to involve them in the process (Meyer, 2000). We succeeded in the first goal as both management teams expressed their support for the proposed project and gave permission to involve staff in their facilities in the research. We had only partial success with the second goal and had an over-representation of managers from the local health authority as reflected in the attendance at the feedback session. A critique of the process is that we involved managers from Province Health too late in the process, thereby possibly creating the impression that local health authority managers were running the process. In our joint reflection on the process thus far described, we recognised this flaw in the process and determined to rectify this in the subsequent action stages.

Representation of staff

Interviewing staff at integrated health facilities (health centres) gave a good overview of staff experiences in curative and preventive services in their respective organisations. The group interviews included the whole range of job designations that normally operate in a health centre. Health centre A was well represented (100%), with all the staff invited to the meeting. A question mark could be placed to the representativeness of staff members who attended the focus group discussion held at health centre B. The criteria on which the choice of participants was made, were not clear and could have been a source of bias. Another possible sample bias was introduced with the absence of the two facility managers from the focus group.

However, regarding content, it may have yielded more information, because staff may have felt greater freedom to express their opinions in the absence of their immediate managers.

Another question mark about the content produced by the focus group discussions could be related to the dominant role that certain staff members played during the interviews and the passivity of others. The dominant characters were not of a specific profession only. (In the first instance the pharmacist was the dominant participant and in the second interview the general assistant was dominant.) This would suggest that personality rather than professional designation played a role in these persons being dominant in the discussions. It may also suggest that these participants would be dominant characters in their respective settings as well.

A significant absence in the focus group discussions was the medical officers. This could be related to the fact that only one medical officer worked on the curative side of the health centre and that he/she may play a peripheral role in the health centre in terms of group dynamics. On the clinic (preventative services) side, the medical officers attended the clinics on sessional basis (i.e. a few hour sessions per week). Thus, their presence in the focus group discussions may not have contributed new and significant content to the data presented in this action stage.

Appropriateness of methods

One of the purposes of this action cycle was to find out what the stressors were that staff experienced in their work. In this goal the research action succeeded. The research question was appropriate and the method of interviewing suited the setting and our purpose well. The method of data collection allowed health staff and managers to contribute in an atmosphere that was non-threatening and encouraged participation. A potential bias in the data collection may be attributed to the fact that I did not record all four interviews (focus groups and interviews), but had to rely on another researcher's fieldnotes. Another shortcoming in the process was that I joined the project mid-way through the current action stage, and did not play a role in the initial conceptualisation of the current cycle of action research.

CONCLUSION

The main findings from our study of the stressors of health workers in this setting (workload, patient demands and integration of health services) correspond well with international literature about stressors amongst health workers (O'Henley, et al., 1997). The problems experienced with integration of services might also be indicative of difficulties with teamwork and top-down management (stressors that are common among health workers). The incomplete and partial integration of health services, rather than the policy decision in itself, has left frontline staff feeling isolated, alienated and unsupported. The broader changes that South Africa is undergoing have placed the public health system under tremendous pressure. The PHC service, as the first contact that people have with the public health system, experienced the pressure as a previously disempowered people became increasingly demanding in the lieu of an awakened political sensitivity in society. Health workers faced the dilemma of dealing with a community that is as weak (as a patient) as it is powerful (empowered by the human rights culture). The changes in society also translated into changes in the work in PHC. Nursing staff was faced with the challenges of having to acquire new skills, without the safety of a sympathetic learning environment. All this led us to hypothesize that the situation in the public PHC settings could be likened to a cooking pot – full of stressors bubbling up, the fire of broad social changes burning underneath and about to explode sooner or later.

CHAPTER SEVEN
JOURNEY TOWARDS INTEGRATION

ACTION STAGE TWO

The conclusion of the baseline assessment of stresses indicated that PHC staff were under severe stress and in need of the type of support interventions that we were interested in developing. As a research team we felt confident that we had sufficiently won the trust of the district management team from the local health authority service and that they would be willing to collaborate with us in the developmental action research (DAR) project. We also determined to approach the managers from the provincial health service to be part of the developmental action research process as well. Through our interviews with staff in the previous action stage we came to know about plans to merge one of the City Health clinics with a Province Health day hospital. In a team-planning meeting we discussed the merits of following the experiences of both these staff teams as they prepared for and went through the merger. Findings from the previous action stage clearly indicated that integration of health facilities was one of the major causes of stress for staff. It was felt that following the integration process with these two staff teams might give us some insight into how to support staff amidst stressful and anxiety provoking changes in the health system. As defined in the previous chapter I will refer to the local authority health service/organisation in question as City Health, and to the provincial health service/organisation as Province Health.

SELECTION OF HEALTH SITES

We felt that the next step in the DAR process would be to approach the respective management teams for potential health sites, where we could work with the staff (and management) in developing intervention programmes that would suit their needs and context.

Meeting with City Health management team

We contacted Ms Jacobs, our informant from the previous action stage, to identify a potential City Health clinic where we could consult with staff in exploring and developing a staff-support programme. During this contact Ms Jacobs asked us to develop an instrument to assess the state of staff morale in her district, and to analyse and interpret the data once they have administered it to all her staff. We agreed to do this survey, despite it being quite a deviation from our intended research focus and preferred mode of inquiry, in order to build further trust and rapport with these City Health managers. The findings from the survey confirmed high levels of stress across all staff categories that participated. A surprising finding was that seventy per cent of respondents stated that they were satisfied in their work most of the time. Thus, the tentative indication from the survey was that staff appeared to be coping well, even though under a lot of stress. When we reported these findings to senior managers, they contested them vehemently. We regarded suggestions from the findings with great caution because the tool used in the survey was not tested or validated for the population to which it was administered. Also, it was not clear under what conditions the questionnaires were filled in, as we did not administer the questionnaires ourselves.

In the follow-up meeting with Ms Jacobs to discuss potential sites, City Health managers had already decided that consulting with the health teams from Youville's two health facilities, St. John's clinic and Baker Street health centre, would suit the process of developing a staff-support model. They invited the facility managers who ran the clinic services at the abovementioned facilities, Ms Robertsen and Ms Petersen, to the meeting. We were very surprised to find that not only was this exactly the type of setting that we had in mind for the DAR process, but that it included the exact sites where we had hoped to work! The managers reported a great deal of anxiety amongst staff from St. John's clinic and Baker Street health centre about the proposed merge. They envisaged that our consultation work would help the two staff teams overcome their anxieties and fears about the merge and "prepare" them for what was inevitably going to happen. City Health managers reported that some members of the day hospital staff at Baker Street health centre were overtly resistant to the proposed move and were instigating other staff

members to oppose the proposed plans as well. To quote one of the chief environmental health officers:

> *The doctor does not want to move. He is busy gathering information that will prove that most of his patients are not from the other side of Youville. He is going to submit his findings to the authorities to qualify why he should stay where he is...*

City Health managers envisaged that a support intervention as we proposed to do through DAR would be like "*pre-marriage counselling*", easing tensions between the two staff teams and facilitating a smoother integration of services at the new health centre.

Rationale for the merger

The rationale for moving the day hospital at Baker Street to the St. John's clinic venue was to accommodate the needs of the less well-off people, who, it was suspected, would need the curative services provided by the day hospital more than those people living in the more well-off areas of Youville. The health committee of Youville had commissioned research to determine the responsiveness of public health service delivery in their area. The findings of the research indicated that the people who most needed the curative services were mostly staying in the areas around St. John's clinic. (Baker Street health centre and St. John's clinic were about three kilometres from each other.) Baker Street health centre was situated in the older, more established housing area. The houses were bigger and the more well-off residents stayed around this area. St. John's clinic on the other hand, was situated in the newer extensions to Youville. The houses in this area were considerably smaller and the area much more densely populated. The proposed plan was to build a large health centre at the site where St. John's clinic was situated to serve the more "needy" population. They proposed to extend the existing building at St. John's clinic to accommodate the day hospital service. The day hospital service would be moved from Baker Street health centre to the new venue at St. John's clinic to establish a large health centre (Youville health centre) that would provide integrated prevention and curative service. The clinic staff that remain at Baker Street health centre would run as a satellite service to Youville health centre.

Meeting with Province Health managers

After meeting with the management team of City Health, the research team met with two managers from Province Health – Ms Randall, the nursing staff manager and Ms Kay, the sister-in-charge of the day hospital at Baker Street – to get their views on the proposal, and permission to involve day hospital staff from Baker Street health centre in the research. Ms Randall agreed that the proposed facilities were ideal sites for the type of developmental work that we intended to do. She reported that staff from both facilities were under a lot of stress and anxious about the proposed merge. To quote: "*there was a great fear of the unknown*". She granted permission to involve Province Health staff in the consultation sessions. Ms Kay, however, believed that memories of the traumatic experiences of the previous integration attempt at Baker Street health centre (discussed below) caused current staff to be pessimistic about the outcomes of the proposed new plans. She said:

> *Ek was betrokke met die deurwerk van al die positiewe en negatiewe gevoelens van die personeel ... Ek voel nou negatief oor die samesmelting van die twee klinieke.*
> *[I was involved with staff in working through all their positive and negative emotions... So I am now feeling negative about the merging of the two facilities.]*

Previous merger at Baker Street

Schoeman and Van der Walt (1997) described the implementation of integration policy at Baker Street health centre, as witnessed in the merger between the prevention clinic which was run by City Health and the day hospital which was run by Provincial Health. The intention of the merge (instruction from upper management) was that the two services be fully integrated at facility level so that a comprehensive service might be provided to the community. Part of the instruction was that the two staff teams should integrate as well and share functions between themselves. However, management of the two services remained separate, which left staff confused about whom they should report to or whose guidelines and policies they should follow. Different conditions of service made it difficult for staff to accept the

mandate of working together. Lack of resources and staff as well as training hampered effective service delivery. Some staff members complained that too much emphasis was placed on curative services at the expense of health promotion and preventive services. Interpersonal relations between staff were strained and this led to an atmosphere of distrust and low morale in the facility. Staff resolved the tension in the centre by splitting the two functions in the facility. Thus, the prevention clinic and the day hospital continued to focus almost exclusively on delivering their specific services and under their own facility manager.

Ms Kay reported that when she was appointed as sister-in-charge of the day hospital service at Baker Street health centre, renewed efforts were made to integrate frontline services. The sister-in-charge from City Health was "unofficially" appointed as facility manager over the health centre and staff from both services had to report to her. In the quote that follows she related the experience:

> *Sister Jones wou hê dat die verpleegsters deur haar werk. Hulle het eerder deur my gewerk. Die nuwe beleid het gelei tot ontevredenheid onder die verpleegsters. Dit het gemanifesteer in uitbly met valse redes.*
> *[Sister Jones wanted all the nurses to work through her. They preferred to work through me. The new policy led to dissatisfaction amongst the nurses, which manifested in absenteeism with false reasons.]*

Although most of the staff who were involved in the previous integration have since moved elsewhere or retired, the underlying frustration were still there *"still simmering under the pot"* as Ms Jacobs described it.

THE SETTING AND PARTICIPANTS

Baker Street health centre

Baker Street health centre had 14 staff members – nine worked in the day hospital and five worked in the clinic (Table 1). The *day hospital staff* complement consisted of the sister-in-charge, three professional nurses, two clerks, a general assistant

(tea-lady), a pharmacist and a medical officer (doctor). The *clinic staff* complement consisted of the sister-in-charge, a professional nurse who had a half-day post (because the other nurse was on sick-leave), and two general assistants – a male "caretaker", who performed cleaning and over-all maintenance functions, and a female "tea-lady", who was responsible for the kitchen and indoor cleaning functions. Four characters stood out above the rest of the staff in terms of their contributions during the consultation sessions. They were the two sisters-in-charge, the doctor and the pharmacist. I describe each of these four people, in turn, as they impressed us during the introductory consultation session.

	BAKER STREET HEALTH CENTRE		**ST. JOHN'S CLINIC**
	Day hospital	**Clinic**	
Sister-in-charge/facility manager	1 (Ms Kay)	1 (Ms Robertson)	1 (Ms Petersen)
Professional nurses	3	1	3
Nursing assistant	-	-	1
Clerks	2	-	1
Medical officer/doctor	1	-	-
Pharmacist	1	-	-
General assistants	1	2	2

Table 1. Staff complement at Baker Street Health centre and St. John's clinic before the merger

Ms Kay, sister-in-charge of the day hospital

Ms Kay was the sister-in-charge of the day hospital. She was reportedly an excellent clinician, but found her dual role as facility manager and clinician extremely stressful. Her workload, therefore, consisted of clinical as well as administrative tasks. She often had to help out with various aspects of the clinical work when there were staff shortages, and as a result she would not have enough time to perform her administrative duties. One of her administrative functions was to represent Baker Street health centre at health committee[7] meetings. As the sister-in-charge she had to give feedback on behalf of her organisation to the health committee on several

[7] The health committee consisted of representatives from the community, in which the health facility was located. They met regularly with health managers and the facility manager(s), to discuss issues pertaining to health service delivery. The focus of this initiative was to give the community a greater voice in the running of local health services.

issues. She found this task very stressful, because she was often not sufficiently informed herself.

> *Ek kan nie terugvoer gee namens provinsiale gesondheidsdienste nie, maar al die besluite kom van 'management' af ... Ek kan net vir die pasiente praat. Ek sit soos 'n zombie daar by die vergaderings.*
> *[I can not give feedback on behalf of Province Health, because all the decisions come from management ... I can only talk on behalf of the patients. I am sitting there like a zombie at the meetings.]*

Dr Zee, medical officer

Dr Zee was the most vocal participant during the consultation sessions with the Baker Street health centre staff. He was the only white, male staff member amidst other staff members who were predominantly coloured and female. (The only exceptions were the pharmacist who was an Indian woman and the coloured male general assistant (GA) from the local authority service). He was resistant to the idea of a staff-support intervention to help their staff, because according to him they were coping well as a unit. To quote him:

> *Not a major unhappiness here as far as I know ... We are coping well ...*
> *No psychological help needed here.*

Ms Reddy, pharmacist

Ms Reddy was new to Baker Street health centre. She was reportedly under severe workload pressure, because the assistant who was promised to her did not arrive. In the meantime Ms Kay helped out with dispensing medication to patients. The structural limitations of the dispensary room were a major source of frustration for her (the pharmacist). It was too small and did not comply with regulations set out by the Professional Board for Pharmacists. Still, she was fearful that the dispensary room at Youville health centre would be even worse than the current one she was working in, and therefore resistant against moving over.

I do not know what kind of room would be given to me over there [at St. John's] ... I just don't want to move. I want to stay here.

Ms Robertsen, sister-in-charge of the clinic

Ms Robertsen was the sister in charge of the clinic service at Baker Street. She was the only staff member from Baker Street health centre who openly opposed statements made by the doctor that every one was coping well in the centre. She was adamant that staff was under stress and in need of support.

Dit is stresvol! By City Health is ons net twee – een is af siek en die ander een werk halfdag.
[It is stressful! At the City Health we are only two staff members. One is off on sick-leave and the other one works half day.]

The clinic staff represented a minority at Baker Street. She felt isolated from her managers and expressed frustration at the lack of support she received from her (City Health) managers.

Die managers van die City Health sê net, "Skryf dit op papier." As ons inspraak kan maak by die dokter vir ons pasiente, hoekom kan ons managers dan nie ook vir ons dieselfde doen nie? Daar is geen evaluasie soos by die Provinsiale gesondheidsdienste nie.
[The managers of the City Health just say "Put it on paper." If we can claim the doctor's attention for our patients, why can't our managers do the same for us? We do not have any evaluations like Province Health.]

The rest of the staff of Baker Street were fairly quiet throughout the consultation sessions. A notable exception was the initial outburst of the general assistant from the day hospital at the start of the first consultation session when she said:

Dis waar wat Shariefa sê. Mens gaan huistoe met soveel stres. Baie bedank of vat die pakket. Nou is ons nog okay, maar wat hou die toekoms in?

[What Shariefa said is true. We are going home with so much stress. Many resigned or took the [retirement] package. We are still okay, but what does the future hold in store?]

It seemed to me that something in the way the researchers presented the baseline findings caused her to open up in a way that was totally out of character with the behaviour of the rest of Province Health staff. After opening up, she quickly returned to a quiet role like the rest, maybe realising that her behaviour was out of kilter with the attitudes of her staff colleagues.

St. John's clinic

The staff complement consisted of the sister-in-charge, three professional nurses, two general assistants, a clerk, and a nursing assistant (Table 1). In contrast to staff at Baker Street health centre, they were more animated and participative during consultation sessions.

Ms Petersen, sister-in-charge

Ms Petersen impressed as a very competent manager, eloquent and quite aware of the issues that concerned her staff. She stated that she had *"many caps that [she] wear[s]"* a clear indication to the dual role that she played in the clinic as clinician (nurse) and manager. I made the following observation about her:

As we sat down and the staff wrote their names on the tags that Hester provided, Ms Petersen seemed to be busy running around doing "urgent things". A baby that has to be weighed, she explained to us. She seemed to be creating the impression that she is working hard or doing important work. It seemed as if she was really trying to impress us - or her managers?

Ms Monieba, professional nurse

Ms Monieba stood out from the rest of the staff with her attitude that was overtly negative. Her body language gave the impression of antagonism towards her managers. I made this observation at the session we had with St. John's clinic staff:

> *All the other staff were quite "gemoedelik" [content/happy] to come in and join the meeting that is to take place. The only exception seemed to be Nurse Monieba who came in late and insisted on positioning herself directly opposite Ms Petersen. I got the sense that she did not want to be sitting too close to the managers nor have direct eye contact with them. She forced her way on that bench despite the protests of the two other nurses. When told to write her name on the tag ...another nurse ... went to get a tag and wrote her name on it.*

Ms Monieba demonstrated some reluctance in coming to the meeting, which seemed out of kilter with the rest of staff. She stated that all attempts to talk about the problems in the health services were a waste of time, because there were no follow-up from these discussions. As an example she stated that the query about job descriptions remained unresolved, despite numerous meetings and discussions.

> *It is a nice thing to air our views, but it just remains there. We talk and talk but nothing gets done. Like with the job descriptions now, Mr Nkonu [area manager from City Health] just said that that is beyond their capabilities. We are all demotivated. All these talks - nothing constructive. Did something positive come out of it? Or am I just negative? For example, the job descriptions... when will it come to an end?*

Her statement that it did not help much to talk to her colleagues about stressors in the job, suggested that she was quite isolated in the clinic.

> *I guess one should not keep it inside of you all the time, but talking does not help much. [I] rather go to the toilet ...*

Ms Garies and Ms Mathews, professional nurses

These two nurses were neutral about the impending merger with the day hospital staff of Baker Street. They were just waiting in anticipation for the merger and would deal with issues as it came up. Ms Mathews was previously involved in a failed attempt by local health authority to integrate health workers across racial boundaries within the department. She was just happy to be working at St. John's clinic after that terrible ordeal. She seemed determined to not let anything take her work enjoyment away.

Ms Christians, clerk

Ms Christians worked at the clinic at Baker Street health centre before she was transferred to St. John's clinic. Based on this experience at the other centre, she foresaw that it would be tough working together with the day hospital staff. Still, she remained optimistic that all grievances would be sorted out eventually.

Ms Nina, nursing assistant

Ms Nina was unsure about her position once the day hospital moved in and started working together with the clinic. As a nursing assistant in the local health authority, her job entailed both clinical and administrative functions. She feared that when the day hospital staff moved in, they would bring two clerks with them, which might render her role redundant. She was anxious to have her job description sorted out to fit into the new integrated service.

> *Ek doen werk as 'n klerk hier. Ek is in die knyp as Provinsiale gesondheidsdienste oorkom met al sy klerke. Ek weet nie wat ek dan gaan doen nie. Miskien oorgeplaas word erens anders. Die Provinsiale gesondheidsdienste susters raak nie aan 'n lêer nie. Hier doen ek die weeg en trek die lêer en so aan.*
> *[I work as a clerk here. I am in trouble if Province Health comes over with all their clerks. I do not know what am I going to do then. Maybe I will be transferred somewhere else. Province Health sisters do not touch a file. Here I do the weighing and draw the files and so on.]*

Ms Doreen, general assistant (tea lady)

Ms Doreen was a warm person, and as tea-lady, *the* personality of St. John's clinic. The following statement from her just typified her role as the 'home-maker' in the clinic.

> *Ek maak tee met warm melk. Ek het al vir die mense by Baker Street gesê hulle kan maar oorkom ek maak lekker tee met warm melk.*
> *[I make tea with hot milk. I told the people from Baker Street that that they should come over, because I make nice tea with hot milk.]*

Although her main responsibilities were cleaning and making tea for the staff, she also helped out with tuberculosis patients and receiving patients (taking out their files) when the clerks were absent. She enjoyed her work thoroughly, yet was somewhat worried whether the day hospital staff would accept her.

Mr Willemse, general assistant (caretaker)

Mr Willemse was quiet in the big meetings. He impressed as being Afrikaans-speaking (first language) and possibly not comfortable speaking in English. The rest of the staff from St. John's clinic mostly spoke English during the consultation sessions, even though the majority of them may have been Afrikaans speakers.

The over-all impression from St. John's clinic staff was that they were anxious about the impending merge, yet fairly confident that they would be able to work things out between the day hospital staff and themselves once the latter have moved in. Natasja, one of the consultants on the research team summarised our impression of St. John's clinic staff as follows:

> *Oor die algemeen kry ek die gevoel dat baie van julle voel hulle moet net "kom in en kry klaar" ...*
> *[In general I get the feeling that many of you feel that they should just come in and get it over with.]*

The middle managers

The management participants changed several times during the course of conducting the research. The first group of managers consisted of Ms Jacobs and her management team from City Health, and Ms Brown as the principal representative of Province Health. This group was instrumental in giving us access to the setting. The second group of managers joined the DAR process after the second consultation session with staff, and were very active in the process after that.

City Health managers

The City Health was divided into three areas (see Figure 3). In charge of each area was an area manager who reported to the Head of Health of the organisation. At the start of the current action stage, the Head of Health, Dr Wilson had already resigned, leaving his position vacant for more than six months (see Table 2). In this time the area manager in charge of the area where we conducted the study, Dr Louw, took over some of the Head of Health's functions. Subsequent to applying for the position of Head of Health and not being appointed, Dr Louw resigned towards the end of the first year, which coincided with the completion of the first action stage (baseline assessment of stressors). Our informant, Ms Jacobs, played an additional role as acting area manager for the first semester of the second year of our study (corresponds with the current action stage).

In the middle of the second year a new Head of Health was appointed in the person of Ms Mzumba. Ms Mzumba immediately proceeded to make new appointments, which included promoting Ms Jacobs to area manager in another district, and appointing two new managers (Mr Nkonu and Ms Ngobela, as area manager and nurse manager, respectively) in the district in which our selected sites were.

Apart from these three area managers, City Health also had a senior medical officer who functioned on the same tier of management as the area managers, and who was responsible for overseeing the work of the medical officers. The medical officers were not restricted to particular areas, but consulted at various clinics within the region on a sessional basis. This category of staff was not involved in the current action research process.

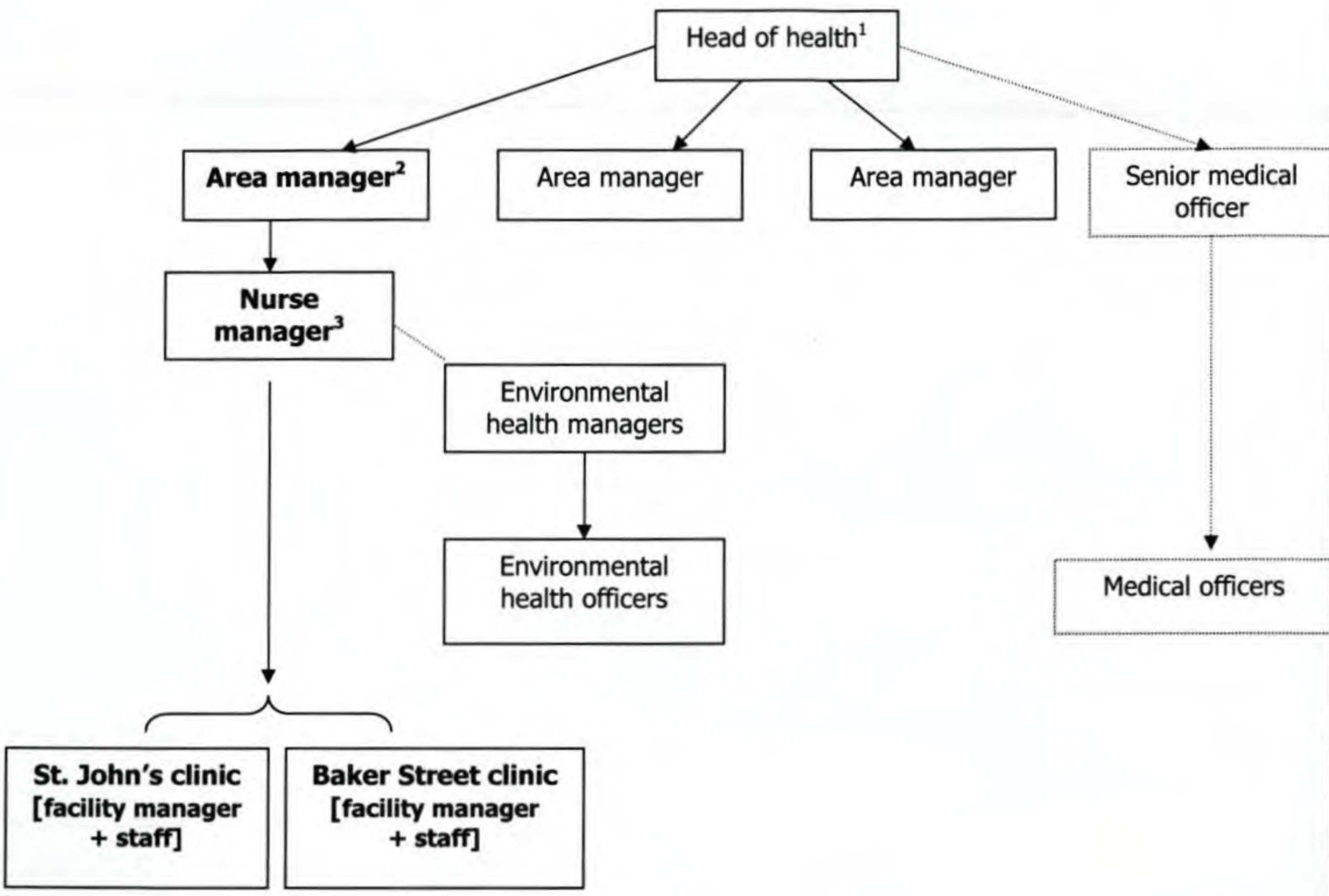

Figure 3. City Health management structure

<table>
<tr><th></th><th></th><th colspan="2">Year 1</th><th colspan="3">Year 2</th><th>Year 3</th></tr>
<tr><td>1.</td><td>Head of Health</td><td>Dr Wilson</td><td colspan="2">-</td><td colspan="3">Ms Mzumba</td></tr>
<tr><td>2.</td><td>Area Manager</td><td colspan="2">Dr Louw</td><td colspan="2">Ms Jacobs</td><td colspan="2">Mr Nkonu</td></tr>
<tr><td>3.</td><td>Nurse manager</td><td colspan="2">Ms Jacobs</td><td colspan="2">Ms Jacobs</td><td colspan="2">Ms Ngobela</td></tr>
</table>

Table 2. Changes in management over the research period

Mr Nkonu introduced himself as Ms Jacobs' replacement at the second consultation session with staff at Baker Street health centre. He impressed us with his dynamic and proactive approach to the issues that staff brought to the discussion. During the research process, he took over the role that our informant, Ms Jacobs, had played as the catalyst for action in the research process.

Our first encounter with Ms Ngobela was during the consultation meeting with St. John's clinic staff. She seemed less experienced as a manager than her predecessor, Ms Jacobs, but demonstrated greater emotional proximity with staff experiences. At times during the consultation sessions she overtly joined in with staff in attributing negative traits to Province Health staff and management.

Province Health managers

Ms Randall, the nursing staff manager at Baker Street day hospital, resigned from the service during the second action stage. Her departure coincided with the restructuring of management structure in Province Health in preparation for amalgamation with various local health authority organisations. Previously, the management structure in Province Health was very hierarchical, with vertical accountabilities along professional categories (that is, line managers over medical officers, nurses, etc.), which were not aligned with the district health system. For this reason they divided the current province into 22 health districts. The health districts corresponded to the areas designated by the various local authority health departments. Previous line managers were grouped together to form district management teams (DMT) and put in charge of specific health districts. Each DMT consisted of three members, including a medical staff manager, a nursing staff manager, and an administrative manager or a manager overseeing the services of the professions allied to medicine (PAM). One of these members would head up this team as the district manager. Due to the shortage in management staff, several line managers were active in more than one health district. The DMT in charge of the area under which Baker Street day hospital resorted consisted of Ms Loxton, who was nursing staff manager and district manager, Dr Ali, the medical staff manager, and Mr Smith, the administrative manager. Ms Loxton was a new-comer to this health district, when she replaced Ms Randall as nurse manager. Ms Loxton impressed as an articulate leader who was very competent, experienced and

authoritative. Throughout the process she listened well and was open to ideas. Most of the energy in action process came from her interaction with Mr Nkonu.

Dr Ali impressed us as being desperately overworked. He was a member of the DMT of two areas. That meant that he was supervising the medical staff in 15 health centres. Apart from his role as manager over the medical staff, he still did clinical work. He stated that he was not coping with his workload and received little support from his managers. He was exasperated at the lack of resources and staffing from which the organisation suffered and had very little hope that anything else but additional funding would improve staff morale.

Mr Smith was a senior manager handling the budget of Province Health. Although new to this DMT, he has been part of senior management of the organisation for a long time. He mentioned that he handled a budget of R260 million. He defined his role as a member of the DMT as empowering all the health districts in the organisation by giving them information on how to run their own budgets. He only attended the first meeting where the middle management teams of both health authorities were present. He did not contribute much to the consultation session. It seemed clear that his role was very senior and thus far removed from the frontline services.

DATA COLLECTION

The process of data collection was not set *a priori*, but followed iterative cycles of inquiry, which were decided upon through consultation with staff and management. Transcript data were collected from consultation sessions with staff and managers as well as team debriefing meetings. Complementary data were collected from electronic communications and field notes and memo's from the principal investigator and myself. Group sessions were either recorded on tape or through detailed field notes taken by the researcher. Detailed notes were also taken from discussions during team debriefings and planning sessions. These notes were checked against the principal investigator's notes to increase comprehensiveness. Reflexivity was built into the process through regular team debriefings and personal reflections by the researchers.

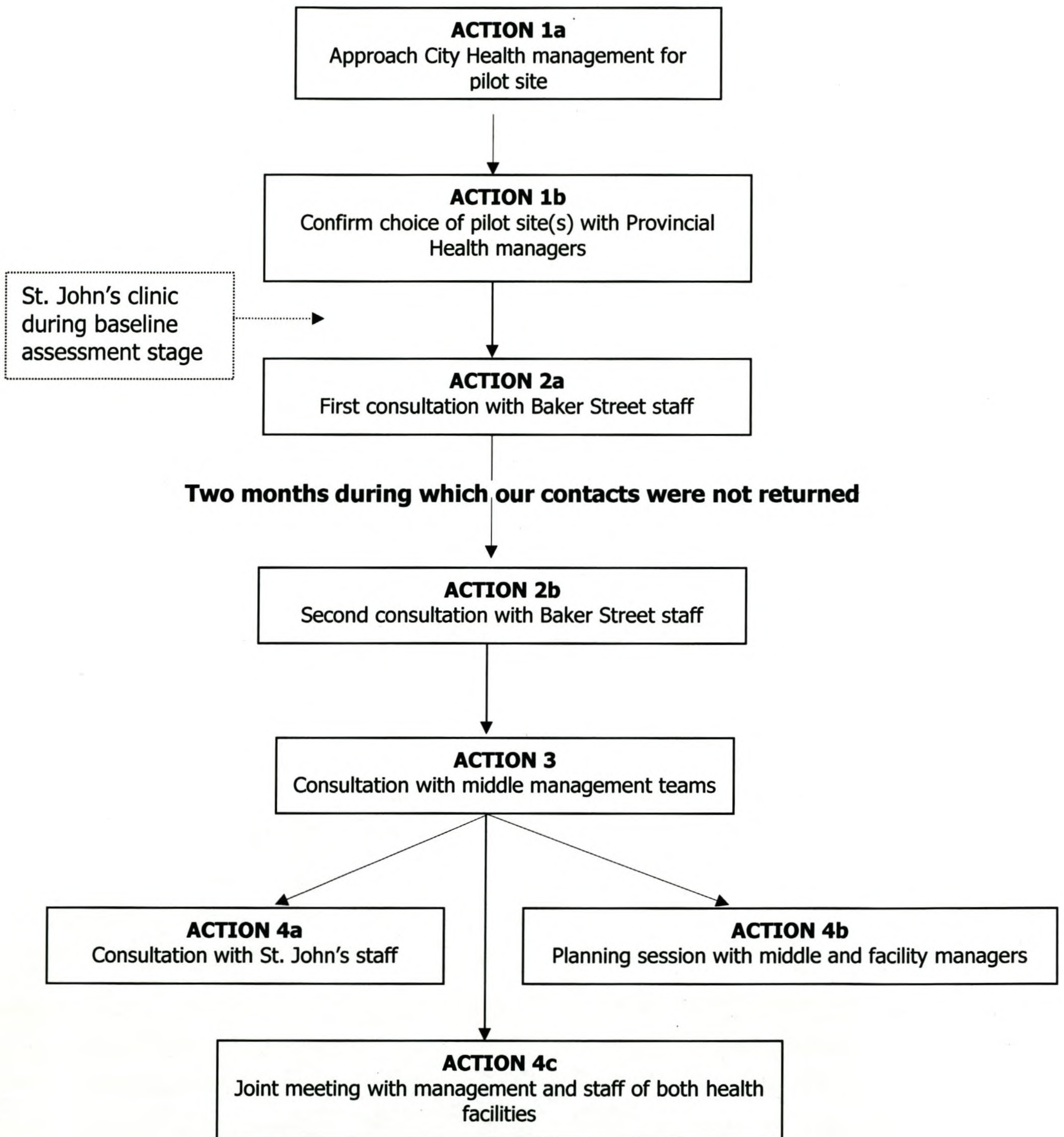

Figure 4. Data collection during facilitation of integration

Data collection started with a consultation session with Baker Street health centre staff (action 2a in Figure 4). We decided to meet at this facility first, because we had not met these staff members yet. We invited the two nursing staff managers from City Health and Provincial health services, but neither Ms Jacobs nor Ms Brown attended. Upon a request from staff we tried to invite the above-mentioned managers to a second meeting so that staff could have the opportunity to put their questions to their managers. After two months wherein we had considerable difficulty in locating the managers, we eventually managed to set up a second consultation session (action 2b in Figure 4). At this meeting only one manager, Mr Nkonu, was present. He was not able to answer all staff's questions, because he was new to the health district. However, he committed himself to bring the other managers (City Health and Province Health) to the next meeting. Spurred on by a mandate from staff to get management involved, we arranged a meeting with the management teams of the two health organisations (action 3 in Figure 4). The DMT of Provincial Health (Ms Loxton, Mr Smith and Dr Ali) was present as well as Mr Nkonu. At this meeting several plans were made to take the process forward. Firstly, it was decided that the researchers should consult with staff from St. John's clinic first to get them on board in the process (action 4a in Figure 4). Secondly, a consultation session with the Ms Petersen and Ms Kay would be conducted to discuss practical steps about the merger of the two facilities (action 4b in Figure 4). Lastly, a joint meeting with both staff complements from Baker Street health centre and St. John's clinic, should be arranged, aimed at bringing all the staff members up to speed with arrangements for services in the new health centre (action 4c in Figure 4). This final meeting took place about two weeks before the actual merge.

DATA ANALYSIS

Verbatim transcriptions of audio-taped interviews were made. A person independent to the action research project was contracted to do this. The researcher (myself) checked transcriptions for accuracy. Data collected from these consultation sessions were analysed using the method of grounded theory (Strauss & Corbin, 1994) as described and illustrated in the previous chapter. Coding of data was done using Atlas.ti 4.1 software package. In the open coding phase I distinguished between the categories of respondents (staff versus managers), while attributing descriptors to the content of their responses. I also coded actions taken and observations made by

the researchers and consultants. I used these codes merely for tracking our contributions to the process. These codes do not form part of the analysis, but I draw on these in my reflection on the process and the researchers' role. In the axial coding phase where I grouped the open codes into categories, I continued the convention of keeping staff responses separate from manager responses. During the course of assigning axial codes it was already clear that staff responses denoted *stressors* in the system and that management responses narrated a *progression in involvement* – a process that I followed through (verified) in the selective coding stage.

FINDINGS

Staff responses were grouped into four coded categories (Partial integration of health services, Poor management of services, Pressure to deliver services, Competing organisational cultures). These coded categories all centred around stressors experienced by staff within the health system. Management responses were described in seven codes (Absence, Empathy, Integration, Manage change, New managers, Plans and Workload). These seven categories denoted four themes (Absent and uninvolved, Aware but distant, Acknowledgement and intention, and Practical and involved), which suggested a progression in awareness and involvement of management with respect to staff stressors during this cycle of action research. I have included the code list in Addendum B.

Staff: stressors within the health system

In the initial absence of management, the staff from Baker Street health centre related several stressors that they claimed made it difficult to integrate frontline services. These stressors were categorised as problems associated with *the partial integration of health services, poor management of services, pressure to deliver services* and *competing organisational cultures.*

Partial integration of health services

According to the policy adopted by the National Department of Health public PHC facilities should strive to provide a comprehensive service to their respective

communities. This meant that previously separate, locally and provincially managed health services would have to integrate service delivery. Mr Nkonu, area manager of City Health, expected frontline services to integrate their services, even though negotiations for amalgamation of the respective health organisations were still under way.

> *The aim is to establish community health centres. This would offer broader services. There cannot be abrupt changing because conditions of services, etc. need to be looked at ... The people on the ground* ***need*** *to merge while the long-term vision is under construction.*

Staff members were reluctant to integrate at frontline (services) level, while their respective management structures operated separately. The apparent inability of top managers to reach an agreement on the conditions for amalgamation caused staff to doubt management's commitment to integration.

> *The clashes come from the top when the managers try to promote the integration. It is a so-called farce. There are too many bosses at the top - a pseudo-integration. The overhead departments do not work and now they want to force it down. The top does not integrate, but they expect the bottom to integrate.*
>
> - Dr Zee

The incomplete (partial) integration meant that staff were still subject to different conditions of service as set out by their respective organisations. In general, Province Health staff were paid less than their counterparts from City Health. These discrepancies in salaries became a major source of dispute and dissatisfaction when day hospital staff were required to take up some of the functions of the clinic service, while not getting remunerated for this work. In similar fashion, clinic staff refused to adapt to the longer working hours by which day hospital staff had to abide. Ms Kay remarked that different conditions of service were an obstacle to integration of services.

Vir my was die verskillende diensvoorwaardes eens op 'n tyd nie regtig 'n probleem nie. Ek het geweet dit sal nie regkom voordat ons nie een is nie. Maar nou dat ek oorgeneem het hier, nou sien jy eintlik die verskille!
[Initially the different conditions of service were not a problem for me. I knew that it would not be resolved before we are one. But now that I have taken charge here, now I see the actual differences!]

Another challenge for integration was to reconcile the organisation of work between day hospital and clinic services. Management did not pay sufficient attention to re-organising and restructuring job descriptions to fit integrated services. An example of this was the role of nursing assistants. In the clinics (preventative services) nursing assistants had both clinical and clerical functions. In the day hospital service, however, there were clear distinctions made between clerical and clinical work. Nurses would not work with patient files, because the day hospital service always had enough clerks. With integration of clinic and day hospital services the position and function of the nursing assistant were not clear. Ms Nina, the nursing assistant from St. John's clinic explained her anxiety about merging with the day hospital:

Ek is in die knyp as provinsiale gesondheidsdienste personeel oorkom met al sy klerke. Ek weet nie wat ek dan gaan doen nie. Miskien oorgeplaas word erens anders. Die provinsiale gesondheidsdepartement susters raak nie aan 'n lêer nie. Hier doen ek die weeg en trek die lêer en so aan.
[I am in a predicament if the provincial health staff come over with all their clerks. I do not know what I would do then. Maybe I would be transferred to another place. The provincial health nurses do not handle files. Here I am doing the weighing and drawing of files and so on.]

Partial integration brought questions about lines of communication. Staff were often confused about whom to report to about what when one facility manager was placed as the over-all sister in charge of the centre. The general assistant related that when she had worked in another integrated health centre, there had been a lot of friction

about whom she should listen to: the sister-in-charge from Province Health (her employer) or the facility manager who was from City Health.

> *Aan die begin was ek gelukkig by die werk, toe ek by die hospitale gewerk het. Maar nou geniet ek dit nie meer nie. Ek moet nou vir plaaslike owerheid en die daghospitale werk. Dit het wrywing veroorsaak by die susters. "Wat as jy seerkry? Wie gaan verantwoordelikheid aanvaar vir jou?"*
> *[Initially I was happy at work – when I worked at the hospitals. But now I am not enjoying it any more. Now I have to work for City Health and for the day hospitals. This has caused friction with the sisters: "What happens if you get hurt? Who is going to take responsibility over you?"]*

Questions like the above-mentioned were left unresolved by management and created the impression that the managers did not think through the practical issues regarding integration of frontline services.

> *I mean this point have been raised countless times: What strategies do you recommend besides keep telling the staff "work together, work together?" What else, what new is there?*
> - Ms Petersen

In the absence of management involvement, facility managers were under pressure to make integration work at facility level. In one of the consultation sessions with middle managers, Ms Petersen challenged the managers about their lack of involvement:

> *The main thing is it is all nice and say, "Right you guys work together." You [Ms Loxton] and Ms Ngobela, how fully integrated are the two of you? We look up at our managers and we would want to see them leading the process. And I mean we on the ground must go off with this and they just got offices next to one another. We want to know how well they are getting together and how well they are communicating this amalgamating message to the*

lower categories. It must not be left up to us to see that the service now runs hunky-dory.

The problems and stresses that staff experienced with respect to partial integration of services, related in part to the following coded category that I will describe, namely poor management of services.

Poor management of services

Staff were dissatisfied with the bureaucratic way the health services were managed. They experienced management as being unsupportive and lacking in consideration for staff needs and concerns. According to staff the middle managers did not address their complaints and left the facility managers to solve problems within service delivery themselves.

> *Die management los ons net so, want hulle weet dat die nurses self dinge sal uitsorteer.*
> *[Management leaves us just like that, because they know that the nurses would sort things out themselves.]*
> - Ms Robertsen

Senior management reportedly only intervened when situations in the facilities reached crisis point, and even then, there would be long time delays before they implemented what they promised they would do. Dr Ali related the difficulties with resolving the crisis with the shortage of pharmacists nationally as an example.

> *The [remuneration] price has been mentioned at head office level. There they have agreed to improve the salary scales for the pharmacist. And they were supposed to have put in adverts nationally for pharmacists. But the wheels of bureaucracy turn very slowly. That is the crisis ... we need to resolve it urgently. For the decision were made that afternoon. But for that motion to be put into action takes ... It has been three weeks since that emergency meeting and that hasn't happened. And there are a lot of complexities. Because they say "no we can't put someone at*

Youville, because priorities are greater at other places like Mnchacha and Llondusi." And these things are complicating matters.

Unresponsiveness of management (on senior and middle levels) coupled with their slow response times to priority problems caused many staff to lose motivation for work. Staff perceived long delays in decision-making and implementation as indicative of management's lack of commitment towards staff well-being.

Back then they started with the upgrading the staff to boost the morale of staff. Upgrading of staff would lead to increases in salary scale. The aim was to boost staff morale. They were re-looking at the job descriptions. We have been waiting and waiting but nothing has come of it. That is why the staff are coming with a lots of baggage carried over from those experiences.
- Ms Petersen

Staff complained that their managers were very demanding of the health services to meet community demands and appease political pressures, and reluctant to acknowledge the realities of the challenges that staff faced at frontline and supporting them to facilitate more effective and efficient service delivery.

Julle sien mos nou hoe leeg die kliniek is ... dan wil die managers hê "please explain" as jy verslag gee van "zero attendance". Dit is waarom baie susters vra vir halfdag poste, maar dit word nie toegestaan nie. Dan bedank die susters. Dan word hulle weer aangestel as "char" hier vir halfdag. Daar is nie geld nie, so hoekom stel hulle nie halfdag poste aan nie?
[You can see how empty the clinic is now ... Then the managers ask that you "please explain" when you report on zero attendance. This is the reason that many sisters ask for half-day posts, but this is not granted. The sisters resign and then they are re-appointed as char [part-time employees] here for half days. There is no money, so why do they not set up half-day posts?]
- Ms Robertsen

The decision to move the Baker Street day hospital to St. John's clinic was viewed as another management decision that was taken to please the community, while disregarding how staff felt about it. Staff felt aggrieved, because they were not consulted before the decision was made in the first place.

> *We were informed about the move, not asked ... We are not happy.*
> - Dr Zee

Secondly, the managers only informed staff about the decision two months before the actual move.

> *It is a bureaucracy! Only two months before the move, do we hear that the decisions to move have been made last year already. "These are the plans" ... and we get the palpitations.*
> - Dr Zee

Thirdly, the managers did not explain the rationale behind the decision to move the day hospital to staff when they informed them about the move initially. This caused unhappiness amongst staff and left them questioning the rationality of management's decision. Dr Zee felt that the move was not justified:

> *This is not well planned. I want to know based on what research did they decide on this move. The majority of my patients come from the small area around here. They are mostly elderly.*

Excessive movements of staff between facilities, without due consideration of the effects that it had on staff morale and organisation of work, frustrated staff. These excessive movements hindered adequate planning for service delivery, because facility managers would not be sure what staff resources would be available to them on any particular day. Futhermore, staff movements caused facility managers to lose motivation for work, because they had to deal with new staff all the time, whom they had to train and orientate into the work again.

> *Die veranderings gee die meeste frustrasie ... die verskuiwing van personeel! 'n Mens kan niks meer beplan nie. Jy verloor motivering*

en jy werk net van dag tot dag. En dis nie soos dit behoort te wees nie.

[The changes cause the most frustration ... the movement of staff! One cannot plan anything. You lose your motivation and just work from day to day. This is not how it is supposed to be.]

- Ms Robertsen

The proposed merger between Baker Street day hospital and St. John's clinic was perceived to be another example of how managers plan to move staff around without consideration of how the staff might feel about it. Staff at the Baker Street health facility was distressed that the "family" unit that was formed under such difficult circumstances was to be broken up again. With Ms Kay in charge, they had succeeded in developing a *"good working spirit"* between the two services. Many staff members expressed their desire for the day hospital and clinic staff to stay together even when they move the day hospital service to the other side of Youville. It seemed to them that management considered their concerns as a trivial matter.

Ek wil saamgaan na St. John's. Ek kan dit nie eens 'n gebedsaak maak nie, want dit sal nie eens help nie.

[I want to go along to St. John's health facility. I cannot even pray about this, because that would not even help.]

- Tea lady from Baker Street day hospital

Baker Street clinic staff were unhappy about the decision to move the day hospital from Baker Street to St. John's clinic, because they would be transferred to other facilities, without being given any say in the matter of their placement at all.

Ons word nie gevra nie; ons word gesê waarheen ons gaan ...

[We do not get asked; we are told where we are going (to be placed)]

- Ms Robertsen

The day hospital staff from Baker Street was also unhappy, because they would have to establish new working relationships with the clinic staff of St. John's. They would

lose some of their current staff members (a nurse) and would have to adjust to a new service and way of working with even fewer staff.

I am stressed about integrating ... I have to take fewer staff with me.
I have to set up something new. New relationship, new service.
- Ms Kay

The predominant feeling amongst staff was that in this highly politicised environment where management was pressured to adhere to community demands, frontline staff seemed to have no rights at all. As the doctor stated:

'Dit laat mens wonder: Het die staff regte?'
[It makes one wonder: Does staff have rights?]

Ms Robertsen's rhetorical question, also previously quoted, summed up the staff's exasperation towards the unresponsiveness of management to staff needs.

As ons inspraak kan maak by die dokter vir ons pasiente, hoekom kan ons managers dan nie ook vir ons dieselfde doen nie?
[If we can speak to the doctor on behalf of our patients, why can't our managers do the same for us?]

The unwillingness of management to address staff concerns coupled with their unresponsiveness towards problems encountered in service delivery, added to the pressures of health service delivery, the next category of stressors.

Pressure to deliver services

As already mentioned earlier, working in the public health service is stressful, even at the best of times, due to the nature of the work, which involves caring for the sick and poor. At the time of the research health services were experiencing a crisis nationally with the shortage of pharmacists. These "operational" stresses were enflamed by "political" pressures placed on frontline staff at PHC facilities to deliver on promises made by political leaders and echoed by senior health management on both local and provincial levels. In this political climate where patient rights were

propagated, the communities became increasingly demanding of the public services in general, of which the local PHC facility presented the frontline of contact between the community and the health system. National government implemented plans to increase coverage of health services without providing sufficient resources in terms of staffing and materials to deliver these services adequately.

> *Hulle het nie geld om mense aan te stel nie, maar die goverment bou nuwe centres. Hulle skep hoë verwagtings onder die mense.*
> *[They do not have money to appoint people, but the government builds new centres. They are creating high expectations amongst the people.]*
> - Ms Reddy

Restructuring health services in South Africa to gain a more equitable distribution, meant that the more well-resourced provinces, such as the one in which the current study was conducted, had to settle with a cut in their budget. This meant that many health organisations could not fill the positions left vacant by staff who left the services or moved to another facility. The shortage of staff meant that the existing staff complements were faced with increased workloads.

> *Met die personeel wat bedank, word daar nie meer mense aangestel nie. Daar is geen apteker aangestel nie; nou moet 'n nurse die werk doen. En die nurse kry geen erkenning vir die werk wat sy doen nie. Dit lei tot baie frustrasie.*
> *[With all the staff that resigned, new staff are no longer being appointed. No pharmacist was appointed, and now the nurse has to do the work. She does not get acknowledgement for the work that she does. This leads to a lot of frustration.]*
> - Ms Robertsen

Management's attempts to increase the effectiveness of service delivery by promoting staff without filling the spaces that they left behind with new staff, created added stress for health staff. Ms Robertsen explained how the management wanted to make the service more efficient by running it as a cost centre, where she as the manager/administrator would adapt the budget and service according to the

unique needs of the community that the health facility is serving. In doing this, they added another function to the service (cost centre administration), without making provision for someone to fulfil the clinical role that the sister-in-charge played in the clinic.

> *Daar was eers vyf verpleegsters hier. Nou is daar slegs drie. Ek was aangestel in 'n senior pos as "cost centre administrator", maar my ou posisie is nie gevul nie. Nou moet ek altwee werke doen ...*
> *[Initially there were five nurses here. Now there are only three. I was appointed in a senior position as cost centre administrator, but my old position was not filled. Now I have to do both jobs ...]*
> - Ms Robertsen

The decision to move the day hospital was made in collaboration with the health committee of two years ago, based on research that was conducted six years ago. When the decision to move the day hospital was later shared with the new health committee, they got the community to demonstrate against the closure of the Baker Street health facility. They argued that the older people who need the clinic (health service) stayed around Baker Street and that they did not have transport to go to St. John's on the other side of town. The managers succumbed to the pressures of the community and promised that Baker Street facility would not be closed. A decision was taken that Baker Street facility should be retained as a "mini" day hospital after the move. Staff criticised the decision to run a mini-day hospital with only two nurses (Ms Robertsen and a staff nurse) as being totally impractical.

> *Die Baker Street fasiliteit moet voortbestaan as 'n mini-daghospitaal wat minor ailments behandel, sowel as bejaardes en kinders onder 16 jaar en gesinsbeplanning.*
> *[The Baker Street facility must function as a mini-day hospital to deal with minor ailments, older adults, children under 16 years and family planning services.]*
> - Ms Robertsen

The decision to retain Baker Street as a mini-day hospital would mean that the day hospital service would have to sacrifice one of their nurses to remain at Baker Street.

According to Ms Kay, the physical structure of the building at St. John's would even make it difficult to run the day hospital service with the same number of staff as at Baker Street. The new building at St. John's had separate rooms for the different procedures, instead of one big room where the different procedure were done as at Baker Street. The new divided internal structure would make it more difficult to co-ordinate shifting nurses between the various functions to ease the work-flow.

> *Dit gaan nie funksioneer by St. John's soos hier nie. Hier by Baker Street is alles gedoen in een kamer. By St. John's kliniek is daar verskillende kamers waar verskillende behandelings gedoen word. Omdat alles hier in een kamer gebeur, is dit maklik vir die verpleegsters om mekaar uit te help. Verskillende kamers maak dit moeilik om die onderlinge help mekaar met pligte uit te voer.*
> *[It will not function at St. John's as here. Here at Baker Street we did everything in one room. At St. John's there are different rooms where different treatments are performed. Because everything here happens in one room, it is easy for the nurses to help each other. Different rooms will make it difficult for nurses to help each other out with their respective tasks.]*
> - Ms Kay

In the face of limited resources, frontline staff was pressured to deliver on promises for services made by senior managers and national government. This situation was worsened by the growing human rights culture where patient rights were emphasised, while staff were left dis-empowered and vulnerable against unrealistic community demands.

> *Hulle stel slegs belang in die gemeenskap. Hulle skeur die staff in twee om in die gemeenskap se behoeftes te voorsien.*
> *[They are only concerned with the community. They tear the staff in two in order to satisfy the community's needs.]*
> - Ms Robertsen

Competing organisational cultures

The expected organisational culture differences between the staff of Baker Street day hospital and St. John's clinic contributed to an atmosphere of competition and mistrust, which posed particular challenges to and for the integration process. The above-mentioned health facilities differed with respect to the type of health services provided and the level of government authority under which they were placed administratively. These differences led to differences in work organisation, management style and over-all organisational culture, which were not easy to resolve. One of the challenges for the new integrated service would be to resolve the difference in starting times. The day hospital unofficially started their work at seven o' clock in the morning, because patients would already be queuing outside the health centre before this time to be seen by the doctor that day. There was usually an overwhelming demand for adult curative services provided by the doctor, which forced the day hospital to set a daily limit on the number of patients who would be seen by the doctor. The prevention clinic, however, started at eight o' clock, because they did not have this pressure from patients. By moving all appointments for antenatal services to the afternoons, they have succeeded in spreading their workload more evenly through the day. The staff from the clinic was resistant against starting an hour earlier with the day hospital staff.

> *Ek wil vra van die diensure - provinsiale gesondheidsdienste wat om sewe-uur begin. Ek begin nie sewe-uur nie.*
> *[I want to ask about the service hours. Provincial Health services start at seven o' clock. I do not start at seven o' clock.]*
> - Ms Christians

The different starting times affected tea and lunch times. Teas and lunches were very important events in the working day of staff at PHC facilities, because these were the occasions where bonding between staff members normally occurred. To establish a fully integrated service at Youville's new health centre, lunch and tea times would have to be scheduled in such a manner that day hospital and clinic staff would have teas and lunches together. The facility and middle managers were challenged to persuade staff to accept changes to their normal work schedules, because having separate tea and lunch times between the day hospital and the clinic would be counterproductive to establishing a fully integrated service.

What we are saying is that you (clinic staff) start work at 8:00. We (day hospital staff) start work at 7:00. Therefore our tea is from 9:30; yours might be from 10. You are still going to miss each other in the tea-room.

- Ms Loxton

Another contentious issue that the integrated health service had to face was the sharing of work between the two nursing staff complements. It was envisaged that staff from both health authorities would be equipped to deliver both types of care, and thus be flexible enough to move around within the service to help out in areas under pressure.

With amalgamation, everybody does everything. That seems to work. But add the different conditions of service, trauma units, day/night shifts. City Health nurses are considered specialists - they do not move around.

- Ms Loxton

Although the nurses went on training to gain skills that would enable them to work in both services, they remained resistant to taking up the "other" side's work.

City Health staff get the training to do curative work, but don't take responsibility for curative functions.

- Ms Kay

Ms Kay was convinced that this was a mindset that was impossible to break and that it would hinder the full integration of services at Youville's new extended health centre.

Plaaslike gesondheidsdienste personeel voel dit is benede hulle om "dressing" te doen ... Ek sal nie die plaaslike gesondheidsdienste staff kan kry om die werk te doen nie... So die werk bly apart.
[City Health staff feels that it is beneath them to do a dressing... I will not be able to get City Health staff to do the work ... So the work remains separate.]

In similar fashion Ms Loxton, nursing staff manager of Province Health, noted that day hospital nurses considered doing health prevention and promotion as less important than their curative work.

> *The people who did curative work and have to do preventative work now, think that preventative services are not that urgent, so "we can put it off."*

The management styles of the two health organisations differed from each other and contributed to an atmosphere of distrust and misunderstanding between the two staff complements. The difference in management style was reflected in the job descriptions of the two sisters-in-charge of the day hospital and the clinic respectively. Province Health was known as a hierarchical, bureaucratic organisation with a strong top-down decision-making style.

> *Working for the government is different from working with local authority. At local authority level problems are easier sorted out. It is more difficult with government. You have to go through the region, and then Rudolf Street, and then Egini. There are six levels to go through. The local government has a flatter structure. They have less management. For example transport have to go to Pretoria to the Minister of Transport. For example, the issue with the uniforms had to be decided in Pretoria. Because of this long hierarchy, staff are also less likely to talk about it.*
> - Ms Loxton

Very little decision-making power was placed in the hands of sisters in charge of the day hospitals. They were usually promoted to management positions on the basis of their good clinical skills rather than their management competencies. This policy was reflected in the facility managers' job descriptions, which stated that they were largely responsible for clinical work.

> *There are problems at Province Health with this, because the centre managers have to perform a clinical function as well as the*

administrative duties. 70% of the sister-in-charge's function is clinical. City Health sisters-in-charge do minimal clinical work. In amalgamation City Health sisters, even when acting as deputy, still go out on workshops and meetings, which causes much stress among Province Health staff.

- Ms Loxton

City Health on the other hand, placed more emphasis on managing the services. Their facility managers' job descriptions reflected that they were supposed to spend 80 per cent of their time managing the service and 20 per cent of the time helping out with clinical functions. The differences in the way that sisters-in-charge's job descriptions were laid out, contributed to the level of confidence that the respective sisters-in-charge demonstrated as facility managers.

Sister Petersen comes across as confident. She will most probably lead. Sister Kay has knowledge and skill, but no confidence. The idea of rotation is in theory a good idea. In practice it can't be done because Sister Kay has to play a clinical role as curative sister too, and won't have time to handle the admin and run the clinic.

- Ms Loxton

For successful integration to occur at Youville's new health centre, it was envisaged that the two sisters-in-charge needed to share the clinical and administrative duties equally. This posed a problem because whereas Ms Kay had a high clinical workload, Ms Petersen was very resistant to her position being demoted to a more clinical function.

I would just think that her job description should then come up to eighty per cent and twenty per cent as well, seeing that you are a first line manager. She should also have the same duties as I have.

- Ms Petersen

The management reported that the most successful integration to date occurred when the clinic sister took over-all charge of the service, because she had a more assertive personality. The sister-in-charge of the day hospital acted as her deputy. It

was feared that the same would happen at Youville's new health centre, which would send out a message that in future integration processes City Health clinic sisters would take charge and the day hospital sisters would be deputies. Such a situation would mean that integration of health services at PHC level would constitute a take-over by local authority health organisations rather than an amalgamation. In a previous study it was observed that the issue of amalgamation-integration was indeed a sensitive topic that caused great anxiety for middle managers from the provincial health authority (Muller, Leon & Van Wyk, 2000). In the current process, participating middle managers were anxious to have Ms Kay learn management skills by taking on a greater portion of the administrative responsibilities, and Ms Petersen to be less threatening as a manager and stepping down to take up more clinical work.

> *Province Health sisters do not have the assertiveness, but they have other strengths. The nurses are trained in a historically doctor-driven health system. The nurses were known as "Yes-amen" people.*
> - Ms Loxton

The fear of an organisational take-over filtered down to facility level and this was evident in the growing resistance to the proposed merge at Youville. The clinic accused the day hospital staff of rebuffing all their attempts to get to know them on a social level.

> *We tried to have social gatherings with them here. Two times. Once we had a braai [barbecue]. The other time we had a tea party. But they don't come. We had the cake and tea, everything ready. They have all kinds of excuses. With the braai: at first I thought [to schedule it] for the fifteenth, but then that's when they get paid and all of them want to go home early. So I held it the week later. Then their excuse was they had no money.*
> - Ms Petersen

The resistance and animosity between the two organisations were also evident in the negotiation of the construction work in the new health centre. Ms Petersen

complained of the day hospital staff's "continual" dissatisfaction with the building and their unwillingness to cooperate in the process of planning the construction thereof.

> *When everything is done, in walk Province Health staff. "We don't want this or that." "This wall must be broken down." I don't want to listen to any more walls that need to be broken down. The people down there are never happy with the building. I don't know the people. I just have to play hostess when they come here. I have to be nice. Then I hear them speaking to the staff that this wall must come down or this must be changed. All these long distance communication is driving me nuts. I ask them to come down and see what is to be done. Then you hear: "we don't have a car", "we can't come down." E.g. we asked the pharmacist to come down to look at the shelves. "Oh I am not going to work there anymore." And all these changes that have to be done, means that I have lots more paper work to do.*

Feelings of animosity were thrown to and fro between the two organisation's staff and management complements. Province Health managers also were accused of being uncooperative in the process of negotiations for integration of services.

> *It's all about attitudes. We go out of our way to embrace Province Health. No ways. [Senior manager] does not attend any meetings down here. He only gives orders.*
>
> - Ms Ngobela

The two organisations were different with respect to culture of communication. The clinic staff felt that they would not be able to work well with the day hospital due to the latter's culture of non-participation in meetings.

> *We try to troubleshoot. I don't know with the staff over there. They don't talk. When we have meetings we have to draw it out of them. It is only St. John's clinic staff that responds in meetings. Baker street day hospital staff is withdrawn.*
>
> - Ms Ngobela

Province Health managers, on the other hand, felt that although City Health prided themselves on keeping their staff up to date with the flow of events, information tended to be communicated prematurely, leading to further animosity between the organisations. The day hospital staff would be dissatisfied that they were not informed, when they heard the status of events from their counterparts from City Health. When they were informed eventually, things might have changed and then it might be different than what was told to them via the City Health staff, and this caused them to believe that the local authority staff were misinforming them of the real state of affairs, contributing to greater distrust between the two organisations.

> *I think one of the problems is that communication is different. Management styles are different obviously. But what has happened in City Health, is they have given a lot of information. Sometimes misinformation: things that have not been decided yet, but are still under discussion. And that has been going down to grassroots level. Whereas we sort of wait until everything is on a circular before we disseminate that information. So, that they are getting information from another source about what is happening. Therefore they are not, the people on our side, are not wholly trustful of what we are saying to them, because they are getting two different messages. We might give the same message but a month later. Or we might give a total different message because now a decision has been made.*
>
> - Ms Loxton

In summary, the differences in organisational culture, management style and organisation of work posed real challenges to integration of services and the management thereof.

Management responses

The responses of management during the action stage could be categorised into four stages of awareness and involvement: (1) Absent and unaware; (2) Aware, but distant; (3) Acknowledgement and intentions; and (4) Involved and practical. Figure 5 below charts the frequencies of responses of the managers over six consultation sessions. The first two events or consultation sessions show that management responses were mostly coded as absent (category 1 responses). An absent code was assigned to a manager who was invited to the meeting, but stayed away without a valid motivation. Managers who excused themselves from the consultation session on the basis of conflicting work commitments (other meetings), were assigned an absent code, because this action may have indicated a decision not to be involved in the consultation process[8]. The progression from category 2 to 4 is evident from the coding of management responses over the last three consultation sessions (4 till 6). The frequency of codes classified in category 1 (Aware but distant) was half the total number of codes assigned to management responses in the fourth consultation session. The majority of codes assigned to management responses in the fifth consultation session could be classified as category 3 responses (Acknowledgement and intention). In the final consultation session (session 6) more than half of management responses were coded as belonging to category 4 (Practical and involved).

A break from this progression is clearly evident in the codes assigned to responses in the third consultation session. The reason for this deviation from the pattern could be related to the fact that this meeting was called for managers only. This meeting was set as an ultimatum to managers to become involved in the consultation process that was taking place in two of their health facilities. The good attendance from the middle managers could also relate to the fact that the meeting was held at a neutral venue, where the researchers were based. The neutral venue, away from the pressures of health service delivery, possibly provided managers mental space to think creatively about their work. We observed how this meeting drew two previously

[8] It is recognized that the managers may have valid motivations for not attending consultation meetings such as receiving other orders from their managers, which may not reflect the priority that they personally placed on participation in the current process.

distant management teams together, and produced creative solutions to problems with integration.

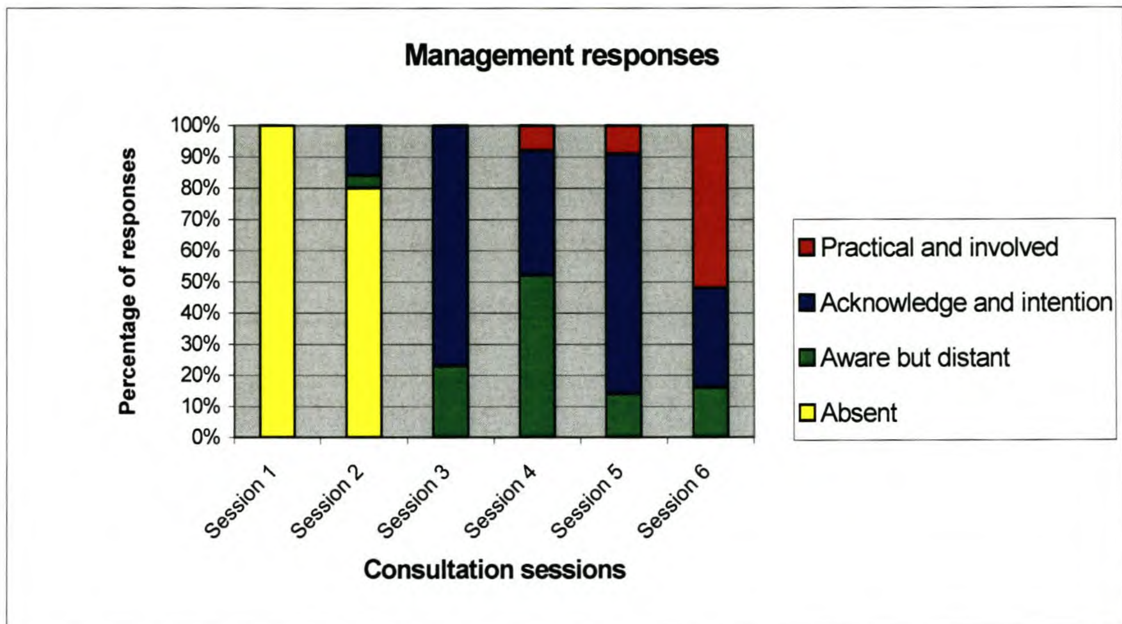

Figure 5. Stages of awareness and involvement

Absent and unaware

The nursing staff managers from both City Health and Province Health were invited to the first and second consultation sessions, but neither attended. Ms Brown gave an apology via Ms Kay that she had to attend another meeting. We were surprised to not having received a personal apology from Ms Jacobs since she was the catalyst to the current process. At the second consultation session we were informed about Ms Jacobs' new appointment and that she would not be part of the DAR process anymore. We also invited Dr Ali, the medical staff manager, who was the line manager over the medical staff of Baker Street health centre. He did not attend the first two consultation sessions either. Thus, the absence of middle managers to the first and second consultation sessions was 100% and 80%, respectively (see Figure 5). By not attending consultation sessions with staff, middle management was perceived by staff as choosing to remain uninvolved with staff problems. Staff at Baker Street felt that middle managers needed to be visible and in direct contact

with what was going on at facility level, instead of sending consultants to facilitate the integration process.

> *Julle doen wat bestuur eintlik moet doen ... Ek weet julle doen dit maar net omdat bestuur julle gevra het om dit te doen.*
> *[You (researchers) are doing what management is suppose to do. I know that you are only doing it, because they have asked you to do this.]*
> - Doctor

Aware but distant

The second category of responses were characterised by managers distancing themselves from their responsibility to resolve problems with respect to integration at frontline level. They distanced themselves from handling the problems with integration by defending the integration policy, and by justifying their unwillingness to intervene by stating that they were still new to the health district. They expressed a magical hope that overhead management processes would produce all the answers to the problems that were pertinent in the services.

The new middle managers responded to hearing about staff's problems with partial integration by defending the national integration policy. At the second consultation session Mr Nkonu spoke at length about the importance of integration of health services within the current political dispensation in South Africa.

> *... as you know from 1994 the new government came up. And what happened is that there arrived some national health plans that were mentioned. What happened was that prior to 1994 we know that there existed a great fragmentation of services. The day hospital operating on its own. The municipality health services operating on its own. Some of them in the same area, but delivering different services. So the most appropriate health system is a district health system whereby we need to have a one-stop shop. Where we can have curative and preventative services operating under one umbrella. Because at the end of the*

day you and I are operating to achieve one goal, which is health. But unfortunately we are being managed by different authorities. That can turn into a costly exercise. When the National Department said that all the provinces should be equal, it came out clear that the Western province has got a lot of infrastructure. When it comes to resources. And like ... the hospitals are there. And we know that when they are allocating funds, the budget, for all the provinces, the [current] province didn't get a lot. A lot of budget was given to the other provinces ... Dr Ali will agree with me that when we cut off our budget, there is going to be problems. When we are not given enough money. So we came up that in one way or another, for me, for us to operate in a fragmented way, it is very much costly. It costs us much. Thus they came up with the idea that we need to integrate the services.

The managers viewed staff shortages and conditions of service as problems that would be resolved in the long-term, yet insisted that integration of service delivery be implemented immediately as promised.

The aim is to establish community health centres. This would offer broader services. There cannot be abrupt changes because conditions of services, etc. need to be looked at. The people on the ground need to merge while the long-term vision is under construction. Staff shortages, etc. will be handled as it comes. But the aim is to merge.

- Mr Nkonu

The group of newly appointed middle managers held high ideals that the merger between Baker Street day hospital and St. John's clinic would become the model for future integration between PHC centres. However, their responses indicated that they expected that the facility managers would mobilise staff to get on with the task of integrating work at facility level, without getting involved with solving difficulties themselves.

I think maybe the ultimate aim of having a comprehensive service is that everybody works throughout that service. So yes, you are and have been working together but we have the local authority people who have a certain function at the moment. And you have provincial health organisation doing sort of curative work. I say curative and preventative but local authority people do do the TBs and the STDs. And yes I know there has been a certain amount of integration along the way with child health and family planning and things like that. But we want it to become after amalgamation that it doesn't matter who you work for - you have to render that service for - you know, comprehensive service. Where you might have been doing a lot of preventative work before, you could work anywhere within the community health centre. That is just the aim so that they do not become too vertical structures again in the same building.

- Ms Loxton

While not actively seeking solutions, the managers expressed the hope that current problems with integration at frontline level would be resolved when over-all amalgamation of all health organisations in the province was completed.

With the [amalgamation of the local health authorities] we are hoping that these differences will be done away with and all staff will be under one employer. The old people are moving out. And there are new people moving in. There is that freshness that is coming in - people that are not stuck in their ways.

- Ms Ngobela

The managers justified their lack of involvement by claiming that they were new to the district and still learning about integration and all the other pertinent issues in the services, despite coming from the "ranks" of staff themselves. They proposed to observe how we as a research team dealt with staff problems with integration and learn from the process.

Maybe I could say from our meeting here the last time we've also said that this is one of the reasons why we as management are here

because we want to learn as well about integration. We were also told: "You are integrating," you know, "go ahead and do it." But it is also something that we had to learn to do in a different manner than it has been done... If you start with Youville, we would sit in on that process. And then we can do it on our own at the other places.

- Ms Loxton

In the second stage the managers moved from staying away from the consultation sessions with staff, to attending the meetings and at least hearing about staff's problems first-hand.

Acknowledgement and intentions

After being confronted by facility managers (fourth session) and being held accountable by research team members (third session) about the reality of the problems with integration, the middle managers started to acknowledge the legitimacy of staff complaints and the role that they played or neglected to play in finding solutions. The managers started to communicate their intentions of taking greater responsibility for managing the change process. They acknowledged that the services were under pressure to deliver due to lack of resources, especially staff, and committed verbally that they would seek ways to relieve the workload pressure created by the additional services.

I share the sentiments of the staff with the problems relating to the shortage of staff and resources ... The problem we are facing is to obtain funding for critical positions. I realise that the current staff are being overloaded ...

- Mr Nkonu

The managers admitted that partial implementation of integration failed at several facilities, and that in order for integration to succeed, mutual communication with staff was needed.

We experience some problems with the changes that are happening. So it is good to talk about things. The managers say things are okay,

but the problems happen at staff level with the work. For example, in Gubigubu health centre the people did not greet each other. In the end they had to divide the building because the two sides could not work together.

- Ms Ngobela

The managers acknowledged that low staff morale was directly related to their responses to the process, which did not create confidence amongst staff that management was looking out for their best interests at work.

There is a reason for the reaction: the job description went in. No response. They asked for a resubmission. This really demoralises staff. This also impacted the process of integration. It has been an on-going process for a long time. Failure of management led to problems with the staff morale. We are not blind to those factors, because they are true.

- Mr Nkonu

Not only did managers acknowledge staff's problems, but made a critical move in acknowledging the fact that their management of staff problems, in particularly integration, needed to change.

What is important is the way one manages this. We've got to engage in discussions about the problems.

- Mr Nkonu

The process of change in management behaviour was initiated by Mr Nkonu who acted as catalyst in bringing the two management teams together to discuss the issues raised by staff.

I think what we need to do now, is to go to the drawing board. The managements of City Health and Provincial Health must meet. Then for these managers to meet with the staff so that these questions can be addressed in their presence to get the answers.

In the first place, they promised to be more supportive and available to staff so that staff would be encouraged to discuss their problems with them.

> *But what we can do as management is to offer you all the support that you need. So it is not ... I must know, sister Loxton must know, if there is something wrong. Don't keep quiet. Don't hide your emotions so that when they burst, and then we don't know what is happening. We are there to offer you some support. Please if you see anything wrong, talk. I have an open door for you. I want to believe sister Loxton also has hers open. Come into my office anytime and tell me ... so that we can see what we can do. And do not keep quiet and pretend as if everything is going okay, meanwhile things are not going okay.*
> - Ms Ngobela

They implored staff to engage in dialogue to help resolve the problems and challenges that would arise in integrating health care at facility level in the face of uncertainties in the overhead organisational processes.

> *Of which I say to them there are long-term things that need to be sorted out by the people ... but in the process let's move together. There are loose ends that I would be tidying up. So I say communication can be structured. It can be informal. What it will be, depends on you. It is nice to have something written down. Then you have something to bounce back on the future. But people are aware of what is going down ...*
> - Mr Nkonu

In the second place, the managers promised to communicate more effectively and more regularly to contain staff's anxieties about their position after amalgamation. They (the managers) recognised that uncertainty about the future caused staff to distrust management. They promised to keep staff informed about what was happening in the negotiation process for amalgamation in the province as these happened.

You know when it comes to the issue of communication we must allay their distrust. In a way ... if a person is dealing with something that is hanging, then we need to give clarity to that.
- Mr Nkonu

In the third place, the managers decided to set an example to the staff in working together, by forming a "*shadow management team*" as a practical management structure for themselves to resolve conflicts at the health centre.

The aim is for the staff of Baker Street and St. John's to combine services. Also to ensure effective and efficient services, bearing in mind the differences in conditions of services, to still work as a team at facility level. What we are trying here is to set up a shadow management structure. This to minimise conflict and build a team among us [as managers].
- Mr Nkonu

As a shadow management team they promised to meet amongst themselves and with staff to resolve conflicts that might arise in the new integrated health centre.

Once in every two months we meet as managers. We could have representatives from the combined facilities there to attend and bring the big issues to this meeting. That doesn't mean we have to wait for these meetings. In-between we meet these facilities. We can also learn from the local successes, absorb the presenting issues and address these.
- Mr Nkonu

The managers sought to use the shadow management structure to resolve issues at facility level that emanated from the organisational differences and competition between the two staff teams.

We are dealing here with two different people. They are used to different management styles. And they come from different backgrounds. City Health staff is good in the development aspect.

In that area the Province Health is not good. But also in other areas where Province Health is good and City Health is not. We need to assimilate these differences. The thinking must be rectified by someone. The attitude lies with us: let's try to be accommodating. There will be conflict but we must manage that conflict. We must guard against professional jealousy. The discretion lies by us.

- Mr Nkonu

The main outcome of the third stage of progression was that communication between middle management and staff improved.

Involved and practical

The final stage of progression in the current action stage was where managers became more involved with aspects of service delivery and began discussing with staff possible solutions to facilitate integrated service delivery. Staff placements, renegotiations of types of service to be delivered at the two facilities, as well as aspects pertaining to joint service delivery at the integrated facility, were discussed. Specific attention was paid to dispensing of chronic medication, sorting out operational hours at Youville health centre and reconciling patients folders for use by curative and prevention care services. Whereas previously staff was merely told to merge and get on with integration of work, managers at this stage gave greater clarity about staff placements and the specific services that would be provided at Baker Street.

At Baker Street facility Robertsen will be staying with a general assistant and a clerk. This will function as a prevention clinic primarily, but also dispensing chronic medication and pediatrics. Initially a staff nurse from Willowbe will help out.

- Dr Ali

The managers proceeded to provide guidance with respect to how patient flow between the two health sites (Youville health centre and Baker Street clinic) would be facilitated. It was envisaged that chronic medication would be dispensed from the Baker Street facility, because most of these patients were the elderly who stayed in

the area around this facility and would be disadvantaged by having to travel to Youville health centre to get their medication.

> *What is happening there is that the service will continue for some time. As we have agreed that you are going to continue the service from two different clinics ...*
>
> - Mr Nkonu

> *The chronic medications will come down to Baker Street. The doctor will have to ... see the patient up at St John's. Say, "This patient is now a chronic medication person. For the next six months they can go get their medication at Baker Street." So initially everybody has to be seen up at St. John's anyway.*
>
> - Ms Loxton

The managers were flexible around respective starting times for the day hospital and clinic services. They suggested that these would remain different, but that these should be arranged by dividing the two staff complements in teams according to starting times, so that there would always be staff from both sides available in the centre.

> *As long as the 7:00 person does not go off at 5:00 (pm), or the 8:00 person does not off at 4:00 (pm). So that is quite important. We do have flexitime. We do have certain places where ... I know that at Raviolli there is the local health authority sister that comes on at 7:00 and the provincial health organisation person comes in at 8:00. There she is the person that actually locks up late. So as long as there is somebody that can unlock, lock up and everybody else slots, in as long as everybody's working eight hours.*
>
> - Ms Loxton

The managers recognized that creating a single database for holding patient information was crucial in running an integrated service. They suggested that while the backlog of patient information was captured on the computer system the clerks

could use the index cards, in addition to checking the computer to draw relevant patient folders.

> *You will have index cards and you will have indexes on the computers as well. You will have a hard copy and the index cards as well.*
>
> - Mr Nkonu

Thus, in the latter stages of the current action stage the middle managers engaged more freely in thinking through the practical issues pertaining to the functional integration of services at the new health centre and coming up with workable solutions in discussion with staff.

DYNAMIC INTERPRETATIONS OF STRESS RESPONSES

The findings derived from staff responses in the current action stages confirmed the notion raised elsewhere about the national PHC system being under severe stress and in need of support programmes for staff (Van der Walt & Swartz, 2002). The role of management support in allieving staff stresses is clearly evident in the communication patterns that took place during the consultation sessions as the managers moved from apathy/absence to greater degrees of involvement. Although I presented staff's stresses as distinct categories, these were intricately interwoven. Staff's frustration with management performance was the thread that connected anxieties about integration with pressures to deliver services. In the discussion to follow I propose that the planned merger could have awoken primitive anxieties in staff, as suggested by Gilkey's (1991) understanding of psychodynamic upheaval in organisational mergers (see Chapter Four). We gave participating middle managers a synopsis from Gilkey's paper during one of the consultation sessions. They found Gilkey's metaphor of the organisation as a family quite applicable to the health setting. They intuitively related to the analysis and even requested more copies of the article after the meeting! We also found that health workers in other settings intuitively accepted Gilkey's interpretation of the effects of integration processes on staff experiences of stress (Muller, Leon & Van Wyk, 2000).

Staff experiences: Anxieties about integration

We suspected that frontline staff's stress reactions may have been caused by unconscious processes related to regression to the first three stages of human development where corresponding psychological conflicts were left unresolved or poorly resolved. We intrepreted that staff experiences might be associated with unconscious anxieties about losing familiar work relationships and support networks, losing efficacy in their work-role and being left uncontained.

Loss of familiar work relationships and support networks

The proposed merger threatened the existence of staff's support system, which played an important role in helping staff cope with the pressures of health service delivery. As already mentioned PHC facilities represent the frontline between the national health system and the public. Staff teams felt isolated on the frontline and exposed to severe political and social pressures from the community, patients and senior health management. In addition to these external pressures, health workers would also be challenged with internal anxieties, which relate to personal feelings of inadequacy, interpersonal relationships at home and work as well as their perceived roles as carers in the community (Van der Walt, 1998). The support networks formed at facility level protected staff from the anxieties provoked by the complexities of the work. The fragile nature of these support networks was evidenced by the strong reactions of staff members to what they described as excessive staff movements and disruptive staff placements. The proposed plans to split the teams at Baker Street health centre, threatened the existence of their support network as they came to know it, and maybe also the survival of the team.

When survival is threatened, groups may resort to basic assumption behaviour (Bion, 1961) or development social defence systems (Menzies, 1960) in order to preserve their sense of identity. Baker Street staff engaged in what could be interpreted as basic assumption fight-flight behaviours to preserve the unity of their group. Fight-behaviour was personified in Dr Zee's active resistance (where he declared that he would conduct his own research to show that he was meeting the needs of the elderly community around the health centre, and therefore did not need to move the curative service). Flight-behaviour was typified in Ms Kay's stoic silence and passive

resistance, which found resonance with the rest of her staff. (She made the ambiguous statement that she was not going to work together with the clinic staff at the new health centre and that she would only concentrate on doing her own work.) Dr Zee's resistance to management plans for the merger was also projected on the research team, who were seen as taking over a task that management should have done. Management became the enemy who threatened the survival of the team and staff united to "fight" this enemy. This "fight" manifested in declarations of active and passive resistance as described above, but was also evident in management becoming the object of staff's criticism during initial consultation sessions. Staff members projected stressful experiences related to patients or community demands onto management who were then criticised for only seeking to please the community or not providing sufficient resources to run the services or meet the demands.

Menzies (1960) suggests that criticism of managers were often done as a means for staff to deal with conflicting emotions of anger and envy towards patients, whom they vowed to care for, but who at the same time "stole" the affection of health management. By projecting the "bad" aspects of self onto managers, staff members were able to maintain their illusory sense of goodness towards patients. The staff tea-room symbolised the physical and emotional flight-space for staff at Baker Street health centre. The imminent departure of the *tea-lady* (female general assistant) at Baker Street, typified the threat to staff's support network. Staff reacted by criticising management for lack of consultation with staff. Anxieties about anticipated loss of support were increased by rumours that the *tea-lady* at St. John's threatened to lock the kitchen outside lunch and tea times.

Gilkey (1991) suggests that in the first stage of development in organisations the psychosocial conflict between basic trust and basic mistrust needs to be resolved in a positive way. However, we understood that management's initial physical absence from the consultation sessions also typified an emotional absence from staff experiences and problems at facility level. This caused staff to distrust their own managers as well as the managers from the other organisation. This distrust of management by members of Baker Street health centre was also projected onto the research team and the staff of St. John's clinic. Distrust and envy between the two health teams were increased by Province Health staff not being fully informed about broader processes (negotiations for amalgamation), irresponsible information sharing

by City Health managers with their staff, and rumours about a take-over of curative health services by local authority organisations. Thus, the outcome of the first developmental stage in organisational upheaval was basic mistrust between the two staff teams.

Loss of role-efficacy

The second stage of development that needs to take place in any merger or preparations for a merge is for staff to develop a sense of *autonomy* (Gilkey, 1991). To achieve this, management need to define work roles and clarify what is expected of staff in the transition stage. This conflict needs to be understood in terms of the basic need that healthcare workers have to feel that they can contribute to patient's health. However, as Van der Walt (1998) argues, health cannot be seen; the only thing that is seen is the flip-side of it, ill-health. The PHC system's task is then described as keeping disease at bay. Through preventative care and health promotion services PHC staff fulfil the unconscious task of protecting the healthy from the sick and the poor, thus becoming the container for community's fears of contagion and disease. It is often found that the community look to health staff to take sole responsibility for their health (Menzies-Lyth, 1990). This is an impossible task that is both imposed on health staff from the outside as well as self-assigned (Roberts, 1994).

Stokes (1994) suggests that health systems cope with this pressure by making sophisticated use of basic assumption dependency behaviour to stimulate adherence to treatment regimes. The message portrayed by the health system is one that states that health workers are professionals who know exactly what to do in every situation and that patients' role in health care is simply to comply with rules, regulations and treatment regimes as prescribed by members of the health system, who are infallible health professionals. Thus, a feeling of omnipotence is evoked in staff (Petersen & Swartz, 2002). Staff members are thus placed under tremendous pressure to live up to this projection. They experience tremendous anxiety in having to make decisions that affect patients' lives and quality of life in an environment where mistakes are costly and not tolerated. In this stress-provoking task they find safety in their skills and competencies as well as their instruments (Van der Walt, 1998). However, it has been reported that these skills and instruments often serve

as defences against the anxieties invoked in providing health care (Hinshelwood & Skogstad, 2000; Menzies, 1960). In some instances this has produced an exaggerated emphasis on technical procedures and skills, which in turn, has negative implications for quality of care and adherence (Dick, et al., 1996).

In the current setting we noted how differences in particular skills and competencies between nurses in curative and preventative care became an issue. In the nursing history in South Africa there has always been animosity between these two camps (Marks, 1994). Traditionally greater esteem, emphasis and resources have been given to the training of nurses in curative care in hospitals. In contrast, training in preventative care has been afforded secondary status and thus regarded as inferior work. The current health reforms towards an integrated PHC service imply that nurses would be trained and required to perform both types of service. Thus the distinction between curative and preventative nursing would be done away with. We suspected that the anxiety about integration could be partially understood in terms of the loss that nurses would incur with respect to their respective specialities. We noticed that the pervading organisational culture in Province Health was one that placed great emphasis on clinical skills. Promotion in the organisation was based on demonstrated clinical competence and experience. The integration of services would mean that this guarded skill (curative care) would be commonly shared with others, making curative nurse practitioners less "special".

In addition, integration with preventative services organisations (City Health in this setting) would bring curative nurses in contact with their counterparts who placed greater value on political ideologies such community participation and dialogue in the delivery of healthcare. City Health management and staff appeared to be more eloquent and experienced when it came to management and administration aspects. The unspoken anxiety amongst Province Health staff members was that they would become the proverbial stepchildren in the amalgamation. We observed the tension in both middle managers and staff that, post-integration, clinical skills might not be valued in the new organisation. Another anxiety that existed among facility managers, was that the tendency in integrated health centres thus far was that sisters-in-charge from City Health took over the role as facility managers, with the Province Health sisters-in-charge deputising. We understood that in the current setting anxieties about losing role-efficacy and possibly management roles caused

staff and facility managers from particularly Province Health to resist the proposed merge in Youville as well as the entire amalgamation process. The differences around and tensions between the prevention and curative services were typified by the debate around the future roles of Ms Kay and Ms Petersen in Youville health centre. The above-mentioned tension was typical of general confusion and lack of clarity about work-roles in partially integrated health services. The abovementioned aspects may have provoked strong feelings of doubt and shame amongst staff, as they anticipated not being sure about which tasks to be performed or whether they would have the ability to perform tasks well that were assigned to them in the new integrated service.

Lack of containment

The third stage of development that needs to take place in any merger or preparations for a merger is for managers to develop the confidence to take initative in line with the stated goals of the new organisation (Gilkey, 1991). This corresponds to Erikson's (1960) psychosocial conflict between initiative and guilt. In PHC in South Africa facility managers were largely left to their own devices to run the services, because they were shown to be highly competent (Bachman & Makan, 1997). Middle managers were mostly absent and intervened only when crises arose. What we observed in the current action stage, with middle management being absent from the consultation sessions, was thus indicative of the general trend in the services. In the absence of management support, facility managers were under pressure to deliver health services in line with recommendations from politicians and senior health managers with shortages in staff and resources. The proposed merger, which aimed to increase the scope and coverage of service delivery, was regarded as making an already difficult situation virtually impossible. Faced with these tremendous pressures, staff turned to their facility managers for some form of containment.

We observed how Ms Kay was, perhaps unconsciously, tasked with the role of keeping the unit together and protecting them from the outside. With the absence of middle management she took over the role of managing the boundary between the health services at Baker Street and the community. However, this role was interpreted solely as protecting staff from the environment outside, as noted from

her obvious distress when she had to represent not only Baker Street health centre, but also her organisation at community meetings. Although the service seemed to be running well on the surface, we suspected that her "initiative" in leading was not totally aligned with management's directives. We suspected that this may have been a source of *guilt* for her and that she unconsciously desired to please her immediate manager. However, due to her continued absence from the actual services, she was forced to take her own initiative. In the process leading up to integration, Ms Kay was forced to deal directly with City Health managers and staff as her immediate managers remained absent from the process. This could have been a very stressful experience for her as she had no one who could contain her anxieties. With the arrival of the new nursing staff manager, Ms Loxton, she found someone who could take up this containing role. As the last-mentioned took a more definitive role in the merger process, Ms Kay became more responsive and relaxed in the process (as observed in the consultation sessions).

Management responses: From linking to thinking

We suspect that middle managers' initial responses (absence and apathy) were related to the anxieties that they experienced in themselves about integration. The change in behaviour noted in the previous section could be described in Kleinian terms as a movement from a paranoid-schizoid position to a depressive position (Halton, 1994). In the current action stage a paranoid-schizoid state of mind was manifested by middle management who acted as a mere *link* between top management and staff, without fully taking up their management function. It is hypothesised that when individuals (or groups) are provided with a "contained space" in which to think about the aspects of their work or life that are provoking difficult or painful emotions, they are able to face the reality of their situation (Gibson, Swartz & Sandenbergh, 2002). This latter condition is characteristic of a depressive situation, where the individual or group is empowered to integrate aspects of the self, even though these provoke anxiety, and find creative ways to deal with these conflicts. In the discussion that follows I will attempt to explain the behavioural responses of the participating managers and the possible role that our facilitated consultation process might have played in helping them move from a paranoid-schizoid position to a depressive position. We understood that the

"contained space" that was created through consultation process was central to this progression.

Management and splitting

Upon reflecting on management's responses it seemed clear to us that they were indeed very stressed about the impending amalgamation of health service organisations, as well as with their role of managing integration on frontline services level. Participating middle managers experienced stress from two main sources: (i) receiving directives from the senior management, (ii) and not getting the power to manage the implementation thereof at facility level with respect to conditions of service, staff shortages and resource allocation. The challenge of managing the implementation of the national integration policy at frontline level was a daunting one and management resorted to a management style characterised by splitting to cope with the anxiety associated with this task. Up to that stage there was not any health centre within the province where successful integration of curative and preventative services had taken place. In the best of cases the services only succeeded in tolerating each other, as they functioned parallel to each other within the same building.

The PHC system acted in a strictly hierarchical fashion where all authority came from above. Thus middle managers had no authority except that which was given to them from the senior management tier. Participating middle managers perceived themselves as having very little power to either motivate staff to follow the directive to integrate services or to influence the process of amalgamation. Concerning the last-mentioned, the middle managers had no input into the negotiation process that was then underway. This meant that they had to await anxiously the outcome of negotiations to see what the new health service would look like and whether they would still have secured their jobs and positions. We envisaged that this uncertainty might have impacted negatively on their motivation to see integration through at facility level. It may be speculated that successful integration of frontline services would hasten the negotiation process for amalgamation of the over-arching health organisations. Thus, slowing down the pace of integration at facility level would then serve the purpose of delaying the "inevitable" amalgamation of organisations. Unconsciously middle managers may have been resisting the amalgamation

themselves. Since admission of this would constitute them being "bad" managers, they projected difficulties with frontline integration onto staff. By splitting off and projecting their bad parts (refusal to integrate) onto staff, the middle managers were able to preserve their self-idealisation of being obedient to their management (in accordance to the basic assumption dependency that operates in health systems). Frontline staff as recipients of this projection, then became the scapegoat for the lack of integration at frontline level.

Following Gilkey's (1991) understanding of mergers it could also be that middle managers felt powerless, because their management role during the transition phase had not been clearly communicated either. Thus, staying absent from the frontline services became a means for them to deny the reality of their perceived lack of power to affect change in their organisation in any real way. Rather than face their powerlessness, the middle managers sought to minimise contact with the frontline staff and their problems. In the event of crises and when they were forced to intervene, they acted in an authoritarian manner to force staff to comply with directives from above. A directive such as "integrate staff and function on services level," for example, was then given to staff without middle management thinking through the practical issues of its implementation.

Obholzer (1994) interprets authoritarian management as coming from a paranoid-schizoid state of mind, where the manager is out of touch with realities with self as well as the surrounding environment. Another reason for middle managers' absence and apathy could be related to their perceived powerlessness to address staff issues regarding conditions of service as well as service delivery issues such as staff shortage and lack of resources. The middle managers felt that since they could not do anything about these issues, they had nothing to offer staff. Thus, they resorted to staying absent both physically and emotionally from the sites of service and staff's problems. Mentally the middle managers distanced themselves from the services by not "thinking" through the issues that staff were facing. Directives from the top were simply passed on to frontline staff via fax, because thinking about it caused too much anxiety for middle managers. Thus, middle managers relinquished their roles as managers and containers of staff anxieties to just become the *link* between senior management and staff.

Creating space for thinking

In consulting to service organisations we were well aware of the pressure and expectation from the service staff and managers to set things right immediately (Gibson, Swartz & Sandenbergh, 2002). We determined right from the start not to provide a quick-fix solution, but rather to seek a greater understanding of dynamics in the health setting and to seek to empower the participants by sharing these insights at appropriate moments. With management's absence from the initial consultation sessions, it appeared as if they expected us to sort staff out so that they (the staff) would be willing to comply with the programme of integrating services at the new site. Though expecting management to be present at these sessions, we used the opportunity to listen to staff and reflect on their experiences in the service. It seemed to us that they were using management as a scapegoat for their problems. We then decided that it was crucial for the process to have management present so that staff could have their issues addressed in the presence of the researchers and consultants who provided a contained space for these interactions to take place. We reflected staff's need for this to management in setting up a meeting where management teams from both health organisations could meet with the research team in a neutral venue.

The managers confirmed our suspicion that they wanted us to make integration happen for them and thus provide the answer to all their problems with integration. We resisted the temptation to provide answers, and chose instead to reflect on their roles in the process. As a result of this two things happened. Firstly, they started to see themselves as empowered through our reflection of them. Secondly, they started to take greater responsibility for the process, spurred on by the safety that the presence of the "experts" provided. The facilitated meeting provided a safe space where the two management teams could meet and discuss issues regarding integration of services. The presence of the research team facilitated a greater freedom wherein managers confronted and challenged each other to take a more proactive role regarding staff problems, especially those related to integration. Initially they were looking continually to the consultants to provide the answers. When we resisted doing this, they felt more empowered to make suggestions to change the current status quo. The consultants acted as containers to provide boundaries within which the meeting could take place. The managers were thus

assured that could safely contribute to the meeting, and this resulted in them entering previously unchartered grounds of working together. The managers quickly progressed to exploring new ways of working together to improve their management of the services and integration in particular.

The effect of this "intervention" was immediately seen in managers changing from being apathetic towards service delivery and staff issues (as a result of their own anxieties about it) to seeking greater involvement in the process as they saw themselves as empowered. Whereas previously management avoided discussing issues such as conditions of service by either staying away or acting in an authoritarian manner about such issues, they now talked openly about them and acknowledged staff anxieties about these. Thus, being contained by our intervention, they became containers for staff anxieties as well. As managers did this and more, staff became increasingly open to suggestions about how the new integrated service would run. We also noted how management were more confident about their management role and how they openly acknowledged to staff that certain issues were outside of their control. We also noted how management went further to admit their role in many of the difficulties that staff faced. Thus, management moved from their previous paranoid-schizoid position where they acted in an authoritarian way, towards becoming more aware of their authority, where it came from and the limitations thereof. This type of behaviour, where the manager seems to be in touch with him- or herself as well as his or her environment, is typical of depressive position state of mind (Obholzer, 1994). In this position middle managers were able to think about their work and move to alternative modes of functioning that presented an improvement on their previous ways.

In the current setting the external difficulties with integration of services related to internal, unconscious issues about integrating aspects of self that were causing distress. When the unconscious anxieties were contained, management and staff could move together towards resolving service issues.

REFLECTIONS ON THE PROCESS

The strength of action research lies in the close proximity that researchers have with participants and participant responses. Thus, it is often not clear what the boundaries are between researcher influence and participant responses. In other words, it is often not clear to what degree the effects observed are the result of the intervention or the intervening agent. For this reason, it is the normative practice for those who conduct action research to engage in reflection about the process and their roles in influencing the outcomes. In this section I reflect on several critical decisions made by the research team and how these possibly biased the outcomes in a particular or general way.

Selection of pilot sites and purpose of research

Right from the start of this action stage we wanted to work with staff at an integrated health centre. We based this decision on the findings of the baseline study, which pointed out that integration of health services was one of the major stressors for health workers in PHC in the region. We wanted to explore the dynamics of integration that provoked the stress responses in staff and model ways to help staff cope. The middle managers, on the other hand, hoped that we would resolve a potential dilemma that they faced with a staff team that resisted proposed plans to merge services in Youville. Even though we communicated clearly to management that we were not interested in providing crisis intervention to integration problems, it seemed clear in our reflection afterwards that management wanted us to deal with a situation with which they did not want to or know how to deal. This divergent interpretation of the purpose of the action research process possibly led to the misunderstanding between the researchers and the managers regarding management attendance at the consultation sessions.

Decision to have staff and management mixed

The first phase was where the first set of managers remained absent from the process and the new set of managers arrived on the scene and initially responded to staff stressors by quoting the political reasons why integration should happen; yet ignoring the challenges at ground level. In this phase staff was using the process to

communicate their grievances through us (they knew that we had to report back to management from the sessions that we had with them). We used the information from our baseline study as an entry point to connect with the staff's experiences and to elicit their opinions. We hoped that sharing this would show that we, as outsiders, had some insight into the stressors that they faced, and thereby facilitate the building of trust as recommended by Carrol (1997). Getting the staff's feedback on the baseline study would also serve to triangulate the findings, and test their applicability to this setting.

Focus on stressors?

We started the process by introducing staff to the findings from the baseline assessment of stressors study. This was done to foster an atmosphere of trust with staff. Carrol (1997) recommends that the first major hurdle for outsider-counsellors or consultants to organisations is to assure the employees that they have an understanding of the context of the work. When we walked into the first consultation session with Baker Street health staff, the atmosphere was tense. Sharing the findings from the baseline study helped build some credibility with staff and opened the atmosphere somewhat for them to participate. This was clearly evident from the general assistant's uncharacteristic outburst as soon as we finished relating the findings from the baseline study. Afterwards we opened the discussion to staff and asked them what the stressors were that they were facing in their job situation. This might of course have given staff the permission to relate all their grievances. Another possible explanation for staff responding to the process by relating their stressors, might be the "squeaky wheel gets the oil" principle. In a system that was poorly resourced, it might be that staff learnt from experience that if they did not complain, then management would think that they were having it easy and might take away staff and resources and distribute these to more needy areas. So it might be that talking about how stressed they were might have become part of the *discourse* used by health staff, as Cooper, Dewe and Driscoll (2001) suggested.

Another more likely explanation for staff's response could be related to the *absence of management*. We invited the two nurse managers to the initial meetings, but neither came. We got the sense that staff might be using the process to communicate their grievances about the current situation to management. For this

reason, we extended the invitation to the managers from the second meeting onwards, creating the expectation of management participation. Only one manager (Mr Nkonu) attended the second consultation session. While being anxious about being used as a stop gap for communication, we felt it necessary to maintain a measure of naivety in the early stage of the action stage so that we could learn from staff about their experiences and gain greater insight into the complexity of the situations with which they were faced on a daily basis.

Mandate to get management involved

Staff were using us to communicate their stressors to their managers. We were not willing to play messengers for staff and management, nor to be seen by staff as sent by managers to soften them up for the impending integration. The only solutions that we suggested were to insist on the participation of management. The staff insisted on the presence of the managers at the consultation sessions. The issue of the management's absence from the meeting was also pointing to staff not being heard in the system, even though both managers had legitimate reasons for their absence. It seemed that the process was going to hit a dead-end if managers did not attend the consultation sessions. After the first consultation session, we felt the caution of maintaining the not-so-distinct lines between researcher roles and management responsibilities. Staff presented many stresses, one of which included the amalgamation with the preventative clinic. We felt that taking up the mandate to get management there would allow us to assert our role more definitively. The *second* phase started when the researchers insisted that managers take part in the process. The managers responded by attending a meeting with the researchers only. From this meeting further plans were made to address issues with respect to integration. The research team took a more assertive stance and challenged the managers to address staff's concerns.

Competing organisational cultures

The differences in organisational culture and management style between the two health authorities became very clear in the course of conducting these two meetings with middle and facility managers. There was some anxiety from Ms Jacobs to get

the managers from Province Health involved in the project, as illustrated by the following quote:

> *We **have to** get Province Health involved in the programme. That means we **need** to work with Ms Randall. Another option is to go to the top manager, because they work from the top. [Senior nursing staff manager] is a new appointment on the nursing side. She has verbally committed herself to integration.*

I perceived that these differences led to a climate of distrust and suspicion between the two organisational camps, which manifested in subtle ways in these two meetings. As illustration, the following quote is taken from a statement by Ms Petersen:

> *Sister Robertsen suggested that staff be prepared for the merge. Less moving around of staff to other facilities. This confounds the work when new people are coming in all the time. Province Health management shift their people around a lot because they work with a pool and not fixed staff placements. City Health has cost centres; which means that staff are placed at a specific facility.*

The above-mentioned statement suggested that ways should be employed to hold Province Health management and staff accountable to the process. It seemed to carry the implicit message of distrust towards Province Health management. The research team was drawn into the competing organisational cultures by unconsciously "identifying" with City Health managers and staff in their feelings of mistrust towards Province Health staff and management as being unco-operative. We sought to rectify this through seeking more direct contact with Ms Loxton in the latter stages of this action stage. In addition, I took part in co-facilitating several workshops with middle and facility managers of Province Health (Muller, Leon & Van Wyk, 2000). Although these did not form part of the current action research process, they provided me with an opportunity to familiarise myself with the organisational culture in Province Health.

SUMMARY AND WAY FORWARD

The current action stage centred on the research team's attempts to explore ways in which staff at two PHC facilities could be supported as they journeyed towards integration. The process started with us approaching certain City Health managers for a pilot site. They requested that we facilitate the process of preparing the staff from two health facilities for a merge. We approached this task hoping to explore why staff found integration stressful, and then, with their participation, to develop an appropriate support intervention. We found Gilkey's (1991) application of Erikson's model of psychosocial development to organisations very useful to gain insight into staff's anxieties as they anticipated the merge. In consultation with staff we found management involvement in the consultation process to be critical. Initially management were resistant to getting involved. Eventually they became more involved as the consultation process provided a contained space wherein previously distant managers could come together and function as a shadow management team. In this joint forum the managers found a voice and the confidence to address staff issues, without resorting to empty promises. During the current action stage we did not find occasion to develop the model for staff-support. However, we were encouraged by the usefulness of psychodynamic interpretation to facilitate our understanding of the dynamics between staff and management and between the two organisational cultures. We determined to go into the next action stage and focus more explicitly on developing the staff-support model.

To summarise, three learning points (hypotheses) from the current action stage would be incorporated in developing support interventions and explored further in subsequent cycles:

- Middle level management involvement is critical to providing support to staff.
- A facilitated consultation process can be useful to help middle managers deal with staff issues during times of organisational change (when they are stressed as well).
- The use of psychodynamic interpretation to give voice to unspoken anxieties within groups can be useful to bring awareness and facilitate change.

CHAPTER EIGHT
CONTAINING THE CONTAINERS

ACTION STAGE THREE

The third action stage took place after the merger between Baker Street day hospital and St. John's clinic took place. The new health centre was called the Youville community health centre (CHC). This move took place about six months after the second action stage started. In this action stage we wanted to focus our actions around implementing a support service, and developing and testing the model in consultation with staff at Youville CHC. From the previous action stage we realised that the health system in South Africa had countless problems and challenges that did not have immediate answers or foreseeable solutions. We postulated that the notion of containment might be central to any support intervention. Through our initial interactions we came to the realisation that the specific health district might benefit more from interventions aimed at creating capacity within managers to provide containment for staff. The notion of "containing the containers" had been raised in support programmes for health workers implemented by Wiltshire and Parker (1996). Both these interventions were designed around creating containing space for nurses in their work setting.

THE SETTING

The building at Youville CHC was designed to facilitate a fully integrated PHC service. There was no hall or structure to separate the day hospital and clinic services. There was a big waiting room and a communal reception area where patients attending both services were received. Treatment rooms (for curative care) and consultation rooms (for health promotion) were placed opposite and/or adjacent to each other with no visible structural separation between services provided by day hospital staff and clinic staff. The staff shared the same staff-room facilities – kitchen, toilets, locker rooms and an office that was shared by the two sisters-in-charge. The pharmacy was at the far side of the building, with a fair sized waiting area furnished with benches.

The day hospital and clinic services, however, continued to function parallel to each other. Ms Kay was in charge of the day hospital service, while Ms Petersen was in charge of the clinic service. Their staff teams for the large part remained separate with respect to their work. The only areas of overlap were the reception and maintenance. Although the reception area was communal as well as having a combined folder system, the clerks operated separately. They received patients from different windows and channeled the patient-flow from there. Patients who stood in the wrong queue would be told to stand in line again for reception at the other window. Patients who came for both day hospital and clinic services on a particular day were advised to queue for the day hospital first. According to staff patients quickly found their way about in the service and knew what to do when they arrived at the centre.

The general assistants shared cleaning duties over communal areas such as the reception area, main waiting room, the corridors and the kitchen and staff room. A roster was worked out to determine who would take responsibility for cleaning mutual areas on specific days in the week. For the rest of their duties, the general assistants were responsible for cleaning the areas/surfaces used by *their* respective staff teams. Thus, the general assistants from the clinic would be solely responsible for cleaning the consulting rooms used by clinic nurses. The day hospital's general assistant was solely responsible for cleaning the treatment rooms, the doctor's consulting room and the waiting area at the pharmacy.

In observing the patient flow at the health centre, we noted the perpetuated separateness between the two staff teams. The day hospital service opened to receive patients much earlier than the clinic. This was done to accommodate patients who arrived early to make sure that they would be able to see the doctor on that day. (The doctor could only see a limited number of patients daily.) Because they started earlier than the clinic service, the day hospital had earlier tea and lunch breaks. The respective tea ladies prepared for and cleaned up after their staff team had their breaks. After lunch the workload for the day hospital decreased dramatically, as most of the patients would already have been seen by the doctor and/or would have proceeded to the pharmacy to get their medication. This allowed

time for the sister-in-charge to do her administrative duties, and for her staff to clean up and prepare for the next day. The day hospital service remained open until 16:30 for emergencies.

The clinic on the other hand, had what they called an "afternoon clinic" for those coming for STIs and family planning. They succeeded in re-routinising patients to comply with certain services as they were delivered at various time-slots (i.e. morning or afternoon). Thus, the clinic side remained fairly busy till about 3:30 in the afternoon. An agreement was reached between the clinic and the day hospital that the clinic nurses who performed curative services for children under 13 years could refer severe cases to the doctor instead of (as before) referring the patient to the nearby secondary hospital. The clinic nurses would also refer some of their patients to the day hospital's emergency room for procedures for which they did not have the equipment, such as giving oxygen to ashmatic patients or drawing blood samples for testing.

Baker Street clinic

Initial intentions to offer a mini-day hospital service at Baker Street facility failed, because all chronic patients came to the pharmacy at Youville CHC for their medication. Baker Street clinic continued to operate as a satellite clinic to St. John's health centre. Sister Pat, the previous sister-in-charge at Baker Street clinic, was moved to another clinic, leaving Ms Petersen in charge of the clinic service at Baker Street as well. The health managers experienced considerable difficulty staffing this service. A temporary position was created for a nurse, because the nurse who worked at Baker Street was boarded. However, this temporary nurse took leave because her mother was ill. In the meantime City Health management froze all temporary posts until amalgamation had taken place, making it impossible for middle managers to have a replacement nurse appointed. Ms Petersen was forced to release one of her nurses to work at Baker Street clinic. With the increase in demand at the health centre all her nurses were fully occupied, forcing her to go to the Baker Street clinic herself to render services.

MANAGEMENT PARTICIPANTS

In the previous action stage the middle managers of City Health and Province Health decided to form a shadow management team. The consultation sessions involved this combined management team and the two facility managers of Youville CHC (see Table 3). The middle managers felt that it was crucial to involve Ms Petersen and Ms Kay in the consultation process, because they were considered to be the people who would facilitate integration at the health centre.

	Province Health	**City Health**
Middle managers	• Ms Adams/ Ms Loxton (nursing) • Dr Ali (medical staff)	• Ms Ngobela (nursing) • Mr Nkonu (area)
Facility managers	• Ms Kay (day hospital)	• Ms Petersen (clinic)

Table 3. The management team

Before the start of the current action stage Ms Loxton went on maternity leave. She was temporarily replaced by Ms Adams who attended the consultation meetings on her behalf. At that stage Ms Adams was the nursing staff manager of another health district. She came to the process not informed about what was happening in the day hospitals in Ms Loxton's health district or what the current action research process was about. Ms Loxton resumed her duties as manager later on in the process and was present at the last consultation meeting (see Table 4).

DATA COLLECTION

Data were collected from four consultation sessions with the management team and two participant-observations at the health centre (see Figure 6 on page 176). In addition, numerous debriefing sessions were held by the research team. The first two meetings were held at St. John's health centre, because it was argued that this would make it easier for Ms Kay to attend. The day hospital had lost a nurse from their staff complement, which meant that Ms Kay needed to fulfill this nurse's clinical role. It was suggested that by having the consultation meetings at Youville CHC, Ms Kay would be able to attend, while still being on stand-by for afternoon emergencies.

At the second meeting the research team suggested that future meetings be held at a neutral venue away from the health centre. This suggestion was partly influenced by the favourable outcomes from a previous meeting that was held with the management team away from the services. It was envisaged that a safe venue away from the pressures of the services would help facility managers think about their work. This would provide an ideal venue for the type of intervention we were hoping to offer managers.

Each session was attended by at least three members of the research team, one of which would be a consultant and one would be a researcher. Table 4 illustrates the attendance of the various managers at the consultation sessions.

	Consultation meeting			
	1st	**2nd**	**3rd**	**4th**
Mr Nkonu	✓	A	A	✓
Ms Ngobela	✓	✓	✓	✓
Dr Ali	✓	A	✓	A
Ms Adams	✓	✓	✓	-
Ms Loxton	-	-	-	✓
Ms Petersen	✓	✓	✓	✓
Ms Kay	✓	✓	A	A

✓ = present
A = absent
- = not part of process

Table 4. Attendance of participants

Ms Kay did not attend the third and fourth consultation meetings. At the third meeting Ms Adams explained that Ms Kay went on sick-leave after being upset that she was not able to attend a training course for which she was scheduled. At the fourth meeting Ms Kay excused herself via Ms Loxton saying that she was not sure where the process was going and thus saw no reason to attend.

Process of implementation

The first contact with the health centre staff after the merge was made through an "informal" visit by the two researchers, which took place two weeks after the merger (see Figure 6 on page 176). During this visit the facility managers informed us that

the health centre was very busy because the demand for the day hospital services had doubled. Mr Nkonu took the initiative for setting up the first meeting with the management team. He intended the first consultation meeting to be a follow-up meeting to the process that was started before the merge. He reportedly spent a lot of energy trying to contact the various members of the management team to set up the meeting.

A month after the merger he managed to get all the managers to meet with the research team. At this meeting he demonstrated an eagerness to see closure to the current research process. The middle managers seemed to share his loss of urgency, as the merger took place without any obvious conflicts at the health centre, and staff simply get on with their work. Wishing to return to the main research objective, we suggested doing participant observations at the health centre to identify possible points of conflict that might warrant further intervention. We intended to do participant observations on two separate days, but this idea was abandoned due to logistical problems. Instead only one day was set aside by the principle investigator and myself for observations at the health centre. The following meeting was scheduled for two weeks later, at which the two researchers reported back on their findings and discussed further intervention with the group.

At the latter meeting we suggested a structured intervention around the concept of containment. The programme would seek to provide containment of the managers as an intervention for them, and simultaneously, to train them in ways in which they could provide containment to staff. The managers accepted this suggestion. At the third meeting we started with the introduction, which was intended to be the first of six sessions. Sessions were scheduled to take place one per month, but this did not materialise. A break of two months followed during which time one consultation meeting was cancelled because too many managers were not aware of the meeting and other efforts to set up a meeting failed. Efforts to arrange further meetings were further bedevilled by the year-end approaching and most participants taking leave during this period. A fourth meeting was eventually scheduled in the second month of the new year. Due to the long break in the research process, we decided to use this meeting to wrap up the process and evaluate the process thus far.

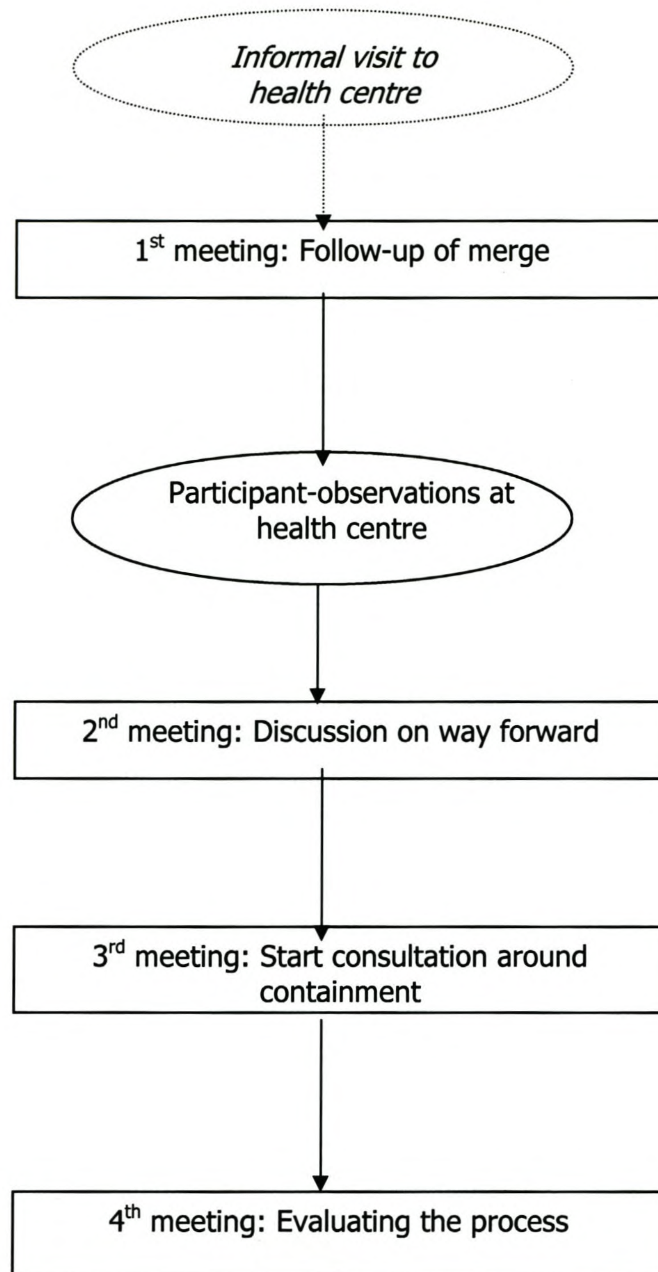

Figure 6. Data collection during action stage 3

DATA ANALYSIS

Data collected during the consultation meetings with the management team were analysed following the same procedure for generating grounded theory described in Chapter Six. A copy of the code list of the current action stage is included in Addendum D.

FINDINGS

Six themes emerged from the grounded theory analysis. The first two themes, *working separately* and *intentions to integrate,* highlight the contradiction between the management ideal of a fully integrated health centre and the realities of working together as perceived by frontline staff and facility managers. The second contradiction is captured in the themes, *bureaucratic management* and *management solutions,* which depict the middle managers' tendency to blame the bureaucracy for many of the unresolved issues in the health system, while being unaware that they were deploying a similar management style in relation to problems faced by frontline staff. The last two themes, *management under stress* and *being contained,* describes an apparent contradiction, wherein they showed awareness of their need for containment, and acknowledgement that they were supported through the intervention, yet remained resistant to intervention throughout the process. I discuss each of these themes in turn and provide substantiating evidence from quotes drawn from the consultation sessions.

Working separately

The two health teams at Youville community health centre continued to function [separately] as they did before the merger. Even though some nurses received training to work in the other service, they refused to do so until their job descriptions had been changed to reflect these new functions.

> *Our nurses have been trained to do adult curative. With the job descriptions not finalised yet, they won't do it. If the conditions of service are accepted, they will do it, because it will be stipulated in the job description that they should do that.*
> - Ms Ngobela

The middle managers felt that although they wanted staff to integrate the services at the centre, they could not force this on staff until the job descriptions had been changed.

These are two different organisations with different conditions of service. We will see things happening later on...
- Ms Ngobela

The problem with integration of frontline services at Youville CHC was further complicated by talks about further salary increases for City Health nurses, which would widen the gap in salaries between them and Province Health nurses even further. Province Health nurses indicated that they would not do the same work that their counterparts in City Health did, while being paid less.

Ms Garies came up with this. We foresee some problems with the job descriptions of the City Health nurses that are being finalised now. City Health will get even more than Province health services' sisters.
- Ms Ngobela

The people are unhappy about that. I hear lot of talk. They do not want to work together.
- Ms Kay

Staff's resistance against working together as an integrated team was reflected in the unusual difficulty in arranging a suitable date to have a staff party to celebrate the opening of the new health centre.

We don't have money. It was difficult for us to get a date ... On Fridays we have a meeting and will decide ... Our party we have decided is going to be on 9 October [two months after the merge].
- Ms Petersen

Even though the two staff teams refused to integrate, they still tolerated each other in the building. Within this "tolerance" Ms Petersen reported that there was a measure of working together, where clinic staff referred patients to the day hospital for specific treatments or further diagnosis.

The staff is relating to each other. We can ask one of them to do a dressing for us or draw some blood.

...We will [refer patient to the doctor], after we've seen them. Most of the things we have spoken to the doctor before and he keeps some spaces open for us.

The two sisters-in-charge reported that initially they were too busy taking care of matters in their respective services to make time to see each other and discuss work-related matters. After their managers insisted that they should make time to meet, they made some effort towards making a connection with each other, even though they still did not about discuss work-related issues as the managers had hoped.

There is no opportunity to sit down and to discuss anything between Mary and myself. Sometimes I don't see the doctor, the pharmacist or Sister Kay. They are just too busy. I only see them in the afternoon. I myself am also very busy. We are just working. No time to think about what we are doing.

We make a point of greeting each other. [Laugh] Seeking each other out to make contact in the morning at least. And at the end of the day we chat and anything.

- Ms Petersen

The separate functioning of the day hospital and clinic services inhibited resourceful management of available staff to meet increased, yet fluctuating, demands between services. Even though the intention was for the two sisters-in-charge to spend time teaching each other about their work, it became clear that learning was much harder as it required that they move outside of their organisational cultures.

We saw it as an opportunity to ***teach*** *each other, but we have been just too busy to* ***learn*** *from each other.*

- Ms Petersen

The facility managers reported feeling guilty about sitting down to meet when their services were needed to help with the clinical load. The prevailing perception from staff was that clinical work was the real work, and that management tasks such as

planning for services were not really part of the work that was to be done at the centre.

We don't get time to sit and talk over tea. Then the other staff think we are not doing any work at all.

- Ms Petersen

The centre's inability to deal with the increased workload contributed to staff suffering from work overload and taking leave more often. This, in turn, increased the workload on the remaining staff, continuing the cycle of work overload and having to take leave. The tremendous stress under which staff worked caused them to be vulnerable to ill-health as well.

The staff over here is getting sick a lot more and that is understandable. We were doing staff absenteeism [statistics] and our rates are very high, which is due to leave. The people are stressed; so they go on leave. It is a good thing you are going on leave. Leaving the others stressed again. But they have to go on leave. They are entitled to their leave. People get sick. People are tiring. We are dealing with the sick.

- Ms Petersen

The increased workload led to increased stress levels among staff and this had further implications for staff relations and caring for patients.

But you see you could see it on the day. On the days that we are really spread thin, you could see the look on the staff's faces, "Just to get through this day." And they are so stressed. Anybody can just say something to you ...

- Ms Petersen

... And they flame.

- Ms Ngobela

Although middle managers held high ideals for successful integration prior to the merge, their reactions to staff working separately at Youville CHC suggested that they did not have such expectations. They were satisfied with the relatively smooth

transition that took place at the centre and wanted to bring closure to the current process, only to be re-opened when new conflicts arose.

> *When I was here, the staff seems to be coping well.*
>
> *Things will surface. We can't accept that all is well. Sister Petersen and Sister Kay, if you see morale of the staff becoming a problem, then we need to build up something... We should give them opportunity to sit down for just an informal discussion. Give them a month to do that. After that they would be able to give you/us some feedback on that. Give them till end of September... From Province health services and City Health management: you can call us together when you have done that [written the report].*
>
> - Mr Nkonu

Thus, middle managers regarded the merger as relatively successful even though full integration of services did not take place.

Intentions to integrate

Middle managers were of the opinion that full integration at St. John's health centre was dependent on the ability of the two facility managers to complement each other in their respective competencies and to facilitate a process whereby each could learn from the other. The current action research would facilitate a process whereby ideas could be shared and learning about integration could take place.

> *Ja. What point I am trying to bring home is that [pause] there are lessons that you can learn from our neighbours, because that is smart ... What can we learn out of these two? Where can we start in all those things that we are aspiring to? The question that she is asking, "where is this meeting trying to take us?" We are here to share ideas. And then, who are the two people to implement these ideas? ... At the end of the day our focus is the two sisters-in-charge. Sister Kay and sister Petersen, to work together and in a way to [gel] despite the organisational problems. So, I for one feel that although it might seem*

like a very slow process, I believe that in the long term it is going to be of good use.

- Mr Nkonu

Examples from other health centres where integration was reported as being successful showed that compatibility of the personalities of the sisters-in-charge were instrumental.

So I would really like to thank sister Cornelius and sister Nel [two facility managers from another CHC], because they seem to me they have a particular ... They have the same type of personality. They get it right. Because even if there is a staff meeting sister Nel moves in. If it is a City Health meeting, sister Cornelius moves in. So there is another thing. It also depends on the personalities of the people.

- Ms Ngobela

However, in thinking about ways how to "integrate" the two personas of Ms Kay and Ms Petersen, it became clear to the managers that the issue went way beyond their individual personalities. Although the two sisters got along well, this did not affect the way they managed service delivery. Ms Kay, for example, spent considerable more time with clinical work compared to Ms Petersen. This difference in work cultures complicated intentions of integrating their respective management functions at the health centre.

For Sister Kay, I think the main thing ... is the fact that she is in charge. She is a nurse clinician ... So she is really in a situation where she has to be a hands-on most of the time .... I don't say more than you, Petersen. You are also hands on and I know that for some time. But with her because she has two nurses, maybe she is forced to work more than to concentrate on the [administrative aspects].

- Ms Ngobela

Despite the tendency for Ms Kay to be taken up mostly by the clinical work, which was reportedly both her main interest and "comfort zone", she was not eager to give

up her management role completely. The managers were also of the opinion that she had to keep her management role to keep the day hospital staff happy.

> *She is not at a stage where she wants to relinquish her management role altogether and I think while she still has a management function. We cannot take that away from her, because of where she ... you know, what she is. You know, I cannot suddenly say oh well "You are the clinician. I am going to deal with sister Petersen." From our point, the red tape point of view I am not allowed to do that ... I feel that Youville CHC has achieved an immense amount ... by working as I said, "side by side, in harmony".*
>
> - Ms Loxton

Middle managers from the Province Health hoped that overhead processes, such as the current management training programmes for facility managers, would lead to facility managers taking up a more proactive role in making integration work.

> *They are going to be trained in facility management, and that includes the budget and the stock. But also how to run meetings; how to, you know, the assertiveness training. Those kind of things ... A training [programme] to get them up as far as their admin skills.*
>
> - Ms Loxton

It seemed that some of the middle managers were resigned to the fact that maybe full integration was not possible at that stage and that what was happening at Youville CHC was good enough. This position seemed to premise more on the fact that they did not know what more they could tell the facility managers and staff to do to get them to integrate their work.

> *Shouldn't we see what is working in other places from the ground level point of view? Because I don't know how much work, how much more work can come from outside into St. John's ... From our side, yes we have been there; we have been supported. But you know, maybe other places have a little bit more.*
>
> -Ms Loxton

Although facility managers did not champion the cause for integration of services at their centre, one of them admitted towards the end of the current action stage that she actually desired that integration would take place at the centre.

> *I would like to see all the staff together as one complement ... Now okay, City Health has four sisters; Province Health has two sisters. But to take that whole complement and let them be interchangeable in all the different consulting rooms so that City Health can cure adults and Province Health can do family planning and immunizing. So that they can rotate. Otherwise it is so boring at the end of the day. Each one with the same old job ...*
>
> - Ms Petersen

Integration of frontline services held several advantages for nurses as well. In the first place, integration would allow for the interchanging of staff, especially nurses, between the different aspects of primary nursing provided at the health centre. One of the reported reasons for nurses leaving City Health was that they were dissatisfied with their job descriptions, as these did not allow for promotion or variety in their work. It was envisaged that an integrated service would provide opportunities for nurses not only to be trained in adult curative care, but also to be promoted to such positions where they would perform (and also be remunerated for doing) a doctor's work.

> *They want to leave. That is the main reason why they are leaving. And also mention doing one thing all the time per year I think ... "This is it, why must I go on like this". So if they have exposure to other services, they won't be leaving. "Next month I am going to do something different. I am going to work in the dressing room." Following month I am going to do something else. But now we have this situation where, because of Baker Street not having a nurse and one of our sisters have to go down there and we have a temp [nurse]. The temp is a wonderful lady but she is not interchangeable, you know. Which leaves everyone else to spend some time there. We can't change anybody now. Because the staff nurse that we would put for family planning have to stay and*

do the immunising because the sister that came, came to see children [only]. So we've got a static [situation]... We can't change people now.
- Ms Petersen

Thus, although middle managers expressed their desire for integration of services, they were passive about promoting this, because they did not know how to manage facility managers and staff to get on with the task of integrating the work.

Bureaucratic management

The middle managers repeatedly cited the bureaucratic system of management as the reason why certain problems in the services were not resolved. They linked problems with staff shortage and work overload to overhead processes that were slow in addressing the needs of the services. This mindset was accompanied by a resignation that they as middle managers could do nothing else to relieve the situation.

It is quite a process to get someone appointed at Baker Street clinic. The board has to decide on that. In the meanwhile we will have to do without.
- Mr Nkonu

Decisions about service delivery were mostly left to senior management. Middle managers assumed a passive role in the planning of services, because they often regarded these types of decisions as financial ones that were outside their ambit. They perceived their role as merely being the link to communicate the outcome of these processes and the decisions taken to staff at facility level.

No, this morning they are still going to find out about the posts. And from the finance department about whether those posts are going to be financed. And then discuss the plan further with Baker Street clinic. It all depends on today's meeting what transpires there. We both still don't know. But Mr Nkonu will first tell her, then I will hear.
- Ms Petersen

The culture of non-participation from lower levels in decision-making in the organisation often resulted in inadequate planning of services. Middle managers had a tendency to blame senior management for problems that would later arise in the implementation of services based on corporate decisions.

> *I think Sister Petersen also mentioned that when one looked at the service the commission planned for, then there are no additional personnel made provision for. It is just a given that you are going to transfer the same amount of people from the one to the other and we have to make do. And unfortunately with the new place like this, you have an increase in patient numbers. And that is where the problems come.*
>
> \- Ms Adams

In the reported absence of adequate planning for service delivery middle managers were often left to resort to crisis management. This was a further source of distress for middle managers, because bureaucratic processes were slow in responding to requests, even when these were urgent. In addition, senior management would respond in ways that were often very confusing even to middle managers. Failing to understand certain management policies, the middle managers faced the distressing task of communicating these confusing policy decisions to frontline staff and facility managers.

> *It's making you feel like not wanting to come to work - because of the clinic that has only four sisters. The nurses and sisters ask: When are you going to get this extra staff? And I am waiting for people for their three-tiered paper. They are supposed to have started on the first, but now ... those are the things that we must wait for. They are approved. In fact, that is the only time that you get a temp person. But now all of a sudden the finance department said 'No' although all the promise must be fulfilled.*
>
> \- Ms Ngobela

The managers associated current high turnover of staff, which led to staff shortages and work overload, with senior management's inadequate handling of negotiations

for better working conditions. Senior management were reportedly slow in addressing staff requests for upgrading of job descriptions and this led to many professional nurses resigning from the health services and others threatening to do the same.

> *We send in our job descriptions for upgrading. That is why we have such little staff. People were promised each area would have one chief professional nurse. Each area, each clinic will have one senior professional nurse. So people were ... they thought it was okay because they were promised that. So they agreed to everything. The people were really motivated to work. But I am telling you only two categories were the seniors that were looked at. Now the work force is the ones who are affected. That is why now I say I think they should have given to the work force rather and then we are can start complaining. But it is worse that got done down here. But now for that they are asking every day "how much am I worth if I leave?"*
> - Ms Ngobela

The managers criticised senior management for not being mindful of the priorities of the services, when they (senior managers) decided to grant promotions to facility and middle managers, while only consenting to cosmetic changes to job descriptions of other (lower) staff levels.

> *When those came out, we [chief professional nurses] were promoted. They [senior professional nurses] were promoted. But the work staff, the professional nurses were just one level upped, which we felt it was unfair. ... from professional nurse downwards didn't get anything. The enrolled nurse, enrolled nursing assistant, only got a name change from enrolled nurse to senior. So that is the whole thing. The work force is the people that are dissatisfied. We cannot move without them.*
> - Ms Ngobela

At the time of the study a deadlock was reached in the negotiation process between the health organisation's senior management and the health workers' union about the upgrading of job descriptions. The middle managers criticised their senior

management for a lack of transparency during the negotiation process. They wanted senior managers to communicate openly and face to face with frontline staff rather than sending down information through written communication such as faxes and letters. They believed that better handling of the situation, such as suggested above, would result in frontline staff being more patient and understanding about the process. In this way the service could continue uninterrupted, while the situation was in the process of being resolved.

> *If maybe management makes time to go to the staff and talk to the staff, maybe then ... Rather than send a letter to me. Go and talk to the people and say this is the situation and this is what we are doing. Maybe the nurses will understand.*
>
> - Ms Ngobela

It seemed to middle managers that their senior management adopted a culture of apathy, whereby they refused to take up issues brought to their attention by staff and managers on lower levels.

> *It is a difficult thing. But some of the managers - I don't know what the situation is like now - but when you have a problem, [they say] "you can talk for yourself". So I don't know if that is the attitude now.*
>
> - Ms Ngobela

The bureaucratic way in which staff issues and other problems in the health district were handled was perceived as a means of senior management avoiding taking responsibility and being held accountable.

> *But it seems to the staff that they do not want to commit themselves to paper. They could just send a memo to say we are at this stage of the negotiations. They could keep us up to date with memo's. That would even work, but it is like they do not want to put anything on paper because people is going to hold it up - that is the feeling that we get. We don't know because I have not spoken to her myself.*
>
> - Ms Petersen

By highlighting the shortcomings of the bureaucratic management in the organisation middle managers placed sole responsibility for the current problems encountered in the services on senior management. The next theme, *management solutions,* illustrates how middle managers demonstrated a similar management style to the one for which they criticised senior management, as they were forced to deal with some problems encountered with the service at St. John's health centre.

Management "solutions"

The consultation session allowed the facility managers to bring difficulties experienced in the services under the attention of their managers and put them under pressure to respond. The middle managers felt pressured to provide answers to problems such as those related to patient load and staff shortages and responded by proposing "quick-fix" solutions that were not well thought through. These solutions were aimed at displacing responsibility from themselves onto others. The middle managers proposed that the problem with staff shortages should be brought to the attention of the local community health forum, because they were supposedly more effective in influencing (senior) management decisions. The community health forum was perceived to be a powerful political body that might be able to put pressure on senior management to provide additional staff for local health services.

> *We feel that you must put this to your community health forums, committees, and communities. And eventually it wears you out ...*
> *We have a meeting with the metropolitan forum ... which comes for the [proposed amalgamation of health services] ... These are the forums that the community will be able to ask for an answer to a lot of these problems ...*
> - Dr Ali

One of the middle managers cited an incident where action was immediately taken when the local councillor (a member of the local civic society) filed a complaint to the health organisation.

> *There was a break in at the clinic on a Friday night. So the councillor got on the phone. That alarm was put in that same day. When we came*

there the Monday the alarm system was there. That is what I am talking about.

- Ms Ngobela

Middle managers were of the opinion that the community health forum should take responsibility for the staffing problem in the local health services, because they represented the community who, as recipients of health care, were directly affected by the quality of service provided.

[The quality of service delivery] is affected locally. Because the people that are coming to you, they must say. I mustn't say ... It is supposed to be eased ... And they can't cope ... This is the work of the health committees.

- Dr Ali

The middle managers resorted to passing responsibility onto the facility managers by urging Ms Kay and Ms Petersen to meet regularly to discuss issues relating to health service delivery, work out solutions for work overload and provide support to each other.

You have to get together so that you can come up with solutions. Look at the set-up of the clinic: the flow of the patients ... Most patients come in the morning. We need to try and spread the attendance over the day to present in the afternoon.

- Mr Nkonu

I support the two of you meeting together. When you meet, you can also be a support for each other. You can air problems that you are experiencing and solve them.

- Ms Adams

Although the two facility managers repeatedly stressed that their individual workloads as well as the pressure on the services were making it difficult for them to find time to meet, the managers insisted that they meet regularly without giving any suggestions on how they could manage the situation differently in order to do that.

I think that you should definitely meet once a week. I feel strongly about that. Just sit down and see how things are going. What can we do; and how can we encourage nurses to work together.
- Ms Adams

Despite the failure to achieve frontline integration, middle managers proposed that the facility managers arrange a party to celebrate the new integrated service. This type of suggestion was made without sufficient thought into the reasons why it was so difficult to coordinate a date to have the party.

All the staff can make money together for a party.
- Ms Ngobela

The middle managers' lack of application when it came to managing the frontline services was illustrated by their failure to follow through on the promises that they made to staff before the merger took place to visit them regularly to monitor the situation.

I promised that I would come here every day, but I didn't get here.
- Ms Ngobela

I must apologise for not being here. I have been on leave for three weeks and got back to work last week.
- Dr Ali

The solutions that the managers offered to the problems encountered in the service not only reflected the tremendous pressure on them to put matters right, but also their inability to think clearly and rationally about and in their work as managers.

Management under stress

Participating managers reported that they were also suffering from the effects of stress in the health system. The tremendous pressure on staff on the frontline to deliver services also affected them as managers of the services.

Yes, the stress is here but it also works up to the managers. Because we have to deal with the staff shortages and we have to try and sort out [the services].

- Ms Ngobela

One of the sources of stress for managers was staff themselves, who looked to their managers to find solutions for the problems encountered in the services.

You see it is as Ms Ngobela says I phone her to go look for staff. The staff here look at me and say 'What are you doing about it?' So then I phone her and then I ask her 'What are you doing about it?' She phones Mr Nkonu and asks him what is he doing about it.

- Ms Petersen

Dealing with staff shortages was a major source of stress for managers as these represented pressing problems that needed to be resolved on a day-to-day basis. It was difficult for managers to pre-empt the problem without substantially more resources, because there was no way they could predict absenteeism on a given day(s).

As management we are really under a lot of stress. For example, I don't know where I would get a person for Zwandile tomorrow. That is another clinic. Two people - the other one sick; the other one, her mother is seriously ill, so she has a to go to her. So where am I going to get a nurse for tomorrow?

- Ms Ngobela

One middle manager reported that stress affected her sleep patterns.

You know this morning I overslept. Because I was so worried. What staff am I going to move to Zwandile clinic?

- Ms Ngobela

Managers' stresses were further exacerbated by expectations from staff to deal with issues regarding service contracts and job descriptions that were outside their control.

> *The professional nurses submitted their job descriptions last year. They are looking at us and they say we are not doing enough for them. I don't know how much more [we can do] ... because with the unions and the bargaining council ... we cannot do that. That is totally out [of our control].*
>
> - Ms Ngobela

The facility managers were expected to contain much of the stress that had become so pervasive in the health services. Staff dealt with stress by staying absent from work. The facility managers who were called to address the problem of high absenteeism among staff were divided about which course of action to take. On the one hand, taking leave was a means for staff to recover from fatigue and prevent total burn-out. In this sense facility managers did not want to act against staff who stayed absent from work. On the other hand, the high absenteeism rate perpetuated the problem of potential burn-out, as the remaining staff would be faced with an even more severe workload. This, in turn, demanded that the facility manager take stern action against those who stayed absent. Either way, the facility managers bore the brunt of dissatisfied staff members and pressure from their managers to deal with the problem.

> *The only thing is that, as you say, how much can you take? And if you go around as being the one in charge that will help you take that load from them. You got to ... in the end ... Ms Ngobela tell me, 'Well you decide whether to close the clinic or not.' I mean I have a passage full of people that I definitely could not do it. I was extremely exhausted. I just didn't want to see anyone. And it is not nice to go through every day like that. If you have an occasional day like that, it is okay. You can go to sleep and you are revitalised. Every single day then I need to look at the need compared to burnout. As I said the absenteeism figures, but there would be good reason for it. You know it won't just be on the*

whim ... but there comes a time when as I say, health workers can't contain the mass. Yesterday I think I was overflooded ...

- Ms Petersen

Middle managers felt under pressure to put things right in the services. However, they perceived that most of the problems were related to resources, which was outside of their control. Although they reportedly did their best to support staff in their demanding work, they felt in themselves that this was not sufficient, so that in the end even their reassurance only added to their stress.

As I said that that kind of problem we ... We try to reassure them ... that is the best we can do with all the resources. But our hands are tied. There is nothing more than we can do as management, except to support them and reassure them. It does tell on you as you feel exhausted at the end of the day. This kind of reassures people. But honestly there is not much more that we can offer physically or in content to [help the situation].

- Dr Ali

While middle managers had understanding for the budgetary constraints that beset the health system, they found it difficult to reconcile certain priorities for spending set by senior managers. They found it even more distressing to explain these budget limitations to staff, while they knew that money was spent on matters not directly related to healthcare delivery.

It is a fact from senior managers. We are continuously told that they do have budgetary constraints. Then you have the newspaper reports about the restructuring of the health department and the millions that are being spent ... One accepts that there are limitations to the budget. You can only spend so much on health. That is a reality: there is not an unlimited pool of funds that we can just keep on drawing from. One has to draw a balance between the service rendering and the resources that we have in terms of budgetary and personal resources available. So as managers we try to explain this to staff and patients and say this is how

much we have budgeted. And that is it. It is not a bank that we can draw from all the time.

- Dr Ali

The middle managers reported that sometimes they felt so stressed that they did not have the energy to make decisions about service delivery. In such cases they admitted to passing the buck to facility managers, who then had to take full responsibility for resolving the situation.

I said 'Petersen, this is your discretion.' I was running away from the problem. 'Use your own discretion - you are in charge.'

- Ms Ngobela

Due to the huge amount of stress experienced by managers, they were more vulnerable to the slightest provocation. During one of the consultation sessions it was reported how one of the facility managers became extremely upset as a result of a misunderstanding that caused her to miss a training course that she was due to attend. She was reportedly so upset that she had to take sick-leave.

Yes, I found her. I was quite concerned about her. I have not seen her, but she phoned me today she is much better. She is off-sick today. She was upset when I phoned her on her cell. I think that was a contributing factor.

- Ms Adams

It was clear that although management's stress was largely caused by lack of physical resources, it affected their emotional capacity to manage. Anecdotal evidence showed that some managers were at risk of burnout.

Being contained

The management team stated that they benefited from the consultation sessions, because the platform built through the consultation sessions facilitated communication between different levels of management. Through the facilitated meetings managers from different organisations found a safe place where they could meet and get to know their colleagues. This space facilitated the breaking down of barriers of organisational distrust as well as greater understanding between the two camps.

> *This has given the opportunity to get to know my colleagues [from] Province Health services ... So to me it was an eye-opener ... We have come to a position where we can understand each other.*
> - Ms Ngobela

The forum provided the opportunity for middle managers to forge healthy work relationships with their facility managers and for facility managers to get to know their new managers.

> *One of the first meetings that we had here, we walked out and me and Sister Kay were standing at - I can't remember, think we had separate cars - but we were standing there for twenty minutes talking. And I thought you know, maybe this is just the environment to get out of the clinic away from ...*
> - Ms Loxton

The healthy work relationships that were established within the management team extended to the outside and manifested in better relationships between middle managers and staff even across organisations. The facilitated discussions brought occasions for information sharing across organisations, which helped to broaden the managers' views on what was going on in the other organisation and learn about the other's point of view.

> *These meetings gave me an opportunity to share with the management. Especially we have never been able to share across to Province Health*

services and our managers at the same time where they are meeting and discussing about problems that we are facing. Because Ms Loxton will hear it from a Province Health service side. Ms Ngobela will hear it from my side.

- Ms Petersen

Within the discussions the facility managers reported that they had found the freedom to challenge their managers without fear of being victimised or shut up.

An unbiased type of forum where I could say exactly how I feel ... You know so that I have freedom to speak in front of my managers so that they know exactly what is happening. Because one tend to not want to say the full story. You know. And I felt that this is a very welcome ... maybe some thoughts and some ways on how to manage some situations ... So this for me was very helpful.

- Ms Petersen

Managers experienced the consultation meetings as a safe place away from the pressures of the services, where they could think about their work and discuss it with colleagues from the other health organisation.

When you are in the community ... you are almost always on the defensive. Whereas here I don't think we have been as defensive about our situations ... And that is why I am a bit sad that Sister Kay has not expressed. That is why I think it might be the language problem or just her personality that hasn't been as open. You know ... In this forum she's maybe have felt a little bit more threatening. That could be because of the language ... to me its been very valuable to come together for one particular place and staff process or ... It is something that we have started but maybe got onto a far more personal ... you know personal ... you know, relaxed atmosphere. Things are always ... when you are away from your office or your center or place of work.

- Ms Adams

Not only did the discussion allow for thinking about the work, it also facilitated a forum where existing thinking was challenged and changed. Middle managers reported how in being forced to listen to facility managers, they were able to put themselves into the latter's shoes, and how this challenged their thinking.

> *I think what is also about this group is that that we as managers also had to identify our problems with integration. Uhm you know, it is not just oh well in the centre they have to work together. But we as managers – it might be fine to sort of sit across the table from her - but my own feelings of integrated service has also been tested. Not maybe verbally, but definitely I have thought about the whole process, you know. And how would I feel if I was still working down on ground level, as well as management.*
> - Ms Loxton

Management participants reported that as a result of taking part in the research process, they felt more relaxed and able to listen to others as well as to share information with staff under them. These two factors, coupled with the safety of being able to challenge their managers (for facility managers) created an ideal space within which good working relationships were formed and greater clarity of thought was achieved with respect to issues in the services.

DISCUSSION

As already mentioned, the themes that emerged from the grounded theory analysis showed three contradictions. In this discussion I focus on these and offer possible ways of understanding these contradictions.

Contradiction #1: The integration ideal

Before the merger middle managers held high ideals for integration "to happen" at the new health centre, even though the odds showed that this was difficult to achieve in the current situation. However, after the merger took place and staff continued to work separately, the managers denied their desires for integration. One way to understand this denial would be to draw from Klein's concept of "splitting". A

possible explanation is that managers resorted to denial of their pre-merger intentions to free themselves from the anxieties they would experience by facing the fact that attempts to integrate failed. By denying that they wanted integration to take place at Youville CHC, the problem of staff not working together became no longer a problem. Thus, they were liberated from having to deal with it. This denial was possibly part of a process of splitting, whereby parts in them that wanted integration to take place were split off and projected onto their senior managers. This partially explained middle managers' responses that seemed to indicate that integration was an ideal held by senior managers only. Simultaneously, parts in them that resisted integration were projected onto staff and facility managers who refused to integrate. This could explain why middle managers sympathised with staff who did not want to work together after the merger, even though they as middle managers, communicated clearly to staff that they wanted them to integrate fully at the new health centre. Consequently, senior management were blamed for failed integration at the health centre, because they did not want to heed staff's demands for changes in their conditions of service. This also relates to the next contradiction observed in management's responses.

Contradiction #2: Management style

Middle managers demonstrated a "perceived powerlessness" through their behaviour. The findings from the grounded theory analysis showed how they consistently pointed out flaws in the bureaucratic approach to problem-solving applied by senior management in the organisation (described under the theme *bureaucratic management*), yet appeared to be unaware that they were resorting to a similar style of dealing with problems at frontline services level (described under the theme *management solutions*). This behaviour of middle managers could be understood as them seeking to avert taking responsibility for problems that existed in the services and thus also the anxieties that accompanied doing so, by splitting off their strong parts (their ability to resolve frontline problems) and projecting these onto senior managers. In this way they looked to senior management to resolve the problems in the services. When senior management was reportedly slow in resolving these problems, they were blamed and criticised.

At the same time the middle managers projected their weak parts (their inability to resolve problems on the frontline) onto the facility managers. By suggesting actions that the facility managers could take to resolve the problems in the services with patient-load, they were projecting their feelings of impotence onto them. These solutions were not well-thought through and seemed to be given without any real expectations that the facility managers would actually succeed in making the changes. Middle managers did not follow-up with facility managers to see whether they had implemented these suggestions in the services. It created the impression that middle managers were giving advice that was doomed to fail in any case, which served to confirm the hopelessness in the situation. This was a hopelessness that they felt within themselves about the problems with service delivery, but projected onto the facility managers. The middle managers would then react to facility managers' inability to resolve these issues by sympathising with them. In this way the middle managers could deal with the anxieties that they faced in having to solve a situation that was perceived as impossible to resolve. By projecting power to the senior management and powerlessness to the facility managers, they were able to cope with the anxieties that they faced in their work. Another outcome was that facility managers received this projection as a projective-identification, and this, in part, contributed to them reportedly feeling emotionally exhausted.

Contradiction #3: Resistance to support intervention

Reports from the consultation sessions suggested that middle managers were suffering from or, at best, at high risk of burnout. Burnout has been described as a lack of efficacy, feeling detached from your work and losing interest (Maslach, 1982). The management participants in the current action stage reported feeling emotionally exhausted at the end of their working day. Middle managers' tendency to displace responsibility onto others (through the processes of splitting and projection described earlier) suggested that they were losing a sense of efficacy in their work. The superficial solutions that they offered to staff possibly pointed to personal detachment from their work as well as an inability to think about their work. All these behaviours indicate that the management participants were not coping well with the stress they experienced in their work.

The intervention was aimed at providing the participants with a contained space within which they could discuss aspects of their work. Within a health system such as the present one, it was clear that many problems were quite complex without easy or short-term solutions, resulting in significant amounts of job-related anxiety. We perceive management's task to be to contain these anxieties in the system. However, little effort was made to provide stress relief for staff, because the managers themselves felt too stressed. Thus, a cycle occurred where management culture was characterised by little listening and where commands were simply passed down from highest management levels, and middle managers resorted to becoming channels of these instructions, without mediating the impact of these commands on the receiving facility managers and their staff.

It was thus imperative that these managers learn how to contain anxieties of staff to ensure that service delivery continued. The intervention sought to teach the participants to contain anxieties in the system, while providing containment to them through the process. Several managers reported that they felt supported through the facilitated discussions, which helped them to think more clearly about their work and build relationships with other managers. Whereas they previously did not want to know about the problems that staff were facing (because they did not have solutions or the emotional space to explore possible solutions), they listened to their facility managers and found that this resulted in them being more sympathetic to their situation. Theory suggests that managers in human services organisations often feel under pressure to put things right (Roberts, 1994b). When they cannot do this, they stay absent rather than acknowledge the problem. In such instances it has been suggested that managers would do better to listen to staff, as this would enable staff to better handle their anxieties. In the current action stage we observed that although facility and middle managers acknowledged that this would help, they reported just being too busy and stressed to provide a listening ear to staff or those under them, until the intervention provided them with an emotionally contained space, which in turn enabled them to behave in an emotionally contained way towards staff.

However, even though the managers reported clear benefit from attending the consultation sessions, they were still reluctant to attend, as observed by the difficulties we experienced throughout the current action stage in arranging

meetings. This indicated that they may have not been ready to engage in such a process as yet. The tendency in the South African health system is that clinical work always comes first. Spending time thinking about their work is not considered working. Van der Walt (1998) reasons that this type of thinking originated from the task-orientation into which nurses were trained in South Africa.

The intervention was also designed to provide a contained space where participants could think about their work. The consultants deliberately did not offer any solutions and listened to the participants without criticising them. This safe space encouraged the participants to think about their work and to exchange ideas with their colleagues from the other health organisation. Bion states that before thinking can take place, space needs to be made wherein the individuals can arrange elements of their thinking (Hinshelwood & Chiesa, 2002). In a bureaucratic organisation such as the health system there is little space made for thinking, as the system is biased towards the practical side of healthcare delivery. Thus the system's capacity for creative problem-solving is diminished. Although the participants reported that the consultation sessions offered them opportunity to think about their work, there was nothing to suggest that this effect transcended beyond the duration of the sessions. Due to the abrupt end to the process, the intended structured intervention was not completed. Thus, the effects of a structured intervention in containment still needs to be determined in a PHC setting, because of the compelling pressures present in public health services.

REFLECTIONS ON THE PROCESS

The current action stage presented several crises for the existence of the project. In the first place there was the managers' suggestion to bring closure to the process, because the merger had taken place "successfully." This brought a period of soul-searching for the research team, wherein we sought to find new direction for the intervention. In addition, the research team encountered several natural stumbling blocks, which derailed the process.

Premature closure

At the first meeting with the management team, it became apparent that the middle managers had different agendas to the research team about the process. They viewed the consultants' presence as an opportunity for them to achieve what was not achieved anywhere in their district – successful integration of PHC services. Although in principle they agreed to the research goal of developing interventions for supporting staff, it seemed that what they actually wanted was for us to work with staff to make them compliant with plans to merge the two facilities. While in the process, they may have recognised the opportunity to utilise the services of the consultants on the research team to get staff to buy fully into the ideal of integration. When the consultants did not play the proactive role that they probably expected them to play, they saw no further benefit from the process.

This dilemma is a classic one that presents itself in all action research processes. Who has the power – the researchers or the participants? Although the process sought to empower the participants and to benefit from their contributions, the play-off against control over research goals was a matter that required careful consideration. In the current action research process the research team maintained control over the research outcomes, while drawing from the expertise of the health managers to make decisions about methods and process. We communicated this to the health managers by stating our primary goal upfront when we negotiated access. This decision (to hold the direction of the intervention in our hands) was upheld throughout the process by us having separate debriefing sessions for the researchers and consultants only. In these debriefing sessions, the outcomes from the consultation sessions were discussed and further plans of action taken. In this way we hoped to ensure that the process stayed on track. The drawback to this approach was that we were not fully assured of the buy-in of the managers as well as their level of commitment to the process. This might be one of the reasons why the intervention came to a premature end.

Focus on managers

Initially we as a research team hypothesised that the action research process would involve working dynamically with staff to help them find alternative ways to deal with

stress in their work. This hypothesis was based on the work of the principal investigator who explored social defences employed by nurses in primary care as part of her doctoral studies (described in Chapter Four). The current process, however, suggested that established work patterns such as that presented by the task-orientation, might not be that salient in a system that was constantly changing. In this setting transformation to an integrated health system was the central process. According to staff reports this was the major source of stress for them apart from staff shortages. The literature suggests that in a period of change it is imperative that management play a visible role in containing staff anxieties (Bachman & Makan, 1997; Fulop, et al., 2005; Gilkey, 1991). This suggested that we shifted our focus from working directly with staff to working with the management team. Due to the amount of consultation time we spent with the two management teams, we saw this as a natural progression in the course of the process. Hence, the decision to schedule a programme around containment aimed at the management participants.

Interruption in the process

The above-mentioned 'programme' was interrupted and consequently aborted after only one session was conducted. We encountered several problems with setting up further meetings with the management team, because middle managers were reportedly occupied with other crises in the services over this time. Another reason why it was difficult to follow-through on the proposed programme was that year-end was approaching. In South Africa year-end is accompanied by the advent of summer holidays and many employees seek to take leave over this period. This also means that the preceding month (November) is extremely busy, because staff and management seek to prepare for closure of the service over the festive season, or to make arrangements for the service to continue with a skeleton staff. Over this period (November – December) the principal investigator took ill and was on sick-leave, which caused further loss of momentum and impetus in the research process. Upon her return to the project the following year, the research team decided that the break in contact was too long, and that we should seek closure to the current process. The final action stage then, describes interviews conducted with participating staff members and managers on what the process meant to them.

CHAPTER NINE

REFLECTIONS ON THE PROCESS

ACTION STAGE FOUR

In the final action stage described in this chapter we brought closure to the action research process by reflecting as a team and with the participants of Youville Health Centre and their middle managers on the process. During this stage there were changes in leadership in the research team as well as in Province Health. In the process of reflection we also noted changes in attitude towards the research process from certain middle managers and one segment of the centre staff.

Changes in research leadership

Following her illness, the principal investigator eventually took early retirement from active employment and ceased her involvement in the research process. Prior to her taking this final decision, there was a period of a few months where no actions were taken in the research process, as the rest of the team waited for her return to active participation in the process. During this time period the research team maintained contact with key managers in both health organisations keeping them up to date with what was happening within the research team. The co-principal investigator took over the role of project leader. I took over the role of project co-ordinator. From that point in time the research team sought to pick up the research process again. Two additional members were invited to join the research team as we embarked on a process of reflecting on the processes of the past two years. Both were clinical psychologists lecturing at a tertiary institution, and had particular strengths in analysing and conceptualising psychoanalytic consultation processes in community settings.

Team reflections on past action stages

A series of meetings were held amongst research team members to discuss ways in which we could work around the unplanned break in the research process and take the process forward. We realised that:

- Even though it may have been ideal to complete our proposed intervention programme around the concept of creating capacity for "containment" amongst facility and middle managers, which we had started in the previous action stage, and then evaluate its effects, this was not possible due to the extended break in time and possible loss of relationship that occcured as a result.
- Implementing a similar intervention programme would require a new process whereby access would need to re-negotiated with managers, which would go beyond simply asking for permission and would probably involve building a new relationship with the management team. In addition, "new" events in the health system as well as in the two organisations needed to be accounted for in negotiating terms of reference for further participation.
- The extended period of inactivity (from the research side) contributed to a loss of connectedness with the participants, which might be felt in an emotional sense by the participants.

It was thus decided that we seek closure to a process wherein staff and managers contributed much in terms of work time and emotional energy. Abandoning the process at this stage would be unethical and undesirable for future collaboration with this group of managers and others in the health services. We envisaged that a plausible way to bring closure to the process would be by interviewing participants individually, and reflecting with them on the effects that the process had on them, their relationships and their work.

PARTICIPANTS

The new PI and I arranged meetings with Mr Nkonu (area manager of City Health) and Dr Ali (medical staff manager from Province Health) to discuss the above-mentioned suggestion of interviewing staff and managers as a means to reflect and bring closure to the process. Mr Nkonu agreed to our proposal to interview participating staff and managers, but excused himself from the process as he felt that the facility manager and the nurse manager would be better able to answer questions about staff morale, service delivery and the progress with respect to integration at Youville health centre. He did not seem interested in any further participation in the research process, except in receiving a research report at the

end. Dr Ali was more agreeable to an interview. He was also supportive of our proposal to interview participating Province Health staff about what the process meant to them. Managers who took part in the consultation sessions, and were still active in the health district, were approached for interviews. The following managers took part in the interviews:

- Dr Ali, the middle manager from Province Health
- Ms Ngobela, the nursing staff manager from City Health services
- Ms Petersen, the facility manager of the clinic at Youville CHC
- Ms Kay, the facility manager of the day hospital at Youville CHC.

Ms Loxton, the nurse manager from Province Health resigned from her post to take up a position abroad. She was thus not available for an interview. Due to the small sample, we decided to interview *all* available and willing (consenting) staff members who participated in the previous action stages. The following staff members were interviewed:

- From the clinic: the tea lady, caretaker and three professional nurses.
- From the day hospital: the tea lady and clerk.

Non-participants

Dr Zee and the pharmacist, Ms Reddy were not interviewed, because they were too busy dealing with their patients. The only refusal came from the staff nurse from the day hospital. Several staff members were absent, but specific apologies were made for staff members from the clinic service, i.e. the adult curative nurse and the clerk.

DATA COLLECTION

Before conducting the interviews the research team set up a list of questions, which were used as a guide for information gathering.

Interviews with managers

PI and I conducted in-depth interviews with managers. Although the interviews were conducted in a manner that allowed participants the freedom to express themselves, we had a list of *a priori* questions at hand (Kvale, 1996). In conducting the

interviews great caution was exercised with the list as we determined not to pre-empt information disclosure by coercing managers into becoming mere respondents to our questions. Thus, these questions were asked where we thought it was necessary to fill in the information gaps and where we felt it otherwise appropriate in the context of the interview. We followed standard qualitative interviewing techniques such as asking clarifying questions and reflecting on information provided by participants to encourage further sharing and to check for understanding. Throughout the interviews we paid particular note to the mood of the participants and their ease in responding. Where we detected, for example, that the participant was becoming uncomfortable with the line of questioning or direction of the interview, we took appropriate action, by either reflecting on this (our perception of them being uncomfortable) or steering the interview in another direction. We determined to remain sensitive to the managers' time constraints and therefore did not spend more than an hour on each interview. Three interviews lasted about an hour. The fourth interview lasted thirty minutes as we detected that no new information was forthcoming from that interview.

Interviews with staff

I visited Youville CHC on two separate days to interview staff members from the clinic and day hospital respectively. There was a time gap of two months between these two days of data collection, due to difficulty in obtaining permission from Province Health managers. I arranged beforehand with the specific sister-in-charge, on which day I would be visiting the health centre to interview her members. Once at the centre, I walked around the premises and inside to observe staff at work. As staff became available I approached them for an interview. The interviews were brief – mostly lasting up to 15 minutes. The only exception was the interview with the clinic's tea lady, which lasted 40 minutes. She impressed the research team on previous occasions as being very articulate and thus this came as no surprise. Another contributing factor might be that she could have had more time available to speak to me on that particular day. The clinic staff were generally more willing to be interviewed than the day hospital staff. I got the distinct impression that whereas the clinic staff expected me on the day of the interviews, the day hospital staff only responded to me when I physically arrived at the centre. The day hospital staff were very reluctant to be interviewed when informed by their sister-in-charge. Even when

she announced my presence to some of her staff members, there was a great deal of reservation (from her) in the way she did it.

The interviews were recorded on audio-tape after permission was obtained from the participants. Only one participant refused to be recorded on tape. Although the intention was to conduct in-depth interviews with staff members, this was not possible due to the time and space constraints. The interviews were conducted at the health centre and the participants took time off from their work to speak to me, because of work pressures. Some were notably uncomfortable about having to leave their work to speak to me. The venue where the interviews with most of the staff were conducted also seemed to contribute to staff feeling uncomfortable during the interviews. Not only was there a lack of privacy, but the fact that one of the clinic's consultation rooms was used, seemed to have made day hospital staff uncomfortable.

DATA ANALYSIS

Verbatim transcriptions of interviews were done by an independent person. The high noise levels in the health centre contributed to poor quality of sound on the recording of the interviews with staff members. This rendered transcription of these tape material impossible. I used personal notes from these interviews (written after the interviews) as a data source to verify or disconfirm finding derived from analysis of interview data from managers. I used the same method of grounded theory to analyse the data from the interviews as described in earlier chapters. A list of codes generated from the interview data is included in Addendum D.

FINDINGS

The emerging themes from the analysis of the interview data describe the effects of the consultation process on staff and their work, as well as factors external to the intervention process itself that influenced the way participants related to the consultation process.

Effects of the intervention

Although managers in particular viewed the current action research process in a positive light, this was not primarily based on perceived positive outcomes of the consultation sessions, but rather on the potential that such a partnership has for addressing issues that may arise in the public health service delivery.

> *Your involvement - it was encouraging. It gave us the hope that ... we have resources to address should then any crisis develop or something. Just to have someone we could sort of ask for assistance if we need. So, I think it was useful.*
>
> \- Dr Ali

The participants had mixed reactions regarding the effects of the consultation process on themselves, their work and relations at work. They reiterated previously mentioned positive outcomes of the action research, i.e. feeling supported and understood, improved communication and creating a platform for middle management to work together across organisations. Ms Petersen, for example, had the following to say about one of the consultants:

> *For me yes I am just thinking back on Natasja ... she always came across as supporting us especially me in the way I wanted to do things. You know take something forward and guide a bit and saying you know, "try it this way." And that was very supporting to me. To think that, you know, there is people that are outside there that understands what one is going through - you know with all these frustrations that were going on.*

She went on to state that the manner in which discussions during the consultation sessions were facilitated created space for facility managers to express their views without fear of being told to be quiet by their managers.

> *Those sessions were very helpful in the sense that it gave both sides - both of us - a chance to speak in an environment where people wasn't trying to ... you know say that one can't talk now. You know the speakers can't tell her to keep quiet.*

The consultation sessions also facilitated sharing of information between the two management teams, which in turn contributed to a greater understanding across organisations and between different levels. The sessions created a platform where inter-organisational conflicts that surfaced at facility level could be brought for mediation.

> *... Both sides of the people heard my story ... and my complaints and my concerns. And that it wasn't only directed to my seniors but the other side people also knew about frustrations with the building ... So that they can know exactly what we feel like on the ground. And not, they get one picture from her side and our people only get my side of the story. So I think it was more like a mediation ...*
> - Ms Petersen

In addition to previously mentioned outcomes, the participants reported that in the consultation sessions they were stimulated to think about their work - how they were managing staff and services delivery. In talking about their work they became more aware of their management style and unconscious expectations they had of staff. Realising how staff may be experiencing their behaviour, moved them to change.

> *I have been through great change myself. And I think together with a whole lot of other things it [the consultation sessions] was probably a wake-up call to me that I wanted to push my way of doing things and were not always listening. And becoming clued up with the staff and their feelings whatever. Because I expected everybody to feel like ... good. But everyone didn't feel good. Ja, I've become more aware of the staff's situations. I've always been someone that [believes] you work with people. They are your colleagues - period. And I don't try and find out about people's personal lives. I feel that is their private thing ... but it impacts so on performance that I've become more clued up to how they look, how their expressions, their behavior, if anything changes in them. And I will say partly due to going and being in those sessions with you guys. I don't socialise with any of the staff. It's always been beyond me. That was so ever since I was a student. It's just that work and play*

don't mix. So whatever happens at work stays at work and it's just: hello and goodbye. And I've become more attentive and more open. And listening a bit more to them and our relationship, my relationship with the staff has improved slightly. I won't say it is so great whatever. But I am more aware of them.

- Ms Petersen

Being part of the consultation process, managers were moved to acknowledge openly that they were overstressed and in need of support. The process of talking about their work and the stresses that work evoked, helped some participants realise their limitations as managers. Upon acknowledging their own need for support, the managers realised that staff most probably experienced similar feelings. This new understanding caused them to relate differently to staff conflicts and to become more supportive of staff members.

Where now I don't want to be involved in each and every squabble that happens. We should have some coping mechanism. You can't just run the show. But I am listening more now. I'm really listening. In fact we had quite a division here in the camp ... And I really had to work on making them all feel very special. It's a bit tiring, but I always said you know you work with adults and not with kids ... I've got to make them feel special. That is my mission.

- Ms Petersen

Ms Petersen claimed that as a result of her change of attitude, her staff was much happier at work.

It is better for me now I have a happier staff ...

Similarly, she found her managers more supportive after the consultation meetings.

I can only say from my side our managers - they are very supportive. They listen to you. They don't always do what you would like them to do ... But they are there for you ... Even though they can't do anything they can listen to me and say "Ag, shame man Beatie [Sister Petersen's first

name] man. I know we can't give you staff" and that. But at least I feel good because I got it off my chest.

- Ms Petersen

Despite these positive reports about the consultation process, several negative outcomes were also mentioned with respect to the uptake of the process. In the first place some participants were not clear about the process, its contents and aims.

I don't know what sort of effort you've put in when you've been out there with when you've had discussions with the staff there. I'm not sure what sort of impact ... I can't comment on ... I don't even know what sort of input ... What sort of interaction you've had with the staff there, but we've haven't had any negative reports from there.

- Dr Ali

Irregular attendance of key managers at the consultation sessions contributed to a degree of ignorance amongst these, and may have devalued the importance of the process. The drawback to the process was its lack of success in soliciting managers' full commitment to the process. The following quote from Dr Ali shows that it may not have been high priority for him to attend the consultation sessions or respond with an apology when he could not make the meeting times:

We didn't have all that much interaction of as to what you've actually been doing at the grassroots level. What you had experience or what your findings were when you did go out there. So we didn't get that feedback, yes. I might have missed a meeting or two, I don't really know.

Another serious drawback to the positive outcomes of the process was the failure of the management forum to implement solutions to resolve problems in service delivery, due to the inhibiting effects of overarching bureaucratic structures and processes.

What they discussed is what they are doing in Province Health services and City Health and how they can actually meet each other. But you

know there is resistance, because they can't really do anything without the approval of this person. And they must get that person's approval.
- Ms Petersen

Staff understood the goal of the action research process to be to facilitate integration of frontline services at Youville CHC. When senior management of Province Health communicated to all staff that they must **not** integrate curative and preventive services, staff saw no reason why this process was still continuing. They acted in a somewhat hostile manner towards their facility managers when the last-mentioned went away from the service to attend consultation sessions.

I felt that they were being left out. But also some of them willingly didn't want to be part of listening ... Just the one comment was " why did I go ..." Ja, but they all were asking, "Is it gonna work? Is it gonna hold up? Why do you still go there if there is not gonna be integration?"
- Ms Kay

The outcomes of the interventions were influenced by many factors that were external to the intervention. I identified these external factors as organisational factors, operational issues, and interpersonal factors and staff attitudes.

Organisational factors

Problems that existed on national and provincial levels with respect to the amalgamation of PHC services affected the way staff at Youville CHC reacted to the current action research process. Staff did not want to commit to integrating work at frontline level until an official announcement about it was made in their organisation.

Then their Head decided, 'No we didn't want to amalgamate' ... So it's the timing that is not right ... It's just, "When is the time right?" I don't know. I don't know if it's in a year's time, two years, five years' time.
- Ms Petersen

At the time of the current study the date on which official amalgamation would take place was postponed several times. The delay created uncertainty amongst staff and

managers about whether amalgamation would ever take place, and under what conditions, and caused middle managers not to want to commit to any process aimed at making integration work at facility level.

> *And as far as the official amalgamation with City Health is concerned the goal post has been shifted. Rather not the goal post, but the date of the amalgamation has been moved each time. And the latest is that it will not happen before June 2002. It's not saying that it's going to happen in July, but it will not happen before that date. The last date it was due to have happened, was July this year. Then they said September this year. Now the latest is not before June next year. ... So we will anxiously be looking forward to what decision is taken there. So we sort of in limbo. And sort of sometimes we just freeze and say, "One can't even think about it until a decision is made at some stage."*
>
> \- Dr Ali

A middle manager noted that there were unofficial reports that senior managers from local health authorities as well as Province Health were having doubts about going ahead with amalgamation. Specific issues that were apparently not resolved were: scope of PHC service delivery, resource allocation and conditions of service. A neutral arbiter agency had reportedly been called in to facilitate the process and take it beyond its impasse.

> *What is happening now is that they have employed again an outside agency... to investigate the feasibility of the amalgamation of Province Health with City Health services. In fact, they've been tasked by Province Health as well as City Health, because both are now having reservations about the whole amalgamation.*
>
> \- Dr Ali

It was further believed that new appointees in the respective health organisations, who were tasked to represent their health organisation on the negotiation committee for integration in the province, were playing obstructive roles in delaying progress because they were not in agreement with proposed plans.

Some senior people in the department are not quite in favour of the whole amalgamation, because the people that have started the process are no longer there. They've moved on. There are a new lot of people that are in the department now and they don't agree with what the pioneers or the people that have initiated the process said.

- Dr Ali

A particular area of contention in the negotiation process was what the scope of service delivery would be in the amalgamated new organisation. At the time of the research Province Health facilities were providing far above the basic primary health care services, and City Health and other local authority organisations were cautious to take up this wide scope of services without an increased budget allocation.

...what we're delivering in the Metropole is more than primary health care... We are almost the agents for out-patient service for the secondary and tertiary hospitals. We keep on more than just the essential drug list for primary health care. We are doing a lot more than that. So, it is a costly package as well. It cost much more than any other primary health care service... Primary healthcare is supposed to be a cheaper level of care than secondary healthcare. But what they are doing is, they are down loading all the expensive things down to us. Be it expensive drugs or psychiatric care... The costly things they have just downloaded to us. So we've become the expensive service and they are working out theirs at a cheaper price. That's making nonsense of the whole primary – secondary care divide.

- Dr Ali

Different conditions of service remained one of the critical obstacles to participants in the current study addressing the various issues related to working together as one team. Staff, in particular, did not want to think about working together while remuneration was not on par. Resolving the issue of different conditions of service would be quite complicated– more than 20 different health organisations and their respective trade unions needed to reach an agreement.

> *And then it's the obstructionist approach of the trade unions as well. They are looking after their own interest - what do they have to gain or lose in it. They might lose certain benefits. The provincial trade unions might lose their members if they were to go to the local authorities.*
> - Dr Ali

Tensions between the respective staff teams (within the same facility) were further enflamed by accusations from higher up blaming staff from the other organisation for not being cooperative to the process of frontline integration.

> *So on Friday in this Effectiveness Study Workshop that we went to, Dr Mitchell, one of their doctors from America asked what is the problem why are we not integrating. Then Dr Rowe [senior manager from Province Health] said that our [City Health] nurses don't want to unite ... We have been interpreting it as* ***they*** *are the people who don't want to work together with us!*
> - Ms Ngobela

Staff's resistance to integration was a tremendous source of stress for middle managers, as they felt powerless to enforce among their staff mandates handed down to them from their senior managers. Participating middle and facility managers found it difficult to contain staff's and their own stresses about amalgamation and to motivate staff to integrate frontline services.

Operational dynamics

The theme, operational dynamics, describes factors related to service delivery that influenced the uptake of the process by participants. Facility managers reported difficulties with implementation of partial integration of services, dealing with increased patient loads and the effects that this had on morale, handling their own workloads, and dealing with security concerns at the health centre. The two facility managers had different ideas about service delivery at Youville CHC, and thus plans for a fully integrated service did not come to fruition. Ms Kay and her team were not willing to collaborate with clinic staff in activities that did not involve direct delivery of care.

There is still no talk. Everything - she moved out! This is all my stuff. She practically moved out and inside. And the desk is actually here for fun, but she just tells me that she would prefer to be there where she's working - in that environment. Keep everything with her. So, she has everything inside. So that thing that we wanted to sit and chat, it never ever happened.

- Ms Petersen

We've never sat together. We have our meetings separate ... We are trying to have our local venue committee in this just to discuss things. And it was also decided from their side that nothing can be done to their problems, so they don't even go to our meetings... They used to be part but now they say because the issues that are raised on their side are never addressed.

- Ms Petersen

The differences in organisational culture and orientation between Province Health and City Health staff is noticeable in the day hospital's willingness to establish a system of referrals and cooperation between clinic and day hospital services for curative care and dispensing.

If there is anything that we don't have in our cupboards, we can write out a prescription sheet and the patient can get it at the pharmacist. But most of them like make it, we've got basic primary health care medicine ... So they keep it for us till we fill up our cupboards from stock that we've received.

- Ms Petersen

Yes, and then the dressings are done in the dressing room because we always referred all our cases to the Day Hospital. And this is the Hospital so... but we found a nice understanding of the referral. You know. We see the patient first; then they see them ... In the meantime when the child comes back, he can go straight to the dressing room.

- Ms Petersen

However, day hospital staff were not amenable to an exchange of staff to allow clinic nurses to do adult curative care.

> *We have a nurse there, Sister Lila who is a clinical nurse who is supposed to be seeing adults ... for curative care. She's got a primary health care qualification. So she has been promoted to a grade 12. And one of the functions of a grade 12 nurse is to see adult curative clients and she's being paid for that. So what we had in plan was to take Sister Lila and she must admit adult clients and see them. But unfortunately what is going on now because of the staff shortage we would need, if she must do it, then the day hospital must give us a nurse to do the pediatrics. But now the facility manager from the day hospital is against that.*
>
> - Ms Ngobela

Middle managers reported that lack of resources and own workloads made it difficult for them to follow through on their promises to contain staff anxieties at Youville CHC. The middle managers used to have a clinical component in their job description, which allowed them to stay in touch with "clinical aspects". However, the changing nature of their management tasks meant that they had very little time to spend on the clinical component of their job description, once the administrative component had been completed. The administrative workload of middle managers reportedly increased so rapidly that they were not able to attend to the practical components of their work, such as visiting and supporting managers at the frontline services.

> *And also, our workload has increased substantially. We are totally overwhelmed. In the past I could visit that place, maybe fortnightly and now if I get there once in three months that would be a lot, you know. It just shows the amount of work - it's just sort of increased. So I'm not able to have that personal contact with a lot of people. Be it the facility manager or the doctor in charge. So, we are more remote from that all the health centres. More than we were a year or two years ago. It's becoming more so all the time.*
>
> - Dr Ali

In general, the middle managers felt that they were spending too much time in meetings, while the operational side of the services, which required urgent and more attention, was neglected. They complained that the frequency of the meetings did not allow time to implement what had been decided or discussed in these meetings.

> *We average of two to three meetings per day, then one would have to prioritise which one do I go to; which one don't I go to. Things like that. It's meetings at various different levels ... It's so much so you don't get time to follow through or follow up on what decisions taken. You go from one meeting to another, not having done anything about the decisions taken at that meeting. You just going from meeting to another, and the month would fly without you knowing and then you back in the same thing. And nothing's been done about anything. So you don't have time to sit back and reflect. I mean we supposed to be managers and sit with the statistics or the budget and evaluate on one or two things.*
>
> - Dr Ali

While the managers' time was consumed with attending various meetings they were not able to be proactive with respect to problems encountered by frontline staff and managers. They only got to deal with these problems when they have reached crisis proportions. They reported high levels of stress and burnout factors among staff (which led to behavioural problems related to patient abuse, absenteeism, etc.). Thus, the middle managers' workload was filled with additional unpleasant tasks, which probably detracted from their job satisfaction. It also created an unhealthy situation where their only interactions with frontline staff were related to disciplinary procedures.

> *It [disciplinary procedure] takes days. And we have a tremendous amount, because of the burnout, the frustration at that level. People are creating more and more problems for us. To just mention operational issues.*
>
> - Dr Ali

The managers reported that their task was made considerably more difficult by the chronic problem with lack of resources in the health system. They had to manage

high workloads with few resources in terms of personal time, staff and financial resources. One manager compared his position to that of a "real manager" to illustrate the enormity and complexity of the task with which he was faced.

> *He's a real manager. He's got time to do all the management, the thinking and sitting down which is quite the opposite of what we are in. He is what a manager should be doing. And he's been remunerated accordingly. You know I can't even compare my conditions of service and my package with his. It's different ... and he's been given resources. He's got a decent looking office. He gets a transport allowance. I mean besides the salary, there are so many [other factors]. Just having a cell-phone, communication. If I get paged I might be able to respond half an hour later - as soon as I get to a public phone or something like that. No matter how urgent, it could say urgent, very urgent than sometimes I just take it easy and say when I get to public telephone, I will then phone you.*
>
> \- Dr Ali

Managers were convinced that the only solution for health services lay with the freeing up of resources, especially staff resources, to do the work. According to them thinking differently about their work would not solve the problems of service delivery, because it (service delivery) required physical labour.

> *People at a higher level seem to think we need a paradigm shift and they are giving us talks, and talks on paradigm shift and lateral thinking ... But no amount of that is really going to resolve it. Anything ... we are very negative, we are caught in our old methods of thinking and of doing things. But this is how should I say: Healthcare is labour intensive. You can't mechanise a lot of these things, you know. You need people to do these things, bandages, you can't, unlike any other industry. You can't get machines to do your work. It has to be humans doing the work that you do.*
>
> \- Dr Ali

While staff resources had been cut, the demands for services had escalated and threatened to become unmanageable in the near future with the escalation of the impact of the AIDS epidemic.

That is the major issue, the statistics show that half, more than half the deaths are from trauma and violence related issues. And those are the things that are draining the resources. I mean you would say about 30% of our patients have trauma, violence related, maybe another 30% would be chronic illness, it's becoming 30% HIV/AIDS related, so there isn't much space for all the other acute cases. You know the coughs and colds and backaches and they going to be or have to be excluded, because so much of our time is taken up with these issues - trauma related, HIV related issues. And that's draining the health resource system. You see what's happened in Makwakwa and other provinces and other countries, you know. Where every second person has AIDS in the hospital. Even at Eagles Crest [hospital] they say now, one in four patients have HIV/AIDS.

- Dr Ali

The tremendous workload on staff as a result of the increases in patient demands and staff shortages caused staff to be more vulnerable to ill-health and to take sick-leave and other leave more often to recover from work-overload. All these factors increased the burden on facility and middle managers who had to deal with these issues in order to ensure that service delivery continued (as mentioned in Chapter Two). Not only did they have to deal with the staff shortage, they were also required to deal with the staff members who stayed absent.

So they also seem down. I have had a lot of absentees on my admin results. People becoming so down and depressed ... so miserable. It's not only not being integrated, but also the workload increases and they've reduced our staff complement. And they are not going to employ any other people. And okay it's rainy weather now but once the sun comes out this place is just packed from the front to the back. And it's a heavy load on two or three people to carry.

- Ms Petersen

Facility managers also had to contend with environment issues such as concerns for the security of the building and equipment as well as their personal safety in working in crime-infested townships.

> *... but we've suffered many losses now for this past two three months. Yes, all the burglaries I was getting so frustrated I was thinking I can't take all the evil that's going on in Youville. I haven't really much aware of all the really bad things going around. We were targeted and so attacked.*
>
> *But to think that people are so cold blooded and heartless you don't know what to do. And its people that stare you in the face when they do things like that. These are people that come into this clinic. I mean we don't know when they're gonna pull out a gun on you one day. I mean I don't want to work in fear, suspect everyone that come. But sometimes we have people that walk through this place just to see what's happening here. You know that's the night we are either burgled or steal something. They steal the equipment out of the room while we are busy. All this nonsense.*
>
> - Ms Petersen

Dealing with all these operational issues demanded facility and middle managers' urgent attention, successfully depriving them of time and space at work to think about their work and apply new ways of dealing with emerging problems.

Interpersonal factors and staff attitudes

The managers reported that they had to deal with staff attitudes and personalities over which they could exercise no influence. These prevailing attitudes, it was believed, determined the measure of harmony and cooperation in the health facilities. In particular, the personalities of the facility managers shaped the way integration would occur at facility level. If their personalities were compatible, then the merger would be without any major staff conflicts.

I'm not taking particularly credit, but it could've been a normal phase and besides when two people are thrown on an island it could either work or not ... You've got to learn to work together with one another - a survivor series that we've seen. And see how people interact. And personalities and you get some person that just can't work with another person. You have that interpersonal conflict. But these people have compromised. They've learnt to work with one another. Things are working well there.

- Dr Ali

Middle managers believed that for full integration to take place, one of the facility managers needed to be willing to be the deputy. When facility managers had equally strong and dominant personalities, then conflict could arise about who should step down. Although the merger went smoothly at Youville, the two staff teams were still working separately. Ms Ngobela argued that this was because neither Ms Petersen nor Ms Kay was willing to step down and play the second-in-command role at the health center:

But I think at Youville CHC the problem is who is going to be who. Who's going to be in charge and who's going to be the deputy? I think that was the main problem that was brought up anyway at Youville. Who is going to be the boss of them?

Prevailing staff attitudes also played a role in whether staff would cooperate with integration efforts or not. As already mentioned, the day hospital staff at Youville CHC did not want to integrate at frontline level. Thus, many of management intentions were left unfulfilled.

And with the new ... because you as the manager you can be how positive, but if the staff down there don't want... And they will give you very good reasons for not integrating. And usually they've already been to the other side.

- Ms Ngobela

The managers believed that the only way to motivate staff to integrate services was by forcing them, and this could only be done with a directive from senior management.

> *And they came up with there will be no integration until they [their senior managers] give the go ahead. So it will be two, three, five, and ten years, maybe never. That's the situation. No matter how much we are gonna try and push from our side, they totally believe they must give the go ahead.*
>
> - Ms Petersen

Individual and group personal characteristics contributed to staff's level of readiness for change. At Youville CHC the clinic staff were reportedly ready for change (integration), but the day hospital staff were perceived as not. Readiness for change also influenced individual's willingness to be open to learn from the process.

> *No, it's a slow process. People sometimes are struggling to accept changes. It takes time ... I think everyone is at different stages of acceptance ...*
>
> *We also decided to have our tea times so that it can be together with the Province Health staff. We can talk and mingle, because we arranged for our times to begin at half past ten. However, all of them are already back inside working. So we never really get the chance to sit and chat.*
>
> *If I must be totally honest I think if they haven't reached that level of acceptance into the integration thinking, then the meetings will be fruitless. Because you won't get any - how can I say - genuine agreements on "we gonna go through this and whatever". Because the minute you come back there you gonna go back which is exactly the same. Because of that top structure not okay-ing the whole thing.*
>
> - Ms Petersen

According to Ms Ngobela it was hard to change people's behaviour about integration, because this was linked with their personality:

You expect things like that. There are totally different types of personalities. There is nothing you can do about it.

On the other side, personal attitude towards work contributed to managers participating in the current process despite and inspite of many shortcomings in the services, which they had to compensate for in a personal way.

No, you do love the community health services ... You've been in it. You've contributed towards this thing.
- Ms Ngobela

I am enjoying my job. I still feel you are responsible for your own happiness. You are responsible for making a happy day. If you are going to be miserable you are going to be alone miserable. We then just overlook you. But we are here to see that the patients also have fun.
- Ms Petersen

Despite the overwhelmingly positive attitude and die-hard commitment towards service delivery, managers did feel at times that what they had to offer to the community was not sufficient.

But it's a miracle that .... We are doing a lot despite that. And if you really sit down and think what are we doing, we are really doing a lot, but it's just not covering, not enough really.
- Dr Ali

In this section I discussed factors in the organisation, in service delivery, and related to interpersonal and group attitudes that affected the way participants responded to broader and frontline integration issues. These factors can be extended to make inferences on participants' experiences of the support intervention/consultation sessions/broader action research process, as they related their feelings about integration when asked about their experiences of being part of the process.

DISCUSSION

As previously mentioned (Chapter Four) perspectives from open systems theory could provide a useful framework for understanding organisations when applying psychodynamic consultancy models (Roberts, 1994a). The themes from the current reflection process point towards factors that existed on different levels within the health system that influenced the way participants perceived the current process and responded to its objectives. Figure 7 represents a simplified illustration of the various levels that influence professional behaviour of health workers within a setting such as the current one researched. The levels noted are organisational, operational, interpersonal and personal. Upon reflecting with selected participants on the process, one comes to the realisation that broader organisational level factors impact in a real way on how individual staff members react at facility level. In the current DAR process three organisational policies and processes were prominent. These were the process of amalgamation in the PHC sector, bureaucratic management structure and decision-making style, and the policy drive to widen the scope of PHC service delivery (Table 5). These organisational level factors can be correlated with emerging themes from previous action stages, which could be classified as operational issues, interpersonal dynamics or personal/individual behaviours and attitudes. I discuss the effects of various organisational level factors on the other levels, in turn.

Figure 7. Factors influencing professional behaviour

ORGANISATIONAL	***OPERATIONAL***	***INTERPERSONAL***	***INDIVIDUAL/ PERSONAL***
Amalgamation of organisations	Partial integration *[problems with conditions of service]*	Competing organisational cultures	Intentions to integrate
			Working separately *[refusal to work together on frontline]*
Bureaucratic management	Management work overload	[$] Passion for their work	Management "solutions" *[quick fixes]*
	Poor management of services	[$] Personalities of facility managers *[conflicting or compatible]*	Readiness for change *[resistance or over-eagerness]*
Wide scope of service delivery	Management under stress *[Lack of resources]*	Lack of support to staff	Aware but distant *[absence from frontline services]*
	Staff work overload *[staff shortages]*	Low staff morale	[#]Absenteeism [#]Burnout [#]Patient abuse

Table 5. Factors influencing professional behaviour in the health system

[$] Codes derived from action stage 4.
[#] Anecdotal reports from managers from action stage 1.

Amalgamation of PHC organisations

The effects of the ongoing amalgamation process permeated every level of the health system, and manifested in one form or the other in the analysis of every action stage. In the first action stage where we explored stressors in the PHC system, staff reported that partial integration (integration of frontline services), which was an interim phase in the amalgamation process, was one of the foremost causes of stress. The issue of different conditions of service was raised here, and repeated in subsequent stages. In action stage two the command for staff to integrate frontline services at Youville CHC, resulted in envy and competitiveness between the two staff teams, as described under the theme "Competing organisational cultures". In the third action stage the amalgamation process gave rise to conflicting feelings between wanting to integrate (to please managers) and continuing to work separately at facility level (to please staff).

Bureaucratic management

Health organisations are known to be bureaucratic organisations with hierarchical decision-making (Van der Walt & Swartz, 1999). In the current setting this proved to be no different. The bureaucratic management structure left middle managers with a lot of responsibilities but few decision-making powers. The result was that middle managers tended to become overburdened with their workload as seen in action stage 3. Though the workload increased continually, they had no freedom to prioritise certain tasks. Overburdened middle managers were thus not able to manage the services effectively. Despite the onerous task, management participants displayed a passion for their work and for healthcare (interpersonal level). This inner motivation propelled them to push staff to make integration work at frontline without fully acknowledging the complexity of the task faced by staff ("Management solutions" from action stage 3). They also tended to give quick-fix solutions that showed that they had little understanding of the problems that staff faced. In the absence of strong middle level management on the operational level, the personalities of facility managers became more prominent. So much so that it was openly stated that success of integration depended entirely on the personalities of the facility managers (action stage 4). Though middle managers wanted to see successful integration of health services, the outcome was now dependent on the respective facility manager's readiness to accept change and motivate staff to integrate.

Wide scope of service delivery

Given the above-mentioned scenario where middle managers in the health system seemed to have no power, the effect of increasing the scope of PHC delivery was devastating. The middle managers were placed under the tremendous stress of managing delivery of services with insufficient resources. Staff suffered from work overload (action stage 1). Middle management felt disempowered because they were not able to provide additional staff. This resulted in them not offering any support at all to staff, which in turn caused staff to become more demotivated and distressed. In the current setting we noticed how middle managers dealt with this growing crisis among staff by staying absent from the actual sites of service and only intervening when urgent attention was required. This tendency was echoed in staff staying absent from work to deal with work stress. Thus, the current research confirms the link between staff stresses and absenteeism and burnout (as evidenced in turnover), which was suggested in literature.

LIMITATIONS OF METHODOLOGY

Use of in-depth interviews

The advantages of in-depth interviews (Kvale, 1990) have already been noted elsewhere in this dissertation. The limitations thereof in the current application are well worth noting. Whereas in-depth interviews allow for free exploration of responses from participants without premature closure, which in turn leads to a wealth of new information, the flip-side of this strength is that it does not lend itself to triangulation of data across interviews. Though the interviews in the current action stage provided a wealth of information from eloquent participants, I was not always able to compare and interrogate the information obtained from different sources. Also, the use of in-depth interviews was biased in favour of participants who were more articulate. This could provide an explanation for the stark difference in length of the interviews between the two facility managers, for instance. This latter fact could also be the reason why staff interviews yielded less information than the interviews with managers. Of course it should be noted that this could also be due to the fact that the staff had simply not

been informed about the intervention. Another explanation is the fact that the interviews were not conducted in the participants' first language, which was Afrikaans.

Sample

The non-participation of key participants in the research project from the current action stage should not be underestimated. The possibility should not be excluded that these people might have been significantly more negative about the process than those who were interviewed. In particular, the resignation of one of the managers during this period might be an indication of negative feelings.

Another drawback to the process of grounded theory analysis is the fact that the management participants differed with respect to organisational affiliation and position, thus making it difficult to triangulate findings across interviews and in turn not being able to reach theoretical saturation. In this regard each interview presented new information. In hindsight it might be that another qualitative data analysis technique might have been more suited to the data collected during the current action stage.

Use of different venues

The use of different venues for staff and management participants played a role in the outcome of the interviews. Although this was understandable given the context of public PHC settings in South Africa, the effect on the amount of information obtained from these interviews was clear. Whereas management had protected time set aside for the interviews, in addition to a private venue, staff members did not have these commodities. Despite the little information that was obtained from the interviews with staff, these provided practical examples that substantiated general statements made by the managers about operational issues in the health centre.

Differing lengths of interviews

Another potential bias introduced by the chosen method of inquiry is the varying length of the interviews. More eloquent individuals were quoted more often, and influenced the analysis in a greater measure, possibly skewing the over-all picture that was created in

the findings. As already mentioned, it could be that positive effects of the intervention were overstated at the expense of the more negative aspects.

SUMMARY

The current process of reflection shed light on mixed feelings that participants had about the DAR process and its usefulness. On the one hand, the process succeeded in bringing together previously distant middle-level managers from the two health organisations. In the process they engaged with their facility managers in a different way that was experienced as both positive and constructive by facility managers. The result was improved communication and a measure of support for the difficult work that the services are called to render. Within the safety of the facilitated consultation process, we learnt more about the stresses that managers experienced in their role as link between senior management and frontline staff. Challenged by the process, the managers moved from being absent and uninvolved to becoming more empathic towards the problems faced by frontline staff. This was seen as a potentially valuable step towards problem-solving.

The myriad of organisational processes, however, posed severe threats to the objectives of the consultation process. Staff members and managers' mental energy was taken up by numerous urgent matters pertaining to the services to which they needed to attend. Thus, it seems that the boundaries that the consultation sessions created only succeeded in facilitating smoother interpersonal relations and dynamics at facility level. The lack of management boundaries and adequate containment made the action research process vulnerable to higher-level system processes and the last-mentioned contributed to the process finally coming to a halt.

CHAPTER TEN
CONCLUSION

In the final chapter I summarise the findings from various action stages and take a critical look at what was achieved through the current research process regarding developing a staff-support model and other outcomes and lessons learnt. I reflect on the methodology followed throughout and comment on the potential of psychodynamic approaches as a framework to develop support interventions in health settings. I conclude with some recommendations and points for future research.

SUMMARY OF RESEARCH FINDINGS

The purpose of the current action research process was to develop an intervention to support frontline staff in primary care in their work. In the first action stage, called "BASELINE ASSESSMENT OF STRESSORS," we interviewed middle-level managers and staff teams to find out what they experienced as the predominant stresses in the health services. In analysis, I identified strengths and weaknesses in the PHC system, as well as opportunities and threats to our proposed research project. Although informal support networks existed at facility level amongst staff members, which represented *strengths* within the system, these support systems were under threat from on-going organisational reforms (integration of PHC services and organisations), operational policies that required excessive staff movement and placement, and high staff turnover. Stressors related to integration of curative and preventive PHC services, heavy workloads, demanding patients and poor management of services presented *weaknesses* in the system. Other causes of stress such as reported lack of formal organisational and management support to staff were interpreted as *opportunities* for developmental research projects such as the one we proposed to do. However, reported low levels of morale amongst frontline staff presented a potential *threat* to our proposed research project, because this could have resulted in staff being demotivated and not interested in participating in any "outside" interventions. The outcomes from the baseline assessment of stressors gave the research team a good overview of the kind of stressors to which health workers in PHC were exposed, and the general climate in the PHC facilities. In feeding back the findings to staff and managers on respective

occasions, there were conflicting responses about the extent to which current restructuring in the PHC system really contributed to staff's experiences of stress. It was agreed that the research team would work closely with (a) selected PHC team(s) to explore the nature of the stresses they were experiencing.

In the second action stage, called "JOURNEY TOWARDS INTEGRATION," the research team followed the experiences of two PHC staff teams and their immediate managers as they prepared for and went through a merger process. This merge between a day hospital and clinic in Youville, represented on a micro- (or facility) level what was planned for the entire PHC system, namely the amalgamation of provincial curative and local authority prevention services. In consulting with these two staff teams we learnt more about their respective anxieties about integration and conflicts arising from perceived (anticipated) and real (experienced) differences in organisational cultures. These anxieties were further implicated by reports of poor management of services and pressure to deliver services under difficult circumstances. Drawing on Gilkey's (1991) understanding of psychodynamic upheaval that occurs in organisations that undergo mergers, we understood staff anxieties to be related to anticipated loss of familiar work relationships and support networks, loss of role-efficacy and lack of containment at the boundaries between the health facility and the community, and the health facility and broader organisational processes.

The action research process brought two, previously distant, management teams together and also succeeded in creating contained space where staff, especially facility managers, could express their stresses and anxieties to their managers. During the process the managers moved from being physically and emotionally absent and uninvolved with respect to problems experienced by staff initially, towards becoming more active and involved in the running of the services and solving emerging operational problems. Dynamically I interpreted management's initial position as one where they interpreted their roles as managers as being mere **links** between senior management and frontline staff. As a link they resorted to splitting off strong parts of themselves and projecting these onto senior management, who were then blamed for being too autocratic in their management style and thus unable to resolve problems at frontline. Also, management participants assumed a position of powerlessness with respect to achieving the goals of integration (of frontline services) by attributing success or failure of integration processes at facility level to the personalities of the facility

managers. Our approach to consulting was one where we did not offer solutions for managers, but rather created contained space through the process where they could safely engage in **thinking** about their work and their roles. In thinking about their work, they were moved to change behaviours previously motivated by defence mechanisms (such as staying absent from the frontline services) and move to higher levels of functioning by listening to staff, discussing possible solutions, and where the latter was not possible, communicating to staff in a way that left staff feeling contained (understood). Staff members, in turn, responded positively when their managers took an active and involved stance with respect to the problems they experienced. Their discourse changed from exclusively complaining about the stresses in the system, to working with their managers to find solutions to the practical problems that would (at that time) arose in the new work setting (the integrated health centre). Observing staff's positive responses to managers when the last-mentioned took up a more containing role, sparked the question: What could be done to motivate managers to take on a containing role towards staff under their supervision?

In the third action stage, "CONTAINING THE CONTAINERS," we explored the possibility of implementing a brief (six sessions) intervention programme, aimed at teaching participants about the concept containment, and how they could act as containers to staff anxieties. The implementation of the abovementioned programme, however, was interrupted after four sessions, due to a break in the research process. In analysis of process notes, I noted three contradictions in managers' responses, which illustrated the extremely complex position that managers were in within the health system and which posed several questions for further exploration. Firstly, managers seemed to be caught between their desires to achieve the goals of frontline integration as per instruction from senior management - and thereby, maintaining their illusory feeling of goodness - and the need to protect themselves from personal anxieties associated with amalgamation in the PHC sector (of which integration of frontline services was a frontrunner). Secondly, managers resorted to blaming senior management for their bureaucratic approach, while they were displaying the same type of behaviour when forced to provide solutions to problems faced at frontline level in the new health centre. The third contradiction was found in managers openly acknowledging for the first time in the process that they were indeed very stressed and in need of some form of containment, yet displaying behaviour (inconsistent attendance to consultation sessions) that could be interpreted as resistance

to participation in the intervention (which aimed to provide containment to them first and foremost).

Upon reflecting with participants on the consultation process (or intervention) in the final action stage, called "REFLECTIONS ON THE PROCESS," we noted several factors that were external to the developmental action research process, which influenced participants' responses to the intended intervention. These factors represented influences that operated on various levels within the PHC system, i.e. the organisational, the operational and interpersonal levels. In synthesising these findings, I noted that these influences correlated with stressors/themes reported (by participants) in the findings from previous action stages (see Table 5 on page 228).

In addition to the above-mentioned factors, internal factors related to research design and implementation may also have influenced the outcomes of the process. In the sections to follow I consider, in turn, the contributions and limitations of developmental action research as our chosen methodology, and the use of a psychodynamic approach to inform the developmental process. I conclude by re-visiting our research goal to develop a model intervention for staff-support in PHC.

THE USE OF DEVELOPMENTAL ACTION RESEARCH

As already mentioned, action research involves two central processes, namely participation, and development of intervention(s) through repeated processes of planning, implementation and evaluation (Greenwood & Levin, 1998). The contributions and limitations to the action research approach are discussed in terms of its ability to draw participants from various levels, and to facilitate the development of a model for staff-support intervention.

Participation and collaboration

Throughout the current research we consulted with various health managers in deciding on the next research action to be taken. This allowed the Caring for Caregivers project to remain close to processes that took place within the various intervention sites, as well as broader organisational processes that impacted on health managers' sense of priorities. One example of a fruitful outcome from partnership with service managers is

what we experienced initially (in action stage 1) with City Health management. Not only were we able to gain their collaboration with respect to the proposed project, we were also able to connect our project goals with an issue that they themselves identified and set as a priority for that financial year, namely, improving staff morale. In planning and implementation of further action stages we were able to adapt the focus of intervention to the experienced realities that existed within the research setting. In action stage two, for example, we inadvertently focused the intervention on facilitating improved communication between staff and middle management across both health organisations.

The current DAR process succeeded in making some impression on stresses emanating from the operational level in the health system (see Figure 7 on page 227 and Table 5 on page 228). The consultation process brought middle managers and staff together to discuss aspects of service delivery (operational issues) in the new health centre, where integration of frontline services was intended to take place. In the forum that was created in the consultation process participants were able to relate their grievances about the way health services and the integration process were managed and, in doing so, finding the opportunity to challenge their managers to become involved in operational issues. Providing space for the necessary communication between frontline staff and managers, the action research process improved communication in the system by moving managers from being absent or uninvolved towards becoming active and involved in operational issues regarding integration as discussed in *Journey towards integration*.

Limitations

However, it should be noted that participation in itself is not a magic pill that provides solutions, as Campbell (2003) found in her community HIV prevention project. The absence of participants on senior management and client/community levels limited the usefulness of the current DAR process in addressing issues that existed on these two levels. The absence of these two parties could be seen as critical, as the data indicated that about 50 per cent of staff's stresses emanated from interaction with broader organisational processes and a demanding public. The absence of senior managers from the current process represented a missed opportunity to intervene on *all* levels of communication that (should) exist within a health organisation. Firstly, if senior managers were involved in the process, we might have been able to negotiate stable

boundaries wherein the intervention could take place. Secondly, the effects of senior management approval of and measure of participation in the DAR process, might have facilitated quite a different response from participating staff and middle managers. Their presence might have provided an opportunity to address certain stressors in the health system (such as complaints about the bureaucratic management style), and to negotiate a measure of stability with respect to staff movements and organisational processes (especially relating to integration of frontline services). Lastly, the possible presence of senior managers in some consultation sessions might in some ways have allayed staff fears and anxieties about the outcomes of the organisational restructuring process.

Although the research process started with the question that revolved around patient-care, the emphasis shifted towards exploring the interactions amongst respective staff teams and between staff and management. The stresses that staff experienced with respect to patient demands pointed to open boundaries that existed between the health facility and the community. Interventions to address these anxieties would involve two levels, namely management containment at the boundary and patient-provider relations. The current process focused exclusively on the first-mentioned mode of intervention, thus not exploring dynamics between patients and health workers at all. I will take this point further in the discussion on DAR's contributions to developing an intervention model in the next section.

Developing an intervention

Whereas the DAR process facilitated the improvement of communication in the system, in the approach that we followed, we did not offer solutions to the operational problems experienced within the health setting. The research team was intentional in not offering solutions, as we wanted to empower the participants to find solutions themselves so that they could see the potential of replicating the communication process in the absence of external consultants. However, in doing this, we may have missed opportunities to bring further insights that may have helped managers and staff to introduce immediate improvements in service delivery. One might argue that this does not constitute a limitation of the method, as one of the objectives of the project was to develop an intervention that would be sustainable and replicable in other settings within the health system and that does not require consistent outside intervention. Another

argument is that the current DAR method aligns itself with the chosen psychodynamic approach to developing and implementing interventions in staff-support.

THE USEFULNESS OF A PSYCHODYNAMIC APPROACH

The psychodynamic approach was very useful in helping to understand relational dynamics within the health setting under research and how specific stressors contributed to experiences of anxiety within individuals. In action stage two, for example, I drew on insights from Eriksson's theory of psychosocial stages of development as applied by Gilkey (1991) on psychodynamics of upheaval in organisational mergers, to understand how staff in the current research experienced the anticipated merger. I also drew on Kleinian concepts such as splitting and projection, to inform possible interpretations of how and why managers detatched themselves from frontline services. Insights such as mentioned above were used to inform or formulate possible areas for intervention.

By using psychoanalytic theory I was able to link observable behaviour of participants to possible deeper level psychological processes that may have caused anxiety amongst staff teams, and that were possibly shared amongst individual staff members. The psychodynamic approach was particularly useful in understanding dynamics between staff and managers, amongst staff members, and across organisations. Aspects of these relationships caused stress and anxiety amongst participants, and by bringing awareness of these feelings, participants moved to higher levels of "work" functioning (cf. Bion, 1961), if changes in dialogue could be regarded as indicators of change in work behaviour.

Interpretations from action stage two were used to inform the intervention that we developed and implemented in the third action stage. One could argue that since the intended "containing the containers" intervention programme was not completed, it would not be fair to make any postulations about its potential for success. On the other hand, the fact that the process was aborted, may give some indication of the difficulties that one is likely to experience when seeking to apply psychoanalytically-informed interventions in highly technical environments such as the healthcare system.

Limitations

One of the mentioned drawbacks to the psychodynamic approach consultation sessions was that it was difficult for participants to understand what the "intervention" was seeking to achieve in terms of objectives. In the current context it was not clear whether this related to some participants being absent from critical (for understanding the process) sessions. Whether this is true or not, the fact remained that participants who did attend all the sessions were not sure what the objectives of the consultation sessions were. This could be due to the disruption in the research team itself (by the introduction of an alternative thinking consultant). In other words, this could have possibly contributed to an inconsistent message being conveyed to participants during the sessions. However, difficulties could also be related to interventions that follow the non-directive process described by Bion (1961) in *Experiences in Groups*.

Another real concern about the usefulness of psychodynamic consultation is its reported difficulty in implementing conveyed concepts in real life situations. Elsewhere it has been noted that participants who attended psychoanalytically informed consultations returned to their work place with an increased awareness of unconscious aspects, but were frustrated that these were not readily accepted by others (Mosse & Roberts, 1994). In this sense the current intervention sought to involve the entire health team in order to cultivate the same verbal culture and awareness among members. Due to the nature of the process we turned the focus onto the management team, and thus did not follow through on initial plans to work with the frontline staff.

A last criticism about psychodynamic consultation is its apparent inability to deal with broader influences. This remains a vital point to all interventions. In the current context we felt it wise to focus the intervention on aspects over which we had control and to stick with our original research objectives. In this, the effects of broader organisational processes on the behaviour of staff were underestimated.

"CARING FOR" CAREGIVERS?

The current research process highlights the dilemma in health care around the issue of care, what it is and how various parties define it. The research team started out with the notion of nurses as professional caregivers providing care to patients, and engaged in

the research process to develop an intervention aimed at supporting nurses (as part of PHC teams). Simplistically stated, the intervention was about caring for nurses so that they would be caring to patients. However, in nursing one can distinguish between "caring for" and "caring about" patients (Green, 2004). *Caring for* refers to fulfilling the technical requirements of giving medical care. The outcome of being *cared for* is that you have received your health care - treatment, medication, education or referral to higher level of care. *Caring about* refers to establishing caring relationships with patients and/or tailoring technical aspects of health care to the lifestyle of the patient/client to enhance adherence and promote health (Lewin, et al., 2004). In literature *caring about* is often referred to as giving patient-centred care. In Chapter Two I have argued that *caring for* occurs more frequent in health services, because this approach allows health workers to remain more detached from clients and patients and aspects of their lives pertaining to their illness or health. This rhetoric (caring for and caring about) can also be extended to the way organisations and managers view their function and obligation in terms of supporting staff.

In the current research we observed that managers saw themselves as *caring for* staff, when they attended to operational problems in the facility, i.e. arranging for relief staff, equipment, drugs, and other resources for service delivery. However, this was in essence managers' taking care of aspects of service delivery rather than of staff! From staff responses it was clear that this was an important step in supporting staff. However, this level of intervention on its own would not take way staff anxieties. From literature it is clear that management has a tendency to prefer direct approaches to dealing with specific stressors in the setting or with individuals who have been identified as being severely distressed (Van Wyk, et al., 2004). These programmes, it could be reasoned, are chosen because they allow management to show that the organisation *cares for* staff, while evading their responsibility to *care about* staff, thus reducing their role as mere links between senior management and frontline staff.

The goal of the current action research process, though not clearly stated, was to develop an intervention to *care about* staff in addition to *caring for* staff. In other words, we wanted the support intervention to deal with psychological aspects of work as well as related technical aspects such as organisation of work. Management understood the staff-support intervention to be about *caring for* staff or more precisely, service delivery. Thus, for instance, when the two health teams moved in at the new health centre and

continued their work, the managers viewed the intervention as successful, because service delivery, though still separate, was running smoothly. This difference in understanding of what type of caring the intervention was really focused on, limited the usefulness of the current action research process to produce an intervention that would deal with all aspects of health workers' needs.

The current DAR process started out with the assumption that caring for staff may cause them to be more caring to patients. However, in the course of the process it became clear that the notion of (staff) feeling cared for is very complex and requires specific and extensive research on its own, before the link between cared for and being caring to is explored. This brings us back to the issue of support. What type of support would then be useful? And what can we learn from the current research process about support interventions?

TOWARDS A MODEL FOR STAFF-SUPPORT

From the literature we understand that stressors occur on different levels within an organisation. This means that staff-support interventions need to target interactions that occur on and between all levels in the system. The current action research process shows that following a psychodynamic approach is useful in intervening with respect to aspects on operational and interpersonal levels within the health system. However, the abovementioned process was not able to deal with organisational influences or intervene with respect to stresses arising on the provider-patient level. Thus, future staff-support interventions that follow the abovementioned approach would do better to include senior management representatives in some way in the process. There are different ways to involve them besides having them sit in on consultation sessions with staff and middle managers, which may not be possible to achieve and, which may also introduce new dynamics that pose different challenges to facilitation of the process.

The research process with all its changes shows that any approach to interventions in health systems needs to take careful account of structural issues in the organizational provision of healthy care. Indeed, it is a basic principle of the concept of containment that structural issues such as consistency of staff, workplace and workplace expectations should ideally be dealt with as a framework within which there is a safe space for psychological exploration and change. A major difficulty with the health system at the

time we worked within it was that there was little predictability and consistency, and less than clear direction from management about work expectations. For psychodynamic interventions to work best – indeed, for any interventions to work best – the basic infrastructure of a consistent and predictable workplace needs to be built. This is a key message from the current study. We made a valiant attempt to provide the best possible intervention but did not have control over the broader work environment. Psychodynamic theory is often misinterpreted as thinking only of psychological issues in a contextual way; the current study builds on the tradition of psychodynamic work in organizations which looks as well at the organizational framework necessary for such work.

A second gap in the current process is the lack of attention paid to the patient-provider interactions, even though these emerged repeatedly as one of the stressors reported by staff. Future development processes (research) should include participant-observations in the health settings as well as interactions with the community (i.e. health committee meetings with the community) to explore areas of intervention on this level. A particular challenge to developing staff-support interventions is dealing with individual or personal level factors. The current research process purposely did not seek to explore this level, although recognizing that these factors play a role. Instead we hoped to deal with individual unconscious processes as these manifest and resonant in group behaviour. Although this approach has been argued to be sufficient in dealing with psychological processes, the issue of individual competencies should still be addressed. In this respect, it may be useful to complement psychodynamic consultation processes with stress management training programmes to increase skills and competencies to deal with stress amongst staff in the short to medium term, and management training to increase management skills amongst facility and middle managers.

To summarise, a staff-support model should intervene on organisational, operational, interpersonal and individual/personal levels. Psychodynamic action research is useful to develop interventions on the operational and interpersonal levels, but should be extended to include representation from senior management level, or at least some form of boundary negotiated to manage (contain) influences of organisational processes. In addition, skills-building programmes for health workers and managers should be included to increase competency to deal with stresses and challenges as a short-term solution.

RECOMMENDATIONS FOR FURTHER RESEARCH

A point for further research is the methodological issue of how organizational and operational processes could be contained and changes kept to a minimum while the developmental action research process is on-going. In order to develop staff-support interventions the goals for staff empowerment should be kept stable for long enough to allow participants to engage in exploring factors that cause anxiety, thinking about alternate ways to deal with stress experience and to experiment with new behavioural responses. In the previous section a few possibilities of how senior management could be involved in the action research process were explored. All of these possibilities need to be implemented in real-life research to inform methodology in action research.

The issue of low morale or lack of worker motivation needs to be addressed in health systems research (HSR). Traditionally, HSR focusses only on motivation amongst frontline staff (health workers). Aspects of motivation amongst health managers have not been researched. Our current research process was based on the presumption that managers would be motivated enough to participate in the process (provided that they felt safe enough with the process). Successes in the current development process seemed to be associated with participating managers' passion for service delivery, which stemmed from their predominantly clinical orientation rather than management competencies. However, the clinical orientation contributed to resistance to the process, when aspects of service delivery were not directly addressed or where intervention goals did not speak to aspects of service delivery in direct ways. Thus, future research should look into aspects of "management motivation" in health sectors in addition to worker motivation.

Another aspect for further research is that of how psychodynamic interventions or processes could deal with "difficult" or unmotivated participants. In the current research we had different responses from the two facility managers to the same process. These differences seemed to be related to their different personalities as well as work orientations. Menzies (1960) had a similar response when she presented the findings of her analysis to the nursing staff managers in the hospital. The critical question in psychodynamic consultancy to organisations is why awareness of causes of anxiety does not consistently lead or motivate individuals to change behaviour. In individual

psychoanalysis it is accepted that not every person is open to analysis. When applying pscyhoanalytic principles to groups, the question is then what amount of "openness" or acceptability is needed within the group or its members to benefit from psychodynamic interventions. The issue of motivation among health professionals is an area that has triggered research in HSR, as indicated by Zwarenstein and Bryant (2004). However, research has focused on professional behaviour regarding their clinical work without integrating psychological aspects of work.

The health services that were researched in the current process could be classified as "middle range" in terms of resources. The health facilities were situated in a predominantly coloured, low-income township in the Western Cape, which was fairly typical of health facilities of this type in the province. However, the HIV prevalence had not yet impacted these services in the way it had in other CHCs in the province. It would be interesting to explore whether stressors encountered in the current setting presented in the same way in areas where the HIV epidemic was more severe.

The current research process was an ambitious attempt to use psychoanalytic concepts to develop interventions in a setting that is clinically orientated. Although findings from the current research could not be assumed to apply to the whole range of public PHC services in the country, insights about the dynamics and relations between staff and management may apply to other settings. Similar research processes, using a psychodynamic approach to analysing professional behaviour in PHC, may add to the current understanding of health worker motivation as well as those of other role-players in health services organisations.

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ADDENDA

ADDENDUM A

Coding list[9] for Action stage 1: Baseline assessment of stressors

Threats (Low morale)

Demotivated
Effects
Low morale
burnout

Opportunities (Lack of support)

Loss of relationship
EAP
Unsupportive managers
Limitations on managers' support

Weaknesses (Stressors)

Workload/
- Staff shortage
- Turnover
- Free health care

Integration of services/
- Organisational culture
- Change in work
- Separation
- Staff relations
- Conditions of service
- Uncertainties
- Staff diversity

Demanding patients/
- health committees
- abusive patients
- community expectations
- media
- politicised community

[9] Note: Atlas.ti not used as tool to do analysis of transcript data.

ADDENDUM B

Code list for Action stage 2: Journey towards integration

Manager Responses/
- absence
- empathy - stressors
- empathy - support
- integration
- integration example
- manage change - communication
- manage change - contain
- manage change - DMT
- manage change - org diff
- manage change - shadow team
- new managers
- new managers - learn
- plans
- plans - chronic's
- plans - flexitime
- plans - reception
- workload
- workload - resources

Organisational/
- culture
- distrust
- nature of work

Staff response/working together

Staff stressors/
- building
- building - dispute
- bureaucratic management
- community demands
- job descriptions
- lack of resources
- partial integration
- staff movement
- staff shortage
- unsupportive management

Support/
- coping
- need

ADDENDUM C

Code list for Action stage 3: Containing the containers

evaluation/
- containment
- relationships

integrate/
- personalities
- broader
- culture
- problemsolve
- retention
- roles
- staff

M[10]: distant/
- absence
- bureaucrasy
- closure
- new

M: stress/
- conditions
- container
- scapegoat

MR[11]: acknowledge/
- building
- communication
- workload

MR: communication/report

MR: contained

MR: solution/
- community forum
- meet
- party
- spread patients

MR: team

S[12]: separate/
- conditions
- party postponed
- tolerance
- workload

[10] M = Management

[11] MR = Manager response

[12] S = Staff behaviour

ADDENDUM D

Code list for Action stage 4: Reflections on the process

amalgamation/
- consultants
- lack of resources
- scope of services
- turnover

integration/
- conditions
- personalities
- planning
- problems
- racial
- readiness
- communication

intervention/
- effects
- ignorant
- management meet
- resource
- staff resistance
- support
- timing

management workload/
- clinical
- increase
- meetings
- passion
- real manager
- resources
- service demand

separation/
- management
- work
- work - load
- work - promotion
- work - refer

stressor/
- setting
- workload
- workload - absenteeism
- workload - staffing

support/
- management forum
- managers
- venting