

**UNDERSTANDING WOMEN'S INVOLVEMENT IN PRIMARY HEALTH CARE: A  
CASE STUDY OF KHAYELITSHA (CAPE TOWN)**



**UNIVERSITY *of the*  
WESTERN CAPE**

**By**

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## ABSTRACT

Women are the principle providers of their families when it comes to issues of health care, even though their health needs and efforts are neglected. The contributions that they make to health development seem to be undervalued, and their working conditions ignored. Societies depend heavily on women as role players in the welfare of their families and of national economics together with their physical well-being which determines the ability to be productive. The study has provided an overview of the experiences of women concerning primary health care and the quality of service in Nolungile PHC Khayelitsha, Cape Town. Primary health care (PHC) forms an integral part both of the country's health system and the overall social and economic development of the community. Central to the PHC approach is full community participation in the planning, provision, control and monitoring of services. Priority has to be given to the improvement of women's social and economic status.

A much neglected perspective in health issues is that, a number of questions arise from the provision of PHC. Does PHC rely on the contribution of women and if so, why women? Women in their communities have joined their hands together as community health workers, educating community members on issues of health. The study has provided an insight of the work that women are doing in their communities, and how do they give meaning to their experiences in PHC. The study also answered questions that raise fundamental issues on gender stereotyping and disparities in PHC. The study gave me an opportunity to work closely with the women while observing the challenges that they are facing and how to they overcome them in the daily lives. Changes are called towards the attitudes of health care providers working in the formal and non-formal sectors. The provision of health education for women ultimately empowers them as health educators for the community.

**KEYWORDS:**

Primary health care

Health care

Women

Gender inequality

Gender stereotyping

Health care providers

Participants

Community health worker

Khayelitsha

Experiences



## DECLARATION

I, Julia Mamosiuoa Kali, declare that “**Understanding women’s involvement in primary health care: A case study of Khayelitsha (Cape Town)**” is my own work and has not previously been submitted at any university. All the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature..... Date .....





## DEDICATION

I dedicate this thesis to my family: mother Masebalo Evelyn Kali, Late father Bernard Kali, my daughter Thabelang Vanessa Kali and my younger brothers Selebalo Kali & Liteboho Kali



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GOD BLESS YOU ALL!

## ACRONYMS

PHC	Primary Health Care
CHW	Community Health Workers
WHO	World Health Organization
UNICEF	United Nations Children's Fund
MDG	Millennium Development Goals
DOH	Department of Health
PHM	People's Health Movement
DOT	Directly Observed Treatment
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organization
USSR	Union of Soviet Socialist Republics
DFID	Department for International Development
CHBC	Community Home Based Care
TB	Tuberculosis
FGD	Focus Group Discussions
SPSS	Statistical Package for the Social Sciences
UWC	University of the Western Cape
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drugs

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# CHAPTER ONE

## 1. INTRODUCTION

### 1.1 Background

Primary Health Care (PHC) forms the bedrock of health care provision in South Africa and was mainstreamed in 1994. The broad guidelines for PHC worldwide was determined at the Alma-Ata conference and involves essential 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. PHC aims are to maintain reliance and self-determination concerning issues of health and illness in communities (Dennill *et al.* 1995). In policy documents, and on paper, the PHC approach sounds logical and practical. Yet, it makes some unexpressed assumptions, for example, that many poor women will be able and willing to take up a wide variety of the responsibilities, work and care for their families and wider communities. According to a joint operation by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) the PHC approach has become the world's most well-known and accepted strategy of health (Shay and Sanders 2008).

Yet it has problems, and new programmes, for example, the People's Health Movement (PHM)<sup>1</sup>, have been trying to fill some of the missing gaps. PHM which recently had its conference at the University of the Western Cape from 6<sup>th</sup> to 11<sup>th</sup> July 2012 The People's Health Movement works towards the revitalisation of PHC to address the social determinants of health, in particular, the growing inequity within and between nations. These are mostly due to uneven and sometimes unfair economic structures which lock people into poverty and poor health. The PHM defines health as a social, economic and political issue and emphasizes health as a fundamental human right. It is committed to making Alma-Ata goals a reality of reaching health for all (Shuftan *et al.* 2009).

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<sup>1</sup> The People's Health Movement (PHM) had a conference at the University of the Western Cape from 6<sup>th</sup> to 11<sup>th</sup> July 2012.



PHC encompasses eight basic elements: health education, adequate nutrition, safe water and sanitation, mother/child care and family planning, immunization, prevention of local epidemics, treatment of common diseases and essential drugs supply. Since the PHC approach has not been as implemented as hoped, much of the “work” involved in the basic elements has largely become those of rural and poor urban women in sub-Saharan Africa. In this regard Dennill *et al.* (1995) reiterates that, while the aim of the primary health care was to approach universally available health care and to attain “health for all by the year 2000”, this objective was not achieved. Consequently, the Director General of WHO, Margaret Chan, called in 2007 for renewed emphasis on PHC as an approach to boost health systems, and as basis for the achievement of health related Millennium Development Goals (MDGs).

This thesis interrogates PHC in South Africa almost three decades later. To do so, I look at it through the lens of the experiences of women who “perform” a great deal of the essential work of PHC in a Cape Town township. It is nevertheless important to also keep in mind that PHC policy and its implementation has underlying assumptions. In this regard Yanow (1992) stresses that there are always contending interpretations and experiences of policy. Groups like policy makers, implementers and “clients” often have their own ideas, values, and practices about policy and give meaning to it in different ways. In this regard it is important that, in the provision of PHC, women have often been articulated as a resource (Pizurki *et al.* 1987). At the same time PHC is also frequently presented as a way to address women’s sexual and reproductive health problems (Allotey 2005). PHC has thus been presented as having inbuilt strategies that promote the health of women and that of their families, while simultaneously assuming that women can carry the burden of much PHC work, especially in under resourced settings.

My interest lies in the fact that, in South Africa, women largely form the unacknowledged backbone of the Primary Health Care approach in terms of health education, prevention and care within households and families. PHC is regarded as women’s work. Not surprisingly, most of the paid and unpaid workers in primary health care are women. They are also the main focus of health instruction and intervention: they are expected to provide and prepare nutritious meals, fetch, carry and store water for cooking, washing and maintaining cleanliness. They must care for children and see that they are immunized. Women must take responsibility for the sick and

elderly. They are also expected to plan their families and the number of children they will have. This is because women are frequently viewed as the main health care providers and 'care takers' within families. Women are also the major group that utilizes PHC, although often on behalf of others such as children, the sick and the elderly. This is the case, even though men often have more power and access to resources than women (WHO 2010).

The focal point of this thesis relates to women's involvement in primary health experiences and health promoting work. In this regard I surmise that PHC, despite its apparent focus on men and women, is gendered. Because most of the unpaid work and volunteering in health issues is mainly done by women, it is rare where by males can volunteer to look after the sick and care for them. I investigated the roles and understandings of women the eight basic 'elements' of PHC as set out by the WHO (as mentioned above). In urban areas in South Africa there is a high prevalence of female headed households, and of households where men might be the *de jure*, but not *de facto* heads because they are not present in the households for most of the time (Battersby 2011:4). Many everyday decisions, as well as the many tasks, responsibilities and concerns related to Primary Health Care are often those of women. At the same time the outcomes of PHC for women remain unclear. What is known is that women often have to carry the burden of community care at a time when PHC is underfunded and understaffed. Low funding for primary care institutions and by extension, community health care structures, where women are the majority, has also had detrimental implications for them. There has often been lack of programme continuity as well, while gender stereotypes and other cultural barriers for women continue (Ncube 2007).

Furthermore, while studies have been done on women as home based care givers for example human immunodeficiency virus (HIV) sufferers, as Directly Observed Treatment (DOTs) workers and such, there are few anthropological studies on women and primary health care in general in an urban setting (Gibson 2000; Lund 2010; Pellizzo 2011; Thakur *et al.* 2009). In this regard Coreil and Mull's (1991) edited volume, anthropology and primary health care, is one of the few publications that stresses an (applied) medical anthropology approach to research, and interventions, in this field. It emphasises the importance of culturally informed and sensitive approaches to PHC and gives examples in this regard from a number of case studies in the field.

While informative, this kind of work assumes that the researchers anthropologists are “outsiders” and not local. A multi-level approach to anthropological studies of PHC was promoted by Van der Geest *et al.* (1990). This approach emphasises the importance of research on perceptions of PHC and its implementation at different levels of social organization such as international agencies, national governments, regional centres of health care and in local communities. This, the authors argued, will give insight into the various interest that are involved in, and even compete in relation to, not only PHC planning but also its implementation and execution. Such an approach makes it possible to understand why and how PHC succeeds or fails. The authors suggested a multi-level research approach which involves the following: vertical as opposed to horizontal organization of PHC; the role of medical personnel, distribution of pharmaceuticals, integration of traditional medicine and family planning in PHC. A collection by Castro and Singer (2004) critically examines the nature of health policy internationally. They interrogate processes of decision-making, issues and factors that influence decision-makers, and, most of all, the impact of policy on human lives. While health policies aim to promote public health, they often, in reality, represent significant structural threats to the health and well-being of the poor, ethnic minorities, women, and other subordinate groups. In the South African setting Kirsten *et al.* (2009) emphasized the need for more anthropological work in PHC. The authors argued for an eco-systemic approach and a move away from the focus on health per se to that of health/wellness instead. Such an approach is more holistic and not premised on the absence of disease.

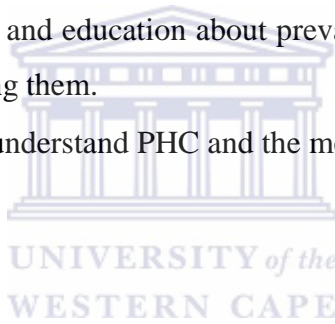
One aim of my own study is to at least partially contribute to filling this gap on anthropological research on PHC and especially on the involvement of women. This is because often they carry the burden of community health care at a time when health systems in general are failing to cope. In addition, primary health care has low status and prestige because it is perceived as a job for women. Women are not necessarily remunerated for the primary health services they provide in their communities, and are mostly volunteers. Women are the main focus of health instruction and intervention especially in relation to nutrition, access to safe water, good sanitation, mother/child care, family planning and immunization. Most daily decisions concerning PHC are often made by a woman and for this reason the study will have particular significance for women as clients of PHC from an anthropological point of view.

## 2. AIMS OF THE STUDY

I want to understand PHC from the experience of women on a day-to-day basis, to tease out not only the many things they do, but also its meanings and implications for them. The purpose of the study was to gain better insight into the gendered aspects of primary health care, specifically with a focus on the understandings, meanings and work women do in PHC in Khayelitsha, Cape Town. Primary health care relies heavily on the contributions of women, particularly in the area of health education and care: they often act as community health workers as well. In this study I had the following aims:

- To ascertain what women do in their communities in connection to the basic elements of PHC, comprising adequate supply of safe water and basic sanitation, promotion of food supply and proper nutrition and education about prevailing health problems and methods of prevention and controlling them.
- To determine how women understand PHC and the meaning they give to it.

## 3. THINKING THROUGH PHC



Women, PHC and its related policies can be theorized in a number of ways in medical anthropology. This sub-discipline is largely multidisciplinary, linking anthropology, sociology, economics, and geography, as well as to medicine, nursing, public health, women and gender studies etc (Janes 2005; Levinson and Ember 1996). In this regard, I attend to local understandings, practices, and ideas etcetera that promote, maintain or contribute to strategies and practices that women developed in their local contexts in order to deal with diseases and illnesses. The focus of my study lies in understanding women's involvement in primary health care. According to Brown (2001) women and men experience health and illness differently but are often treated the same by the health care services. Brown (2001) further stresses that women's and men's health issues and needs should be approached in a complementary way. The author recommends that, rather than a constant emphasis on statistics about women's limited access to services and their poor health status, it is of importance to think in terms of a gendered

approach to health (Brown 2001). In this thesis, I accordingly look at the work that women do in relation to PHC in an urban, low socio-economic setting.

Although this is not a focus of my study it is of import to acknowledge that PHC policy makes sense of, underscore, weaken or harden gender in practice. In most policy documents on health, gender represents fairly inflexible “categorical” understandings of it and mostly focus on disparities between women and men as groups. Gender itself remains unexamined, while categories and their statistical differences to all intents become “the meaning of gender” (Connell 2012:1675). Such “categorical thinking” does not conceptualise gender dynamics, historical processes or the creation and maintenance of gender orders and inequalities, except in very superficial ways: i.e. in relation to educational differences, economic factors, “cultural” issues or change, etc. According to Yanow (1992), policy makers form a kind of community or group, including, for instance, medical specialists, non-governmental organization (NGO’s), reproductive or HIV rights activists and other ‘stakeholders’ who frequently interact around and communicate in relation to policy. Although such communities may be fluid, they nonetheless develop and share similar meanings and understandings and use similar language.

For the purpose of the study one possible approach was to utilize the concept of mainstreaming a gendered perspective – also very popular in relation to health policy. Brown (2001) explains gender mainstreaming as the process of assessing the implication for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. Such an approach supposedly makes women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres. The ultimate goal is to enhance gender equality. The approach nevertheless largely tends to think of men as groups and women as groups.

In contrast, poststructuralist theory explores the cultural dimension of health and illness, but also of PHC for instance (Lupton 2003). Policy is understood as discursively constructed, while simultaneously constituting particular interests (Bacchi 2009). Poststructuralism is of import in much gender, queer and transgender activism, and efforts which attempt to destabilise discursive norms and to alter subject positions. Yet, policies are highly normative and often prescribe actions. In this regard poststructuralist approach does not give much insight into forms of

power that are non-discursive, material concerns or gender dynamics in the health political economy (Connell 2012).

Connell (2012) instead suggests relational approaches to gender, i.e. interrogating it as a multifaceted structure that operates in an intricate network of institutions. Such an approach understands gender as embodied and interlinked with a history of colonialism, current globalization, and the construction of gendered institutions, such as PHC. Gender is thus an active social process that generates, e.g. gendered health assumptions and outcomes in “the making of gender itself” (*ibid*: 1676). A relational approach to gender makes it possible to also acknowledge many contradictions. For instance the institutional settings through which PHC is delivered, has regimes of gender, which affects the planning of PHC and frequently marginalise women or make assumptions about their availability as informal care providers.



#### 4. SETTING THE SCENE: HISTORY



*The star represents Khayelitsha where the research was conducted.*

As indicated above, my study was situated in Khayelitsha. It is one of the many Cape Flats townships and means “new home”. In 1990, the population of Khayelitsha increased to 450.000 as migrants from the Eastern Cape moved to Cape Town. At the time the unemployment rate was high at 80%. Only 14% of the people lived in core housing, with 54% in serviced shacks and 32% in unserviced areas. By 1995 the population of Khayelitsha was over half a million. The majority of Khayelitsha’s present population consists of people who have recently relocated to the city, mostly from the Eastern Cape. People who have moved to Khayelitsha from older residential areas such as Langa, Nyanga and Gugulethu are frequently third and fourth generation Capetonians (Lingeletu West City Council, 1992). According to the Department of Statistics, the 2001 census recorded the size of Khayelitsha population at 329002 people living in 85614



households. This compares to 1996 figure of 249540 implying a growth rate of 5.3% per annum between 1996 and 2001.

The townships of sites of Langa, Nyanga and Gugulethu were allocated to black South Africans by the Minister of Co-operation and Development of apartheid era in 1980. These areas were made up of single quarters for black Africans and contract migrant workers who were registered by the Western Cape Administration Board. Single quarters were built to accommodate exclusively male migrant labourers from the former 'Bantustans' of Transkei and Ciskei. Later the contract workers were joined by their families: they often lived with them in the single quarters (Volume 3 of the Surplus People Project Report 1983). Rampele's (1993) study on life in migrant labour hostels, for instance, showed how concepts of space shifted for labourers as they tried to live under such constraining conditions.

Site C in Khayelitsha emerged as an informal settlement area of families migrating from the Eastern Cape. Poverty is pervasive and living standards are well below the national poverty line. The Western Cape has been faced serious housing crisis since the early 1980's. This was because the Western Cape was a "*Colored*" Labour Preferential Area (African people of mixed races), and the influx of people from the Eastern Cape was controlled by harsh measures. Nonetheless Khayelitsha Township was established in 1983 and grew rapidly thereafter (Mangwana 1990). In February 1983 people from the overcrowded township houses in Langa, Nyanga and Gugulethu began to occupy illegally a vacant tract of land between Nyanga and Gugulethu opposite New Crossroads. Others rapidly joined them. Many of these residents were "*illegal*" according to apartheid rules in Cape Town. Demolition of their shacks by the apartheid force machinery followed and the residents were forced to move to Khayelitsha. In March 1983 Dr Piet Koornhof, then Minister of Rural Relations, announced that a black township at Swartklip, (east of the "*colored*" township of Mitchell's Plain) would be developed. This was the beginning of a new housing development called Khayelitsha. It was meant to house '*legal*' informal settlement residents in core houses and '*illegal*' informal settlement residents on 'site and serviced' land. The original plan to move '*illegal*' informal settlement residents living in and around Old New Crossroads to Khayelitsha never occurred and the area became a symbol of black poverty and resistance to resettlement. Residents of Crossroads refused to budge, and the controversial



decision to clear the old townships was eventually dropped (Lingeletu West City Council 1992).

#### **4.1 Population**

According to a survey done in Khayelitsha for the City of Cape Town (2006), 65% of the population is younger than 30 years, with most being between 20 to 24 years of age. The second largest age group falls between 15 to 19 years. A very small percentage (2%) is over the age of 65. The largest groups of people living in Khayelitsha are females (56%), with 44% being male. Households include four people on average with a median income of R1 606 per month. The unemployment rate is 48%. The vast majority (95%) of residents are isiXhosa speaking people.

#### **4.2 Sanitation and garbage collection**

A formal sewage system exists in the formal sector of Site C. Khayelitsha Site C has no storm water drainage and therefore is prone to flooding, particularly during the wet winter months. At present each dwelling in Site C has got its own flush toilet and a tap outside the house next to the toilet. In the early years there were taps on the streets, scattered all over the settlement to be shared by a number of dwellings. These taps are still used by people who stay in shacks (Rendall *et al.* 1999).

Garbage collection happens once a week. The people of Site C have designated empty spaces between the houses to store garbage for collection, but many people throw garbage outside. Sometimes residents burn the garbage. The rains wash the garbage to the houses, the strong winds blow and scatter it, and the heaps of decaying produce leave bad smell all over the area. When garbage is burnt the whole area is filled with smoke.

#### **4.3 Hospitals and clinics**

Site C is serviced by Nolungile day clinic. Clinics run in the area run by the University of Cape Town's Community Health Project also operate in the area. The Nolungile clinic can refer clients to clinics in other sections like Site B, Harare and Town 2. There is a community development

centre in Site C where people from the community are trained as volunteer health workers. Approximately 50 such workers operate mainly in Site B. There is also a mobile tuberculosis clinic at Site C. The Regional Services Council runs them. Approximately forty private doctors operate from surgeries mostly located in the middle-income group areas as well as some dentists and pharmacists (Lingeletu West City Council 1992).

Some 500-600 people per month attend the Site C clinic, of whom some 230-350 are females, and some 140-200 are males. Women often attend the clinic on behalf of others for example to take their children for immunizations and also take their loved ones to hospital. Every day in the clinic, prior to consultation, nursing staff conducts a health education workshop, which takes at least 20 to 30 minutes (Community Health Worker 2003).

#### **4.4 Physical health**

Poor housing conditions, lack of essential services, and poverty are root causes of ill-health among the urban poor. In Khayelitsha shacks often have damp walls and floors, especially in winter. There is inadequate insulation, which permits infiltration of dust, rain, unwanted insects and rodents like rats, mice etc. Overcrowding poses a big problem as dwellings are poorly ventilated and can affect the spread of communicable disease like, tuberculosis. Lack of food and poor nutrition is common.



[http://www.capetown.nu/life\\_in\\_khayelitsha.html](http://www.capetown.nu/life_in_khayelitsha.html)

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#### 4.5 Structure of the thesis

This thesis is made up of seven chapters.

**Chapter one** looks at background information of PHC, the aims of the study and introduces the setting of the research (Khayelitsha).

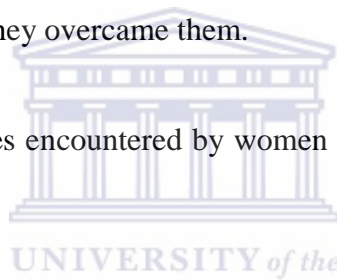
**Chapter two** is the literature review of the study. The chapter looks at the overview of primary health care in South Africa. I draw on the involvement of women in PHC, the challenges and what PHC means to them. Most of the literatures that I have used are informed by a public health perspective. There is very little anthropological research on PHC *per se* in South Africa. Lastly the chapter explores women as formal/informal care providers in their communities.

**Chapter three** explains the various methods and strategies that I used when conducting my research. The chapter looks at the challenges of doing fieldwork outside my home base and of being an ‘outsider’. The chapter also deals with positioning of self in the study and with the issue of ethics in the field.

**Chapter four** describes the gender of primary health care policy by looking at the implementation of South African policies in connection with PHC. I scrutinized the following: How do the policies implemented affect the women who work as informal/formal health care providers. How do women who participate in primary health care give meaning and understanding of primary health care in their every day challenges in the community?

**Chapter five** focuses on the everyday work of women as PHC workers, the challenges that they face in the communities and how they overcame them.

**Chapter six** looks at the challenges encountered by women concerning primary health care and the different tasks they do.



**Chapter seven** concludes the thesis and states the main findings of the study and raises issues for further research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **1. INTRODUCTION**

Although many generalizations are made about the influence of the PHC approach on women's work as care providers, formal or informal, few context-specific studies of the wide array of issues related to women in PHC have been done. There is little anthropological research in South Africa concerning PHC, its meanings for women and its interrelationship with the experiences of women. Most of the literature that I used draws on public health and other disciplines.

#### **2. WHAT IS PHC?**

Haan (1994) describes PHC as giving ordinary people ordinary skills to protect, promote and develop health, to treat minor illness and injuries, to be able to manage chronic disease. He further explains that PHC should be shaped around the life patterns of the population and should meet all the daily health needs of the community. PHC forms an integral part both of the country's health system, and the overall social and economic development of the community. It is the first level of contact for individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care services (WHO 1995). Ideally PHC services should be integrated with other services concerned with community development, such as agriculture, educational services and communications. In addition Coughlan (1994) states that PHC should be community based with full participation, be ambulatory, include health education, immunization and drug follow-up and offer home care and home visits. Above all it needs to offer services that are acceptable and affordable (Phillips 1990:152; Coughlan 1994).

In 1978, the World Health Organization (WHO) stated in the Declaration of Alma-Ata that:

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care (1995).

Coulson *et al.* (2002) states that health promotion should enable people to have control over, and to improve, their health, to reach a state of complete physical, mental and social wellbeing. PHC should ideally identify and meet the aforementioned needs. PHC furthermore emphasizes social and personal resources, as well as physical capacities; it is not just the health sector responsibility but includes a healthy lifestyle to promote well-being. Primary health care is supposedly the key to attaining this target as part of development in the spirit of social justice. The Alma-Ata declaration thus positioned PHC as a level of care and a set of services. It is also considered it as a strategy to achieve health for all and ensure universality, quality, equity, efficiency and sustainability of essential services.

In short, according to the WHO statement, and as briefly introduced in chapter one, PHC encompasses disease prevention, health promotion, and curative and rehabilitation services for example ensuring adequate nutrition, promoting high standards of environment hygiene through the provision of suitable housing, satisfactory ventilation and the prevention of overcrowding, the efficient disposal of refuse and effluence and the provision of safe water supplies - all of these are seen as promoting optimal health in individuals and communities (Haan 1994).

The term 'primary health care' has nevertheless been interpreted in different ways. It is supposed to be a dynamic product of community involvement that evolves from its economic, socio-cultural and political characteristics and the needs identified by it. The basic idea behind PHC is that community members and health workers have to work together to prevent and address health problems in a community. For example, community members are supposed to use the clinic mainly for referral purposes if home remedies and/or care cannot assist the sick. In this regard, once more, "home remedies and prevention" involves *inter alia* intergenerational knowledge passed from the grandmothers or elderly knowledgeable women in the community to younger women (Dennill *et al.* 1995). Ethel (2010) argues that primary health care relies heavily on the contributions of women, particularly in the area of health education. PHC supposedly raises women's self-esteem and empowers them to serve their communities in a number of ways by: improving women's health and the health of their families, training women both as care givers and as health educators, placing them in positions of responsibility, and encouraging individual initiative.



### 3. THE EMERGENCE OF PRIMARY HEALTH CARE

Primary health care is more than a program. It entails change. Its implementation was a process which called for wide ranging changes in established systems and institutions as well as in communities. WHO (2010) argues that primary health care approach was a response to perceived dissatisfaction on the part of populations that their health services were expensive, unequally distributed, inaccessible and not always appropriate. The idea behind PHC is basically that individuals, families and communities take responsibility for their own health for example by being actively involved in the health care activities that will include planning and monitoring and implementation of new policies that might affect the community somehow. The health professionals and health systems should, ideally, assist and support this process to function. Their functions must change from being providers to enablers (Ebrahim and Ranken 1993).

Dennil *et al.* (1995) argues that by the 1970s healthcare throughout the world was in turmoil, with fragmented health systems. The treatment for the ill was expensive and did little health promotion. Inequalities existed in both developed and developing countries worldwide. An international conference on PHC jointly sponsored by WHO and the United Nations Children's Fund (UNICEF) was hosted in Alma-Ata by the then government of Union of Soviet Socialist Republics (USSR) from 6 to 12 September 1978. The reason behind this conference was to achieve universally available health care and a general condition of health for all people by 2000. The conference also looked at health policies of many nations, some with more success than others.

At the Alma-Ata conference a declaration of intent was drawn up that stated the principles and components in terms of which PHC by different countries can be established. Dennill *et al.* (1995) writes that, according to the declaration, PHC should address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services, including at least education concerning prevailing health problems and the methods of preventing and controlling them (Dennill *et al.* 1995).

Nonetheless, the aims of PHC have not been achieved. There are several disparities in the implementation of PHC across countries. Firstly, in most countries more than three quarters of the health budget was spent on hospitals. These were mainly in urban areas and catered for diseases whereas the need was for prevention, improved nutrition, personal hygiene and environmental sanitation. Secondly, cost of the health care resources catered for people in the urban areas. Thirdly, rapid population growth exacerbated existing inequalities. One response was the development of the basic health services concept and efforts to move away from hospital centred health care towards health centres and sub-centres using auxiliary personnel (Ebrahim and Ranken 1993).

#### **4. PHC IN AFRICA AND SOUTH AFRICA**

After gaining their independence, many African countries adapted health services that were based in urban areas where the new post-colonial elite were settled. During the 1960s and 1970s there was economic growth with the increase in health both geographically and technologically across large parts of Africa. However, political instability and armed conflicts arose in many areas and a global economic recession, followed by droughts and the HIV pandemic had a negative impact on the health of majority of Africans. This left many countries with little progress in development and in the attainment of “Health for all” (Dennil *et al.* 1995).

The PHC system emphasizes preventive rather than curative health care (Nicholson 2001). The World Health report (2008) states that globalization puts the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, not performing well. Health services in most African countries are unable to deliver national coverage in accordance with health needs, and cannot provide services as expected.

According to the South African national health plan (1994) women's health should be understood within a wider socio-economic context and not just the narrow parameters of women's reproductive health. The mission of the primary health care plan is to ensure the provision of cost effective primary health care to all the inhabitants of South Africa. Priority is meant to be given to the improvement of women's social and economic status. In addition to legislation which



guarantees equality, the development of national infrastructure, specifically on water and fuel, must be a priority. The aim is to empower women through improved knowledge. This will, so it is thought, enable them to address health issues themselves and thereby, hopefully enhance their independence.

To all intents PHC in South Africa can arguably be traced to two physicians Drs Sidney and Emily Kark, who started Pholela Health Centre in the then called Zululand in the early 1940s, and developed a community-oriented primary care programme. The unit's aim was to provide comprehensive preventive and curative services and to serve as a model upon which other health centres, both rural and urban would be developed (Kautzky and Tollman 2008). Pholela Health Centre addressed the social conditions and determinants that influenced population health more broadly; targeting hygiene and sanitation, nutrition, water, housing conditions and occupational threats. Its approach was thus fairly close to that of primary health care as it is understood today. Social conditions that Pholela Health Centre focused on are currently part of the eight elements of PHC by Alma-Ata. Pholela Health Centre also specialized in programmes and interventions to address the health needs of vulnerable and high risk groups, particularly women and children who were provided with a package of health services that included immunizations, school feeding schemes, household and community food gardens (Kautzky and Tollman 2008).

The Pholela Health Centre model contributed to community empowerment and participation in the delivery of health care. The centre recruited and trained local individuals as health assistants and community educators to facilitate the provision of health education, promotion and skills development at the village and at household level. Initially this model was used in Durban only. Currently PHC is presented as a possible answer to many problems in the health system in South Africa. Yet PHC can never be disassociated from wider development issues in the country and is often hampered by it. For example, a 2004 survey of PHC facilities found that almost a quarter of the clinics still did not have basic facilities such as, piped water. About 10% did not have sanitation, electricity and telecommunications. Only half of all PHC facilities in South Africa were reported to have functional clinics or a community health committee, which means that communities are not actually involved in their own healthcare planning etc (Cullinan 2006).

In 1994, PHC was mainstreamed in South Africa. The then, President Nelson Mandela promoted PHC as the driving principle for health care provisions in South Africa. Two policies PHC, free health for pregnant mothers and children under the age of six years as well the universal access to PHC for all South Africans were implemented. Special emphasis was given to the development of clinics and basic health care programmes such as safe motherhood, child health and nutrition, expanded immunization, management of communicable disease and the treatment of chronic ailments ([www.doh.gov.za/docs/reports/2000/dhis2000.pdf](http://www.doh.gov.za/docs/reports/2000/dhis2000.pdf)).

The new government of the new democratic South Africa then adopted a PHC philosophy on community participation in the planning, provision, control and monitoring of services. According to the constitution adopted by South Africa, clause 27.1, confirms the right to access to health care services, including reproductive health, sufficient food and water and social security if they are unable to support themselves and their dependents appropriately (Cullinan 2006). Nevertheless, according to Draper and Louw (2007) the PHC approach in South Africa has not been as effective as intended. It has been hampered by ineffectiveness within the health system, lack of infrastructure, finances and resources. Kautzky and Tollman (2008) equally argue that an amalgam of factors limit the achievement of PHC in South Africa today. These include high rates of medical migration, a shortage of care health workers imbalances of resources and distribution of personnel; a complex and evolving burden of disease; still curative-oriented health service; deficiencies in managerial capacity and health system leadership. In addition Cullinan (2006) reckons that health services in South Africa are still largely doctor-dependent and focused on medical care rather than prevention. PHC needs a multi-sectoral approach, and should include nutrition, education, clean water and shelter as central tenets. Communities should be involved in the planning, provision and monitoring of their health service. Furthermore the PHC approach promotes greater emphasis on preventative services. Technology should be appropriate, for example all clinics must have working fridges etc. that work for the storage of vaccines before equipping them with high-tech medicine facilities.

## 5. PRIMARY HEALTH CARE AND WOMEN

In most of the literature on PHC women are framed as a wide category. For example, Thakur *et al.* (2009) emphasizes that women and men face different risks and vulnerabilities, some specific to their gender and others exacerbated by gender inequalities and discrimination. Yoon (1982) also focuses on gender and argues that women have been victims of health systems, their contributions have been undervalued, and gender has been ignored in general health statistics and research. Women in developing countries are the main health care providers, care takers of the aged and decision-makers about child health. They are vital to national development as producers as well as reproducers. However, their own lives are often considered less valuable than those whom they feed and take care of. Women's opportunities are limited by their primary responsibility for childcare and domestic work, cultural restrictions on their public mobility in some regions of the world, and the gender segmentation of employment opportunities. Kabeer (2008), in turn, focuses on social protection and its integration into a unified framework with social security and poverty reduction. In this regard the absence of women from the social protection agenda is mentioned. Although some measures are targeted primarily at female-headed households, gender is rarely used as a differentiating lens through which to understand poor people's exposure to risk and vulnerability and to design social protection measures accordingly. At the same time, however, social protection programmes are rarely gender neutral, and poorly designed programme can exacerbate or contribute to inequalities (Luttrell and Moser 2004).

Such constraints mean that girls and women are disproportionately represented among the extreme poor (Department for International Development (DFID) 2005a) in many parts of the world. They not only limit women's access to the labour market, but also often confine working women to more poorly remunerated, more casual and more insecure forms of waged and self-employment, particularly in the informal economy, without access to social protection. Increasing informalisation of women's work and growing sources of vulnerability (e.g. due to rising food prices and climate change) affect women's ability to provide for their families and cope with insecurity. Moreover, women are particularly affected by the human rights violations, pervasive poverty and physical insecurity that often characterize fragile states (DFID 2005b).

These factors underscore the need for greater understanding about the rationale and policy and programme implications of a gendered approach to social protection. Male-dominated cultural values are taught in the family and had become a way of life. Many girls carry an unequal economic load in family chores; they carry water, gather fuel, take care of younger children, and “fill in” for their mothers (Yoon 1982). There are times whereby they are taken out of school so that their brothers and sisters’ school fees can be paid.

Social security measures in many developing countries tend to be restricted to the small, male-dominated section of the workforce employed in the formal state and private sector. While their market contributions have become more important within household livelihood strategies, women are concentrated in informal and labour intensive work, often face particular risks and vulnerabilities (e.g. health risks, interrupted and insecure employment) and are less likely to have been able to save or contribute to pensions (Commonwealth Secretariat 2009). In most regions of the world, women live longer than men and hence face a longer period of widowhood, and risk of decline into greater poverty and insecurity. In many poorer countries, large numbers of women make up the bulk of volunteers and community health workers, working conditions vary as they seldom receive fees for their services and time (Yoon 1982).

Community/home-based care (CHBC) has become a central concept in the provision of care in the era of HIV/AIDS. The literature suggests that there are basically two forms of home care giving: formal and informal (WHO Study Group 1999). Formal care giving is initiated and implemented through a formal structure or program. Informal care giving is provided by unpaid family members and friends – once again almost always done by women. This is problematic, because women, who have traditionally been the care-givers, are currently pulled into the paid labour force by economic necessity or personal desire. They may accordingly be unable to continue providing those unpaid services of care. Their roles are changing in many societies, and as they do, questions arise more often as to whether they can be fairly expected to sacrifice their own education and ambitions to become caregivers (WHO 2002).

In relation to the above, Campbell *et al.* (2007) present a case study of the existence and quality of support networks available to people with AIDS and their carers in a South African rural area.

The most effective support comes from families and neighbors and volunteer health workers which, in most cases, are women. Similarly, in an article on care-givers to men with advanced chronic illness, Gibson (2000) stressed that women mostly took up this role. This was in accordance with wider societal gendered expectations. Even in clinical settings health care staff assumed this and usually insisted on “educating” the wives, daughters, daughters-in-law in this regard.

In most reports a focus on gender often relates health behaviour to women’s position in society. With the exception of policy documents and health science publications, some publications have attended to the intersection of PHC and gender. For example, a discussion paper by the World Health Organisation (2010) on gender, women and primary health care renewal focused on gender as determinant of health, integrating a gendered perspective into service provision and on enhancing gender equity in services<sup>2</sup>. Studies focused on gendered barriers to access to PHC (Salway *et al.* 2003) and the gender gap in the utilization of PHC services (Cashin *et al.* 2002). Although PHC is often reliant on the contributions and work of women, it is viewed as contributory to women’s empowerment: e.g. by training them as health caregivers and educators, situating them in responsible positions and enhancing individual initiative.<sup>3</sup>

Such report accordingly presents women as ‘objects’ of PHC, rather than as active subjects. For example, Ethel (2010) argues that primary health care relies heavily on the contributions of women, particularly in the area of health education, it raises their self-esteem and empowers them to serve their communities in a number of ways by: improving women's health and the health of their families, training women both as care-givers and as health educators, placing them in positions of responsibility, and encouraging individual initiative.

There have also been a number of studies in relation to gender and health-seeking behaviour. Here the focus is frequently on differential access to health care between men and women as a

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<sup>2</sup>World Health Organization ‘Women and health: today's evidence tomorrow's agenda’ (2009). Available at <http://www.who.int/gender/documents/> (Accessed on 8 March 2012).

<sup>3</sup>Primary Health Care and the Empowerment of Women Available at <http://info.bahai.org/article-1-7-5-10.html> (Accessed 08 March 2012).

result of gender inequalities. The latter, especially in developing countries, as well as in poor and marginalised groups, are thought to negatively affect the health of women (Hausmann-Muela *et al.* 2003). A number of studies focused on gender inequalities in access to health care, both preventive and therapeutic. It is argued that women often have to overcome a range of obstacles to use services. Female health care staff is also more often exposed to sexism than men, or health providers give more attention to males than to females (Ojanuga & Gilbert 1992). Economic issues furthermore affect health seeking behaviour and choices of, and related to women (Bonilla & Rodriguez 1993).

In this regard several studies (Mwenesi 1993; UNICEF 1990; Vlassoff *et al.* 1995) showed that, while women take care of their families' health they do not necessarily control economic resources. The nature of the work women have to do: in families, the household, the community, agriculture and such, can also impact on women's access, the time and energy they have to spend on travelling to and waiting in health facilities (Hausmann-Muela *et al.* 2003). Maclean & Groves (1992) argue that it is largely women who spend time enabling other members of their family to have access to and the use of social welfare services, they acknowledge their unpaid care in the home which is important to the economy and healthy of the health and social services. Women frequently are nevertheless expected to value the health of their families above their own, an issue that health education which is mostly aimed at women, may even exacerbate. In this regard (Ojanuga & Gilbert 1992) list the difficulties for women as the following:

- institutional barriers- unequal treatment by health providers
- economic barriers- different access to resources
- cultural barriers- social status of women which situates them in socially inferior positions, male doctors who attend to women with sensitive health problems, etc
- education barriers- women having less access to education (for example, seen in literacy and education rates)
- personal factors- knowledge and beliefs about illness, user/provider relationship
- social and reproductive activities- roles in health at household level, decision-making at household and community level, use of services, quality of received health services, social stigma

- Economic/productive activities- division of labour, substitution of labour, exposure to infection, opportunity costs, economic policies in relation to accessibility of services/care, availability of cash (Hausmann-Muela *et al.* 2003).

In relation to care provision, PHC literature sometimes focuses on female nurses or female doctors who are working together with the community in the prevention and treatment of diseases (World Health Report 2000). Mostly the health workers rely on other women to provide family planning and maternal health care for the reason that the clinic is used more by females than males (Department of Health 2000).

Coughlan (1994), for example, argues that universal PHC is seen to relate to individuals and families in the community through women's full participation. The issue of affordability is then raised as well: in this way it seems as if the unpaid contribution made by women, is also what makes PHC less costly for governments. While women's availability to do the work of PHC is largely assumed, there is some reference to them in policy documents from public health perspective. According to the South African National Health Plan (1994) women's health should be understood within a socio-economic context and not within the narrow context of women's reproductive health. Priority is meant to be given to the improvement of women's social and economic status. In addition to legislation which guarantees equality, the development of national infrastructure, specifically on water and fuel, must be a priority. The aim is to empower women through improved knowledge. This will, so it is thought, enable them to address health issues themselves and thereby, hopefully enhance their independence (Hausmann-Muela *et al.* 2003).

Women's gendered roles in society, especially in less developed countries influence their health. Examples of this have been documented extensively by women's health researchers and activists, from the effects of care giving on their own health and financial well-being, to the consequences of women's paid work and working conditions on health, and the impact of women's multiple roles (paid and unpaid) on their health (Peterson and Donner 2007). Good PHC for women should incorporate this knowledge and be a catalyst for change, helping to reduce the contribution of gender differences to health inequalities. Health systems depend on



women as providers of health care. Paradoxically, health systems are often unresponsive to the needs of women despite the fact that women themselves are major contributors to health, through their roles as primary care-givers in the family and also as health-care providers in both the formal and informal health sectors. The backbone of the health system, women are nevertheless rarely represented in executive or management-level positions, tending to be concentrated in lower-paid jobs and exposed to greater occupational health risks. In their roles as informal health-care providers at home or the community, women are often unsupported, unrecognized and unremunerated (World Health Organization 2009).

## **6. PROBLEM AREAS IN PHC AT THE MOMENT**

Women still continue to occupy vulnerable positions in society. This is often reflected in their health status and in their inability to access relevant services. In the past years great strides have been made in policies to improve women's health, including the implementation of the Choice on Termination of Pregnancy Act in South Africa. Some of the policies that were implemented to cater for women's needs include the appointment of a national committee for confidential equity into maternal deaths and the drafting of the national contraceptive policy guidelines and national maternity care guidelines. However, women's health has yet to improve significantly. Women's health should no longer be seen as limited to reproductive and child health, but should be viewed more holistically, encompassing all the aspects of women's health needs throughout their lives (Adar and Stevens 2000).

In addition the concept of women's health still needs to be articulated and mainstreamed, despite all the different policies concerning women's health. Many women live lives characterised by poor health and inadequate access to the benefits that health care can give, for example South Africa is connected to several international commitments such as the UN's Millennium Development Goals (MDGs), which seek to address the health needs of women and children. However, in South Africa the health of mothers and children remains poor. Russell (2000) argues that much of the burden of HIV care in developing countries is now falling onto households and communities, and in South Africa, home based care has become a national policy priority.



## 7. CONCLUSION

This chapter gave an overview of literature on the role and involvement of women in PHC. I have shown how primary health was implemented in South Africa. In the next chapter I will turn to my own fieldwork and to the research tools I used to do my study.

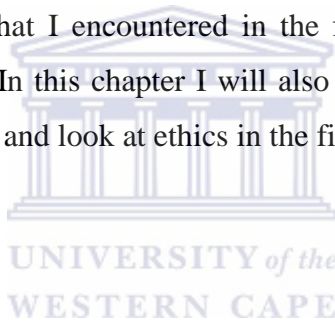


## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **1. INTRODUCTION**

I did my research in an area with which I am not familiar, even though I am a South African anthropology student. I am originally from Lesotho and speak South Sotho. I have been in Cape Town for nine years now at the University of the Western Cape. As an anthropology student I decided to get more exposure and did my research in Khayelitsha which is one of Cape Town's biggest informal settlements. In this chapter I discussed the difficulties of doing fieldwork outside my home place, by reflecting and sharing the ups and downs of my own research and also positioning myself as neither 'insider' nor 'outsider' in the research domain. The chapter discussed methodological issues that I encountered in the field. In this regard, I will discuss various methods that I employed. In this chapter I will also deal with positioning of self in the study and being an insider/outsider and look at ethics in the field.



#### **2. THE FIELD SITE**

Khayelitsha is one of the many Cape Flats townships and means "new home". By 1995 the population of Khayelitsha was over half a million. The majority of Khayelitsha's present population consists of people who have recently relocated to the city, mostly from the Eastern Cape. People who have moved to Khayelitsha from older residential areas such as Langa, Nyanga and Gugulethu are frequently third and fourth generation Capetonians (Lingelethu West City Council, 1992). According to the Department of Statistics, the 2001 census recorded the size of Khayelitsha population at 329002 people living in 85614 households. This when compared to 1996 figures of 249540, implied a growth rate of 5.3% per annum between 1996 and 2001. Ramphele (1998) argues that physical space constraint is overwhelming to an outsider. It is difficult to make sense of, what seems like, a haphazard world which seems to defy all rules of order and logic, but which is home for many thousands of people who live in Khayelitsha. It gives one a sense of being uncomfortable, the streets are pot holed and teeming with people and vehicles. There are no pavements, lawns or trees to be seen.

Site C in Khayelitsha emerged as an informal settlement area of families migrating from the Eastern Cape. Poverty is pervasive and living standards are well below the national poverty line. The Western Cape has been faced with a serious housing crisis since the early 1980's. During the early 1980's, the Western Cape was declared a Colored Labour Preferential Area. Harsh influx control measures were imposed and later Khayelitsha Township was established in 1983. It grew rapidly (Mangwana 1990). This was because the population of black South Africans in Cape Town was increasing drastically. Influx control had been rigidly enforced before and for two decades development was frozen in the old townships of Langa, Nyanga and Gugulethu.

## **2.1 Livelihoods**

I will give a description of Site C when I went to do the fieldwork. I was not shocked but amazed at how people in the streets were making ends meet to support their families. Just from the taxi rank you are welcomed by different colorful containers. Meat is barbecued on the streets ranging from chicken feet, sheep's heads cooked in big containers, tripe and cow liver are fried – and sold along the streets. Other people are selling vegetables and fruits. Every business person is visible to the people passing by the streets in Khayelitsha in all the direction of the taxi rank. Competition is tight but the relationship between the sellers seems good because sellers also take care of the stalls of their neighbours and sell on their behalf.

Employment patterns affect quality of life. The level of employment in Site C is difficult to determine because the movement of people into the area is continuous. Most of the people who are in formal employment are either unskilled or semi-skilled. Men usually work as labourers, employed, for example, in the construction industry, with the women usually employed as domestic workers in the wider metropolitan area. The formal sector within Khayelitsha itself is very small and consequently does not provide enough job opportunities for residents. The lack of job opportunities in the formal sector and its location in relation to Site C has resulted in the mushrooming of the informal sector. This sector is an important aspect of survival strategy for the residents (Ndingaye 2005).



Source: [http://www.capetown.nu/life\\_in\\_khayelitsha.html](http://www.capetown.nu/life_in_khayelitsha.html)

As seen in the pictures above, the feminization of work is very apparent in Site C. Women are the primary breadwinners in subsistence economies. They work long hours and devote a larger share of their earnings to supporting their families. Men's wages often are siphoned off for the purchase of alcohol, tobacco, or other consumer products. Some women contribute most of their earnings to meet the needs and demands of their families effectively. Men contribute at most 75 percent of theirs and are even less likely to pull their families out of poverty. The higher poverty rate among women in female-headed homes is accounted for both by the great reliance of these households on remittances and pensions and also because of unequal opportunities for employment. Women are usually predominant in low waged and less skilled jobs (Ndingaye 2005).

### **2. 3 Hospitals and clinics**

Site C is serviced by Nolungile day clinic which is owned by the city of Cape Town. Clinics run by the University of Cape Town's Community Health Project also operate in the area. The Nolungile clinic can refer patients to clinics in other sections like Site B, Harare and Town 2.

There is a community development centre in Site C where people from the community are trained as volunteer health workers. Approximately 50 such workers operate mainly in Site B. There is also a mobile tuberculosis (TB) clinic at Site C. The Regional Services Council runs it. Approximately forty private doctors operate from surgeries mostly located in the middle-income group areas as well as some dentists and pharmacists (Lingeletu West City Council 1992).

Nolungile clinic operates five days in a week from Monday to Friday, from seven o'clock in the morning till four in the evening. It offers different services to the patients, including child health, family planning, TB treatment, HIV testing and pap smears. On weekends the clinic is closed. Emergency patients go to Delft hospital or Khayelitsha district hospital, which opened its doors for patients in February 2012. It includes twenty four hour emergency centre. According to (Engelbrecht *et al.* 2003) the clinic is comprised of medical wards, surgical, gynecology and nursing ward.

Some 500 – 600 people attend the Site C clinic per day, of whom some 230 – 350 are females, and some 140 – 200 are males. Women often attend the clinic on behalf of others for example to take their children for immunizations and also take their loved ones to hospital. Everyday in the clinic, prior to consultation, medical staff conducts a health education workshop, which takes at least 20 to 30 minutes (Community Health Worker 2003). Engelbrecht *et al.* (2003) argues that the nurse clinical workload in the hospital per day is 64% and for the child case load is 45%. The workloads in general range between 45 and 154 patients per nurse per day with a total number of 18 nursing staff including the community health workers. The full time doctor works for four hours per day. There are two doctors who are on call seven days per week. They come once a week for TB and HIV positive patients.

## **2.4 Physical health**

Poor housing conditions, lack of essential services, and poverty are root causes of ill-health among the urban poor. Based on poverty alone, it is evident that the poor are often more susceptible to disease than the affluent. Shacks often have damp walls and floors, especially in winter. There is inadequate insulation, which permits infiltration of dust, rain, unwanted insects

and rodents like rats, mice etc. Overcrowding poses a problem as dwellings are poorly ventilated and can affect the spread of communicable disease like, TB. Lack of food and poor nutrition is common.

### **3. ENTRY INTO THE FIELD**

Before I began my research I had never travelled to Khayelitsha. I had heard stories about how dangerous the townships are, and was always too scared to go there. Once I decided to work in Khayelitsha I had to travel there. The first time I did so I got lost at the taxi rank and entered into a wrong taxi. I asked the woman seated next to me whether the taxi was going to Khayelitsha site C and she answered that we were going to Makhaza, but I could wait until everyone to be dropped off and then ask the driver to take me to Site C. It took me almost half a day to reach my final destination. Finally the driver dropped me off in Khayelitsha site C, next to the Nolungile clinic. He told me that the taxi rank was just around the corner, from where I could get a taxi back to Bellville. I went to the clinic, met the security people at the gate and was directed to the reception. I asked to meet with the director at the clinic. I introduced myself and showed him my letters of ethical clearance from the University of the Western Cape (UWC), and most importantly, from the Provincial Department of Health for the Western Cape. It gave me permission to do my research. I explained to Mr. Mxolisi what my study entails and what my intentions were concerning my research in Site C.

On my first day of fieldwork I met Faith. She was the receptionist and briefed waiting clients to fetch their folders before seeing the doctor or nurse. She told me she worked for a non-profit organization in Khayelitsha. Each day she presented lectures and demonstrations on different topics for clients. For example, on that day she showed people how to make the diarrhea treatment mixtures at home and people were eager to see and taste it. Faith was very well informed about the clinic and became a wonderful resource for my research. I later told her about my study and what I was really interested in what the women were doing here in Khayelitsha. She gave me the name of the NGO that she is working for and told me that if I go there I will be able to interact with other women who are doing the same job but in different places in Khayelitsha. I was really interested in what this NGO was doing; she explained that she joined

the NGO through a friend. She gave me the contacts of Ida, who is the manager and works with the women. I decided to give Ida a call and met up with her. I finally met with her and found about 15 women some were working in the small gardens and some were cooking. I greeted and introduced myself and my research study and explained to her that I would love to volunteer and be part of the team so that I can see the role that women are playing in the community to curb illnesses.

She explained to me that the NGO has programmes for elderly women who come to the NGO two times a week to sew some dresses, dolls and make the necklaces with beads. The products are sold to the tourists who go there as part of the township tour. The money that they get from selling of the products is used to feed the after-care children who go there to eat a healthy meal a day and do activities to stimulate their minds. Most of them are vulnerable and orphaned children. They also use the money to buy the children school uniform and stationery for school. The women from the NGO do home visits which found more educative for me as now I had a chance to interact with the people from their houses. The women who were volunteering in this NGO are women who were participants in my focus group discussion and I got to learn from them while interacting with them. The home visits included delivery of food packages that have been sponsored by Woolworths and the cleaning of houses for the sick at home and the elderly women. We also visited the houses of the vulnerable children who have been registered with the NGO as most of them are HIV positive so the purpose of the visit is to find out if the children are taking their medication properly and whether are there any problems at home or not because there were times whereby we are told when we get to certain houses that the kids are not attending school well so the child would be referred to a social worker in the PHC in Khayelitsha to find out what is bothering the child.

There was also a support group that met every Thursday for HIV positive people to come and share their burdens with some of the group members. The support group would normally start with a prayer and one hymn song. All the people present in the support group would introduce themselves then after Phelisa who is the facilitator will first ask questions to the group but before the group members share their grievances or positive things that occurred to them over the week and weekend and explain how to the members how the medication is treating them, and their



next visit to the doctor. They normally shared information about the increase of their CD4 counts and what they are doing to keep it going up. Members normally shared information concerning their health and motivated other members to keep on taking their medication and eating healthy.

After the discussion the facilitator gives them feedback on other members who not present at that time whether they are sick or not so that they can visit them. The discussion will end up with a meal composed of vegetables from the garden and juice and they will depart and meet next week again. This was a routine that took place every week and the members looked after each other and normally the clinic would refer new people who have tested positive to come once they are ready and meet other people who are also living with the virus. This is how I managed the women to participate in my focus groups they were also taking place at the day they are meeting at the NGO after the sessions I would also have sessions with them so I came to the NGO three times a week and the other day I would be in the clinic doing my questionnaires.

As indicated above, I was infected with TB while doing my research and, to all the intents, became a client myself. I spent a lot of time with people waiting at the TB clinic. There were many signs and posters that were put on the walls of the clinic and masks were available for all. There were huge messages on the wall asking people not to enter the clinic without masks. Clients were encouraged to use these masks. Nevertheless many patients did not wear them, and neither did I, mostly because I was worried that clients might feel that I was somehow discriminating against them or fearing that they may infect me. If I think back, perhaps I felt somehow naively that, because I was a researcher and also healthy, I would not be infected.

When I began to feel sick, I went to the pharmacy to get over-counter-medicine. I convinced myself that I was getting a stomach ulcer because of stress. I still continued with fieldwork and spent a lot of time in the clinic. After four weeks of agony I went back to the pharmacy again for other medicine. One evening I thought I was going to die and the next day I was waiting in line to see the doctor. I was diagnosed with abdominal TB and put on treatment.



#### 4. METHODOLOGICAL TOOLS

I utilized different ethnographic methods for data collection. According to Mather *et al.* (2009) social scientists ask questions, observe photograph and make recordings, take notes and pry into the details of the daily lives of participants. One of my primary method data collection methods involved “participant observation”. I participated as much as possible the everyday activities of the people who participated in my study (Mather *et al.* 2009). In this regard I was closely involved with women who worked as community health volunteers. With them I visited the sick every Wednesday. I also worked closely and interacted with women who regularly used the PHC services in Khayelitsha’s Nolongile clinic. I used to spent time with women as part of my volunteer work and also as a result of my growing social relationship with them. This kind of ongoing involvement in the women’s lives enabled me to gain an insight into what they did in their homes concerning PHC. In all, I spent three months in the field documenting the participating women’s experiences in PHC.

I did interviews with twenty women who came to clinic everyday and had focus group discussions with women who visited the clinic. I also had focus group discussions two times a week with women in the community. Each group involved five women who participated every week to the NGO. In total I had five focus groups. My focus was on women’s experiences in the PHC context and the meanings women give to their work, their everyday experiences of providing care and their understanding of involvement in PHC. Although I understood what participants were telling me, I used an interpreter in focus group discussions (FGDs). All FGDs were transcribed and a content analysis of all data was done. The health care providers in the clinic were also interviewed five females and five males. The health care providers are all nurses in the clinic who work in different sections. The health care providers were interviewed on what is seen as women and men’s work in relation to the following thing; Health Education, Nutrition, Water, Sanitation, Mother/Child Care, Family planning, Prevention of local epidemics, Immunization, Medicines, Treatment of common diseases and care for sick family member

One innovative approach I used was to ask six women participants among the ones who were in the focus groups to take photographs of everything that they think is women’s work in primary

health care and what they think PHC means to them in their communities. I gave the women disposable cameras and showed them how to use it. The photographs were developed and women were interviewed about the meaning of the photos in connection with how they are maintaining health in the family concerning PHC. In this way I hopefully got additional interaction about women's work and their understanding of it. I also made use of survey questions which were on client perception on PHC. In total the participants answered thirty questions with my assistance filling in the questionnaire. The interviews were conducted in one day by fifty participants who were not part of the focus groups but were making use of the clinic on the day that I was conducting my research.

#### **4.1 Data analysis**

Qualitative research does not describe a single research method. It entails research methods such as participant observation, interviews, focus groups and content analysis. Qualitative research can use naturally occurring data to find the sequences (how) in which participants means (what) are deployed and thereby establish the character of some phenomenon (Struwig and Stead 2001). It includes information such as words, pictures, drawings, photographs and films. Its relevance to my research assisted in understanding the issues being researched from the perspective of the research participants. Furthermore indulging in the participants' behaviour and being able to see from their own perspective. I also made use of quantitative research method which involves large representative samples and fairly structured data collection procedures. It examines variables which are based on the hypotheses derived from a theoretical scheme. It requires that the data collected be expressed in numbers (Struwig and Stead 2001). Both qualitative and quantitative were relevant to my research because of the credibility and trustworthiness from the participants that I interacted with.

#### **4.2 Sampling**

I chose Khayelitsha as my research site because it is one of the biggest informal settlements in Cape Town, is characterized by high rate of poverty, unemployment and poor service delivery. According to MCA Africa (2006) a number of households remain under-served, particularly in

terms of access to adequate sanitation services (where backlogs have been reduced from 30 000 in 2001 to 22 000 in 2005). In 2001 (from 33% to 24%), according to the 2001 census, 20 619 households did not have access to electricity for lighting. In 2001, 32 971 households did not have access to piped water either within their dwelling or on site. 13 582 (almost 16%) households in Khayelitsha only have access to water through a communal tap more than 200m away. MCA Africa (2006) further argues that respondents stated that, the most pressing challenges, in order of prioritization, were identified as: crime, jobs and unemployment, housing and health. These are the reasons that led to the selection of Khayelitsha as a research site to see how the women are involved in PHC and whether are they opting for preventive measure rather curative measure since they are living in poverty with the shortage of proper sanitation and water close to the place where they stay.

### **4.3 Sampling strategy**

The strategy that has been used is purposive sampling. According to Tongo and Doleres (2007) the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience. Key informants are observant and are reflective members of the community of interest who know much about the culture and are both able and willing to share their knowledge. Creswell (1998) argues that the data collection for purposeful sampling is extensive, drawing on multiple sources of information such as observations, interviews and visual material.

### **4.4 Sampling size**

Purposeful sampling is not concerned so much with random sampling as it is with providing a sample of information, rich participants. The participants show certain characteristics that the researcher is interested in (Struwig and Stead 2001). For the focus group discussion there were twenty women from Khayelitsha community. There were five focus group discussions in total meeting two times a week with five members per group, for the period of three months. Interviews in the focus groups discussion were answered by the twenty women in total comprised of ten questions based on the impact of primary health care on women and semi

structured interviews with fourteen questions on perception of primary health care for the women making use of the clinic in Khayelitsha. The research also had six women who took photographs on what they think primary health care mean to them in their community. I also used stratified random sampling for the fifty participants who were attending the clinic in Khayelitsha. Stratified random sampling is designed so that a predetermined number of items are chosen from each section so I chose health centre clinic in Khayelitsha instead of the youth clinic or Khayelitsha day hospital as they are situated under one roof but function independently. I went to the reception area and different waiting stations in the clinic where the patients were waiting for their folders, and asked them to fill in the survey questions for me individually. Then I went to the waiting rooms where patients were waiting to consult with the nurses and doctors and also approached the patients individually and asked them to fill in the survey questions for me which I was assisting in filling it. My final stop was the pharmacy where the patients were waiting for their medication I joined them in the cue and asked them to fill in the survey questionnaire for me. All the fifty questionnaires were done in one day.

#### **4.5 .Data analysis strategies**

Interviews were transcribed since they were in English they did not have to be translated. Creswell (1998) argues that after collecting all the interview material one has to read through all the collected information to obtain a sense of the overall data. I used the open coding for the questionnaires and the focus group discussions, which Creswell (1998) states that the researcher forms initial categories of information about the phenomenon being studied by segmenting information. Within each category, several properties showed the extreme possibilities on a continuum of a property. Meetings were arranged with the participants in Khayelitsha during which the aims of the project were explained to the women. Individual participants were provided with a disposable camera, and requested to take pictures of what they felt was women's work in PHC in their communities and the most significant aspects of the work that women are doing in PHC.

This took two weeks before I got back the cameras back from the participants. Not all of them gave back the cameras. The participants were assured that they could capture what PHC meant

amongst the women and what symbolized PHC in Khayelitsha. The pictures were later developed and I numbered them according to their names and had one on one interviews with them to specifically ask them why they took those pictures and does it mean to them as women. I explained to the women about the assurances of confidentiality and anonymity; and permission to use the pictures they provided for me. A tape recorder was used during my interviews with women. I later transcribed the interviews and analyzed them. For the survey questions I assign codes for each category and analyzed the data through Statistical Package for the Social Sciences (SPSS) for the percentages and the bar graphs. The percentages that I got from the SPSS assisted me in analyzing the information on women's experiences in PHC.

## **5. DOING RESEARCH**

Numerous anthropological studies have focused on doing fieldwork "at home" (Abu-Lughod 1991; Van Dongen and Fainzang 1998). In a volume devoted to medical anthropology at home, van Dongen and Fainzang (1998: 245) highlighted the challenges that face anthropologists doing fieldwork "at home". One of these, they argue, is the danger of "lack of distance" when reflecting on and analysis data. Anthropologists, according to them, need to overcome their "insiderness", including shared history and experiences which may, unconsciously, make the researcher identify very strongly with participants. From my fieldwork experience I realized that even though I am perhaps a "native" (Narayan 1993), I or a "citizen" anthropologist. A South African citizen working in my own country, this did not necessarily make me an "insider" in a particular research site. I had to be aware of that reality: my identification with participants and theirs with me fluctuated and involved complex power relations (Narayan 1993). Initially it was not easy for me to do my fieldwork in Khayelitsha. I do not speak isiXhosa fluently, but understand well when people do not speak too quickly. With time I managed to learn to speak very basic isiXhosa. Nonetheless, as Rabe (2003) argues, one may be an outsider regarding certain aspects of a person's life, but not others. This was certainly the case for me.

I tried to be as self-reflexive as possible in the research process and found that my understanding and insight changed over time and in different situations (Aull Davies 1999). When I began with fieldwork I tried to be mindful of Coghlan and Brannick's (2010) suggestions that there are three key areas for action and reflection in the research process. The first was to develop an awareness

of my own position within the group of women I was working with. The second was to be cognizant of relation soft power within the group and between the women and myself. The third issue of importance was to gain the trust of my participants. It was important for me to be always aware of, and to reflect on the relations of power between myself as the researcher and the women who participated in my study. In this process I sometimes felt myself shifting from being an outsider, i.e. I am not isiXhosa-speaking person and I come from another province. I also have a higher level of education than most of the participating women. In certain moments I felt like an insider and others recognized me as such. I was involved in the women's activities as volunteer health workers, I am a mother, and I contracted tuberculosis during my research and had to adhere to the directly observed treatment (DOT) regimen. The relationship between myself, as researcher, and the women who participated in my study was an important mechanism of data production both in an ethnographic and autoethnographic sense (Mayday 2010). As I built a strong relationship with the women I had to negotiate different meanings attached to my shifting insider/outsider identities by being self-awareness and by continuous reflective self-evaluation (Mayday 2010).

In this regard Irwim *et al.* (2009) argue that reflexivity in ethnographic research requires consideration of the social context and setting within which the research takes place, as well as for the identity and biography of the researcher. In this regard I was upfront with my participants about my own history and experiences and consistently tried to gain their trust and to make them at ease when I was around. I became a close friend to the women but had to be mindful that I was also a researcher who wanted to investigate a how women were involved in primary health care. As a woman, a mother and a researcher I had some experience of the issues affecting women. As a researcher, I had done an extensive background study on PHC and was cognizant with, for example policy issues, to a greater extent than many of the women I worked with. Yet I also had my own emotional baggage and life history to keep in mind.

What struck me deeply during this study was witnessing of how women worked to change circumstances in their families and in their communities to improve health. They did not wait for the government to do so. Nonetheless, the first time I went into the township I was dismayed to people living in shacks. I was, for example, very distressed by a woman we visited who was

HIV positive and had TB as well. She lived in a shack and had twin boys. She was the only breadwinner, but had to stop work and stay at home because she was very weak. Her TB and ARVs was delayed at the local clinic. When she asked for a doctor to fill in papers for her so that she could get a grant, there was no doctor available. She returned a week later, but on that specific day there was again no doctor on site.

The doctor comes only once a week but there are no specific days that are given to the patients so that they can only come when the doctor is on site. This somehow might show that there is a shortage of doctors at the clinic because I assumed a doctor has to be on site daily to attend to any emergencies that might occur which cannot be handled by the nurses. When we visited her again, she had left. I felt very emotional afterwards: I felt that she had been send up and down unnecessarily without being given the so-called free treatment and never got to get any grant to feed her family. Our Wednesday visit to sick peoples' homes also distressed me at times. Almost each week, people complained about the clinic and I felt somehow responsible for their disgruntlement. I also felt anguish when grandmothers had to eke out their old age pension to take care of the grand children who had been left in their charge. When I read my journal records of my experiences during and reflections on the fieldwork, I realize how sad I felt at times.

## **6. ETHICAL CONSIDERATIONS**

As an anthropologist, I understood that ethics involved more than the design and signing of consent forms. I knew I may have to deal with ethical concerns on an on-going basis, even though my proposed research was not particularly contentious or confidential. I had to the rights of my participants in mind all the time. The names of my participants were changed. Where I use peoples' real names, they had given me consent to do so. I have also kept all the information that I obtained from the questionnaire and photographs confidential. I am not permitted to publish any of the material shared with my participants without their written consent. I did not force anyone to be part of my research study. I made it clear to participants that they could withdraw from my research any time they wish.



In accordance with UWC's ethical guidelines, I obtained formal written informed consent. I also got permission from my participants to make use of the tape recorder where participants were unwilling to sign consent forms, but wish to participate nevertheless, I took verbal informed consent, which was taped and stored. I kept all information, as well as consent forms, in a locked cupboard to which only I have access.

A consent form was issued for the photographs taken by participants. They all agreed that I could use the photographs in my thesis. If I wish to publish it, I will have to obtain their consent again. The project proposal was submitted to the Research Ethics Committee of the University of the Western Cape and subsequently to the Provincial Health Department as well as the Department of Health in the Cape Metropole. I complied with the ethical guidelines of the UWC Ethics code as well as that of Anthropology Southern Africa.

## **7. CONCLUSION**

I had some difficulties while doing fieldwork outside my own comfort zone, even though I was to some extent doing research 'at home'. Like all researchers I experienced up and downs in the course of my study. Because I was concerned that people might think I was discriminating against them, I ignored the clinic's rules about the wearing of masks and became infected with TB. This however, gave me some insight into the experiences of patients. My identity shifted over time and in different sites. Although I tried to be objective, I was much involved in the experiences of my participants and had to be aware of my subjectivity. The knowledge I gained was an on-going process, always situated and negotiated (Narayan 1993).



## CHAPTER FOUR - GENDER ASPECTS IN PRIMARY HEALTH CARE

### 1. INTRODUCTION

PHC and its gendered health processes and effects have a history which draws women in gendered ways. As Connell (2012:1677) writes:

Complex social structures of gender relations are involved, with groups and populations of bodies engaged in them, producing and suffering bodily effects. Men's health work and women's health work may have different priorities at times, but they are fundamentally not separate fields; they are linked both through the institutions of health care and through the larger gender dynamic of society.

This chapter describes the gender of primary health care by looking at the services and how women make sense of it. In the next section I briefly refer to policy.

### 2. PHC AND ITS INTRICACIES

Policy refers to the official guidelines implemented by a social institution intended to set direction for action. It refers both to codified guidelines relative to health or which have a direct impact on health or health-related programmatic actions. These can involve codified guidelines or what is sometimes referred to as unstated policy (Castro and Singer 2004). To understand the implications for people it is important to question how, when and why health policies are implemented. In this regard it is also important to understand all policies are in some of other way political (Townen in Singer and Castro 2004). They are formulated by international organizations, development organizations, and health care providers. Policies are to some extent a compromise and an effort to create a balance of power among oppositional groupings, for example social or political groups with different interests. Critical medical anthropology emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience and health care. It recognizes that health itself is a profoundly political and even contentious issue. For example, Choice on the Termination of

Pregnancy Act of 1966 was bitterly contested in South Africa, often based in religious arguments, but also in relation to political. The implementation of related policy was not straight forward both (Varkey and Fonn 2000) as services had to be made available, staff retrained and community resistance overcome.

Many issues were raised by my participants and the health care workers in Nolungile clinic, some were negative and some positive. The first issue raised by participants was long waiting hours. A second issue that was raised related to the perceived rudeness of nursing staff. On the whole participants were satisfied with the quality of care or at least neutral about it. Women indicated that they use the PHC facilities to take children for vaccinations and check-ups. They also visit it for family planning and birth control. Pregnant women attend the antenatal clinic and some women attend the clinic for checkups in relation to their chronic diseases. Women also visit the clinic to bring the elderly and to fetch chronic medication for them.

In addition, key concerns for women seeking health care include respect, trust, privacy and confidentiality - values that are often compromised in busy facilities, particularly among certain age groups and social groups. As the day progresses, the health care workers find themselves under the increased strain of dealing with many patients. As the participants indicated, even when the health carers are rude at times, it does not mean they turn them away without assisting them. Clients leave the clinic satisfied after having consulted with the health care providers. This was despite long queues and waiting times which started from the collection of the patient folder to the consultation and waiting for medication at the pharmacy.

Louw and Draper (2007) argue that the state of health care in South Africa is not good, and that there is a need for change specifically on townships and rural areas. However, nurses often have to consult with over 200 patients a day. According to Engelbrecht *et al.* (2003) the shortage of staff compromises the quality of PHC service provision and limited provision of comprehensive PHC. In addition, in Nolungile clinic, the clinical workload of nurses is 64% per day and for the health workers looking after the children under the age of five it is 45% -those offering services to the elderly and sick in general have a high workload. Meyer *et al.* (2003) found that the workload in general range between 45 and 154 patients per nurse per day with a total number of

18 nursing staff, including five community health workers, in Nolungile PHC. There are two doctors who are on call five days a week. A full time doctor is on duty for four hours at Nolungile clinic (Meyer *et al.* 2003).

The WHO (2009) stresses the importance of the health services being responsive to women's health needs. This aim however is not always easy to fulfill on a daily basis. Women said:

The issue of nurses not paying attention to what we are saying while in the consultation room which does not give a patient an assurance whether are we going to be prescribed the correct medication or not because, even before they have finished explaining ourselves a prescription is already being written without proper medical check. If we come for consultation we expect to be touched and examined which puts us at ease that the nurse is really paying attention and trying to find out the source of sickness from the patient also the shortage of medication where patients are asked to come check again later in the week or to go to the pharmacy to buy the medication.

Louw and Draper (2007) argue that health policy continues to be driven by financial institutions with larger, market based, reform agendas rather than by physicians, public health personnel, nurses, and other health care experts which permits a clearer understanding of the ways in which dominant global health policy can often become more of an obstacle than a facilitator of good health. Poverty and socioeconomic contributes to, and are caused by poor health.

There are times whereby things at the clinic work differently but not all the time, the nurses are friendly and when we ask questions they are always eager to answer them with a great smile. The staff will greet us which some of them do not do at all and it does not make the patient to feel comfortable at all, you become shy to speak. There are problems in the clinic are not every time, it is a concern when a patient experiences a bad day with the health professionals especially for a patient who is using the PHC for the first time. The health care providers are supposed to be the people who are showing care and concern to assist the patients as it is their duty to make sure that every patient leaves the clinic with a smile and is always welcomed whenever they are not feeling well.

From the above comments of a respondent it seems that patients do not always feel comfortable to express how they feel.

### **3. THE ROLE OF WOMEN AND MEN IN RELATION TO PHC**

The new health system in South Africa is based on “Batho-Pele” meaning people first. The integration of health care delivery is assured by introducing a PHC intervention package and setting norms. The National Planning Framework emphasizes the constitutional rights that are significant for women. These rights include ; freedom from unfair discrimination on the basis of sex and gender, a the right to equality (Section 9) ; Freedom and security of the person, which includes the right to be free from all forms of violence, and the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction (Section 12). It also includes the right to access to health care services, including reproductive health care, sufficient food and water and social security (Section 27) (WHO 2008). The South African government has become a world leader in the empowerment of women and in its commitment to ensuring that women become actively involved in all decision-making that affects their lives and the lives of their families. But all these changes would come without the thousands of health workers and community leaders who have laboured tirelessly to ensure that policy is translated into reality and that legislation is worth more than just the paper it is printed on.

### **4. PHC IN PRACTICE**

In Nolungile clinic itself, i.e. in terms of staffing and services delivery, gender does not seem to be problematic, for example family planning is offered by men. When I visited the first time I was somewhat taken aback but the male took time with female clients to make them feel comfortable. They took time to explain procedures and options carefully to the women which types of contraceptives are available. Then they made suggestions to the patient about which one is probably most suitable for them. The respondents explained that health education is both a man and woman’s responsibility so it cannot be classified as either male or female work. They are responsible to teach about health education both in the workplace and in their communities.

The South African Constitution makes provision for the right to access to reproductive healthcare. This includes family planning advice, access to contraceptives and the choice of termination of pregnancy (Choice on Termination of Pregnancy Act of 1996). Much education is still required to drive broader understandings of options related to reproductive health among South African women (Department of Health 2010). According to the World Bank publication (1999) female education is important to health improvement that it merits special attention in any reformation of health policies that aim to improve health outcomes rather than solely improving the delivery of health care services. The health care workers argued that mother and child care, family planning, immunization and prevention of local epidemics is both man and woman's responsibility:

“Both man and woman have to look after the children and meet their needs and wants. Times have changed is not the women's duty alone to look after the children both parties play a role in seeing to it that the children grow healthy, whether taking them to the clinic or school both are taking turns in the child care. Both man and women are responsible in planning the number of children that they would want to have so the woman and the man have to attend the family clinic as to see which method of family planning suits them both. Only few people indicated that is the woman's work to make sure that she attends the family planning and educates herself on the types of planning that are available at the PHC (PHC staff member).”

In Nolongile clinic family planning is supervised by male nurses and who also educate the women who attend the family planning facilities there. Female clients said they felt as comfortable with them as with the female nurses.

The staff also argued that in relation to seeing to it that the children are immunized and the prevention of local epidemics is the responsibility of both men and women. Three staff members indicated that is the women's work to take the children for immunization, mostly because, women usually spend more time with small children and are more alert to their health condition. Staff stressed that the primary health care approach focuses on the following key aspects; an emphasis on preventative health measures (such as immunization and family planning) rather than on curative measures, the importance of participation of individuals and groups in the

planning and implementation of health care, an emphasis on maternal and child health care, the importance of education on health problems, giving high priority to the provision of health care to vulnerable and high risk groups, such as women, children and underprivileged elements of society; and equal access of individuals and families to health care at a cost the community can afford (Jaffray and Miti, 2010). Staff argued that women and men should take the responsibility to use the services that are being offered to them and work together without any gender barriers or perceptions that each has to this or that.

In answer to a question as to how staff sees the gendered role of women in PHC, the nurses answered:

It is still mainly woman's work to look after the sick people. They cook and bathe the sick family members. But lately nowadays due to HIV/AIDS both genders are taking a role to care for their sick family members. In most cases the man goes and looks for work in the urban areas and leaves the children and wives behind. When they get the job they do not come at home they just send the money and will be seen when they are sick and now the wife must care for him. The children at home is normally the mother who looks after them by taking them to the clinic, making sure they take their medication and attend the checkups. Both men and women should work together to see to it that common diseases are prevented and when they do occur they must take responsibility to seek the cure. Even though the women are normally the first to see if someone is not feeling well but when coming to treatment both parties play a role in prevention and treatment of common diseases. The health affects both men and women; together they have to look after one another when the other is sick. We have seen males taking part in their children's health and taking them to the clinic for immunizations without their wives being there, this is showing that males also play an important role in health sector.

Another male nurse added:

Community participation is central to empower individuals and communities to be part of their health decision making processes. Health is every individual's responsibility not women alone men also are taking responsibility in health care being active in their families and communities also as professional nurses and doctors. They further indicate

that primary disease prevention focuses on health risks, and health education and/or other preventive strategies are directed to the individual or family, rather than the social or environmental factors that influence disease progression.

Community participation and empowerment can be best fostered through transparent policy decisions and equitable resource allocation that recognizes community needs and priorities (Dookie and Singh, 2012).

## **5. CONCLUSION**

While the PHC seems under stress in South Africa because of various obstacles such as disorganization within the health system and lack of proper facilities and infrastructure to meet the needs and demands of the patients, finances and resources to cater for the needy and sick, staff in Nolungile clinic seemed to somehow manage to be fairly gender sensitive. They consistently stress the importance of good, gender sensitive policies and its implementation in their own clinical setting. They were convinced that both men and women are responsible for the health needs of their families and their communities in collaboration with the clinic. The health needs of women and children are catered for, often in surprisingly considerate ways. Women make up the highest percentage of health care providers and users of health services. Women who come to the clinic usually come with or on behalf of others. Women occupy a special place in efforts to improve health because they participate in, and often manage many activities that affect the health and well-being of their families.



## CHAPTER FIVE

### WOMEN'S WORK: MAINTAINING HEALTH IN THE FAMILY AND COMMUNITY

#### 1. INTRODUCTION

For local inhabitants, PHC meant a cut in government support, "second-hand health care", and "forced self-reliance" (Van der Geest and Obirih-Opareh 2002:2).

In this chapter I drew on photographic material generated by ten of my participants to enhance an understanding of how they make sense of the basic tenets of PHC, as well as what they do in relation to it. In Khayelitsha women did a great deal to, first of all, try to maintain their own health, that of their families and of the community at large. They also try to deal with illness conditions by accessing a range of remedial strategies. The women in the study were not paid for the work they do. After 1994 the South African government formulated policies which focused on empowering previously disadvantaged groups including women, children and disabled persons. The current Minister for Women, Children and People with Disabilities, Lulu Xingwana, commemorated women's month 2012, under the theme 56 years of women united against poverty, inequality and unemployment, in a speech on 7<sup>th</sup> August. She emphasized that, despite many changes, they still bore the burden of the challenge of poverty, inequality and employment.

What became obvious from my research is that women are deeply concerned with day-to-day survival for their families. Thus finding a way to earn an income is very important. They also spend a great deal of time in what they loosely called "prevention", i.e. efforts to clean up the general environment, thereby hoping to improve general well-being, but also to prevent the spread of illnesses. From the photographs it became apparent that women see cleaning up 'dirt' as one of the primary issues of PHC. Issues of food and nutrition were also high on their agenda of concerns, as was clean water and sanitation. Sanders *et al.* (2010) argues that the millennium development goals (MDGs) aim to decrease poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women by 2015. Its goal is also to ensure children's rights to survive grow up healthy, and develop to their full potential. The authors stress that child mortality trends in South Africa show no few signs of progress over the past 15 years. According



to WHO (2012) child mortality is due to conditions that could be prevented or treated with access to simple, affordable interventions. The cause of death mostly among the under five children are pneumonia, preterm birth complications, diarrhea, birth asphyxia, malaria and malnutrition and general vulnerability to diseases.

## **2. REFLEXIVE PHOTOGRAPHY**

When participants took the photographs, they defined the scope of my own analysis by identifying the issues of importance to themselves. This procedure is not directive and the influence of my own research bias is minimized (Thorp and Morris 2001 in Schulze 2007). In addition photographs produced by research participants are “reflexive” because the participants share in the definition of the meaning of the photographs during the interviews, and are thus said to “reflect back” from the subject matter. It enables the research participants to document their experiences through photographs (Zambon 2005).

I asked the participants to explain to me why they took particular photographs, what it meant to them and such during photo elicitation interviews. Usually such interviews can provide additional insight into the meaning and symbolism inherent in the photographs (Harrington and Schibik 2003 in Schulze 2007). Photo-elicitation interviews are non-threatening because participants express themselves through an interpersonal and socially acceptable communication medium (Perka, *et al.* 1992). It reveals unconscious perceptions individuals hold about their social and psychological environment. This provides insight into how people perceive and organize their worlds (Schulze 2007). Photographic feedback creates a state of awareness and evokes emotional feelings that lead the interview into the heart of the research. Photographs sharpen the memory, give interviews immediate character and help to keep the participants focused (Bender *et al.* 2001; Collier 1967; Schulze 2007). This is what the participants responded concerning the photographs they took.

Through the reflection on their photographs the women communicated feelings and ideas concerning what they, as women, are doing concerning PHC, what it meant in their everyday lives and how it related to their health and that of their families. All the women in my study

emphasized the need for some form of an income as part of maintaining health. It influenced both how women define their health and their ability to function as healthy people. In this regard it is important to note that income and access to resources like work may have more impact on women's lives than the personal practices for example drinking, exercising and dieting (Schellenberg 2001).

The picture below (Photo 1) shows Nandipha who stated about this photograph:

PHC means eating healthy and nutritious food daily and the least that one can do if you cannot afford to buy other food you can substitute that with vegetables as they are cheaper to buy and stay a little bit longer without getting rotten because I do not have a refrigerator. I enjoy cooking vegetables for the family vegetables as I cannot afford meat and milk. We also eat grain sent from Eastern Cape by my mother.



**Photo 1: Nandipha**

*Women are one of Africa's greatest assets. To many of us, this is self-evident. But they are an asset too often taken for granted. This is not only unjust, but deeply damaging for the continent's prospects. For*

*Africa's political, social and economic health and progress depends above all upon the empowerment of her women."*

– Graça Machel



**Photo 2: Veliswa**

Veliswa earns her living through selling maize on the streets. All her income from selling of the maize helps to buy food for the family of five and pays the children's school fees. Apleni (2012) argues that the new South Africa wants women to be visible in the economy. According to Veliswa, reflecting on this photograph:

I am not staying at home waiting for a husband to provide for my family instead I am up on my feet assisting in whatever way I can to have an income. I do not stay at home doing nothing. I am busy selling maize, and then I worry less about what to eat and

children's school fees. I stay active for the rest of day and when I get home later I just cook for the family. The only issue that is of concern to me is condition of the area where I am selling my maize as is polluted by dirty water that is just flowing pass me and papers which are just scattered and not put in the bins. I can get illnesses if it is not sorted out.

Douglas (1966:3) argues that societal notions about pollution operate at the expressive or the instrumental levels. Veliswa, above, emphasizes the latter. Her ideas are also in line with Green's (1998) argument that indigenous contagion theories in Africa often base disease aetiology on "naturalistic infection (or indigenous germ theory)" and "environmental dangers (the belief that elements in the environment including the air one breathes can cause or spread illness)" (1998:128). The World Bank (1999) also stresses the importance of garbage disposal, as well as the major impact its absence can have on personal, domestic and food hygiene. This issue was emphasized by Mama Nokuthula (Figure 3) who said about her photograph:



**Photo 3**

Mama is collecting big blue plastic bags storing them in a container where they will be collected by the municipality disposal truck.

“I am an unemployed mother of three children. I maintain my family through the use of my old-age grant. In the community beginning of 2011, I decided to take an initiative in playing a role to cleaning our surroundings for our health. It brought shame to the community when tourists are visiting Khayelitsha. The community members have been complaining to the government but nothing has been done so far so far so, as women, we decided to take things I to our own hands and do what every mother would do for their children if they felt that they will be in danger young children, when coming back from school and also on weekends, used to take the rubbish that has been kept in the plastic bags and play with it or throw it anywhere when they are tired of playing and they later get sick from those dirty things. The people in Khayelitsha are provided with blue big plastic bags to throw in anything that they want to get rid of. And most families keep their plastic bags outside next to their shacks where they will be collected once a week by the municipality vehicle but during the time of usage they just leave them outside and the children play with them. PHC to me means living in a clean environment, even if one does not have anything to eat, but dirt should be kept away from people as far as possible so that they can live healthy. People get diseases from living in a dirty place.”

Like Thulisa and Nozama, Mama Nokuthula links maternal and child health to cleanliness and sickness to ‘dirtiness’, which should be combated all the time. What becomes apparent from the above narratives is also the importance of women in their own health development as well as with dealing with problems of ill-health and under-provision of resources in communities (Rohde and Morley 1997). The women actively try to promote health and to prevent illness for a wide number of people, particularly those most in need. As Wallace *et al.* (1995) argues, these women are often the primary providers of family health care and also bear the principal responsibility for caring for the health needs of children and the elderly. Nonetheless, as the women also stress, the conditions where they live can lead to ill health and create an additional health burden for them.

According to van der Geest and Obirih-Opareh (2002:2) sanitation and waste removal can be seen as “an excellent case to test the workings and adequacy of governance”. Although the



women who participated in my study tried to clean up their neighborhoods, most locals, surprisingly, rather did the opposite. While people complained about poor services they, unlike my participants, did not try to them “take sanitary governance into their own hands” (*ibid*: 11), but rather threw waste outside. This may be because many of the people living in shacks in Khayelitsha come from rural areas, especially the Eastern Cape. Interestingly Cox (2007:153) stressed that “the traditions of writing on urban sanitation, squalor and decay have no counterpart in rural studies”. In this regard Holloway *et al.* (2007) argue that urban spaces are supposed as clean and rubbish, excreta and waste are understood as “matter out of place” (Douglas 1966). Contrastingly in rural areas dirt, manure and the presence of flies, for instance are seen as part of rural livelihoods.

Thozama, an unemployed mother and informal health care worker who looks after the HIV/AIDS patients and TB patients to make sure that they take their medication daily, stressed the importance of sanitation and clean water in her photograph.



**Photo 4: Photo by Thozama**

There is a close connection between poor housing and the prevalence of sickness (Krieger and Higgins 2002) as made apparent by the above photograph (Figure 4) taken by Thozama. She explained that:

“PHC means good living conditions, which the people in Khayelitsha are not receiving at the moment. We live in jam-packed shacks whereby four to five people live in one shack. As the picture shows, there is no suitable sanitation and running water for people living there. The people who are living there are also making matters worse by throwing rubbish and dirty water nearby to their place of stay and children, on the other site, are seeing that as a playing ground for them to pick up rubbish and play in that dirty water not knowing that is the cause of their illnesses as the parents are also waiting on government to change the situation for how long one does not know. The running water in the *donga* smells even though the children are playing in it. It is harmful to their lives as they are young and uninformed about what is good or bad for them. If they are out of their parents’ sight that is where now they go and play there not because the parents do not care but because they are busy with household issue so they cannot be able to watch over the children when they are playing outside. Health is affected by many decisions that have nothing to do with health care: poverty affects people’s health, pollution, contaminated water, poor sanitation and policies which are implemented but not working for their purpose (Walt *et al.* 2009).”

For Thozama, like other participants, shacks represent poor planning and governance, which in turn, affects disease. According to Krieger and Higgins (2002):

“Beyond the condition of the housing unit itself, the site of the home may be a determinant of health. Neighbourhood-level effects on health have been documented; these include elevated rates of intentional injury, poor birth outcomes, cardiovascular disease, HIV, gonorrhoea, tuberculosis, depression, physical inactivity, and all-cause mortality in neighbourhoods of low socioeconomic status, independent of individual level risk factors (2002:759).”

In the next photograph, Thulisa takes up the narrative of unhealthy or ‘dirty’ neighbourhoods and the particular vulnerability of children. The possibility for contamination seems to be everywhere, even though it is not always possible to know what the exact prevalence of illness is, nevertheless the link between ‘dirtiness’ and disease transmission was strongly emphasized by all participants. This is very similar to the findings of Abney (2011) in relation to a study done in Khayelitsha on tuberculosis and ideas about its transmission.



**Photo 5: Thulisa**

According to Thulisa:

“I took this photograph to show what women are doing in the community to clean the surrounding areas that are close to where they are staying as dirty place can cause illnesses. PHC means good sanitation and proper disposal of dirt in the dust bins away from children’s reach. But since I have been staying in Khayelitsha, the conditions have gone from better to worse and now mothers fear for their lives and that of their children. Women need to be healthy in order to keep on being productive and caring for the sick in their communities but how are they going to stay healthy if the conditions are not conducive for them? They are staying next to a stream, people nearby just use it as a



dumping area, and the children are often the ones who suffer in most cases because they always go to the stream to play with the dirty things there. So if the rubbish is removed and packed into plastic bags it will reduce the child diarrhea and other illnesses.”

Omimbo (2003) argues that lack of clean water, sanitation, food, and low literacy all impact on health. PHC seeks to strengthen health care systems to facilitate efficient delivery of health care in a sustainable manner, but also seeks to harness participation of the community in caring for its own health, i.e. the ‘self-reliance’ referred to in the quote at the start of this chapter. Yet this ‘self-reliance’ is deeply gendered. While the third Millennium Development Goal (MDG) is to promote gender equality and empower women (Connell 2012), such ‘empowerment’ meant that they did a great deal of the unpaid work of ‘cleaning up’ after their communities. This includes doing the washing and carrying of clean water to their homes.





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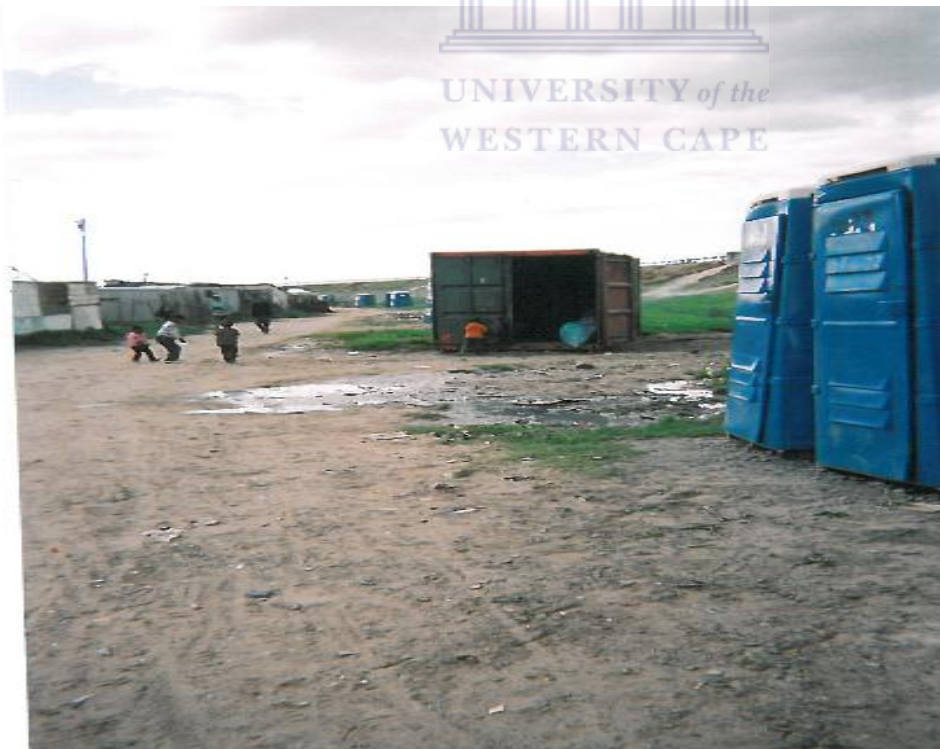
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#### **Photo 4 & 5: Noluthando**

“Clean water means life, because without water life can stop as water is used for most of the households’ necessities and a person can never live without water. We use the water for cooking, bathing, watering of the gardens and washing the clothes. The tap is situated in the middle of the shacks and still some of the community members have to walk for more than ten minutes to come and get water for their houses. Some women even prefer to do their washing there as the water will be too heavy for them to carry it back to where they are staying if they need to wash. In addition they just come with the washing powder and basins there to do their washing and just throw out the dirty water after washing; there not far from the tap and it will flow to the drainage in the road. Clean water is not a

problem and we have never experienced any sicknesses from the tap water in the community. The water is kept in big buckets and stored in the house, once it is all used up, and then the women or children will go and get the water again. The water in the bucket normally takes up to three days before it gets finished. PHC means being able to get access to adequate water supply for drinking, cooking and watering the garden which means without the accessibility of clean water in this community our survival would be at risk of even contraction some illnesses due to shortage of water or usage of dirty water for the household (Noluthando).”

From the photographs and from interviews and observations of my participants it seemed that the home, the inside – even of a shack- is kept meticulously clean and neat. At home, healthiness can be promoted by cleanliness, good food, providing for the needs of one’s family. The outside, the public space, was where the possibility of contagion lay. For these women, it was a struggle to keep the outside at bay and to return it to order and healthfulness.

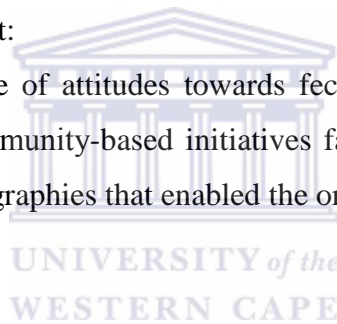


**Photo 6**

“This picture (Photo 6) shows the blue toilets which most of the people in Khayelitsha are using. PHC refers to basic sanitation with the blue plastic toilet for cleanliness and health purposes. The buckets in the toilet are changed every Monday. To maintain the toilet they have to keep clean and the surrounding areas free from flies. The problem is just that there is a time whereby the bucket gets full before the next change and now we go to the neighbors to help ourselves. That is an inconvenience and unhygienic because different families have to share one toilet. The toilet is provided by the city of Cape Town and also the changing of the buckets is done by the city. There are those whose toilets are placed in one place because there is no space to put the toilet, the shacks are squashed together they are not lockable so young children still have access to play inside them if unnoticed by adults (Phumeza).”

Sanitation is one of the MDG aims for 2015, but in this regard Jewitt (2011:609) argues in relation to informal settlements that:

“Culturally sensitive nature of attitudes towards feces and sanitation often means that attempts to ‘scale up’ community-based initiatives fail because they are uprooted from the social and political geographies that enabled the original projects to function.”





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**Photo 7, 8 and 9**

“This picture (Figures 7, 8 and 9) shows the green and blue toilets which most of the people in Khayelitsha are using. PHC refers to basic sanitation with the blue plastic toilet for cleanliness and health purposes. The buckets in the toilet are changed every Monday. To maintain the toilet they have to keep clean and the surrounding areas free from flies. The problem is just that there is a time whereby the bucket gets full before the next change and now we go to the neighbors to help ourselves. That is an inconvenience and unhygienic because different families have to share one toilet. The toilet is provided by the city of Cape Town and also the changing of the buckets is done by the city. There are those whose toilets are placed in one place because there is no space to put the toilet, the shacks are squashed together they are not lockable so young children still have access to play inside them if unnoticed by adults (Phumeza).”

Sanitation is one of the MDG aims for 2015, but in this regard Jewitt (2011:612) argues in relation to informal settlements that:

“Culturally sensitive nature of attitudes towards shit and sanitation often means that attempts to ‘scale up’ community-based initiatives fail because they are uprooted from the social and political geographies that enabled the original projects to function. The condition of the toilets is not good for any human being’s sight as it endangers one’s health. The other problem is that when the toilets get full people just help themselves anywhere inside and outside the toilet whereby feces is just laying around without anyone caring how is affecting the health of their families.”

### **3. NUTRITION, FEEDING FAMILIES AND CHILDREN**

Kholisa works voluntarily in a community garden. The vegetables are sold by a non-profit organization that provides a meal a day for vulnerable children and the elderly. Like all the women in my study, Kholisa provides almost all the unpaid health care within and outside her home (Schellenberg 2001). Kholisa explained:

#### **Photo 10 & 11**

“PHC means healthy nutrition and that can be gained by planting of vegetables and eating a balanced meal a day for the prevention of diseases and malnutrition for children. The community needs to eat healthy so that they can be able to do their daily jobs while staying healthy. Most women do not have a basic income, they rely on the child grant money to feed their families, but through the small projects of gardens in the community they can now save money for school fees and other necessities needed in the family while daily they collect vegetables in the garden to cook.”

As Omimbo (2003) argues, PHC was initially intended to be comprehensive: to cover food supply and proper nutrition in prevention and control of prevailing health problems, for example maternal and child health, prevention and control of endemic diseases, treatment of common diseases and essential drugs.



**Photo 10 and 11**





**Photo 12**

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**Photo 13**

Figure 12 & 13 shows the picture of mother Ayanda and her healthy child, who have also made a home in Khayelitsha in one of the shacks next to the dumping area. As the pictures reflect the inside of her shack she maintains it properly inside to make it conducive for her family. The cleanliness inside does not keep the flies away from entering into the house because of the dirty environment that is surrounding the area. Which is a problem because no matter how much she keeps her house clean, it does not help at all first of all she is staying in shack with no basic services like water in the house flushing toilet is accessible to the family members only. She is making use of the communal tap that is situated far from her house and uses buckets to store water in the house for cooking, bathing and washing dishes which can be a problem if the water gets finished in the middle of the night or the flies from outside enter inside the water. She will

just have to throw away the water and get another bucket full of water. Keeping in mind that she is alone at home with no one to assist her so she puts the baby on her back and goes to get water and cook for the family. It puts a lot of strain on women like her as they will have to run up and down to get water and meet all the needs of the household.

#### **4. CONCLUSIONS**

The women whose photos are in this chapter have taken measures to try and control their outside environment and to keep it from penetrating to the inside. I tried to comprehend the women in Khayelitsha in relation to their environment and looked at how reflexive photography can be useful in understanding how meaning is formed when individuals from different social and cultural groups interact with their environments through the use of photographs. The chapter illustrates the importance of reflexive photography for qualitative research, whereby images can inspire conversation and can also be essential as a research technique in the human and social sciences. From the women's responses one has learnt that bringing health care closer to the people at community level and provision of the basic human needs can promote healthy living in the poor communities. Preventive measure have to be taken into consideration like the small gardens that the communities use to get at least one healthy nutritious meal a day in order to stay healthy and curative measures can be recommended to motivate all the community members to grow small gardens outside their households because not everyone can afford to buy fresh vegetables.

**CHAPTER SIX**  
**CHALLENGES ENCOUNTERED BY WOMEN CONCERNING PHC AND THE**  
**DIFFERENT TASKS THEY DO**

**1. INTRODUCTION**

*One day at the PHC clinic in Khayelitsha on a Wednesday morning. It was a normal clinic attendance day for the patients. As I observed formally walking through the clinic, I observed something that caught my eye. The comprised of both man and women sat on the wooden benches at the different locations. Women were either alone or accompanying the elderly or the children. The men were mostly sitting at the TB clinic I guess it was a day for TB consultations and check-ups. Only few women were joining the men, mostly they were sitting by the family planning clinic some with their partners and the section for immunisation of the children. There were mostly women and few men escorting their family members. This was a day to contact the survey questionnaires on perception of clients on PHC. The survey was done in one day by fifty participants who were attending the clinic on that day (field notes).*

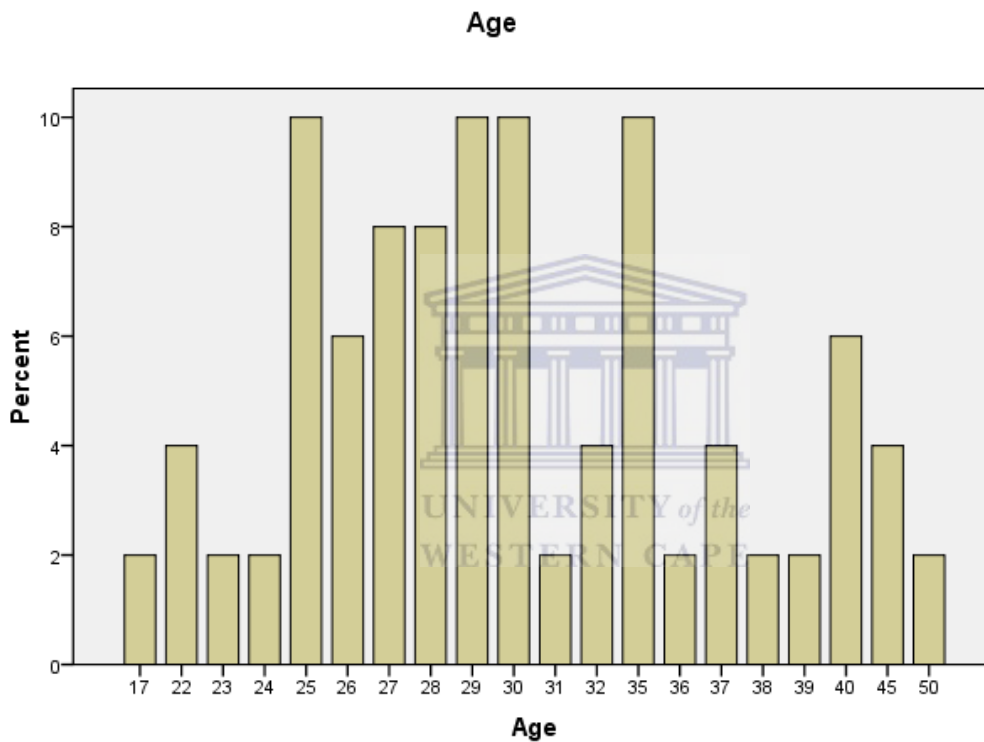
In this chapter I will discuss the challenges that the women in Khayelitsha experience in their day to day lives in the community. The chapter explores the different responsibilities that women have and actions they take to overcome some of the challenges that they are experience in relation to PHC.

Dennill *et al.* (1995) identified five principles on which a successful strategy on PHC should be based to make services available to all. They are the following: *Equity*- all people should have equal access to basic health care and social service; *Accessibility*- services must be extended to reach all people in the country; *Affordability*- the level of health care offered should be at a reasonable cost that the community and the country can afford and no person should be denied health care because of their inability to pay. In South Africa, health care at the government PHC centres is free; *Availability* - there must be sufficient and appropriate services to meet the particular health needs of each community; *Effectiveness* - services provided must do what they

were intended to do for the specific community and *Efficiency*- the results attained should be proportionate to the input, in terms of effort expended, money, resources and time.

All the five principles are supposed to also address the needs of women. In this chapter I set out the quantitative findings of the survey I did in the clinic.

## 2. FIGURE 1: AGE OF THE PARTICIPANTS IN PERCENTAGES



According to Figure 1 the people who mostly make use of the PHC facilities ranges from 25 and 35 years of age. In the case of women, the highest percentage was attending the clinic on behalf of their children and some had taken their parents to the clinic. A small number of women were attending the family planning clinic. Ebrahim & Ranken (1993) argue that, central to the concept of PHC is that, individuals, families and communities take the major responsibility for their own health but it seems women are the people who actually do so.

### 3. FIGURE 2: THE GENDER OF PARTICIPANTS IN PERCENTAGE

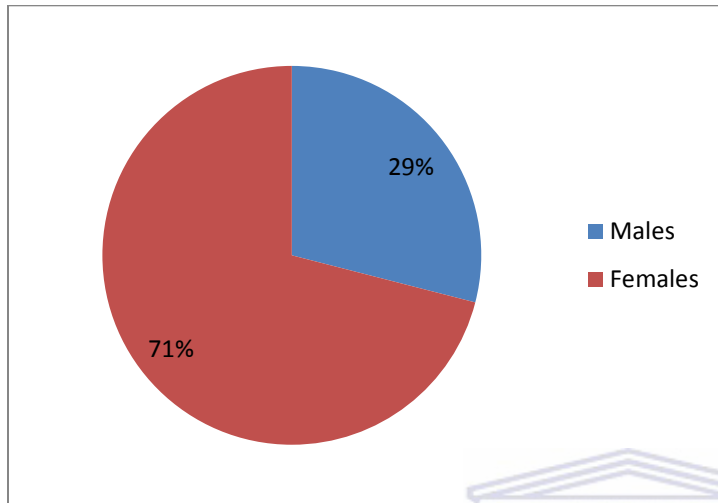


Figure 2 indicates that 71% of the females utilise the clinic on a specific day more than the 29% of males. Mostly women attend the clinic on behalf of their children and family members. Just the small number came for family planning and to collect the chronic medication. The less percentage of the males was mostly at the clinic to also collect medication and some to see a doctor but not attending the clinic on behalf of any family members.

#### 4. FIGURE 3: LEVEL OF EDUCATION OF PARTICIPANTS IN PERCENTAGE

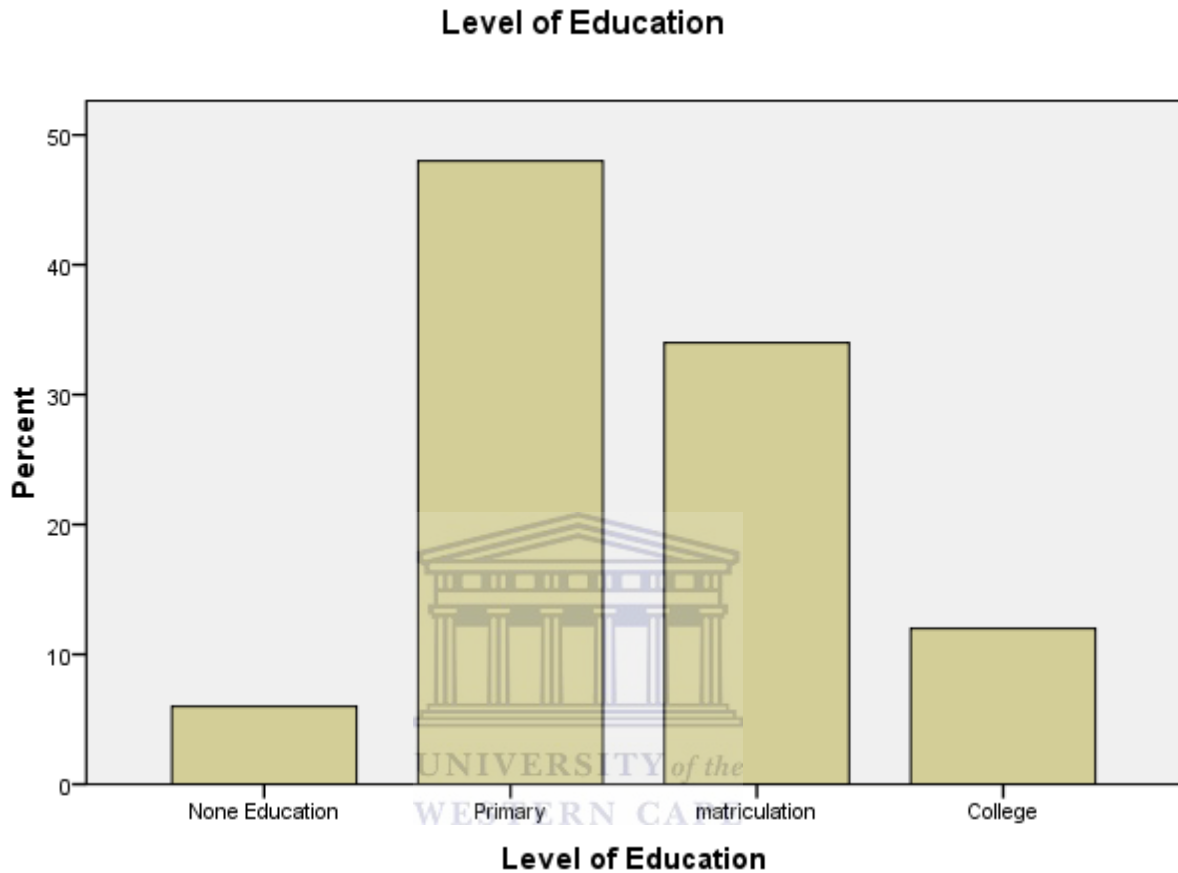


Figure 3 (below) indicates that the majority of participants in my survey who attended the clinic on one day had primary school education (48 %.) The PHC facilities in Khayelitsha offered free of charge. I found that most of this group of people attending the clinic did not have formal employment. In the case of women, they worked as domestic workers or sold fruit and vegetables on the street. Some receive a government grant for child support.

The participants with matriculation make up 34% of the sample and are mostly employed. Only 65 have no education. They are all unemployed, but try to earn money by selling fruit, liquor and barbecued meat on the street as a source of income. Some of the women receive child support grants from the government. Ramphela (1993) argues that low education level is usually



accompanied by the disruption of family life through labour migration in Khayelitsha C. Twelve per cent of the people surveyed had some form of tertiary education or training (see below).

**5. FIGURE 4: MEDICAL CONDITION OF PARTICIPANTS IN PERCENTAGE**

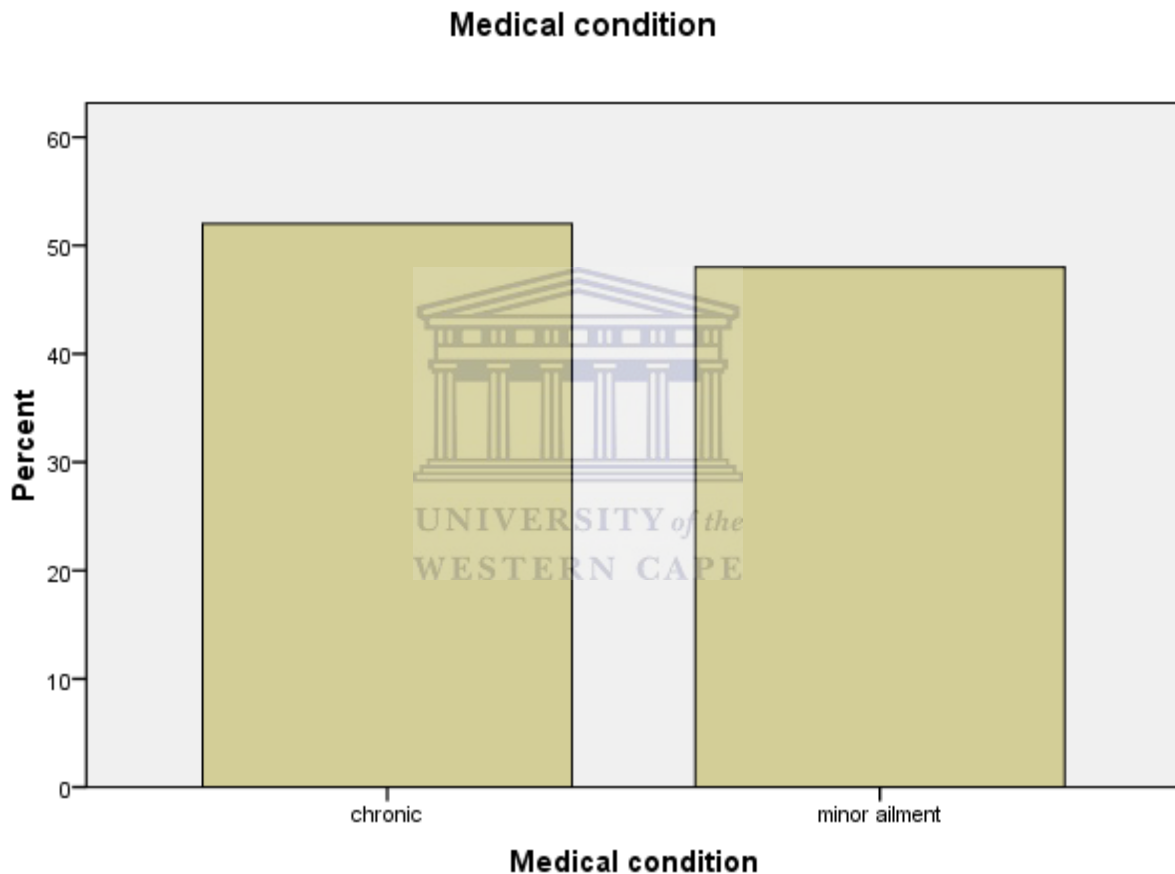
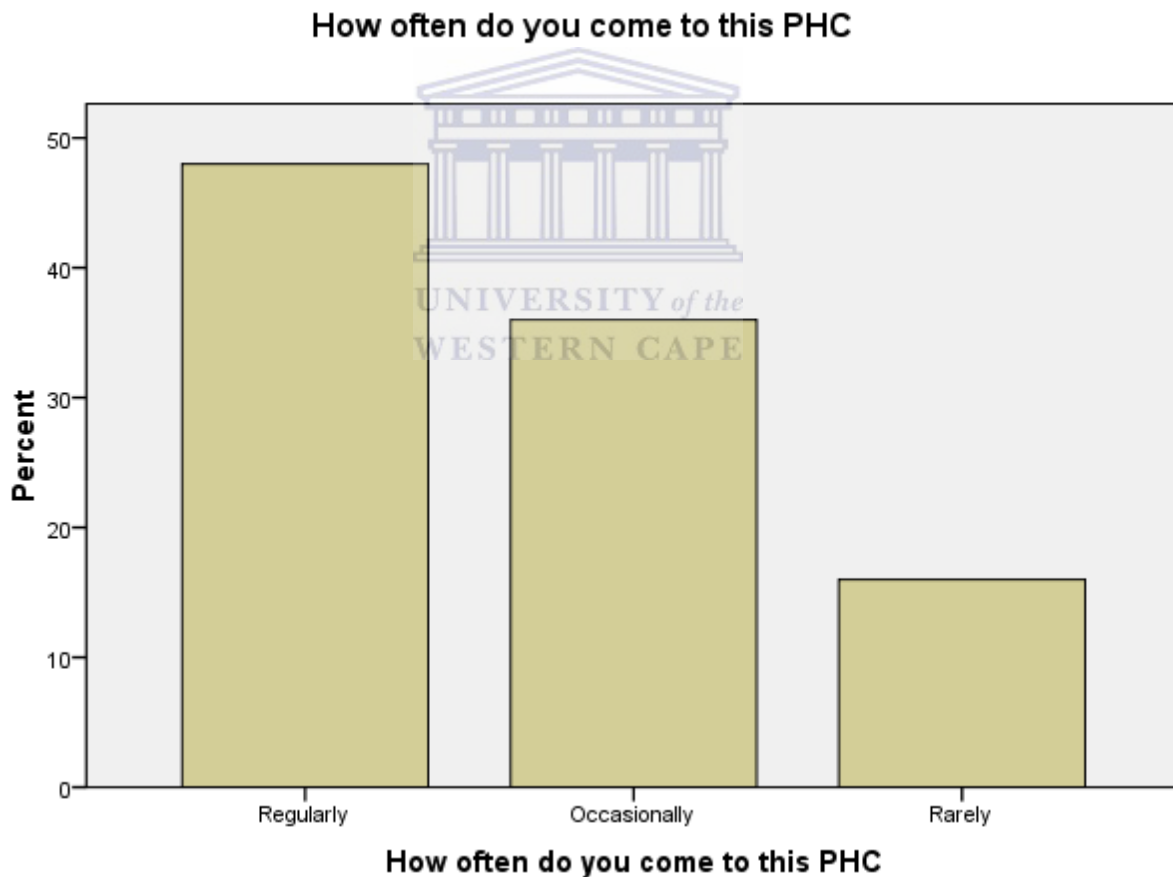


Figure 4 indicates that 52% of the respondents' use of the PHC clinic for chronic illnesses, for example attending checkups and collecting medication for high blood pressure, TB and ARVs. As indicated earlier, most of them do not have a steady income. Poverty, unemployment and education ultimately determine the living standards of the poor in Site C. Poverty is associated with a lack of food, finances, education, poor sanitation and inadequate housing all of which are major causes of ill health (Ndingaye 2005) . According to Ramphele (1993), poverty forces many children to drop out of school and to look for income-generating activities to give

assistance to the family. Gray (1993) discusses the meaning of health as a state of complete physical, mental and social well being, and not only the absence of disease.

Poor nutrition can lead to malnutrition which can exacerbate their chronic condition. Only 48% of respondents used the PHC facility for minor ailments such as stomach pains, flue, headaches and coughing. Because there are many chronically ill respondents, they also visit the clinic regularly, as seen below in Figure 5.

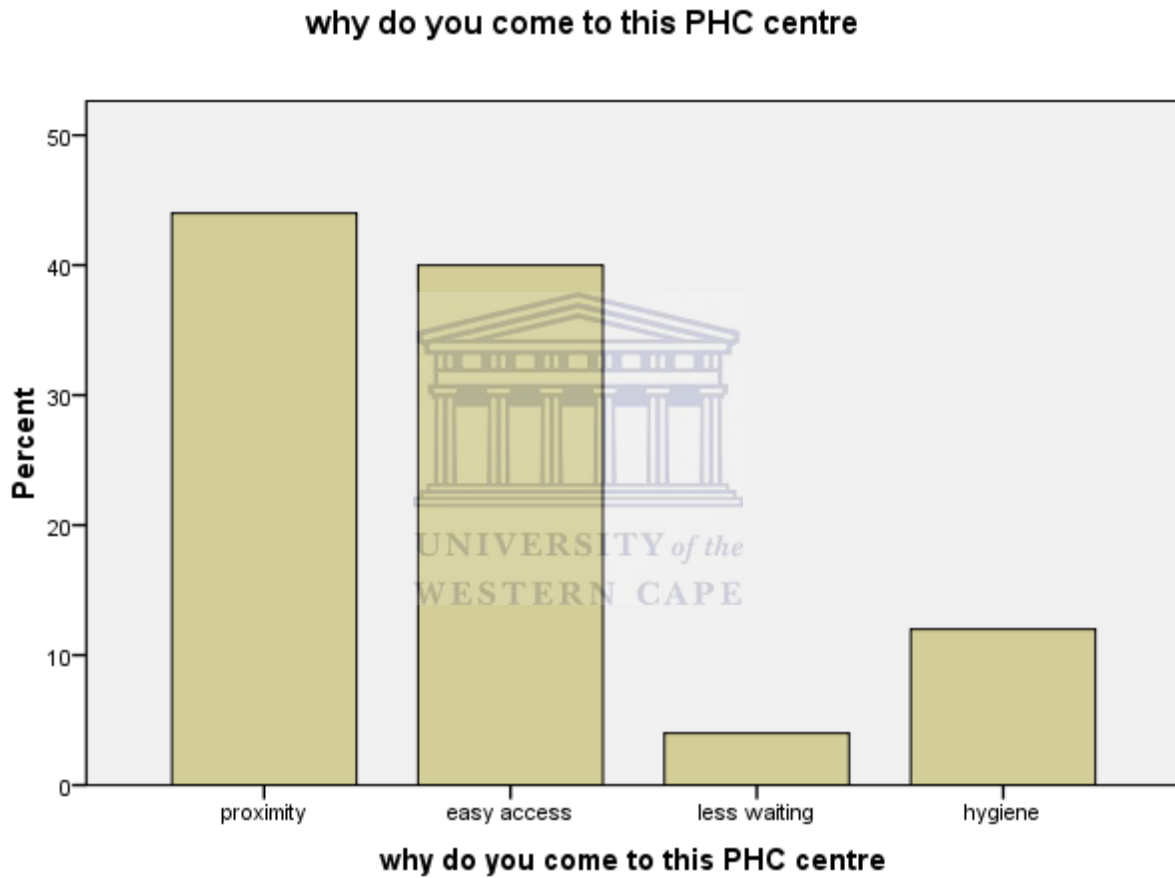
**6. FIGURE 5: PERCENTAGE VISITATION BY PARTICIPANTS TO PHC**



According to figure 5 48% of often visit the PHC centre, usually to collect their medication and for checkups. Mothers to take their children for vaccinations and weighing to see if they are growing as they should. They use this PHC centre because of its proximity. Thirty-six per cent as

(36%) of respondents indicated that they use of the PHC occasionally and 16% indicated that they rarely use the PHC facilities.

**7. FIGURE 6: PERCENTAGE OF PARTICIPANTS AS TO WHY THEY COME TO PHC**



According to figure 6, 44% of respondents indicated that they make use of this PHC clinic because of its proximity, while 40% indicated that it is easy to get to the PHC centre. Twelve per cent (12%) visit facility because it is clean and hygienic. Four per cent (4%) indicated that they wait in long queues before they are assisted. Yet, as seen in figure 8 below, once they have been assisted, they are generally satisfied with the services given to them.

**8. FIGURE 7: PERCENTAGE OF GENDER OF THE HEALTH CONSULTANTS**



Figure 7 represents 77% respondents who indicated that they consult with a female nurse or doctor. Twenty-eight (28%) per cent were assisted by a male doctor or nurse. When asked whether they were satisfied with the overall of the PHC system in general, the majority answered in the negative as seen below in Figure 8.

**9. FIGURE 8: OVERALL SATISFACTION OF PARTICIPANTS WITH PHC SYSTEM**

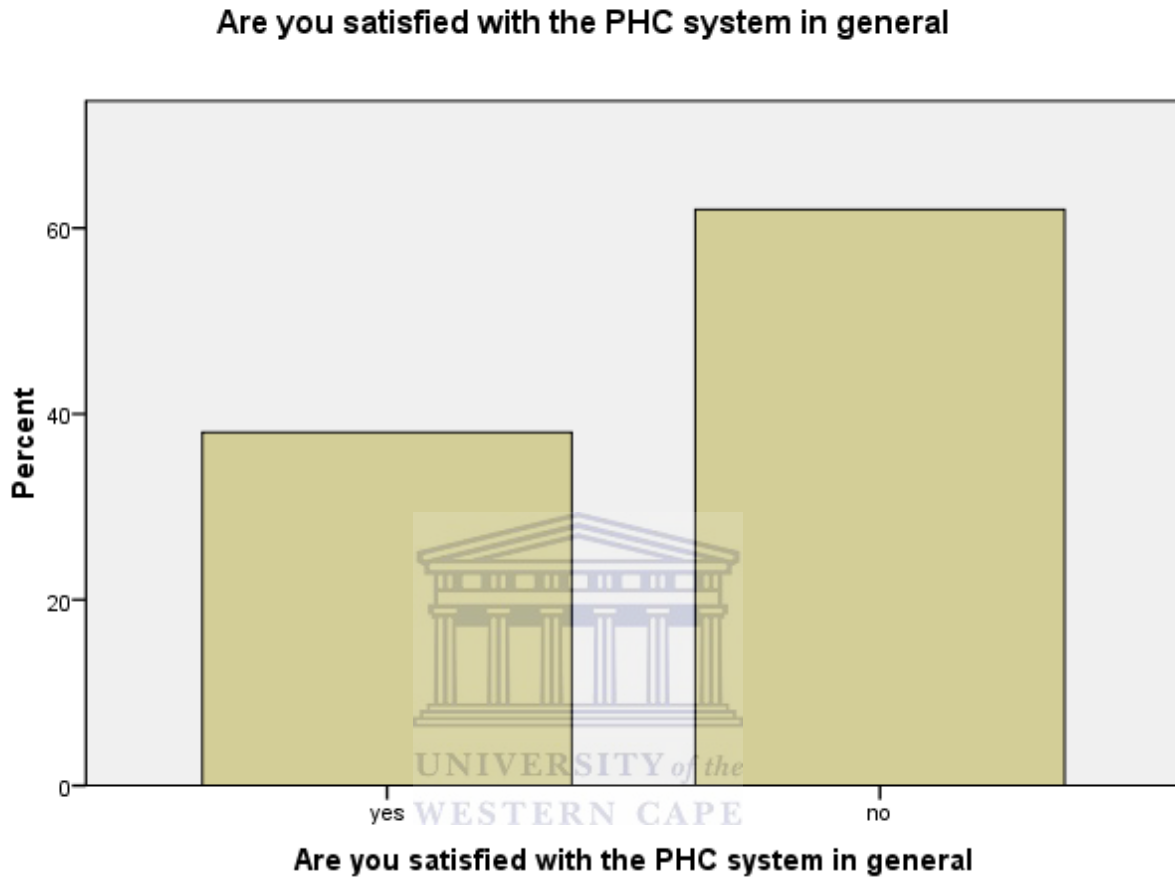


Figure 8 indicates that 62% of respondents were dissatisfied with the overall services. This was mostly because they had to be transferred to other facilities for certain levels of treatment. Sometimes the medication prescribed for a client is not available at the pharmacy and (she) he has to go to a chemist to buy it. Clients felt that, when the clinic is full there are not enough chairs for all the patients, there are a shortage of nurses, and clients have to wait long to see them. Clients also said that sometimes nurses are “*rude and disrespectful*” to the patients. Thirty-eight per cent (38%) of respondents indicated that they are satisfied with the overall system in general at this PHC.

## 10. FIGURE 9: BARRIERS TO USING THE SERVICES

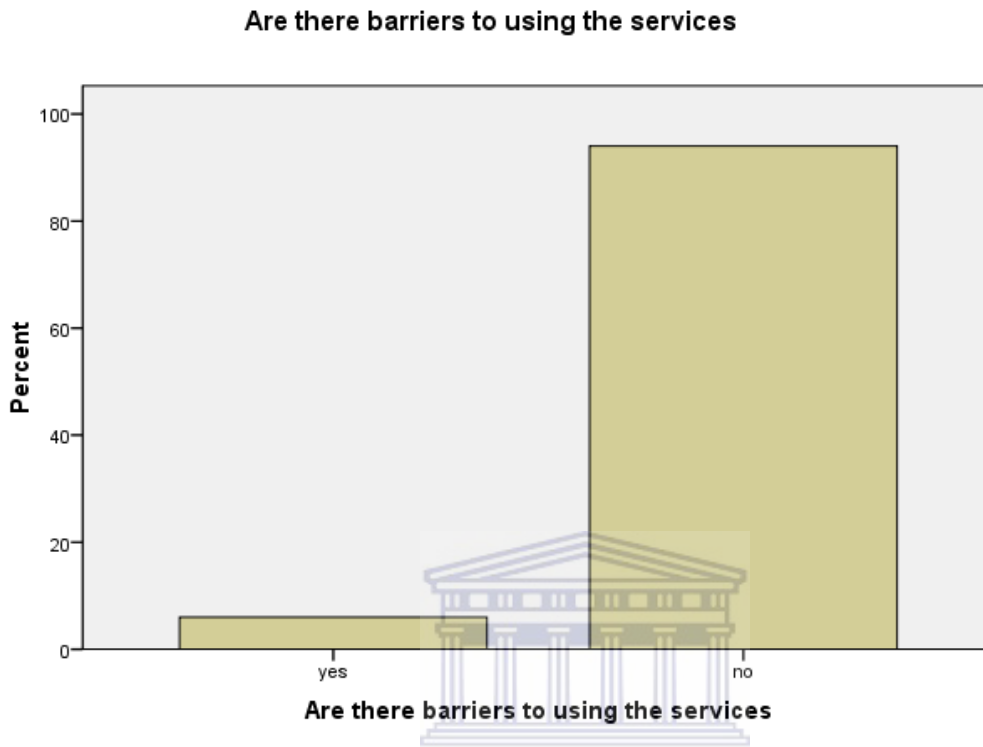
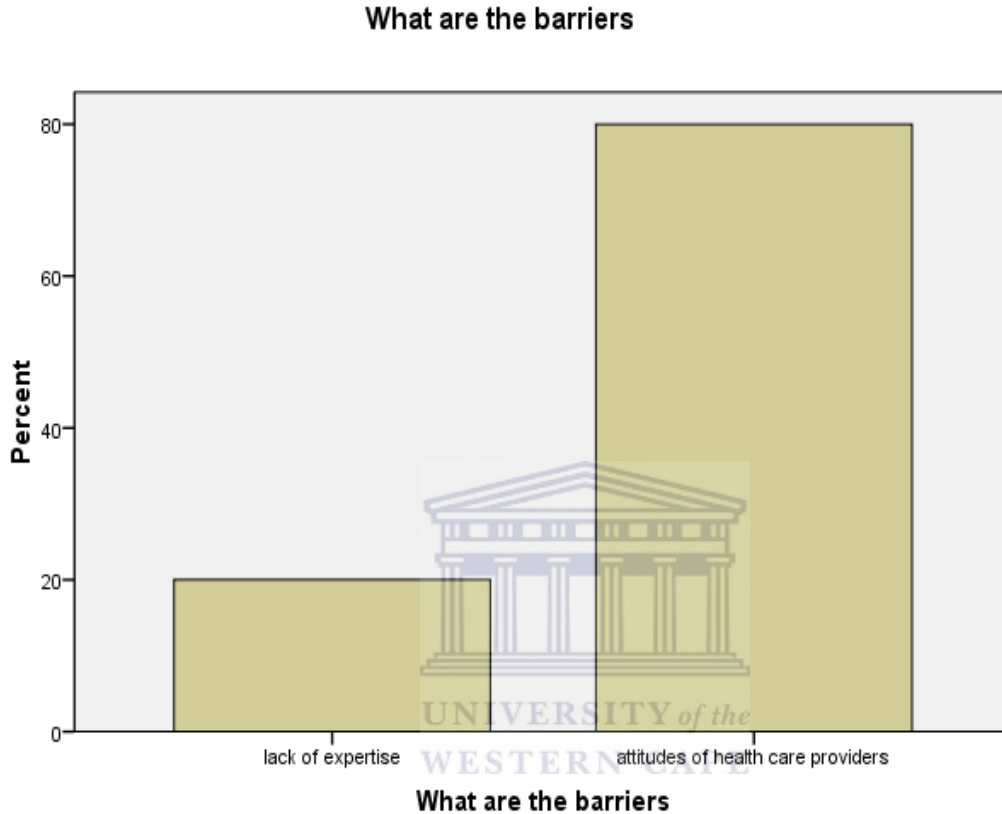


Figure 9 represents 94% of the participants indicated that there are barriers to making use of the PHC services. But the barriers do not prevent them from being assisted. Even when the nurses are rude and shouting at the patients at the end of the day, clients are ultimately served. Although clients complained about long waiting times to see a doctor, they were also satisfied with the service provided to them by the doctors.

In figure 10 below patients indicated unhappiness (80%) about the attitudes of the health care providers. In addition 20% indicated that the expertise to address their particular needs was not always available at clinic level.

**11. FIGURE: 10 BARRIERS PREVENTING THE PATIENTS FROM GETTING THE SERVICES**



**12. CONCLUSION**

There are advantages and disadvantages of having a PHC facility next to the community members but still it does not solve women’s problems. Women are the majority of people who not have formal education and basic salary to support their families they rely on government grants that they are using to buy vegetables and fruits to sell in the streets so that they can take care of their families. They are the pillars in their communities who take care of households and still volunteer to look after the sick patients and most of the work that they are doing is unpaid and without any appreciation from any one, they do the work out of their good willing and for the love and care of being a mother and parent to the community members. Because of lack of basic income they find themselves having to make use of the PHC facility that is close by as they



do not have enough money for transport and feed their families at the same time the only reason to use what is close by is because of accessibility and cost for them. Women also need to be taken care of as their health is also at stake while focusing on assisting others. They normally neglect their own health because of the stress levels as they have to think of feeding their families and making money at the same. Women need to be appreciated and recognized for all the efforts that they are doing to fill the gap of taking care of the sick at home without any medical training of facilities to enable them to look after the sick.



## CHAPTER SEVEN- GENERAL CONCLUSION

This thesis has tackled the issues affecting women in Khayelitsha while looking at their involvement in Primary health care. I mainly looked at the work that women are doing in their communities in connection with the basic elements of PHC. I also looked at how women understand PHC and the meaning they give to it in their communities. The aim of the study was to gain an understanding into the gendered aspects of PHC in the community and the health centre concerning the work that women do in their settings. I looked at the history of PHC where it originated and what was the main motive behind its implementation. In South Africa PHC was implemented in 1994 as a way of reaching health for all the people of South Africa and complying with the eight basic elements that will enable a healthy nation free from illness and ways of promoting preventive measures instead of curative. The main findings of the study are summarized below;

Some of the women are deeply concerned with day-to-day survival for their families. Thus finding a way to earn an income is very important. They also spend a great deal of time in what they loosely called “prevention”, i.e. efforts to clean up the general environment, thereby hoping to improve general well-being, but also to prevent the spread of illnesses. From the photographs that the women took, it became apparent that women see cleaning up ‘dirt’ as one of the primary issues of PHC. Issues of food and nutrition were also high on their agenda of concerns, as was clean water and sanitation. The photographs that women took was a reflection of their communicated feelings and ideas of what the women are doing concerning PHC and what it meant in their everyday lives concerning their health and that of their families. It was also a concern of how they would eradicate the problem of dirt and sanitation in their living spaces because the longer they wait for the government to do something about those grievances the more chances of children being born and raised in those conditions which are not conducive at all for any human being. It is a violation of their rights and denying them health which is also not complying with the basic elements of PHC in order to achieve its goals.

In addition the women have to look after their families and be able to put food on the table. All the women in my study emphasized the need for some form of an income as part of maintaining

health. It influenced both how women define their health and their ability to function as healthy people. The women found volunteering in the community as health care providers doing a difference in their lives. As the NGOs that they are working for are at least providing them with skills and making sure they get a healthy meal a day while making ends meet.

The other issues that were raised by participants and the health care workers in Nolongile clinic; some were negative and some positive. They showed the long waiting hours and the rudeness of the nursing staff. This indicates that the long queues are due to the shortage of staff somehow that is leading to the slow services, the nurses are not motivated to be assisting the patients as they have to cope with the pressure of assisting the patients who knock at their door steps for help. Women indicated that they use the PHC facilities to take children for vaccinations and check-up. They also visit it for family planning and birth control. Pregnant women attend the antenatal clinic and some women attend the clinic for checkups in relation to their chronic diseases. Women also visit the clinic to bring the elderly and to fetch chronic medication for them.

The other issue was that the women felt that the health care providers are not paying attention to what we are saying while in the consultation room which does not give a patient an assurance whether the health care provider will prescribe the correct medication or not because, even before they have finished explaining their problems to the nurses, a prescription is already being written without proper medical check. The women indicated that when they come for consultation they are expecting to be touched and examined which puts them at ease that the nurse is really paying attention and trying to find out the source of sickness from the patient. The other concern was the shortage of medication whereby patients are asked to come check again later in the week or to go to the pharmacy to buy the medication. This might mean that the supplier from the pharmaceutical depot does not have the medications that the patients needed.

This research has shaped me as a woman who is planning to have a family one day of the challenges that other women are facing and how do they cope to deal with those challenges daily as part of their learning experiences in dealing with health issues affecting their families. I learnt that illnesses are part of the living space that one calls home in order for one to stay healthy

cleaning and shifting needs to take place in the living environment. The experience of contracting TB made me aware that anyone can get TB and as a research I was supposed to comply with the rules of the clinic as it was a new exposure of environment to me.



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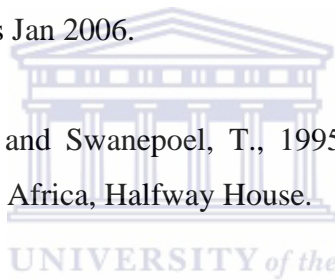
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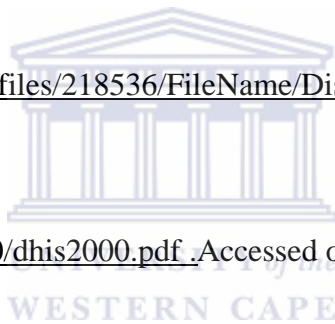
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## APPENDICES

### APPENDIX 1

**INFORMATION SHEET: Understanding women's involvement in primary health care: A case study of Khayelitsha (Cape Town).**



UNIVERSITY of the  
WESTERN CAPE

### Department of Anthropology & Sociology

I am Julia Mamosiuoa Kali studying at the University of the Western Cape. I am currently doing Masters in Medical Anthropology. My supervisor is Professor Diana Gibson (Anthropology and Sociology Department). I am doing research for my MA degree titled **Understanding women's involvement in primary health care: A case study of Khayelitsha (Cape Town)**. I am looking at the work that women are doing to maintain health in their families and communities.

I am kindly requesting you to participate in this study and share your knowledge and understanding related to the topic of this research. I wish to gain an insight into the knowledge, attitudes and practices concerning PHC among women. To look at what women are doing in their communities in connection to the basic elements of PHC, comprising of adequate supply of safe water and basic sanitation, promotion of food supply and proper nutrition and education about prevailing health problems and methods of prevention and controlling them. The study will motivate the women in realizing their self-confidence by volunteering as health workers in their communities and will empower them to serve their communities through the paid/unpaid health services.

The study involves interviews and focus group discussions designed to be not more than an hour at a time. The photographs that will be taken are for my academic purposes only. Each participant in the photographic study will be given a disposable camera after the completion of the task.

All information obtained in this study will be kept strictly **confidential**. When I use information concerning you I will use a pseudonym (not your true name). If you agree to participate, you will

be asked not to disclose anything said within the context of the discussion. All your identifying information will be removed from the collected materials, and all materials will be destroyed after the completion of the research. All consent forms will be kept safely by me in a locked cupboard. Only I will know your name,

**PLEASE NOTE:** Participation in the study is voluntary. You can withdraw from it any time you wish. Participating or not participating in the study will not affect your access to the Primary health Care Services in any way.

If you have any queries or complaints please contact my supervisor:

**Prof Diana Gibson at Tel 0219592336 or Myself Julia Kali on 0732385367 Email address: kali.julia@gmail.com**



**APPENDIX 2**



**“Title” Understanding women’s involvement in primary health care: A case study of Khayelitsha (Cape Town).**

**Researcher:** Julia Kali

**Please initial box**

1. I confirm that I have read and understand the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. (If I wish to withdraw I may contact the lead research at anytime)
3. I understand my responses and personal data will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports or publications that result for the research.
4. As a participant of the discussion, I will not discuss or divulge information shared by others in the group or the researcher outside of this group.
5. I agree for the data collected from me to be used in future research.
6. I agree for to take part in the above research project.

---

Name of Participant  
(or legal representative)

Date

Signature

\_\_\_\_\_  
Name of person taking consent  
*(If different from lead researcher)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Lead Researcher  
*(To be signed and dated in presence of the participant)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*Copies: All participants will receive a copy of the signed and dated version of the consent form and information sheet for themselves. A copy of this will be filed and kept in a secure location for research purposes only.*

**Researcher:**

**Supervisor:**

**HOD:**





### APPENDIX 3



Consent Form

University of the Western Cape

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**“Title” Understanding women’s involvement in primary health care: A case study of  
Khayelitsha (Cape Town).**

**Researcher:** Julia Kali

**Please initial box**

7. I confirm that I have read and understand the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.

8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. (If I wish to withdraw I may contact the lead researcher at any time)

9. I understand my responses and personal data will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports or publications that result for the research.

10. I agree for the data collected from me to be used in future research.

11. I agree for to take part in the above research project.

\_\_\_\_\_  
Name of Participant  
(or legal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent  
(If different from lead researcher)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_

Lead Researcher

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

*(To be signed and dated in presence of the participant)*

*Copies: All participants will receive a copy of the signed and dated version of the consent form and information sheet for themselves. A copy of this will be filed and kept in a secure location for research purposes only.*

<b>Researcher:</b>          
--

<b>Supervisor:</b>          
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<b>HOD:</b>          
---



## APPENDIX 4

### Photograph consent form: Understanding women's involvement in primary health care: A case study of Khayelitsha (Cape Town)



UNIVERSITY of the  
WESTERN CAPE

Department of Anthropology & Sociology

#### Information sheet and Consent form



Dear Participant

The photographs taken may not be used or published in any magazine. They will be used for research purpose only. They will not be circulated to the media. You may withdraw from the study if you do not feel comfortable with the taking of photographs.

If at any time you wish your photos to be deleted from the camera, please contact me on this number **0732385367**. My email address is [kali.julia@gmail.com](mailto:kali.julia@gmail.com). **Supervisor's no/ 0791860279**  
**(Prof Diana Gibson)**

I give permission to for the use of the photographs I have taken for the following research:

I confirm that I have read the letter attached to this permission form and understand the proposed uses for the photographs. I understand that I can withdraw the photo and delete it from the camera at any time by contacting the researcher.

I understand that there will be no payment for my participation. I will receive a free disposable camera after participating.

Signature of participant:

---

Date

---



**APPENDIX 5**

**QUESTIONNAIRES**

Survey form no .....

**Primary Health Care and Women in Cape Town Clients' Perception Questionnaire**

**A DEMOGRAPHIC and HEALTH CONDITIONS**

Name:

Age:  SEX: Male:  Female:  Income:

Education: <High School  High School  >High School

Medical condition: Chronic  Emergency  Minor ailment (e.g. stomach   
Discomfort; swollen part of  
Body; continuous headache)

**B VISITS TO PRIMARY HEALTH CARE (PHC) CENTRES/UTILISATION OF SERVICES**

How often do you come to this PHC? Regularly  Occasionally  Rarely

When was the last time? <3months  3-6months  6-9months  9-12months  >12months

Why do you come to this PHC centre? Proximity  Easy access  less waiting  Service  hygiene

Who do you see? Doctor:  Nurse:  Both:  Other (e.g. physiotherapist):

Is the person you see: Male:  Female:

How often do you see the person? Regularly:  Sometimes:  Rarely:

How long does it take you to see the person? <30mins  30-60mins  >60mins

How long do you have to travel to get to the centre? <5miles  5-10miles  >10miles

What is the travel time to the centre? <30mins  30-60mins  >60mins

**C PERCEPTION**

**1: Services**

The services are: Adequate  less Adequate  Not Adequate

The doctors are: Attentive  Less Attentive  Not Attentive

The Nurses are: Attentive  Less Attentive  Not Attentive

The Health Care Professionals are: Attentive  Less Attentive  Not attentive

The Doctors are: Friendly  Less friendly  Not Friendly

The Nurses are: Friendly  Less Friendly  Not Friendly

The Health Care Professionals are: Friendly  Less Friendly  Not Friendly

**11: Infrastructure**

The clinics are: Big in Size  Reasonably-sized  Small

The clinics are: Very clean  Reasonably clean  Not clean

The clinics have: Adequate Facilities  Less adequate facilities  No facilities

The clinics are: Well maintained  Less maintained  Not maintained

**11: Structural**

Are there barriers to using the services? Yes  No

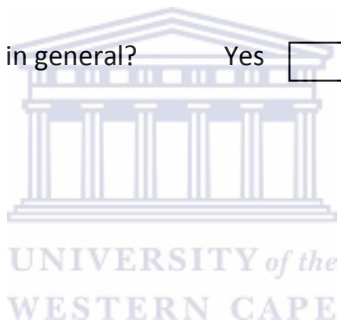
What are these barriers? Physical access  Lack of expertise  Attitudes of Doctors/Nurses/others

Are your needs met? Yes  No

Do you pay for health care at the PHC centre? Yes  No

**D: Overall satisfaction**

Are you satisfied with the PHC system in general? Yes  No



## APPENDIX 6

### Client perception PHC: Semi-structured interview

#### Male/Female (please distinguish)

1. What do you use the clinic for most of the time? Please give me examples.
2. How is the clinic different for men and women? Please give examples (in relation to services provided and staff attitudes).
3. How do staff relate differently to men and women in the clinic? (Probe also for men who come with 'women's work or women who come with men's work?)
4. Why do you think men and women have different experiences in the clinic? Please give examples.
5. What has been your own experience with the clinic? Please give examples.
6. What are the differences in the way that the clinic handles young and old people?
7. What differences are there in the way you are served by staff of the opposite sex? Give examples.
8. What differences are there in the way you are served by staff of the opposite race? Give examples
9. What is the most problematic for you in terms of the services provided by the clinic? Give examples
10. What is the most positive for you in terms of the services provided by the clinic? Give examples
11. Which clinic in your area is the best? Why and how?
12. Are there any issues related to the clinic that you think we should also look at? Please give examples



## APPENDIX 7

### Questionnaire for the health care providers

**What is seen as women and men's work in relation to the following things?**

Health education

Nutrition

Water

Sanitation

Mother/ Child care

Family planning

Prevention of local epidemics

Immunization

Medicines

Treatment of common diseases

Care for sick family member



## APPENDIX 8

### **Impact of PHC for women.**

#### **FGD Questions**

1. What is a typical day at the clinic like for a woman?
2. What would you see as good quality health care for women?
3. How efficient is the health centre?
4. What are the positive aspects of the health centre?
5. What are the negative aspects of the health centre?
6. How is the quality of care at the health centre?
7. What are the staff attitudes towards clients?
8. What are clients' experiences receiving medicines?
9. What is health education like at the health care centre?
10. How can quality of health care for women be improved in this health care centre?

