3. The ethnographic lens

Karina Kielmann
Queen Margaret University, Scotland, United Kingdom of Great Britain and Northern Ireland

While ‘ethnographic’ has mistakenly come to be used as a blanket term to refer to various qualitative methods, ethnography is more accurately seen as a particular methodology. The term refers to both a research approach (literally, ‘writing about people’) as well as the written product of the research (such as a text, report or book). It represents a defining moment in anthropology, the point at which scholars abandoned the ‘armchair’ in favour of fieldwork to capture the totality of social life in an alien setting. The classical approach to ethnography generally involves lengthy periods of fieldwork, immersion in the ‘everyday life’ of a chosen setting through observation, interaction, talking to members of the particular social world being studied, and looking at documents or artefacts. The written account is a synthesis of the researcher’s impressions recorded as fieldnotes, observations or interview data – sometimes handwritten, but increasingly captured with the help of recording devices. Perhaps because of the tensions involved in being a participant-observer, as well as the open approach to what constitutes ‘legitimate knowledge’ (Savage, 2000:1401), ethnography has raised more concerns than any other form of social research regarding the problem of ‘representation’, i.e. the way in which researchers choose to depict the ‘reality’ of people’s lives and give voice to their subjects.

Classical ethnographic approaches are rare in applied health research not only because of the constraints on time, and practical feasibility, but also because they do not resonate with the positivist framing of most health-related study designs. However, the various genres of ‘traditional’ ethnography that have been conducted by medical anthropologists and sociologists offer important insights for understanding health policy and systems issues.

First, ethnographies that have followed the life, or lives, of individuals and groups affected by a particular health condition have developed our understanding of how and why people are enabled (or hindered) in their efforts to make effective use of services and manage their conditions. For example, recent work has examined how people living with a condition draw on a collective ‘biosocial’ identity to formulate claims to treatment, compensation, and other social resources. In the case of HIV, some have argued that this form of ‘therapeutic citizenship’ has directly affected policies around access to treatment as well as the delivery of HIV care (see Nguyen, 2008).

Second, ethnographies that have explicitly focused on practitioners and their professional socialization within health systems provide important insights into the feasibility of health systems interventions that assume (or introduce shifts in) particular professional hierarchies or working arrangements. One focus has been to examine how working environments and workplace dynamics shape provider identities and interprofessional collaboration. For example, attention has been paid to the often complex working relations between nurses and clinicians (Fitzgerald, 2008) as well as to the working ‘cultures’ of less visible cadres of health staff, such as ‘peons’ (Justice, 1986).

Third, a number of classical ethnographies have focused on organizations. Stemming from the work of a feminist sociologist (Smith, 1987), such studies aim to examine how work activities shape and maintain the institution, analysing the ideological procedures that make these work processes accountable and exploring how work processes are connected to other social processes. Here, the ethnographic lens allows a nuanced analysis of organizational culture and dynamics, a means of identifying, for example, how “… the organization’s formal structure (its rules and decision-making hierarchies) are influenced by an informal system created by individuals or groups within the organization” (Savage, 2000:1402). Examples include hospital ethnographies (for example, Van der Geest & Finkler, 2004) and project ethnographies (for example, Evans & Lambert, 2008) that examine the
contexts within which policies formulated at a national or international level play out in the context of local institutional codes of practice.

Finally, ethnographies have also focused on controversies or debates in order to bring to light the tensions between rhetoric and practice in health systems relationships. Taylor, for example, one of the first to undertake an ethnography of a health system, uses a controversy over resource allocation in a Scottish archipelago to make visible the ways in which “… different groups formulate and pursue their interests both within and outside of the formal structure of the local health care system” (Taylor, 1977:583).

Although there are very few extensive ethnographies of biomedical practice and health systems in low- and middle-income (LMIC) settings, anthropologists have explored ‘biomedical’ or ‘Western’ health care ideology and practices within discussions of medical pluralism, for example in South Asia (see, for example, Leslie & Young 1992). Classic ethnographies have also examined the ideas of the ‘great’ traditions of institutionalized non-allopathic medical traditions (for example Ayurveda and Chinese medicine) or the realm of ‘traditional healing’, as opposed to everyday ‘practiced medicine’ (Khare, 1996). Important insights regarding the historical and structural bases of Western medical policies and systems and health care organization in LMIC settings can be gleaned from ethnographies of colonial medical systems (for example see Allen, 2002). Additionally, there are a limited number of ethnographies on global health policies as introduced in local contexts. An excellent early example is provided by Judith Justice’s (1986) ethnography on international health bureaucracy in Nepal that examines the context of policy-making and implementation for an initiative known as the Integrated Community Health Programme. Whiteford & Mander- son’s edited volume (2000) also provides a good range of rich case studies of the gaps between the world of global health policy-making and local implementation within specific social, political and health systems contexts.

Health policy and systems researchers can benefit from reading classical ethnographies to better understand the theoretical framing, social, political and historical contexts of policy formulation and critical assessments of how policies translate in local health systems. At the same time, an ethnographic approach can be used in time-limited studies to allow for a more in-depth, rich, and nuanced analysis of the relationships between power, knowledge, and practice in health systems – and how the introduction of changes (in the form of interventions and initiatives) may “… generate different and often unexpected results in different circumstances [helping to] identify system dynamics and their key outcomes, which may not be apparent at the outset.” (Huby et al. 2007:193). An ethnographic lens is, therefore, useful in studies seeking to explore and explain health policy and systems experiences.

Rigour in adopting an ethnographic lens

Three key methodological characteristics underpin the rigour of the ethnographic lens as applied within HPSR studies. First, such studies adopt methods that are open-ended, in-depth and flexible in order to capture multiple dimensions of how things work (or don’t work) in ‘real time’ and with privileged attention given to the perspective and experiences of those being interviewed or studied. Some researchers specifically triangulate methods to improve validity, but also to explore diverse perspectives in the data. Second, their analysis is interpretive, seeking to situate the meaning of particular health policy and systems ‘practices’ in social, political and/or historical context. Third, to address the challenge of representation, they adopt a reflexive position vis-a-vis their areas of inquiry, that is they explain how their own position as researchers and participant-observers (in some cases) help to shape their areas of interest, the questions they posed and their interpretive lens.
References


Overview of selected papers

The selected papers provide examples of work conducted by social researchers who have adopted ethnographic approaches and methods in their work on policy-making, disease control programmes, ‘routine’ health systems practices and provider dynamics in low-income settings.

Aitken (1994) examines the implementation of provider training activities in Nepal and shows how the values providers demonstrate in their daily actions (values in use) shape their engagement with these activities and undermine the performance improvements that they are expected to achieve.

Behague & Storeng (2008) examine global policy debates around vertical and horizontal approaches to maternal health care provision and evidence-based policy-making, teasing out the underlying epistemological positions and relevance for policy and advocacy.

George (2009) examines routine human resource management and accountability practices in Koppal state, India, showing how a complex web of social and political relations among different actors in primary health care influences local understandings and channels of accountability.

Lewin & Green (2009) explore two sets of common rituals in South African primary health care clinics – Directly Observed Therapy for tuberculosis and morning prayers – in both of which nurses and patients participate, showing how these different rituals serve to reinforce traditional power relationships between providers and patients.
References for selected papers


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Debts about vertical versus horizontal approaches to health improvement have a lengthy unresolved history in public health. Vertical approaches are generally disease specific and promote targeted clinical interventions delivered by a specialized service. Horizontal approaches, by contrast, tackle several interrelated health issues by strengthening health systems and developing integrated delivery systems. Despite prolonged efforts to combine vertical and horizontal approaches, vertical programs have dominated and are often found competing with one another for funds and professional recognition. Professionals in the international maternal health subfield are currently grappling with how to improve vertical and horizontal synergy. This has lead to lively debate on the role of evidence production. Whereas some call for the scientific rigor of randomized controlled trials, others claim that using randomized controlled trials is misplaced because of the complex health systems needs of maternal health interventions.

Using the international maternal health field as a case study, we draw on ethnographic research to investigate how public health researchers and policy experts are responding to tensions between vertical and horizontal approaches to health improvement. Despite nominal support for an integrative health system approach, we found that competition for funds and international recognition pushes professionals toward vertical initiatives. We also highlight how research practices contribute to the dominance of vertical strategies and limit the success of evidence-based policymaking for strengthening health systems. Rather than support disease- and subfield-specific advocacy, the public health community urgently needs to engage in open dialogue regarding the international, academic, and donor-driven forces that drive professionals toward an exclusive interest in vertical programs.

**METHODS**

Our research focused on debate at the international level because of our interest in developments that are critical to the field’s overarching reputation and identity. Conceptually, we explored how the maternal health field has emerged as a coherent and recognizable network of specialist actors, technologies, and ideas. We triangulated 3 methods—open-ended, in-depth interviews; participant observation; and review of published and gray literature documents—to improve the validity of findings and explore diverse perspectives. We interviewed a total of 67 professionals (Table 1), identified opportunistically through professional networking, publications, and conference proceedings. Of 67 informants, 19 were from developing countries. Many informants had experience working in multiple domains of public health.

Interviews followed a semistructured guide to explore definitions of evidence and evidence-based policymaking, professional experiences with production and use of evidence for policymaking, historical shifts in policy, debates around integration and health systems strengthening, and relationships with donors. Using an inductive process, we modified the interview guide to reflect concerns that emerged during data collection. We conducted participant observation within academic settings, as well as at 15 research meetings, academic conferences, and policy meetings. Of these, 8 were not specific to maternal health but focused on general public health or child, neonatal, or reproductive health. All informants were interviewed formally once, although participant observation enabled repeated contact with many of the informants. Because key players in the field often represent their views via publications, we used published and gray literature as forms of ethnographic data.

We transcribed interviews verbatim and stored and organized them in NVivo7 version 7.0 (QSR International, Cambridge, Massachusetts). Both authors read the interviews and notes taken during participant observation and carried out thematic analysis independently. No significant discrepancies in identified themes and analytic conclusions were found.
was the pressure to support vertical approaches because of an intense sense of competition between subfields. As one informant stated:

The maternal health field really competes against other fields for money. And other fields, like the big spenders—malaria, HIV/AIDS, even child health—have a better record of promoting evidence-based interventions. Maternal health might be at risk of being left behind, because if you miss the target too often, with traditional birth attendant training, then risk screening, you create donor fatigue.

Anxieties around how donors view the relative importance of health problems were paramount. “All fields have that anxiety,” said one policy expert. “Maternal health had its heyday, and newborn health is now having its heyday. They’re all scared they won’t get the attention and money they had before.” Several informants claimed that integration, although theoretically sensible, would in actuality divert funds and policy attention from maternal health. As one academic stated, “I think the jury is out on whether [the fields will integrate] or whether one will get sucked into the other’s agenda and get lost.” The lack of funds for strengthening comprehensive health systems added to the view that strategies promoting evidence-based interventions, maternal health’s “very sad history,” could be attributed to “a failure of policy experts” and donor priorities.

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By contrast, a minority of informants felt that the “attention-seeking strategies of vertical initiatives such as [Global Alliance for Vaccines and Immunisation and] Roll Back Malaria” were disempowering because they alienated subfields from one another and fragmented initiatives within each subfield. These informants explained that maternal health experts had attempted to bolster the field’s reputation by searching for a single targeted vertical intervention, or “magic bullet,” that would appear to be globally applicable and feasible to donors and governments.

The search for a single intervention was not only reductionistic; some argued, but contributed to infighting and the constant shifting of proposed vertical interventions, from training traditional birth attendants to antenatal care to emergency obstetric care, each vying for policy attention. Such dynamics resulted in the splintering of what could be a comprehensive community and facility-based health systems approach into specific targeted subcomponents, or, as one policy expert described, isolated “bits of the jigsaw puzzle.” These informants claimed that the search for new, targeted vertical solutions ironically had the opposite effect than originally intended. Rather than boost the field’s reputation, the picture that emerged to donors and governments was that of an uncoordinated and divisive group.

The Role of Researchers and the Limitations of Current Evidence-Based Models

Polarization of academic researchers and policy experts. Our second research question examined the factors that constrain researchers from producing evidence that enables synergistic vertical and horizontal policymaking. Our results indicate that researchers were hindered by a detrimental polarization that positions the academic community in stark opposition to a group we termed policy experts. In broad terms, this group includes professionals from UN agencies, international nongovernmental organizations, and developing country governments.

Our informants’ attention to this polarization reinforced opposing views regarding the relative importance of advocacy and program development versus research for ensuring the field’s survival. In general, researchers felt policy experts were more deeply involved in the

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*Note: UN = United Nations; NGO = nongovernmental organization.*
process of advocating for political and financial investment in maternal health. Researchers reluc-
tantly accepted the need for such advocates, even if what they espoused was empirically unfounded. One informant claimed,

There would not be a penny of funding if people listened to me... I’m too negative. Some people are good spokespersons for Safe Mother-
hood. [They] will stand up and say things; they know there is no data behind it, but they will keep saying it. And it gets the work done.

Other researchers went further, claiming that the field’s failures relate directly to an insufficient “evidence-based approach” that was partially caused by advocates’ “militant” style. As one interviewee noted,

When people became aware of the M in MCH [Maternal and Child Health], the field was dominated by people on a mission, and while it is good to have such people, because they are the ones who attract attention and bring money, if it is too exclusive, you will miss the scientific rigor and skepticism.

In contrast to this critique, policy experts frequently held researchers responsible for paralyzing action and political will by empha-
sizing the scientific uncertainty of the current evidence base. These informants claimed that research often directly contradicted policy ex-
erts’ need to persuade donors of the impor-
tance of maternal mortality and suitability of a particular programmatic approach. As one informant highlighted,

The big challenge is that there’s uncertainty no matter what. And policymakers have to deal with uncertainty. When it’s uncertain, the re-
respectroscope is going to prove that you were wrong in your efforts to be certain. Policymak-
ers can’t sit on the fence. Researchers can.

Some policy experts even claimed that investing resources in effectiveness research would undermine the field by diverting atten-
tion and funds from much-needed programs. As one senior policy expert described,

This field has been so contentious because there hasn’t been enough money. If [only] there had been money to do both research and [develop] programs in the way that child health has had money... This contentious-
ness causes donors to turn around and run in the opposite direction, so it’s a vicious cycle.

At the same time that informants put forth such dichotomizing statements, several re-
searchers were well aware that tensions be-
tween research, advocacy, and policymaking needed to be assuaged for the sake of the field’s professional coherence and future success. In response, some researchers explic-
itely devoted considerable attention to what they termed “advocacy research,” such as estimating the global magnitude of maternal health problems compared with other dis-
cases. Researchers highlighted the political importance of this work, even if some claimed this type of research does not answer analytic questions relating to programmatic development and evaluation.

Policy experts and researchers are clearly in a mutually interdependent, if tumultuous, relationship. When asked to reflect critically on this relationship, informants often made reference to the rapidly expanding body of literature on communication problems be-
tween academic researchers and policy ex-
erts.36 Indeed, several respondents felt that these difficulties were at the core of failed effectiveness for evidence-based policymak-
ing and argued for improved communica-
tion channels, more effectively disseminat-
ing new evidence, and capacity building for each respective group.

Diverting attention from questions of episte-
mology. Although important to elucidate, the intensive focus on improving communication diverted our informants’ attention from en-
going with epistemological questions relating to evidence-based health system policymak-
ing. Despite growing debates regarding the limitations of current epidemiological meth-
ods for health systems questions, few inform-
ants spontaneously engaged in discussions about research models. Rather, several re-
peatedly espoused the superiority of the ran-
domized controlled trials design for providing definitive proof of the causal relationship be-
tween intervention and outcome, irrespective of the type of intervention being evaluated.

With the randomized controlled trial, said one statistician, “you don’t need to understand how the interventions work” to establish its relative advantage. Another claimed that no design can [control confounding] as the ran-
domized controlled trials. One should probably always aim at doing randomized controlled tri-
als. If you want to deviate from this rule you should have very good reasons.

It was only after prompting informants to describe specific instances involving the use and interpretation of evidence for policy that issues relating to the limitations of experimen-
tal research emerged. Core to these discus-
sions were the logistical, ethical, and analytic difficulties of conducting effectiveness re-
search on horizontal approaches. As one in-
formant explained,

Designing a study for skilled attendance at de-

delivery is [very difficult] because how the hell do you do a trial of a midwife versus no mid-
wife or a midwife versus a traditional birth at-
tenday? It becomes a very difficult medical and organizational dilemma. Do you get women to deliver at home and women to de-
liver at hospital?

Informants interested in health systems questions (e.g., budget support and human re-
source strengthening) expressed frustration at the scientific method’s inability to adequately research these topics. As one informant argued,

It’s really hard to measure the impact, you know, what are you measuring? And the line of attribution [from budget support] down to improvements in maternal health outcomes is also difficult.

According to many informants, resistance to the Partnership for Maternal, Neonatal, and Child Health’s promotion of the continuum of care approach is based largely on difficulties relating to affect evaluation:

If you want to say the continuum of care is the answer, how do we validate and monitor that? How do we say it was proven to work, what are the outcomes, how many lives are saved?

Despite such frank discussions, most in-
formants rarely questioned their own episte-
mological positions or ventured into new meth-
odological and disciplinary arenas. Rather, they modified their research questions—specifically, the types of interventions being tested and the units of analysis used—to suit an experi-
mental or quasi-experimental design. Most of-
ten this meant avoiding questions relating to health systems strategies and focusing on vertical clinical interventions, such as the ef-
fect of calcium supplementation or oxytocin administration. These informants explained
that clinical research will always be relevant to policy and that such research allows them to carve out their own area of expertise and publish successfully.

Other informants more committed to studying health systems issues attempted to overcome the limitations of experimental study designs by testing only a single subcomponent of a larger health systems package. Examples include the effect of road construction or introducing mobile phones and ambulances on health utilization rates. As one informant explained, conclusively evaluating complex multicomponent interventions is such a challenge that “people are avoiding those kinds of studies and instead proposing studies like ‘what if we put an ambulance in the villages? Will that do it?’” However, as another informant aptly summarized, the practical implications of using the randomized controlled trials for multicomponent interventions are tremendously complex:

To do a [sic] good randomized controlled trials, you have to ask a very narrow question. There isn’t enough money in the world to answer all the questions with randomized controlled trials. So people say, ‘we’ll put three things together that we think work and then we’ll test that against no change.’ But it’s highly unlikely that all of [the components] are equally cost-effective or that you need all to be synergistic. You could take a few and get the same amount of change. . . . Your hypothesis could be that it’s any one or the combination of factors or even some synergy about using certain ones together. To test all those combinations is impossible!

Reasons for the predominant research focus on vertical interventions. The normative power of scientific values surely persuades researchers to abide by experimental designs. However, informants highlighted other important reasons for the predominant focus on experimental studies of vertical interventions. Results from studies that clearly demonstrate the effectiveness of a single specific subcomponent were said to generate consensus, to be easier to disseminate to policy experts, and to have more straightforward applications in policy development. Vertical studies were also allegedly preferred by donors, who demanded to see a return on their investments by encouraging governments to implement policies for which both intervention and outcome could easily be monitored. Informants felt mounting pressure to use evidence about the relative cost-effectiveness of different subcomponents to help governments in developing countries with resource allocation.

A less explicit reason for informants’ reticence to deviate from experimental designs relates to the field’s low status and to the issues of competition reviewed in the “Results” section. Referencing a recent publication, a number of informants claimed that because the lack of an evidence-based approach in maternal health has compromised the field’s standing, only the highest research standard should now be accepted. Contextual, observational epidemiology, and multidisciplinary research were not viewed as proper academic research and were often relegated to the less scientific realm of operations research. As one international policy expert described, “Health systems research can’t really ever tell us much, other than at a highly contextualized level.” One researcher stated that only those in well-established subfields who are “starting from the top” can afford to take on the professionally risky activity of pushing the limits of epidemiological theory and methods. Maternal health, by contrast, is starting from the bottom and, therefore, needs more-rigorous experimental studies to be able to provide conclusive recommendations and secure its status.

Other informants were more critical of this position, stating that the scientific community’s insistence on using randomized controlled trials has created a dogmatic and detrimental donor demand for experimental evidence. As a couple researchers stated, the indiscriminate use of the randomized controlled trials often provides very rigorous answers to irrelevant questions. However, being bold and diverting from experimental designs means opening oneself up to criticism and potentially losing publications, funds and political credibility. As another epidemiologist stated,

I am so convinced of the argument. . . . But what makes policymakers shift? Do we need another beautiful trial showing that traditional birth attendants make no difference? I hope not. It’s not whether in the perfect circumstances you can train traditional birth attendants and supervise them. Of course that can make a difference. But then you’re talking about an expensive system; you might as well train skilled providers. . . . Quite a few people are calling for trials of community health workers . . . and the donors are taking note. If we’ve gone that far . . . what a waste of money. Maybe we have to play the game; I don’t know.

As this comment suggests, informants sometimes felt that reducing the focus of the research question to conduct randomized controlled trials was scientifically unnecessary but politically and professionally indispensable. At the same time, informants also frustratingly acknowledged that this approach reinforced the dominance of vertical approaches and compromised a health systems approach. As one researcher aptly summarized, the scientific attempt to discern if a particular community- or facility-based strategy has a greater effect on mortality over another “is just trappings, and feels like a waste of time and money. . . . I wouldn’t say one is better than the other, I would say if you neglect the nuts and bolts of the system, you risk getting nothing done.”

DISCUSSION

Many policy experts support the agenda to integrate subfields and wish to work toward health systems strengthening. In practice, however, the competitive playing field pressures policy experts to support subfield-specific initiatives and funding in an effort to bolster the field and advocate for resources and political will. These findings indicate that a distinction exists between what can be termed policy-relevant approaches and advocacy-sensitive approaches. The former respond to policymaking and program implementation needs, be they vertical or horizontal. The latter, by contrast, are used to advocate for the survival and status of the maternal health professional community and tend to be vertical approaches. Under the pressures of subfield competition, our results show that key experts are being pushed toward advocacy-sensitive practices, and because they are more vertical by nature, this is happening at the expense of practices that could more adequately respond to synergetic vertical–horizontal policymaking.

Maternal health researchers, in turn, respond to the pressures for financial support and professional prestige by aiming to produce evidence that is politically expedient, useful for securing their academic reputations, and able to ensure the survival of the maternal health community. For many, this means the use of experimental research to
evaluate either clinically targeted interventions or vertical subcomponents of larger health systems packages. These dynamics impede researchers from following the lead of recent literature that scrutinizes the suitability of an experimental clinical research model for questions relating to complex health systems interventions. As a result, the production of useful evidence for horizontal policymaking, as well as for vertical–horizontal synergy, is sorely lacking.

The issues of rivalries over funding, diverse donor-driven agendas, and what informants describe as the “false and damaging” dichotomies between maternal and child health, as well as between community versus facility-based interventions, have received considerable attention in the literature. The recent Lancet series on maternal survival had as one of its main aims to “provide an opportunity to mark a shift [away] from unhelpful dichotomies that slow action in countries [and] stifle funding.” Given the results of our analysis, we must question whether such high-profile statements will have the desired effect of joining diverse factions if they do not (or cannot) address the factors that drive vertically oriented programs and research.

Policy researchers have argued that significant obstacles to a coherent policy agenda on vertical–horizontal synergy include weak health systems, current priority-setting mechanisms based on uncritical support for traditional disease ranking and cost-effectiveness measures, and uncoordinated and conflicting donor agendas on which many developing countries are reliant. In addition to these obstacles is the crucial issue of how to improve evidence-based policymaking practices.

The literature suggests that poor communication between researchers and policymakers is a key constraint to improving evidence-based policymaking. Our informants have clearly been influenced by this literature, yet our findings suggest that the limited ability of experimental methods to provide evidence about integration and complex health systems is a more important impediment. This is being increasingly recognized in the public health and sociological literature. As we have shown, when it comes to actually changing evidence-based practices, the messages issuing from this body of research remain theoretical and difficult to operationalize.

CONCLUSIONS

On the basis of our findings, we suggest modifying evidence-based policymaking practices in 2 main ways. First, it is important to create institutional environments that actively promote the development of new research models for investigating complex and context-specific interventions. As we and other authors have shown, context-specific health systems research contradicts the need in public health for a generalizable and marketable evidence-base of vertical programs that are easy to evaluate and show a measurable impact on outcomes. A major challenge for public health lies in prioritizing context-specific horizontal initiatives even where impact cannot be as precisely shown as in the case of vertical interventions. This is particularly the case in developing countries, where vertical initiatives to reduce mortality quickly are vital and, yet, where progress in general development requires active intersectoral collaboration and wide-ranging social initiatives.

Second, it is important to examine the larger international, donor-driven, political, and academic factors that persuade policy experts and researchers to adhere to current normative models of vertical programming and evidence production. Otherwise, competition will continue to encourage subfield-specific advocacy, give preeminence to vertical and subcomponent interventions, and push researchers toward the uncritical application of experimental methods. Continuation of the status quo may also lead to the marginalization of one of epidemiology’s primary contributions to public health: that of identifying interrelated determinants of disease patterns and mechanisms of change.

About the Authors

At the time of the study, Dominique P. Béhague and Katerini T. Storeng were with the Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London, England. Requests for reprints should be sent to Dominique P. Béhague, Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, Kappel Street, London WC1E 7HT, United Kingdom (email: dominique.behague@lshtm.ac.uk).

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Contributors

D. P. Béhague led development of the project proposal for funding and wrote the article. K. T. Storeng contributed to developing the project proposal for funding and commented on several drafts of the article. Both authors collected and analyzed the data.

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We would like to thank, first and foremost, all our informants for being such forthcoming and helpful participants in this research. Their willingness to discuss sensitive problems and tensions emerging from within the field of maternal health should not be taken as an objective indicator of the field’s shortcomings compared with other fields. Rather, our informants’ open and frank discussions indicate high levels of critical awareness and self-reflection and an ability to engage with the difficult questions that many, if not most, experts in diverse public health subfields currently face.

Note. The Economic and Social Research Council had no involvement in determining the study design, the collection, analysis, and interpretation of data, or in writing this article.

Human Participant Protection

Ethics approval was granted by the London School of Hygiene and Tropical Medicine ethics board.

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11. Victoria C, Habicht J, Bryce J. Evidence-based public...
Ritual and the organisation of care in primary care clinics in Cape Town, South Africa

Simon Lewin*, Judith Green

Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, United Kingdom

A B S T R A C T

Few sociological studies have examined care organisation in primary health settings in low- and middle-income countries. This paper explores the organisation of health care work in primary care clinics in Cape Town, South Africa, by analysing two elements of clinic organisation as rituals. The first is a formal, policy-driven element of care: directly observed therapy for tuberculosis patients. The second is an informal ritual, seemingly separate from the clinical work of the team: morning prayers in the clinic. We draw on data from an ethnography in which seven clinics providing care to people with tuberculosis were theoretically sampled for study. These data include participant observation of clinic sessions, and interviews and group discussions with providers and patients, which were analysed using approaches drawn from grounded theory. Our findings suggest that rather than seeing the ritualised aspects of clinic activities as merely traditional elements of care that potentially interfere with the application of good practice, it is essential to understand their symbolic values if their contribution to health care organisation is to be recognised. While both staff and patients participate in these rituals, these performances do not demonstrate or facilitate cohesion across these groups but rather embody the conflicting values of patients and staff in these clinics. As such, rituals act to reinforce asymmetrical relations of power between different constituencies, and to strengthen conventional modes of provider–patient interaction.

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Introduction

This paper concerns the organisation of work in primary health clinics in Cape Town, South Africa that deliver care for tuberculosis (TB). It explores the usefulness of considering two rather different elements of organisation – Directly Observed Treatment (DOT) for TB patients and morning prayers in the clinic – as rituals. DOT is the practice recommended by the WHO in which TB treatment taking is observed for the full duration of treatment – usually six months or more – by a health care provider or someone nominated by the patient and the provider to take on this role (WHO, 2002). The development and implementation of DOT, and the wider TB control strategy in which it is embedded, have been described extensively elsewhere (Ogden, Walt, & Lush, 2003; Raviglione & Pio, 2002; Volmink, Matchaba, & Garner, 2000; Walt, 1999). Supporters of DOT have argued that it is required to ‘protect’ the limited set of TB drugs from the growth of drug resistance,1 and that it needs to be seen as just one component of a larger TB control strategy (Ogden et al., 2003). By exploring the symbolic content of DOT and morning prayers in the clinic, we aim to contribute to an explanation of seemingly ‘non-rational’ behaviours in health care work.

In studying care organisation in this setting, we were struck by reports from clinic nurses that TB patients, on hearing that their six months of DOT was complete, sometimes asked whether they could continue attending the clinic until the week ended. That patients would want to prolong what, for many, was a burdensome treatment regimen was unusual. Why might TB patients want to persist with DOT treatment for a week after it was complete, and in so doing, extend their clinic attendance? To explore this unusual practice, we undertook an ethnography in which we observed for the full duration of treatment – usually six months or more – in two of the seven clinics in the study. To understand the ritualisation of DOT and morning prayers in the clinic, we analyse data from interviews and group discussions with providers and patients. To provide a context for the ritualisation of DOT and morning prayers, we review the formal and policy-driven element of care: directly observed therapy for tuberculosis patients. The second is an informal ritual, seemingly separate from the clinical work of the team: morning prayers in the clinic. We draw on data from an ethnography in which seven clinics providing care to people with tuberculosis were theoretically sampled for study. These data include participant observation of clinic sessions, and interviews and group discussions with providers and patients, which were analysed using approaches drawn from grounded theory. Our findings suggest that rather than seeing the ritualised aspects of clinic activities as merely traditional elements of care that potentially interfere with the application of good practice, it is essential to understand their symbolic values if their contribution to health care organisation is to be recognised. While both staff and patients participate in these rituals, these performances do not demonstrate or facilitate cohesion across these groups but rather embody the conflicting values of patients and staff in these clinics. As such, rituals act to reinforce asymmetrical relations of power between different constituencies, and to strengthen conventional modes of provider–patient interaction.

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1 The use of a multi-drug treatment regime helps to ensure that if the tuberculosis bacillus becomes resistant to one of the drugs, it will be eliminated by one of the other drugs, thereby helping to reduce the overall development of resistance. Resistance is problematic because of the relatively limited number of effective TB drugs; the difficulties, in terms of length of treatment, mode of treatment delivery (injection), and costs of treating multi-drug resistant cases; and the danger of multi-drug resistant strains spreading in the community.
daily clinic visit to receive treatment suggested that DOT had become an integral part of their routine. Yet its completion – a significant event – went apparently unmarked. Staff would record the patient’s completion of treatment into the TB register but, for the patient, there was no ritual marker of their reintegration into the social body (Van Gennep, 1960). Health care settings are replete with ritual, from the organisation of surgery in the operating theatre (Katz, 1981), to ward rounds (Strange, 1996), patient clerking and the traditional return of a patient’s ‘normal’ clothes to mark the end of an inpatient stay. Yet, at a point when some ritual might be expected, these patients were left seeking a natural end point, the weekend, to mark their new status as ‘healthy’.

The puzzle of this ‘missing ritual’ raised a more general question of the functions served by the unusual procedure of DOT for both TB patients and health care providers. Why are TB patients in particular treated in this way? Although DOT is now commonplace within TB programmes, there are clearly other ways in which treatment delivery could be organised. Following from McCreery’s study of meaning in therapeutic ritual, we address two key questions: “What are the possible meanings of this [ritual] work? What is the audience to which it is addressed and the situation to which it speaks?” (McCreery, 1979, p. 70) Because the care of TB patients includes a set of highly standardised and detailed procedures, some of which are of proven efficacy (Volmink & Garner, 2007), this care presents an interesting opportunity to examine the role of ritual in the management of a common infectious disease. To illuminate the possible meanings of ritualised activity in this context, we also draw on data on a more obvious ritual in the clinic – that of morning prayers. We suggest that examining the symbolic meanings of these two contrasting work practices contributes to understanding the ways in which care is achieved (or not) in formal health settings.

**Accounting for rituals in health care**

The term ‘ritual’ has been used in multiple ways (Douglas, 1966; Katz, 1981; McCreery, 1979; Turner, 1969), and the growing body of literature on the role of ritual or ritualised practice in nursing work (Chapman, 1983; Holland, 1993; Strange, 1996; Wolf, 1988) draws on a range of theoretical starting points. First, the term ‘ritual’ has been used atheoretically by some commentators, to merely differentiate those practices that have a good ‘evidence base’ from those that do not, characterising the latter as ‘traditional’ practices, or ‘rituals’. Such ‘rituals’ are cited as reducing the effectiveness of nursing care (Walsh & Ford, 1989). Thomson, for instance, notes: “Ritualistic practices have long stood in the way of effective infection control” (Thomson, 1999, cited in Strange (1996, p. 106)). Within this perspective, a ritual has no meaning, being merely an obstacle to greater efficiency rather than a theoretical tool for understanding nursing work.

Others have drawn on social science literature to explore the meanings of ritual. From a functionalist perspective, ritual has been seen as serving: psychological, social and protective functions; the identification of values and rules; and the negotiation of power (Bell, 1992; Helman, 2000; Strange, 1996). From Van Gennep (1960 [1909]) onwards, there has been a particular interest in rituals of transition, and their functions in helping to ameliorate and control danger and anxiety related to changes of state or to a lack of clarity in classifying a category or state. This has been of particular interest in health care, with a focus on how health providers, in their day-to-day work, cope with uncertainties of diagnosis and management and how patients manage the transition between illness and wellness (Helman, 2000). Rituals provide boundaries to categories in the context of transition, for example, between being ‘well’ and being diagnosed with TB, thus allowing social actors, such as health care providers, family and friends, to respond appropriately (Katz, 1981). Ritual therefore entrenches, through performance, categories created within biomedicine, such as ‘sick’ and ‘well’, ‘adherent’ and ‘non-adherent’.

In nursing, one functionalist argument draws on psychoanalytic theory to identify the functions of ritual for individual health care workers, proposing that it is through unconscious defence mechanisms that individuals deal with painful or difficult feelings, such as fear or loathing, that may harm the self (Lupton, 1997). This perspective suggests that providers may experience difficult, even conflictual, feelings as a result of patients’ emotional expectations and direct contact with patients’ bodies (Menzies-Lyth, 1986; Ohbolzer & Roberts, 1994; Skogstad, 1997; van der Walt & Swartz, 2000), arousing deep anxieties that may be too difficult to consciously examine (such as helplessness in the face of inability to cure). Psychoanalytic approaches go on to note that ritualistic defensive techniques on both individual and collective levels may protect against these anxieties (Chapman, 1983; Skogstad, 1997).

More sociologically, rituals in nursing work can be seen as having social functions. Turner’s definition of rituals as “dramas of social events which emphasize the importance of the event they symbolize or represent” (Turner, 1969, p. 59) emphasises rituals as performances that enact and institutionalise culturally constructed categories. Thus, in health care, ritual practice is not only used as a defence against anxiety, but also for social effect, creating and reflecting cultural values regarding the treatment of the sick (Chapman, 1983). Rituals are essential to healing itself, especially in terms of reintegrating the ‘sick’ person into the ‘healthy’ social body. For example, the discharge of a patient from hospital involves returning their civilian clothes, indicating that they may rejoin the world of the ‘healthy’. Ritual may also be used to maintain boundaries between states, such as dangerous or safe, sterile and non-sterile. This reduces uncertainty and increases the autonomy of actors by indicating clearly which states are operative at any particular time (Katz, 1981, p. 336).

Much work on the social role of rituals assumes that they act to unite a homogenous group, with all those participating sharing values and meanings, as expressed in the enactment and symbols of the ritual (Baumann, 1992). For Leach (1976), for instance, the key aspect of ritual is that there is no separation between performer and audience. Such assumptions of homogeneity are problematic in modern health care organisations, in which different constituencies (of staff groups, of patients) may not subscribe to the same set of meanings. More recent work on ritual has highlighted these potential conflicts. Drawing on the work of Durkheim, Baumann, for instance, argues that rituals may be “performed by competing constituencies” (Baumann, 1992, p. 99) with different relationships to the performance, symbols and meaning of the rituals. Rather than being limited to “insiders”, participants in rituals in plural societies may include a range of outsiders with these different parties “each using symbolic forms to stake mutual claims” (p. 101) through the enactment of the ritual. Ritual, Baumann suggests, is therefore a platform for defining and negotiating relationships with others. This paper takes this approach as a starting point, to explore how ritualised practices in primary care clinics may embody and entrench power relations, being potentially functional for some constituencies while being dysfunctional for others.

**Methods and setting**

This study formed part of a larger ethnographic study of the impact of clinical organisation on professional responses to change in primary health care clinics in Cape Town (Lewin, 2004). The setting was urban and peri-urban municipal primary health clinics within the Cape Town metropolitan area that deliver care to TB patients. The size, patient load and staff complement of these clinics ranged...
from small ‘satellite’ clinics to very large clinics seeing over one hundred clients per day. All employed a mix of nursing cadres as well as additional nursing assistants, administrative staff and cleaners. The larger clinics may have a health educator and sessional doctors, social workers and pharmacists.

A ‘theoretical sampling’ approach was used to select clinics for study (Glaser & Strauss, 1967), taking into account issues such as staff mix, patient load and the ethnic group served by the clinics. Four clinics were studied in depth (in this paper called Tortoise Lane, Old Oak, Hilltop and New Township), while three others were studied in less detail (Windy Plains, Steady Village and Border’s Edge). New Township, Hilltop and Windy Plains were large, relatively new clinics serving extensive ‘black’ townships on the periphery of Cape Town and largely staffed by ‘African’ Xhosa-speaking nurses. Old Oak was a large, well-established clinic serving a historically ‘coloured’ or ‘mixed-race’ residential area and largely staffed by ‘mixed-race’ nurses. In contrast, Tortoise Lane was based in a busy business district, drew clients from a wide range of areas and was staffed by nurses with a wide range of socio-cultural backgrounds. Both Border’s Edge and Steady Village were smaller clinics serving the rapidly developing townships of low cost housing further from the city centre and staffed by ‘mixed-race’ nurses. For the most part, the clients of all these clinics were poor and many were unemployed.

Data were collected over two years, from 1999 to 2001, by the first author (SL) and two research assistants. Fieldwork included around 120 h of participant observation of clinic sessions; formal individual in-depth interviews (n = 21) and group discussions (n = 8) with staff; and informal interviews with staff. All formal interviews and group discussions were taped, transcribed and translated from Xhosa into English where appropriate. A number of interviews and group discussions were undertaken along with clinic observations and a large number of provider–client interactions were observed. Data were generated using an iterative and inductive approach, with analysis of the initial data collected informing later data collection strategies.

Analysis was guided by elements from the grounded theory approach (Strauss & Corbin, 1990). Field notes and interviews were examined as one body of data and indexed into categories. ‘Open’ coding resulted in a re-ordering of data as thematic links between sections of data became evident. Interpretive hypotheses were cross-checked against the data and deviant cases sought. The notion of ritual, as developed in the sociological and anthropological literatures, was then used as a conceptual tool to link observed micro-level practices with the broader patterns of work organisation. So, while the conceptual categories emerged from the data, they were subsequently framed within relevant theoretical perspectives and linked to the work of others. For each key category, data extracts were identified on the basis of being representative and/or interesting illustrations of that category.

Ethical approval for the study was granted by Medical Research Council of South Africa and the London School of Hygiene and Tropical Medicine. Municipal health department managers in Cape Town also gave their permission to conduct the study. Each clinic was asked to consent to participation and clinic staff gave written or verbal consent for all individual and group interviews.

Ritual in the primary health clinic

The DOT ritual: its functions within the clinic

International TB policy suggests that the swallowing of all 130 doses of TB drugs by the patient, in the case of new patients, should be supervised either by a health worker or by a community or family member or work colleague nominated by the patient and the health provider for this purpose. For retreatment patients, the number of doses is higher as treatment is continued for eight months. That TB patients, along with substance users and people suffering from leprosy, have been singled out for the ‘supervised consumption’ of medication is unlikely to be coincidental. All are stigmatised groups, with little power within the health system or society at large (Cross, 2006; Munro et al., 2007; Room, 2005). With small local variations in procedure, the key features of DOT remained constant across all the clinics studied. Hilltop was typical:

At 8.40am the staff begin dispensing DOT. There are about eight patients waiting, including one child and one woman. One of the patients looks very thin and weak. Most of the [TB] patients look very poor – even poorer than those in the clinic as a whole. All the patients come into the DOT/TB room and sit on chairs against the wall, facing the desk where one of the nurses is seated...the nurse...counts out the pills for each patient on DOT, which they swallow in her presence, having helped themselves to water from the tap. [Clinic Observation – Hilltop]

At the start of treatment, the patient and nurse decided where the patient should best receive DOT. The majority of patients opted for clinic-based supervision. The procedure for daily clinic-based DOT was as follows: referring to the patient’s treatment card, the nurse counted out the daily batch of pills for each patient into a small cup labelled with the patient’s name. Most patients on clinic-based DOT visited the clinic just after it opened in the morning. They went straight to the treatment room where the cups of pills were waiting. A member of the clinic staff was assigned to observe the pills being swallowed. She usually greeted the patients and gave the patient her cup of pills. The patient then swallowed the tablets under supervision and left the clinic. If the observing staff member had time, she spoke briefly to the patient. Often, however, the treatment room was very busy and conversation with the patient was not possible. Direct observation was often conducted by a non-clinical member of staff, such as the cleaner or a clerk, either because patients arrived before the clinical staff (officially) began their shift or because they were engaged in other tasks. After the patient had taken the pills, the attendant recorded this in the patient record.

Patients defaulting from this daily regimen were usually questioned by the professional clinic staff on their next visit. These discussions often involved the provider chastising the patient for his or her non-adherence; highlighting the patient’s lack of responsibility for his or her own health; and demanding better performance. One staff nurse, who had worked at Old Oak clinic for many years, noted:

I like doing TB, but you can’t do TB for a year. After nine months it becomes very frustrating. Sometimes you have to give patients a scolding because of defaulting...[ ]...Some of the patients really get to you. The same old patients from last year. [staff nurse – Old Oak]

Some providers attempted to focus their interactions with patients on barriers to treatment completion and how these might be overcome. However, such exchanges were the exception rather than the rule.

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1. Under apartheid, the Population Registration Act classified South Africa’s population as ‘African’, ‘coloured’, ‘mixed race’, ‘Indian’ or ‘white’. These categories are used in this paper as, although the structures of apartheid have been dismantled, this classification has had, and continues to have, profound effects on socio-economic conditions, the provision of health services and health status. The use of these categories is not intended in any way to legitimise or support the notion of genetically distinct race groups. The term ‘black’ is used to refer to those designated, under apartheid legislation, as ‘African’, ‘coloured’ or ‘Indian’.
Symptoms of TB rapidly improve during the first two to three weeks of therapy and patients usually report feeling much better after one month. However, in order to be effective, treatment needs to be continued for the full six month period. The management of TB therefore parallels that of many chronic illnesses, such as hypertension, in that patients are expected to continue therapy despite feeling physically well. The rationale for DOT is that it ensures patients complete their course of therapy, maximising the chance of cure and reducing the risk of drug resistance. DOT is also portrayed, on paper, as an opportunity for the health worker to provide support to the patient (WHO, 2002). Patient support and treatment completion are important goals, but considerable research evidence suggests that DOT does not fulfil these aims (Ogden, 1999; Volmink & Garner, 2007). If not clinical effectiveness, what, then, is the function of DOT within the primary health clinic? Is it meaningful at the symbolic level, and if so, for which of its different constituencies?

DOT is clearly ‘ritualised activity’, in that there are formalised arrangements of objects, people, bodies and spaces which ‘trigger the perception that these practices are distinct and the associations that they engender are special’ (Bell, 1992, p. 220). DOT involves specific and specialised ‘personnel’ – the health care provider and the TB patient – both of whom are assigned specific roles and follow a largely predefined series of steps or tasks during their interactions. The interactions often involve several patients and take place within a designated space to which public access is restricted. The interaction also involves a range of objects used largely in this activity alone, such as the cups of pills labelled with each patient’s name and the TB treatment supervision card. We suggest, however, that DOT is more than ritualised activity. It derives its significance as ‘ritual’ from its symbolic meanings, evident in the ways it produces and reproduces relations of power between patients and providers: first, through the medicalisation of the illness to create a sustainable ‘sick role’, and second, through constructing the patient as a passive, non-trustworthy recipient of care in need of monitoring and control.

Having received a diagnosis of TB, the patient is cast into the sick role, with a responsibility to follow the prescribed treatment of the health provider and to endeavour to become ‘well’ (Parsons, 1951). In the early stages of treatment, ongoing symptoms reinforce the provider’s message that this is a serious ailment requiring careful treatment and supervision. As the patient’s health improves, however, it becomes less clear that the sick role is appropriate. The illness is resolved, and she may now wish to shed the sick role and resume a normal life. However, this is not possible as patients are expected to return daily to the clinic for treatment for the full six months if they are to be cured. This ambiguous period of transition between resolution of illness and cure, in which the patient no longer feels ill but still harbours TB bacilli, is dangerous for the health care system in that patients may fail to attend the clinic for weeks of therapy and patients usually report feeling much better after one month. However, in order to be effective, treatment needs to be continued for the full six month period. The management of TB therefore parallels that of many chronic illnesses, such as hypertension, in that patients are expected to continue therapy despite feeling physically well. The rationale for DOT is that it ensures patients complete their course of therapy, maximising the chance of cure and reducing the risk of drug resistance. DOT is also portrayed, on paper, as an opportunity for the health worker to provide support to the patient (WHO, 2002). Patient support and treatment completion are important goals, but considerable research evidence suggests that DOT does not fulfil these aims (Ogden, 1999; Volmink & Garner, 2007). If not clinical effectiveness, what, then, is the function of DOT within the primary health clinic? Is it meaningful at the symbolic level, and if so, for which of its different constituencies?

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…I try to be at the same level as the patient and not talk down to them. Then it’s a pleasure for them to come to the clinic. [professional nurse – Old Oak]

If there were lots of patients in the clinic and I am new. I told them finally that they must sit down and I will call them. They were all crowding around. You don’t want to come across too aggressively, but you want to show that you are in control. You have to make them understand that there are boundaries and they have to respect those. I realised that this is my clinic and this has to be safe to me. [professional nurse – Old Oak]

If DOT is in part a ritual to sustain the sick role, one might expect it to include an element to indicate the end of illness and the reintegration of the patient into society. Interestingly, this was not found. For providers, treatment completion is marked by entering the words ‘cured’ or ‘treatment completed’ into the official TB Register. For patients, treatment is merely stopped from one day to the next. The absence of any form of closure suggests a flawed ritual, which fails to give meaning to the illness or to shape the boundaries between disease and cure.

The second set of symbolic meanings of DOT relates to the ways it functions to construct the patient as a passive, non-trustworthy recipient of care in need of monitoring and control. Health care providers had ambivalent feelings towards TB patients. On the one hand, they expressed a need for more ‘patient centred’ care, even if this was difficult to enact within the clinic:

There’s something about the TB patient – I don’t really trust them. We watch them swallow their tablets. If not, they can put it in their pockets. [staff nurse – Old Oak]

Must have all eyes on the patient during the TB session. That to me is very important. [senior professional nurse – Old Oak]

Beyond the desire to monitor patients, all cadres of nurses expressed concern about the problem of ‘control’. This was an immediate issue for them in terms of controlling the physical bodies of patients within the clinic:

…there were lots of patients in the clinic and I am new. I told them finally that they must sit down and I will call them. They were all crowding around. You don’t want to come across too aggressively, but you want to show that you are in control. You have to make them understand that there are boundaries and they have to respect those. I realised that this is my clinic and this has to be safe to me. [professional nurse – Old Oak]

It also referred to the more general problem of control of bodies within the community:

…some patients should be admitted [to hospital] to ensure compliance, but they refuse. As a health worker, you don’t have any control over that. [nurse – Tortoise Lane]

Although professing to provide patient support, DOT is, then, largely orientated towards control of patients and their bodies, and the suppression of resistance to the treatment regimen. This desire for control at the clinic level mirrors in many ways the public health policies of ‘TB control’ at management level. Others have suggested that, in the case of TB care, the desire to control the spread of the TB
bacillus has extended to a desire to control the person in whom the bacillus is resident (Ogden, 2000; van der Walt, 1998). The more stringent the control of the patient, the more likely control of the bacillus will be achieved. DOT sanctions the surveillance and disciplining of patients who, through ‘ignorance’ and ‘poverty’, have contracted TB. They are belittled by a ritual that emphasises their dependency and disempowerment and the need for them to accept the moral authority of health care professionals. Furthermore, patients who do not adhere to TB therapy are constructed as being to blame for their own illness. This scapegoating places the accountability for treatment failure on the patient rather than on the disempowering rituals enacted within the primary care system or the deeper structural issues such as poverty and migration which have contributed to disease spread and to poor treatment adherence (Munro et al., 2007). DOT therefore juxtaposes professional authority with patient disempowerment, constructing and maintaining the micro-level power relations within the provider-patient interaction in which patients are subordinated and in which the patient’s body is the centre of both control and resistance. Studies from other spheres of health care delivery in South Africa have identified similar difficulties in relationships between nurses and patients (Jewkes, Abrahams, & Mvo, 1998; Kim & Motsei, 2002), perhaps suggesting that poor nurse attitudes to patients extend beyond care for people with TB.

Patients, of course, do not necessarily subscribe to norms of obedience to medical authority embodied in DOT, seeing instead the ritual as inappropriate or humiliating (van der Walt et al., 1999). Turner suggests that, “By exposing their ill-feeling in a ritual context to beneficial ritual forces, individuals are purged of rebellious wishes and emotions and willingly conform once more to the context to beneficial ritual forces, individuals are purged of rebellious wishes and emotions and willingly conform once more to the ritual as inappropriate or humiliating (van der Walt et al., 1999).” Patients may have the opposite effect from that originally intended. DOT, as a ritual, therefore has potentially conflicting symbolic meanings to the different constituencies who participate in it. The performance of DOT is functional for health care providers and the health care system as, at the micro-level, it allows control to be asserted over patients and the medicalisation of illness to be sustained. At the macro-level, it allows providers to adhere to international policies for TB control. In this, the DOT ritual may speak as much to the local constituency – health care providers and managers – as to the more distant constituency of national and international policy makers. On the other hand, the ritual is dysfunctional for patients in that it does not sufficiently incorporate their values and beliefs, or address their need for empathy and support nor their likely perception of their own progress in being ‘cured’. The failure of DOT, as a ritual, to engage patients in a way that allows them to manage their transition to ‘wellness’, instead of potentially prompting their resistance to treatment, may be one of the major failings of the current system of TB care.

Morning prayers in the clinic: breaching the boundaries?

A contrasting ritual activity was morning prayers, which were observed in clinics in Xhosa-speaking areas. These clinics, largely staffed by Xhosa-speaking nurses, served clients who mainly belonged to a range of Christian denominations. Here staff and clients therefore shared more cultural resources than was the case in the other settings of this study. Morning prayers are a long established part of clinic practice in many parts of South Africa. As Marks and others have noted (Marks, 1994; Stein, Lewin, & Fairall, 2007; Sweet, 2004), nursing, and biomedicine more broadly, are closely associated with Christian belief systems in the country. However, the ways in which these connections play out in the day-to-day provision of care is little described or analysed from a sociological perspective. Although not a formal part of health care provision, and at first sight more inclusive than DOT, prayers too enacted and facilitated power relations within the clinic. At Hilltop clinic, staff led patients in prayer every morning before starting clinical work:

At 8.25am the clinic staff start morning prayers. They stand at the front of the clinic waiting area, facing the rows of clients, and lead the waiting clients in a hymn, the Lord's Prayer, and a second hymn. Everyone in the clinic stands, and almost all of the clients participate in the singing. [Observation – Hilltop]

These prayers lasted approximately 10 minutes and had a solemnity and restfulness which contrasted with the usual hurly-burly of the clinic. Although the clinic prayers could be led by staff or patients, they were usually initiated by the staff. Nurses indicated that many gatherings in the Xhosa-speaking community routinely began with prayers, including meetings at schools and clinics. From the staff perspective, prayers served a number of explicit functions. One of the nurses noted that the morning prayers helped the staff to relax before they started work, so that they could face the day. She also suggested that the prayers drew patients and staff together and reinforced the idea that everyone in the clinic was human and should be treated as such. Another nurse explained that prayers allowed patients to “open up” to staff as, “If I [the patient] prayed with so-and-so, they can’t be that bad’” [nurse trainer – 7/6/01]. In the view of some staff, the prayers, as a shared activity, facilitated communication with their clients in a setting in which there were few opportunities to release emotion and establish rapport (Dick & Pekeur, 1995; Jewkes et al., 1998). Prayers were, then, a form of emotional labour (James, 1992) in that they provided for the sharing and management of feelings between providers and patients. During this process the clinic staff acted as ‘priests’, albeit unofficially and temporarily. Although their roles as clinicians and managers were temporarily suspended, the hierarchy of provider (priest)–patient (congregant) was maintained.

On a symbolic level, however, prayers enacted some key tensions between different ritual constituencies, through the apparent breaching, but in a limited and controlled way, of three key boundaries. The first was the separation between the clinic – and the cultural ‘world’ of biomedicine – and the broader community in which the clinic is located. The presence of prayer introduced elements of the community’s world into the medical world and thereby acted to emphasise the clinic’s location within a particular socio-cultural setting and to provide a bridge between these two worlds. By participating in the prayers, both patients and providers exposed and shared a part of their private (non-medical) selves. Patients were also allowed to ‘see’ an aspect of providers which they would otherwise not usually be able to observe. However, this breaching was limited and controlled, in that the ritual took place in separate time, before the official start of clinical work. As others have noted in this setting, nurses may attempt to limit their emotional relationships with clients. This may occur particularly where nurses’ clients are very similar to themselves and therefore act to undermine nurses’ feelings of being safe from these diseases of poverty (van der Walt & Swartz, 2000).

The second partial breach is that of the normal relationship between professional and client. Prayers in which both patients and staff actively contribute, rather than one being the recipient of the ministrations of the other, provided a mechanism for displaying unity across the typically hierarchical nurse–client relationship in this and other settings. However, this brief display of unity did not significantly challenge the underlying power relations in normal ‘clinic time’.
Thirdly, introducing a spiritual element into daily work breached the boundary of 'scientific' biomedical practice, indicating to both staff and patients that care and healing are not simply rational processes amenable to health care intervention. The prayers suggested that there were other forces operating to which both patients and staff might appeal, in their respective roles as 'healers' and the 'sick'. Morning prayers cast the staff into the role of healers in a broader sense, both spiritual and physical, emphasising that they were responsible for the physical and spiritual health of their clients. In some ways, this resembled more traditional forms of healing which do not routinely separate the physical from the spiritual, as is typically the case in Western biomedicine, and act to both treat illness and reduce the tensions brought on by it. However, the use of Christian prayer in the clinics also echoed the historical role played by nurses in South Africa in bringing 'enlightenment' to what were seen as heathen, diseased communities (Marks, 1994). The use of prayer in conjunction with the delivery of nursing care therefore also reinforced the links between Western biomedicine, and the scientific and moral superiority it claims, and the godliness and order of 'Christian civilisation'. It acts, if subtly, to marginalise more traditional health systems.

In the example of prayers there appeared, then, to be more cohesion and continuity between the different constituencies to the ritual – that is, patients and providers – than was the case for DOT. Prayers spoke to a single congregation of both clients and providers, for whom this ritual had shared symbolic content. The ritual was not generated from within the world of biomedicine, from which non-professionals are largely excluded, except as patients. Rather, it was generated from the world of religion, where patients and professionals could participate, on apparently equal terms. However, the separation in time between 'prayers' and clinical work demonstrates the limits of this equality. As ritual, the prayers reproduce relations of power in the clinic rather than challenge the roles of providers and clients. Prayers also embody the tensions experienced by nursing staff, who are simultaneously apart from and part of the community they serve (and of course potentially also patients) and thus anxious to establish boundaries for control.

**Discussion**

This paper provides insights into two areas that have been under-explored – the roles of ritual within TB care, and the more general issue of the organisation of nursing work in middle- and low-income settings. DOT is used worldwide as part of the management strategy for TB, although its form varies from setting to setting (Volmink et al., 2000). The use of DOT does not appear, in Cape Town at least, to achieve its aim of improving adherence to TB treatment and, indeed, research evidence suggests that it is unlikely to do so (Munro et al., 2007; Volmink & Garner, 2007). For many health care professionals within the TB programme in South Africa, the national goal of 85% cure rates may therefore seem unachievable. Unfeasible goals, it has been suggested, may create boundaries for control. DOT reinforces traditional modes of interaction in which the patient accepts the 'sick role', and relinquishes responsibility for the management of therapy to the health care professional. The patient's role is confined to becoming well (Parsons, 1951). That the DOT ritual usually fails to include any form of closure for patients – an issue that they seem to see as important – illustrates its limitations in assisting patients in coping with their illness and its focus on the needs of the health system.

Much of the work on ritual in nursing and health care has assumed, at least implicitly, a functionalist perspective. Ritual is seen as serving particular social or psychological purposes, with all those participating sharing the values and meanings of these performances. We argue here that the constituencies to a ritual performance do not necessarily share a common relationship to its symbols and meanings. Indeed, in this case the DOT ritual acts to divide health care providers from patients. Unlike providers, who appear to 'buy-in' to the DOT ritual, many patients resist participation. The most obvious form of resistance is a refusal to subject their bodies and persons to this form of control. That absenting themselves from treatment is one of the very few avenues of resistance available to patients is unfortunate, given the repercussions on individual wellbeing and the ways in which their resistance is seen by providers to confirm their view of patients as irresponsible and non-compliant. In contrast, participants in the prayer ritual seemed to share a common relationship to its symbols and meanings. Here too, however, ritual was used to circumscribe the limits to this common bond, separating it from 'clinical' relationships and underlining the co-option of religious symbolism to medical power. Prayer rituals may therefore act to maintain the distancing by providers of clients by reinforcing how any bond that nurses and their clients share in the wider social world is constrained within the world of the clinic.

The public rituals described here are concerned with shaping relationships with others – in this case providers and patients – who form the constituencies to the ritual performance. Their reasons for participating; the meanings that they bring to these rituals; and their responses to them reflect the position of their constituency, both within biomedicine and the wider community in which these clinics are situated. There are, of course, other approaches to understanding the roles of ritual activities and the meanings that these communicate within health care (Bell, 1997). However, by considering the meanings that different constituencies bring to ritual performances, we show how DOT can be functional for health care providers, in reinforcing relations of power with patients. Simultaneously, DOT can be dysfunctional for patients, in that it attempts to render them as passive subjects of health care. Rather than uniting patients and providers in the treatment of disease, DOT highlights the differences between their viewpoints of those participating in it.

There is growing evidence that the asymmetrical power relations of health care encounters are being challenged by both consumers and providers (Brown, 1999; Farrell, 2004). In many settings health care is shifting towards models of shared decision making and patient centredness (Clive, Granby, & Picton, 2007; van der Weijden, van Veenendaal, & Timmermans, 2007). This is reflected to a limited extent within the field of TB care (Macq, Torfoss, & Getahun, 2007). In general, however, it remains one of the few areas of health care where this asymmetry continues to be actively promoted both explicitly in policies and implicitly through the symbolic content of these policies. This can be contrasted with the rollout of highly active anti-retroviral treatment (HAART) in South Africa and other low- and middle-income country settings. For example, the South African government's national plan for the treatment of HIV and AIDS notes that, "specific education or drug-readiness training is essential to provide the knowledge to enable individuals to take ownership of their own health" (p. 73). It also suggests that providers need to "negotiate a treatment plan that the patient can understand and to which he/she commits" (p. 73) (National Department of Health, 2003). Findings from a recent
study of nurses’ views on HAART implementation in South Africa appear to reinforce these differences between the TB and HAART programmes, highlighting the strong engagement of nurses with people living with HIV and AIDS and nurses’ strong desire to be able to offer a patient centred approach to treatment (Stein et al., 2007). Similar views have been described in other studies (Rajaraman & Palmer, 2008). A number of factors may account for these differences between the HAART and TB programmes. These include the very large number of people who have died from AIDS; the politi- cisation of the government’s response to the epidemic in South Africa; and the fact that most health care providers have experi- enced HIV and AIDS in their household or social group, which is not the case for TB.

We would argue that efforts to change professional practice in TB, for example to make it more ‘patient centred’, need to engage with the symbolic level of clinic ritualised practices, as well as with the more usual concerns of the clinical and public health evidence base for practice. Viewing ritual simply as an impediment to evidence based practice in nursing fails to acknowledge these symbolic functions and their importance in the construction of health and health care. Furthermore, by ignoring ritual in health care organisations, policy makers may inadvertently doom their change efforts to failure or, at best, partial success. Their efforts may result, as Douglas (1996) has suggested, in one ritual simply being replaced by another that embodies similar power relations.

It is not clear how generalisable the findings presented here are to TB care in other settings or, indeed, to care for other health problems. It seems likely, however, that the findings would be widely applicable in South African settings that share a similar organisation of care (Oskowitz, Schneider, & Hlatshwayo, 1997; Petersen, 2000). Further, we acknowledge that patient–provider relations, and the rituals and structures that construct them, are only several of many factors impacting on treatment adherence. We do not intend to suggest that addressing the one component discussed here might result in measurable improvements in adherence in TB care. However, turning a sociological lens on the current patterns of care with a view to unpacking the less obvious mean- ings of these organisational behaviours does suggest that interven- tions relating to rituals of closure might be worth considering.

We started this paper with the observation that, in the study setting, there was no marker of the reintegration of patients into the healthy social body on the completion of their TB treatment. Given that ritual may be an important element of healing, it is possible to create rituals within TB care which are more responsive to both patient and staff needs over the course of therapy? Can rituals be established that create a sense of closure for patients who complete a long course of medical treatment and have to re-adjust to being well again? This applies not only to TB but also to a wide range of other chronic illnesses, and might include markers such as a certificate or a completion ceremony, organised by the health services, for people who complete successfully their course of TB treatment (Blumenfeld, de los Santos, Teoxon, Cruz, & Dizon, 1999), or other acknowledgements of patients’ progress through the treatment cycle. Such attempts to ‘engineer’ culture through creating rituals that speak to disparate constituencies are wide- spread within the so-called post-Fordist workplace (Ezzy, 2001; Manley, 1998). Even within health care, it has been suggested that rituals may be manipulated to make care more patient oriented and flexible (Brooks, 1996; Brooks & Brown, 2002). Our findings could be read as suggesting that any such interventions would need to have symbolic value to both the provider and patient constituencies and, possibly, to the policy-making constituency. There may, however, be difficulties with ‘engineering’ rituals that, on the one hand, do not act as a form of normative control and, on the other hand, speak symbolically to a wide range of groups. Rituals that genuinely embody the wide range of values of the constituencies involved in health care, foster empowerment and are therapeutic, may have to evolve rather than be specifically engineered. More research in this area, which draws on sociological analyses of work organisation, is needed.

References

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